



2015

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Recommended Citation

Frederick R. Parker Jr., *Law, Bioethics, and Medical Futility: Defining Patient Rights at the End of Life*, 37 U. ARK. LITTLE ROCK L. REV. 185 (2015).

Available at: <https://lawrepository.ualr.edu/lawreview/vol37/iss2/1>

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LAW, BIOETHICS, AND MEDICAL FUTILITY: DEFINING PATIENT RIGHTS AT THE END OF LIFE

*Frederick R. Parker, Jr.**

There are few greater disagreements than the meaning of life and death
J. Budziszewski¹

I. INTRODUCTION

As a matter of both law and bioethics, the general question concerning the existence of a patient's right either to accept or refuse care at the end of life has largely been resolved through a fairly consistent body of jurisprudence, statutory schemes, and pronouncements of professional ethics, all of which recognize the fundamental nature of the right to refuse treatment in the abstract.² Notwithstanding the broad-based recognition of that right as a matter of principle, both the courts and the various state legislatures have struggled to define its boundaries, and issues on the periphery remain the topic of discourse among scholars and practitioners in the disciplines of law, medicine, and bioethics.³ This continuing discussion concerning the scope of the patient's right takes place primarily at the margin between life and death, where physicians, lawyers, and moral philosophers find it most challenging to appropriately balance the competing interests of the individual in the exercise of autonomy and of the community at large in the preservation of life.⁴

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1. J. BUDZISZEWSKI, *WHAT WE CAN'T NOT KNOW* xxii (Ignatius Press 2011) (2003).

2. See generally ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* §§ 2.01–2.06, 7.01–7.03 (3rd ed. 2004). These issues initially arose when surrogates for permanently unconscious patients who did not satisfy the legal criteria for “whole brain death” began to refuse treatment that offered no reasonable hope of either restoring the patient's capacity or reversing the dying process. Perhaps the most widely cited United States Supreme Court case in this regard is *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). See also TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF MEDICAL BIOMEDICAL ETHICS* 170–81 (4th ed. 1994).

3. See generally MEISEL & CERMINARA, *supra* note 2, §§ 7.01–7.15.

4. See, e.g., *Betancourt v. Trinitas Hosp.*, 1 A.3d 823, 830 (N.J. Super. 2010) (“[T]he public has at least an equal, if not greater, interest in a patient's right to live than in a patient's right to die.”). The courts also have recognized countervailing state interests in preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third

Historically, the debate concerning life-sustaining treatment centered on the negative aspect of the patient's right either to withhold recommended treatment at the outset of care, or to withdraw treatment that already had been initiated.⁵ In contrast with the traditional view of this right as a negative one, the contemporary variant of the question asks whether the right to *refuse* recommended treatment necessarily encompasses the right to *compel* interventions that have not been offered, and, if so, what constraints might limit the exercise of that positive right.⁶

This aspect of the question finds expression in two principal forms. The first relates to the right of a permanently unconscious or otherwise severely and irreversibly incapacitated patient to compel the provision of treatment that would merely postpone the moment of death. The second reflects a nuanced application of the negative right to refuse one particular form of treatment by combining with it the positive right to demand another: under what circumstances might established principles of law and bioethics recognize the right of a terminally ill patient, not only to refuse artificial nutrition and hydration, but to be rendered unconscious and then maintained in that state without sustenance until death ensues?

At first blush, these questions might appear separate and unrelated: one bearing upon the limit of a patient's right *to demand* treatment that his physician considers futile as a restorative measure, and the other implicating the scope of the patient's right *to refuse* treatment that will prolong his life. It is submitted, however, that the responses to both questions are informed by identical principles of law and bioethics. Accordingly, this article focuses on those principles as common reference points to address the specific issues of (1) when should the law define treatment as so futile that the patient has no positive right to demand it, and (2) in any particular case where all available interventions are futile in that sense, under what circumstances should the law accord the patient a positive right to receive palliative care in the form of being sedated to unconsciousness, having exercised in advance the negative right to withhold or withdraw nutrition and hydration and thus pre-arrange death at a time of his choice.

The first of these issues relates to the right of a permanently incapacitated patient to have a surrogate speak on his behalf about the provision of treatment his physician considers to be medically futile. As a preliminary matter, therefore, it is appropriate first to consider the relevance of a patient's capacity to that question.

parties. See, e.g., *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985), and MEISEL & CERMINARA, *supra* note 2, § 2.01.

5. See generally MEISEL & CERMINARA, *supra* note 2, § 13.06.

6. *Id.*

II. MEDICAL FUTILITY AND THE SEVERELY INCAPACITATED PATIENT: THE RELEVANCE OF CAPACITY TO THE PHYSICIAN'S EXERCISE OF MEDICAL JUDGMENT AND THE PATIENT'S RIGHT TO SELF-DETERMINATION

Despite the significant volume of discourse and commentary on the matter, neither the various state legislatures, the courts, practicing physicians, nor bioethicists have been able to find any consensus on a meaningful definition of medical futility.⁷ As traditionally expressed, these questions are most commonly framed in the context of a physician's exercise of professional medical judgment when determining whether a proposed treatment regimen offers a meaningful physiological benefit under the specific circumstances of a patient's case.⁸ The more contemporary version of the futility debate goes beyond this fundamental issue and asks under what circumstances a physician may override a patient's request for treatment that is non-curative but nevertheless offers an identifiable, though temporary, physiological benefit.⁹

This contemporary expression of the futility issue most commonly arises when a surrogate insists on the indefinite continuation of artificial nutrition and hydration on behalf of a patient who has been diagnosed as

7. In general, it has been said that futility is not "a discrete and definable entity, [but] merely the end of the spectrum of therapies with very low efficacy." MEISEL & CERMINARA, *supra* note 2, § 13.03[B]. In the narrow sense, treatment would be considered futile if it lacks efficacy in terms of being able to accomplish the specific physiological objective for which it is sought. Physicians generally are regarded as having the professional prerogative to unilaterally withhold or withdraw such objectively futile clinical interventions, and to do so without the patient's consent. In a broader sense, however, futility has been described as "the inability to prolong life for a time," or the "inability to maintain an acceptable quality of life." *Id.* § 13.03[B]. The American Medical Association considers decisions about interventions that are not futile in an objective physiologic sense to be sufficiently value laden as to make them a matter of the patient's prerogative. *See, e.g.,* Code of Med. Ethics Op. 2.037, *Medical Futility in End-of-Life Care*, AM. MED. ASS'N (1997), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2037.page>.

8. One might expect this lack of consensus to become increasingly problematic as our population ages and as financial considerations increasingly constrain the provision of health care, making the issue likely to be both more common and more significant over time. *See* MEISEL & CERMINARA, *supra* note 2, § 13.09. According to Professor Meisel, the futility debate might be difficult to resolve because it "revolves around fundamentally irresolvable moral conflicts concerning our most deeply held beliefs about the value of life." *Id.* § 13.03 (quoting E. Haavi Morreim, *Profoundly Diminished Life: The Casualties of Coercion*, 24 HASTINGS CENTER REP. 33, 33 (1994)). It also has been suggested that the debate about medical futility will arise with increasing frequency as the scope of advance directives expands beyond their traditional purpose of expressing the patient's wishes concerning the withholding or withdrawal of life-sustaining treatment to directing the administration of treatment that physicians might consider to be futile. MEISEL & CERMINARA, *supra* note 2, § 7.01[B][3], § 13.09. *See also* Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 3-4 (2007).

9. Pope, *supra* note 8.

being in a persistent vegetative state, a state of permanent unconsciousness, or another such state of severe and irreversible incapacity.¹⁰ On occasion, for example, physicians have withdrawn nutrition and hydration from permanently unconscious patients after concluding that the continuation of treatment would merely (and indefinitely) prolong the patient's physical existence without offering any hope for his return to a sapient state. Physicians have withheld treatment in these cases unilaterally, and despite clear evidence that the patient would have wanted the treatment to continue under the circumstances, or in direct contravention of a clear direction to that effect by an authorized surrogate.¹¹

Some physicians would justify a unilateral decision to withdraw treatment in such cases as the legitimate exercise of medical judgment, and some courts would frame the question in that manner.¹² The logic of a focus on professional judgment breaks down, however, unless treatment also would be withdrawn from a similarly-situated patient who has a reasonable prospect of regaining consciousness. It could not be said that a professional custom of unilaterally withdrawing treatment only from permanently unconscious patients reflects the exercise of professional discretion concerning the efficacy of a procedure that a physician reasonably expects to prolong life. Rather, such a custom would appear to reflect the physician's value judgment concerning the right of severely incapacitated patients to accept or refuse treatment.¹³

Viewed in that light, it is submitted that the medical futility debate in its contemporary form raises questions that don't necessarily relate to the exercise of medical judgment or the circumstances under which treatment is futile (and thus beyond the scope of a physician's professional obligation to provide it). Rather, it compels us to consider whether there is something different about a patient with a severe cognitive impairment that qualifies his general right under the law of informed consent to have a surrogate speak on his behalf. Much of the tension in the debate about medical futility

10. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). Patients in a persistent vegetative state generally maintain sufficient brain stem function to enable them to breathe, digest food, and produce urine without assistance. They tend to experience cycles of sleep in which their eyes are closed and of awakening, in which their eyes are open. They might smile, utter unintelligible sounds, and move their eyes and limbs, though sporadically, and they might exhibit reflexive responses to physical stimuli by grimacing, coughing, or gagging, all of which give the appearance of consciousness when there is none. In contrast, persons in a coma are in a sleep-like state and exhibit no indications of consciousness. See, e.g., MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *HEALTH CARE LAW AND ETHICS* 530-31 (7th ed. 2007).

11. See e.g., *Causey v. St. Francis Med. Ctr.*, 30732, p. 5-7 (La. App. 2 Cir. 8/26/98); 719 So. 2d 1072, 1075-76.

12. *Id.*

13. *Id.*

arises more out of a fundamental conflict of visions concerning that issue than the respect to be accorded the exercise of medical judgment.

Some participants in this debate would resolve the futility question with reference to the traditional legal and ethical principles that have come to define the scope and durability of one's general right to accept or refuse medical treatment at the end of life.¹⁴ Increasingly, however, others are coming to question the relevance of those principles in the context of a patient who has no reasonable prospect of returning to a sapient existence, especially when the continued provision of care offers a prognosis for an extended physical life that may span years rather than mere hours or days. With respect to patients in a persistent vegetative state, for example, Peter Singer has said:

They are not self-conscious, rational, or autonomous, and so considerations of a right to life or of respecting autonomy do not apply. If they have no experiences at all, and can never have any again, their lives have no intrinsic value. Their life's journey has come to an end. They are biologically alive, but not biographically.¹⁵

One who adheres to this view would deny the relevance of principles concerning one's fundamental right of self-determination by simply denying that a permanently unconscious patient possesses such a right.

Others would argue that any human being should be defined as the subject of rights and intrinsic value by virtue of what he is, by nature, rather than with reference to any actual capacities he might possess at any point in time during his life.¹⁶ Adherents to this view would find it both illogical and unjust to define one's rights with reference to his state of consciousness:

To base the intrinsic value of a being on an accidental attribute—such as consciousness or the immediately exercisable capacity for consciousness—is to base a radical moral difference on a mere quantitative ontological difference. We treat beings who are subjects of rights radically differently from the way we treat other beings. The basis for that radical difference in treatment must be some radical difference in the different types of beings treated differently. Between any human being and a corpse or an aggregate of tissues and organs there *is* a radical difference. But the difference between a healthy, self-conscious human being and a human being incapacitated, even severely incapacitated, is only a difference in degree. It is unjust, then, to pick out such an accidental attribute as self-consciousness or the immediately exercisable capacity for self-consciousness and make that the criterion for whether someone should

14. See generally BEAUCHAMP & CHILDRESS, *supra* note 2, at 170.

15. PATRICK LEE & ROBERT P. GEORGE, *BODY-SELF DUALISM IN CONTEMPORARY ETHICS AND POLITICS* 152 (2008) (quoting PETER SINGER, *PRACTICAL ETHICS* (3rd. ed. 1993)).

16. *Id.* at 154–55.

be treated as a subject of rights or not. Thus, a human being is valuable as a subject of rights in virtue of what he or she is (a person, a subject with the basic nature capacity for conceptual thought and free choice even if he or she cannot right now actualize that basic capacity). And so a human being remains a subject of rights, someone who has a right not to be intentionally killed, for as long as he or she exists.¹⁷

It is submitted that established principles of both law and bioethics concerning the right of a patient to accept or refuse medical treatment implicitly reflect and rest upon this conclusion.¹⁸ For that reason, the arguments presented in this Article are premised upon the following assumptions:

1. Because biological life is essential and intrinsic to human personhood, a person comes into being not later than the time of his birth, by which time the human organism itself has been identified as a discrete biological entity that is “a whole . . . member of the species *homo sapiens*.”¹⁹

17. *Id.* at 155. A detailed discussion about the scientific and philosophical grounds for this perspective is presented in LEE & GEORGE, *supra* note 15. In short, a member of the species *castor canadensis*, without his tail, is still a beaver, a member of the species *sylvilagus floridanus*, without her ears, is still a bunny, and a member of the species *homo sapiens*, without his or her consciousness, is still a human being, and thus a “person” in the eyes of the law.

18. Advance directive statutes, by definition, rest on this premise. *See generally* BEAUCHAMP & CHILDRESS, *supra* note 2, at 170–81 (discussing surrogate decision-making, which rests on the fundamental rule of law that the right either to give or refuse consent to treatment survives incapacity, thus leaving for resolution only one’s preference under the circumstances).

19. LEE & GEORGE, *supra* note 15, at 122. Professors Lee and George ground this reasoning in the science of embryology, from which they conclude “the life of an individual human being begins with the joining of sperm and ovum, which yields a genetically and functionally distinct organism, possessing the resources and active disposition for internally directed development toward human maturity.” *Id.* at 118–19 (citing WILLIAM J. LARSEN, HUMAN EMBRYOLOGY (3rd ed. 2001); KEITH L. MOORE & T.V.N. PERSAUD, THE DEVELOPING HUMAN: CLINICALLY ORIENTED EMBRYOLOGY (7th ed. 2003); RONAN R. O’RAHILLY & FABIOLA MÜLLER, HUMAN EMBRYOLOGY AND TERATOLOGY (3rd ed. 2001); SCOTT F. GILBERT, DEVELOPMENTAL BIOLOGY (7th ed. 2003)). More specifically, they announce “three important points.” *Id.* at 120. First, they announce that the embryo, from its inception, is distinct from any cell of either the father or the mother, as reflected in the fact that “[i]ts growth is internally directed to its own survival and maturation, a distinct end from the survival and flourishing of the mother in whose body this distinct organism resides.” *Id.* Second, they announce that the embryo possesses the genetic composition of a human being. *Id.* Third, they announce that the embryo “is a *whole*, though obviously immature, human being.” *Id.*

Professors Lee and George distinguished the embryo as a separately identifiable organism from the gametes whose union brought it into existence by noting:

They are not only genetically but also functionally identifiable as parts of the male or female potential parents. Each has only half the genetic material needed to guide the development of an immature human toward full maturity, and none

2. A person ceases to exist only when the biological function of the human body is extinguished by death;

3. Every human person is, by definition, indistinguishable from his or her body, both the person and the bodily organism constituting but one and the same entity. Accordingly, a human person is a particular form of physical organism that integrates into one uniquely identifiable being both biological life and the kinds of things that persons, by nature, have the capacity to do. The person is an “embodied mind” or a “living bodily entity” rather than a consciousness that possesses or inhabits a body, or a series of conscious experiences. In short, one’s self, or person, is so inextricably identified with the human physical organism that we are essentially bodily beings,²⁰ and

4. Every human being is intrinsically valuable as a bearer of rights by virtue of what he or she is. Further, just as no human being can come to be and later acquire intrinsic value, so no human being can continue to be but lose the intrinsic value imputed to him or her as a subject of rights.²¹

of these cells will survive long. They clearly are destined either to combine with an ovum or sperm or to degenerate. Even when they succeed in causing fertilization, they do not survive; rather, their genetic (and cytoplasmic) material enters into the composition of a distinct, new organism.

Id. at 120–21. In contrast with the gametes, they state:

The human embryo, from beginning of fertilization onward, is fully programmed actively to develop himself or herself to the mature stage of a human being. And unless deprived of a suitable environment or prevented by accident or disease, this embryo *will* actively develop itself in its own distinct direction, toward its own survival and maturity. The direction of its growth is not extrinsically determined, but is in accord with the genetic information and cytoplasmic factors within it. The human embryo is, then, a whole (though immature) and distinct human organism—a human being.

Id. at 121.

20. LEE & GEORGE, *supra* note 15, at 132.

21. Professor Budziszewski relates the logic of attributing intrinsic value to all human beings.

To be a person is to be a proper subject of absolute regard—a “neighbor” in the sense of the Commandments—a being of the sort whom the Commandments are about. It is *persons* whom I am not to kill, *persons* whom I am to love as I love myself. But what is a person? If we accept the biblical revelation that man is the *imago Dei*, the image of God, then every human being is a person—a person by nature, a kind of thing different from any other kind, a being whose very existence is a kind of sacrament, a sign of God’s grace. Trying to understand man without recognizing him as the *imago Dei* is like trying to understand a bas-relief without recognizing it as a carving.

....

In contemporary secular ethics, the ruling tendency is to concede that there are such things as persons, but to define them in terms of their functions or capacities—not by what they *are*, . . . but by what they can *do*. . . . To give but a single well-known illustration, philosopher Mary Ann Warren defines “personhood” in terms of consciousness, reasoning, self-motivated activity, the capacity to communicate about indefinitely many topics, and conceptual self-awareness.

These premises are consistent with the longstanding recognition in American law that a patient's right to express either an informed consent or a knowing refusal concerning treatment is not conditioned upon a finding of capacity—rather, that right both arises and is extinguished with the patient's life.²²

III. DEFINING MEDICAL FUTILITY AS A MATTER OF LAW

The law of end of life decision making arose over the past 40 years primarily from two related developments: advances in forms of medical

If you can do all those things, you're a person; if you can't, you're not. The functional approach to personhood seems plausible at first, just because—at a certain state of development, and barring misfortune—most persons do have those functions. But Warren thinks persons *are* their functions

. . . [U]nborn babies are not capable of reasoning, complex communication, and so on. . . . If unborn babies may be killed because they lack these functions, then a great many other individuals may also be killed for the same reasons—for example, the asleep, unconscious, demented, addicted, and very young, not to mention sundry other cases such as deaf mutes who have not been taught sign language.

. . . [We need] to stop confusing what persons are with what they can typically do.

. . . [A functional definition is] appropriate for things that have no inherent nature, whose identity is dependent on our purposes and interests—things that do not intrinsically deserve to be regarded in a certain way, but which may be regarded in any way that is convenient. For example, suppose I am building an automobile and I need to keep two moving parts from touching each other. . . . Anything can be a spacer that fills the space The particular lump of matter I use to accomplish this purpose is not intrinsically a proper subject of absolute regard; my regard for it—even its very identity as a spacer—is relative to how I want to use it, or to what I find interesting about it.

By contrast, if I am a person, then I am by *nature* a rights-bearer, by *nature* a proper subject of absolute regard—not because of what I can do but because of what I am. Of course, this presupposes that I *have* a nature, a “what-I-am”, which is distinct from the present condition or state of development of what I am, distinct from my abilities in that condition or stage of development, and, in particular, distinct from how this condition, stage of development, or set of abilities might happen to be valued by other people. In short, a person is by nature someone whom it is wrong to view merely functionally—wrong to value merely as a means to the ends or the interests of others. If you regard me as a person only because I am able to exercise certain capacities that interest you, then you are saying that I am an object of your regard not in absolute but only in a relative sense. . . . And so the functional definition of personhood does not even rise to the dignity of being wrong.

See BUDZISZEWSKI, *supra* note 1, at 74–77.

22. See *In re Conroy*, 486 A.2d 1209, 1229 (N.J. 1985) (“The right of an adult who, like Claire Conroy, was once competent to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectuation.”); See generally BEAUCHAMP & CHILDRESS, *supra* note 2, at 170.

intervention that enabled the indefinite maintenance of biological life for patients who did not desire such treatment, and the concern of health care providers about the legal implications of withdrawing treatment at the request of those patients or their surrogates.²³ Although these cases first came before the courts in the context of permanently unconscious patients, they eventually led to legislative responses in the form of advance directive statutes that (i) expressly recognized the right of all persons to refuse life-sustaining treatment in certain circumstances and (ii) immunized physicians from liability when they act in accordance with their patients' decisions to withhold or withdraw such measures.²⁴

The following discussion begins by setting forth a general overview of these statutory schemes and relating how they have been construed in the evolving debate over the problematic meaning of medical futility. It then analyzes that construction in light of both legislative intent and statutory structure. This analysis reveals that although advance directive statutes have a legitimate bearing on the definition of medical futility, they are increasingly being used to inform the definition of that term in a manner that contradicts both their intended purpose and fundamental bioethical norms. Finally, the discussion considers recent legislative efforts to resolve futility disputes by focusing on process rather than definition, and it suggests how those processes might not only reconcile conflicts between physicians and their patients about treatment decisions but also return advance directive statutes to their original ethical moorings.

A. Advance Directive Statutes and Implications for Defining Treatment as "Futile"

The customary advance directive statute reflects the negative implication of the doctrine of informed consent: if a physician is obligated to obtain a patient's consent prior to providing treatment, the clear inference is that the patient has a corresponding right to deny that consent.²⁵ Although one's

23. See generally MEISEL & CERMINARA, *supra* note 2, § 2.01. Although many of the early cases arose in the context of competent patients who objected to treatment either on religious grounds or simply as a matter of personal preference, the rapid emergence of advanced medical technology since the 1970s provided the main impetus for the modern so-called "right-to-die" cases. Such technology has enabled biological life to be sustained almost indefinitely by a combination of devices for artificial respiration, circulation, feeding and hydration. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 328 (1990).

24. See MEISEL & CERMINARA, *supra* note 2, § 7.01[C].

25. See, e.g., *Natanson v. Kline*, 350 P.2d 1093, 1103–04 (Kan. 1960) ("Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered the master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but

exercise of this right generally is not controversial, it becomes problematic when the refusal relates to treatment that either would prevent death or extend the life of a patient who has been diagnosed with a terminal condition. A refusal of treatment in either of those cases would bring the patient's specific interest in self-determination into conflict with the state's broader interests in preserving life,²⁶ preventing suicide,²⁷ preserving the ethical integrity of the medical profession,²⁸ and protecting members of vulnerable groups.²⁹

Advance directive statutes represent legislative efforts to balance these competing interests. The fact that they tend to be narrow in scope, however, reflects the inherent difficulty of fulfilling that purpose. For example, these statutes commonly acknowledge in broad, general terms that patients have a

the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.") See also *In re Conroy*, 486 A.2d at 1222.

26. See, e.g., *In re Conroy*, 486 A.2d at 1239. Some commentators have observed that the predominant jurisprudential trend is to view the state's interest in preserving the life of any particular individual as dependent on that individual's interest in preserving his own life, and that most courts seem to have abandoned any effort to balance the individual's right to refuse treatment with the state's interest in preserving life. See, e.g., HALL ET AL., *supra* note 10, at 531. The United States Supreme Court noted in *Washington v. Glucksberg*, 521 U.S. 702, 729–30 (1997), however, that the states "may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy," and "[t]his remains true, as *Cruzan* makes clear, even for those who are near death." (citing *Cruzan*, 497 U.S. at 282). Without regard to the perceived momentum of the states toward qualifying their interests in preserving life, that fact would not bear upon the issue when the patient has affirmatively requested treatment. Meisel has summarized the general judicial consensus concerning this right as follows: 1) patients, whether competent or incompetent, have both a common law and a constitutional law right to refuse treatment; 2) the state's interest in opposing a competent patient's right to forgo life-sustaining treatment is "virtually nonexistent," and the state's interest is "very weak" with respect to incompetent patients who have a dim prognosis for recovery (although the state likely would not disavow that interest if the patient has chosen not to exercise his right to refuse treatment; as noted by Professor Meisel, "the right of self-determination has . . . traditionally been thought to require that treatment *not* be forgone without the informed consent of one legally authorized to provide it." MEISEL & CERMENARA, *supra*, note 2, § 2.06.); 3) decisions about life-sustaining treatment generally should take place in the clinical setting, although the courts are available to resolve disputes about those decisions; 4) surrogate decision makers for incompetent patients should express the patient's own preferences to the extent made known prior to the loss of capacity, and to the extent the patient's preference is unknown, decisions should be made on the basis of the patient's best interests; 5) physicians and surrogates may rely on an incompetent patient's advance directive in ascertaining the patient's preferences concerning life-sustaining procedures; 6) artificial nutrition and hydration is a form of medical treatment that may be withheld or withdrawn under the same conditions as other forms of medical treatment; and 7) the withholding or withdrawal of medical treatment is both morally and ethically distinct from euthanasia and assisted suicide. *Id.* § 2.02.

27. See, e.g., *In re Conroy*, 486 A.2d at 1223.

28. *Id.*

29. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 281 (1990).

fundamental right to control decisions relating to their medical care, and that this right encompasses the refusal of life-sustaining treatment. However, they tend to be vague in terms of defining the ultimate scope of that right, commonly expressing only the right of terminally-ill patients to refuse treatment that would merely postpone the moment of death, but remaining silent with respect to one's right to withhold or withdraw other forms of treatment that offer a reasonable prospect of reversing the dying process.³⁰

Moreover, and in a manner consistent with the state's recognized interest in preserving life, these schemes commonly define the right to refuse treatment as a voluntary matter solely within the patient's discretion, thus establishing that the law does not require the withholding or withdrawal of life-sustaining procedures in any particular case.³¹ Likewise, these statutes

30. The Louisiana statute, for example (LA. REV. STAT. ANN. §§ 40:1299.58.1–1299.58.10 (1985)), expressly provides that a patient who has been diagnosed as having a “terminal and irreversible condition” has the right to withhold or withdraw “life-sustaining procedures,” which by definition serve only to prolong the dying process. LA. REV. STAT. ANN. § 40:1299.58.1(A)(1) (1985). The 1989 version of The Uniform Rights of the Terminally Ill Act (URTIA) is similarly limited to “treatment that is merely life-prolonging, and to patients whose terminal condition is incurable and irreversible, whose death will soon occur, and who are unable to participate in treatment decisions.” UNIF. RIGHTS OF THE TERMINALLY ILL ACT, Prefatory Note (1989) [hereinafter URTIA]. According to Meisel, “several” states have adopted the URTIA in either its 1985 or 1989 version. See MEISEL & CERMINARA, *supra* note 2, § 7.04[B]. Other statutory schemes, however, are broader in scope. The Uniform Health-Care Decisions Act (UHCDA):

acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues. . . . The Act recognizes and validates an individual's authority to define the scope of an instruction or agency as broadly or as narrowly as the individual chooses.

UNIF. HEALTH-CARE DECISIONS ACT, Prefatory Note (1994) [hereinafter UHCDA]. According to the Uniform Law Commission's Legislative Fact Sheet, the UHCDA had been adopted by Alaska, Delaware, Hawaii, Maine, Mississippi, New Mexico, and Wyoming as of 2014, although the advance directive statutes of some states appear to be modified forms of the UHCDA. The National Conference of Commissioners on Uniform State Laws, *Legislative Fact Sheet—Health Care Decisions Act*, UNIFORM L. COMMISSION, <http://www.uniformlaws.org/LegislativeFactSheet.aspx?title=Health-Care%20Decisions%20Act> (last visited Mar. 7, 2015). See generally MEISEL & CERMINARA, *supra* note 2, §§ 7.03[B][1], 7.06[A][1]–[2] (summarizing the law in this regard in other jurisdictions). Notwithstanding the narrow scope of this right as expressed in statutory schemes, however, the various advance directive statutes are cumulative with existing law. According to Meisel, “they are intended to preserve and supplement existing common law and constitutional rights and not to supersede or limit them.” See *id.* § 7.03[B][2].

31. See, e.g., LA. REV. STAT. ANN. § 40:1299.58.1(B) (1985). The URTIA Prefatory Note states that “the Act is not intended to affect any existing rights and responsibilities of persons to make medical treatment decisions.” URTIA, Prefatory Note. Sections 10(f) and 11(d) of the URTIA suggests the voluntary nature of the patient's choice under the Act (Section 10(f) provides that a person who coerces or fraudulently induces an individual to execute a declaration under the Act is guilty of a crime, and Section 11(d) states that “[the Act] cre-

commonly provide that they are not to be construed as condoning euthanasia.³² Taken together, therefore, it might be fair to say that these provisions suggest a legislative intent to affirm and retain the state's traditional interest in preserving life, both where the patient has chosen not to exercise his right to refuse treatment and under circumstances that fall beyond the express provisions of the statute.

To give practical effect to the patient's right of self-determination and to encourage physicians to respect patient preferences, these statutes customarily incorporate immunity schemes that insulate physicians from liability when they follow their patients' decisions to withhold or withdraw treatment in accordance with the limited scope of the law.³³ They also expressly deny any intent to interfere with the exercise of "medical judgment"³⁴ or to require the provision of "life-sustaining procedures"³⁵ or treatment that is "medically inappropriate,"³⁶ "medically ineffective,"³⁷ "contrary to generally accepted health-care standards,"³⁸ or "contrary to reasonable medical standards."³⁹

Although these provisions originally were enacted in order to alleviate concerns by physicians who were uncertain about the legal and professional consequences of failing to provide treatment that would prolong a patient's

ates no presumption concerning the intention of an individual who has revoked or who has not executed a declaration with respect to the use, withholding or withdrawal of life-sustaining treatment in the event of a terminal condition." *Id.* §§ 10(f), 11(d). The UHCDA Prefatory Note provides that the model version of that Act "seeks to ensure to the extent possible that decisions about an individual's health care will be governed by the individual's own desires," and both the text of Section 2(e) of the UHCDA and the "Optional Form" included in Section 4 appear to reflect this general intent. UHCDA, Prefatory Note, §§ 2(e), 4. Paragraph 7 of the "Optional Form," for example, appears to allow the declarant broad discretion to either refuse or direct the provision of artificial nutrition and hydration. *Id.* § 4. *See also* MEISEL & CERMINARA, *supra* note 2, § 7.03[B][2]. Other provisions of the UHCDA, however, indicate that the patient's authority to compel the provision of such care is less certain than a cursory glance might suggest. *See infra* notes 79–83 and accompanying text.

32. *See, e.g.*, LA. REV. STAT. ANN. § 40:1299.58.10(A) (2014); URTIA § 11(g); UHCDA § 13(c). *See also* MEISEL & CERMINARA, *supra*, note 2, § 7.07[D].

33. *See, e.g.*, LA. REV. STAT. ANN. § 40:1299.58.8(A)(1) (2012); URTIA § 9; UHCDA § 9. According to Meisel: "statutes do not confer wholesale immunity; rather, most confer qualified immunity conditioned on the physician's acting in good faith and pursuant to reasonable medical standards." MEISEL & CERMINARA, *supra* note 2, § 7.10[E].

34. *See, e.g.*, LA. REV. STAT. ANN. § 40:1299.58.1(B)(3) (1985).

35. *See, e.g., id.* § 40:1299.58.1(A)(4).

36. *Id.*

37. *See, e.g.*, UHCDA § 7(f). According to the comments, "medically ineffective . . . means treatment which would not offer . . . any significant benefit." *Id.* § 7 cmt.

38. *See, e.g.*, UHCDA § 13(d).

39. *See, e.g.*, URTIA § 11(f).

life,⁴⁰ they have come to be relied upon not only to justify a physician's acquiescence when a patient refuses such treatment, but to substantiate the denial of treatment that a patient (or his authorized surrogate) has expressly requested.⁴¹

*Causey v. St. Francis Medical Center*⁴² is an interesting example of such a case. Sonya Causey, who was 31 years old, quadriplegic, comatose, and suffering from end stage renal disease, was totally dependent on a ventilator, regular hemodialysis, and the continuous provision of artificial nutrition and hydration.⁴³ Although Sonya's attending physician believed that continued treatment could preserve her life for at least two additional years, he was of the opinion that she had an insignificant chance of regaining consciousness.⁴⁴ He therefore recommended that treatment be withdrawn and that Sonya be allowed to die.⁴⁵ When her family insisted that treatment be continued, the physician presented the case to the hospital's Morals and Ethics Board, which concurred with his recommendation.⁴⁶ Treatment then was withdrawn, and Sonya died shortly thereafter.⁴⁷

In response to this unilateral withdrawal of treatment, members of Sonya's family initiated a legal proceeding and sought damages from both the physician and the hospital under the theory that the act constituted an intentional tort.⁴⁸ The defendants responded to the petition by filing an exception of prematurity on the grounds that the case first should have been considered by a medical review panel.⁴⁹ They also argued that the physician was under no obligation to provide treatment he considered to be either futile or "medically inappropriate" within the meaning of the Louisiana advance directive statute.⁵⁰ The court demurred on the first prong of this argument concerning "futility" (a term not employed in the statute) in the following terms:

40. According to Meisel, "[Advance directive] statutes are intended to provide assurance to individuals that their wishes will be respected and to provide assurance to health care providers that they will be immune from legal liability if they rely on these instructions." MEISEL & CERMINARA, *supra* note 2, § 7.01[A].

41. See *infra* notes 72–78 and accompanying text.

42. 30732 (La. App. 2 Cir. 8/26/98); 719 So. 2d 1072.

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

44. *Id.*

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

46. *Id.*

47. *Id.*

48. *Causey*, 30732 at p. 2, 719 So. 2d at 1074.

49. *Id.* Louisiana conditions the jurisdiction of the courts in actions grounded in medical malpractice and informed consent law upon the case first having been submitted for review by a Medical Review Panel. See LA. REV. STAT. ANN. § 40:1299.47(A)(1)(a) (2008).

50. See *Causey*, 30732 p. 2–3, 719 So. 2d at 1074–75.

Futility is a subjective and nebulous concept which, except in the strictest physiological sense, incorporates value judgments. . . . To focus on a definition of “futility” is confusing and generates polemical discussion. We turn instead to an approach emphasizing the standard of medical care.⁵¹

Then, with respect to the second prong of the defense, the court stated “[a] finding that treatment is ‘medically inappropriate’ by a consensus of physicians practicing in that specialty translates into a standard of care.”⁵² On that basis, the court concluded that the action was subject to panel review, and thus sustained the defendants’ exception of prematurity.⁵³

51. *Id.* at p. 4, 719 So. 2d at 1075.

52. *Id.* at p. 6, 719 So. 2d at 1076.

53. *Id.* There also was evidence that the physician in *Causey* based his argument, at least in part, on his opinion that continued treatment would have been “medically inappropriate” because he considered it to be inhumane. *Id.* at p. 7, 719 So. 2d at 1076 n.3. That fact, however, arguably would raise only the question of whether the patient would have given consent to continuation of the treatment at issue, rather than whether a reasonably prudent physician would have considered the treatment to be inhumane. Even if the withdrawal of treatment in *Causey* would have been justified on the grounds of inhumanity, it is arguable that the informed consent question would be inappropriate for consideration by a medical review panel because of the conflicting legal standards that apply to informed consent issues, on the one hand, and standard of care issues, on the other. Those arguments would have been resolved with reference to different legal standards because Louisiana is a “material risk” jurisdiction for purposes of informed consent law, *see, e.g.,* *Hondroulis v. Schuhmacher*, 553 So. 2d 398, 411 (La. 1988), whereas issues concerning a physician’s compliance with the standard of care are resolved with reference to the professional standard. In this sense, the facts of *Causey* raised an interesting legal issue concerning the role of a medical review panel in informed consent cases and the inevitable conflict between these legal standards. Although that issue is beyond the narrow scope of this article (which focuses only on the court’s decision to bypass the issue of futility and turn instead to the standard of care as the relevant reference point for determining the scope of the physician’s professional obligation with respect to the provision of life-sustaining procedures that a patient or his surrogate insists upon), there is no small irony in the fact that the court looked to the Natural Death Act to support its decision to sustain the defendants’ exception of prematurity when the Act itself would lead to a different result in terms of both legal process and substance.

It also is interesting to note that the case arose after treatment had been withdrawn and the patient had died. *See Causey*, 30732 at p. 1, 719 So. 2d at 1073. Had the defendants sought judicial sanction for the withdrawal of treatment prior to acting, it is difficult to envision the court referring the case to a medical review panel. Rather, it most likely would have been subjected to an expedited judicial review in order to address the issue of whether the patient would have refused consent to continued treatment under the particular circumstances of the case. Although resolution of that question might have required the same sort of expert testimony that would inform the opinion of a medical review panel, the ultimate issue would focus on determining whether the patient would have given consent to continued treatment if she were capable of expressing a reasoned decision on the matter. That said, it is interesting to consider how the *Causey* court might have approached the issue had it been raised prospectively, rather than after the fact.

It is not altogether surprising that the *Causey* court chose to evade the issue of medical futility by deferring to the medical review panel process, particularly in light of the difficulty of defining that concept in the abstract. It is arguable, however, that the specific provision of the statute on which the opinion rested should have led to a different outcome.

B. The Relationship Between the Right to Refuse Treatment, Medical Futility, Medically Inappropriate Treatment, and the State's Interest in the Preservation of Life

Contrary to the *Causey* court's demurrer, a reasonable argument can be made that advance directive statutes like Louisiana's provide meaningful reference points for reducing the admittedly abstract philosophical notion of medical futility to a workable legal standard, at least when considered in the context of their original purpose. This argument is grounded in the correlation between the concept of medical futility, the state's interest in the preservation of life, and the patient's right to accept or refuse life-sustaining medical treatment.⁵⁴ Just as these statutory schemes tend to establish the objective threshold of one's unqualified right to refuse treatment, without defining the ultimate scope of that right in the abstract, they likewise establish the objective point at which treatment becomes "futile," without defining the ultimate parameters of that definition.

Questions about medical futility tend to arise when a patient or his surrogate requests treatment the physician believes will offer no meaningful medical benefit in a physiological sense. From a legal perspective, these questions implicate the law of informed consent and the patient's correlative right to refuse treatment.⁵⁵ They also necessarily bear upon the state's recognized interest in the preservation of life.⁵⁶

As noted above, advance directive statutes tend to expressly disavow any intent to interfere with the exercise of medical judgment, and they give practical effect to that denial by expressly stating that physicians have no

54. As noted above, the majority of these statutes do not expressly recognize one's right to withhold or withdraw treatment under all circumstances; rather, many advance directive statutes are limited in scope not only to patients who are in a terminal condition or who are permanently unconscious, but also to forms of treatment that only prolong the dying process for such patients. See *supra* note 30 and accompanying text.

55. The right of self-determination traditionally is understood as requiring the patient's consent before treatment is either withheld or withdrawn. See, e.g., MEISEL & CERMINARA, *supra* note 2, § 2.06[A] at 2-25 & n.107. As a practical matter, however, it is arguable that these cases are unlikely to be raised on the basis that the patient did not give an informed consent because the patient would either have known, or should have known, the risk (or, more accurately, the certainty) that accompanies the withholding or withdrawal of treatment necessary to sustain life.

56. See *supra* note 26 and accompanying text.

obligation to provide either “life-sustaining procedures” or treatment that otherwise would be “medically inappropriate,” “medically ineffective,” “contrary to generally-accepted health care standards,” or “contrary to reasonable medical standards.”⁵⁷ It was on such a provision that Sonya Causey’s physician relied to justify the unilateral withdrawal of treatment that, in his opinion, would have been medically inappropriate to continue.⁵⁸ In response to this defense, the court construed the term “medically inappropriate” as raising an issue concerning the physician’s exercise of medical judgment, and then went on to hold that it would be premature to consider the case on the merits before a medical review panel had addressed the question of whether his actions were consistent with the professional standard of care.⁵⁹

It is submitted that the *Causey* court erred in taking this approach. Although questions about the propriety of any treatment protocol inevitably bear upon the physician’s exercise of medical judgment, a reasonable argument can be made that advance directive statutes do not employ terms such as “medically inappropriate treatment” in a manner that necessarily calls into question the standard of care. With respect to the Louisiana Natural Death Act, for example, reason suggests that a determination of whether treatment is “medically inappropriate” should be made primarily in contrast to the term “life-sustaining procedure,” against which it is juxtaposed in the statute, rather than with reference to the exercise of medical judgment, interference with which the statute expressly disavows.⁶⁰

57. See *supra* notes 34–39 and accompanying text.

58. See *supra* notes 50 and accompanying text.

59. See *supra* note 53 and accompanying text. It is not surprising that the court sought an opportunity to demur in a case such as this, which the courts have long considered to be more appropriately within the realm of the legislature. See, e.g., *In re. Farrell*, 529 A.2d 404, 407–08 (N.J. 1987) (citing *In re. Conroy*, 486 A.2d 1209, 1221 (N.J. 1985)) (“We recognize, as we did in *Conroy*, and as have numerous other courts, that given the fundamental societal questions that must be resolved, the Legislature is the proper branch of government to set guidelines in this area[.] ‘Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type [of] issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.’”); see also *Betancourt v. Trinitas Hosp.*, 1 A.3d 823, 833 (N.J. Super. Ct. App. Div. 2010) (“The issues presented are profound and universal in application. They warrant thoughtful study and debate not in the context of overheated rhetoric in the battlefield of active litigation, . . . but in thoughtful consideration by the Legislature as well as Executive agencies and Commissions charged with developing the policies that impact on the lives of all.”).

60. LA. REV. STAT. ANN. § 40:1299.58.1(B)(3) (2008). Under this construction, the term “medical judgment” would have meaning for purposes of determining whether a patient is

The specific statutory provision at issue in *Causey* provides that it is not to “be construed to require the application of *medically inappropriate treatment* or *life-sustaining procedures* to any patient.”⁶¹ The statute’s use of the disjunctive “or” to separate these terms suggests quite strongly a legislative intent to treat them independently. The grammatical basis for this distinction is buttressed by the fact that a synonymous construction would yield a result contrary to the stated purpose of the law by creating an obligation on the part of the patient to refuse treatment rather than merely recognizing one’s right to do so.⁶² This result could be avoided only by construing these terms separately. This is not to deny that there are occasions when it might be “medically inappropriate” for a physician to provide a “life-sustaining procedure,” but to say merely that these terms need not universally be construed as synonymous, and that they sometimes must be distinguished in order to give effect to the statute’s underlying purpose.

The necessity of distinguishing these terms can also be demonstrated by categorizing treatment modalities in terms of their expected efficacies and then correlating them with the patient’s right to accept or refuse treatment, the state’s countervailing interest in the preservation of life, and the physician’s professional obligations. This approach not only clarifies the meaning of these key terms in the statute, but also leads to a very practical definition of futility that comports with the voluntary nature of the patient’s right to refuse treatment.

Because advance directive statutes were intended to establish a reasonable balance between the competing interests of the individual in exercising his autonomy and the state in the preservation of life, reason would posit that the states waived that interest to the extent their legislatures expressly recognized one’s unqualified right to refuse treatment. Moreover, logic suggests that the state’s interest in preserving life is, by definition, a function of the professional expectation that a clinical intervention will positively affect a patient’s injury, illness, or disease in a physiological sense.

It is submitted that the concept of medical futility is an inverted function of the same expectancy. Thus, under this view, the state’s interest and the concept of futility would lie at opposite ends of the same spectrum: as the expected benefit from a particular treatment protocol increases, the state’s interest grows and futility dims. Likewise, the state’s interest becomes ever more dim as the expected benefit from a treatment modality declines, making it increasingly futile. This gradation of treatment along the

terminally ill or if the treatment at issue is a “life-sustaining procedure.” Once those determinations have been made, the question of whether the treatment should be provided would require not the exercise of medical judgment, but the consent of the patient.

61. *Id.* (emphasis added).

62. See LA. REV. STAT. ANN. § 40:1299.58.1(B)(1)–(2) (2008).

spectrum of futility versus efficacy is similar to the correlation historically drawn by the courts between the individual's right to refuse treatment and the state's interest in preserving life: the individual's right grows and the state's interest diminishes as the degree of invasiveness increases and as the prognosis dims.⁶³

Although the notion of medical futility is admittedly nebulous, this analysis offers a meaningful and workable definition of the term in the context of advance directive statutes, and it does so without violating their purpose. It is self-evident that the law would universally define as "medically inappropriate," "medically ineffective," and objectively "futile" any intervention that offers no prospect of relieving, mitigating, or deterring the progression of an illness, disease, or injury.⁶⁴ It follows that neither the professional standard of care nor the state's interest in preserving life would obligate a physician to provide such measures, nor would the law recognize a patient's right to demand them.⁶⁵

63. See, e.g., *In re Quinlan*, 355 A2d 647, 664 (N.J. 1976) ("The nature of Karen's care and the realistic chances of her recovery are quite unlike those of the patients discussed in many of the cases where treatments were ordered. In many of those cases the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good. We think that the state's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the state interest.").

64. Physicians are not ethically obligated to provide care that has no reasonable chance of benefiting their patients. See, e.g., Code of Med. Ethics Op. 2.035, *Futile Care*, AM. MED. ASS'N (1994), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2035.page?>

65. The President's Commission on Bioethics explains a physician's ethical duties in this regard as follows:

Respect for the self-determination of competent patients is of special importance in decisions to forego life-sustaining treatment because different people will have markedly different needs and concerns during the final period of their lives; living a little longer will be of distinctly different value to them. Decisions about life-sustaining treatment, which commonly affect more than one goal of a patient (for example, prolongation of life and relief of suffering) create special tensions. Nonetheless, a process of collaborating and sharing information and responsibility between care givers and patients generally results in mutually satisfactory decisions. Even when it does not, the primacy of a patient's interests in self-determination and in honoring the patient's own view of well-being warrant leaving with the patient the final authority to decide.

Although competent patients thus have the legal and ethical authority to forego some or all care, this does not mean that patients may insist on particular treatments. The care available from health care professionals is generally limited to what is consistent with role-related professional standards and conscientiously held personal beliefs. A health care professional has an obligation to allow a patient to choose from among medically acceptable treatment options (whether provided by the professional or by appropriate colleagues to whom the patient is

Such objectively inappropriate interventions, however, differ significantly from treatment modalities that yield an identifiable physiological effect, even if the expected benefit offers no hope of an ultimate remedy. To place a patient's affirmative request for such treatment at the discretion of his physician, as a matter subject to the exercise of medical judgment, would seriously distort the traditional balance in the physician-patient relationship. This conclusion is grounded both in the doctrine of informed consent and in most advance directive statutes, which clearly recognize that the patient's right to withhold or withdraw treatment is a permissive right rather than a legal duty.⁶⁶

Two legal consequences might be inferred whenever a patient has chosen to exercise this right: first, that a refusal of treatment that would merely prolong the dying process implicitly and automatically effects the state's waiver of its interest in preserving life, and second, that a physician's provision of such treatment *after the patient has refused it* would be "medically inappropriate" and contrary to "generally-accepted health care standards" or "reasonable medical standards." In this sense, the patient's refusal of treatment would reflect his own subjective determination that it would be "futile" for him to receive it, without regard to the unique, personal reasons that might have led him to that conclusion. In effect, this approach would define futility with reference to the patient's subjective preference, as justified by the voluntary nature of his right either to accept or refuse treatment. Thus, it is submitted that the law would define any "life-sustaining procedure" as both "medically inappropriate" and "futile" if, in fact, the patient has declined it.⁶⁷

referred) or to reject all options. No one, however, has an obligation to provide interventions that would, in his or her judgment, be countertherapeutic.

Report, President's Comm'n Study of Ethical Problems in Med. and Biomedical & Behavioral Res., *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions*, at 44 (1983), <http://hdl.handle.net/10822/559344> (last visited Nov. 14, 2014).

66. See *supra* notes 60–62 and accompanying text.

67. The same logic would support a definition of treatment as futile if its provision to a patient who permanently lacks decision-making capacity would cause such intolerable and interminable pain that the courts would infer his decision to refuse it under either the pure or the limited objective tests as developed by the court in *In re Conroy*. See discussion *infra* note 93 and accompanying text. The facts of *Casey* also raise the issue of whether the physician's unilateral act of withdrawing life-sustaining procedures would be legitimated by the fact that continued treatment would have been inhumane. The professional standard arguably would be relevant if the patient has not directed the withdrawal of life-sustaining treatment and is suffering (in which event it might be appropriate to apply a version of either the "pure objective" or "limited objective" test developed by the New Jersey Supreme Court in *Conroy* when addressing the propriety of a physician's unilateral decision to withdraw a life-sustaining procedure; a determination that the patient was suffering arguably would be subject to the professional standard and, thus, to review by a medical review panel). The *Conroy*

Reason compels the opposite conclusion with respect to treatment the patient has expressly requested.⁶⁸ Advance directive statutes suggest quite strongly the legislative intent to retain the state's interest in preserving life in such cases, as evidenced by their express provisions that (i) clarify the voluntary nature of the patient's right,⁶⁹ (ii) deny that any presumption is to be drawn from a patient's silence,⁷⁰ and (iii) require that any doubt concerning application of the statute be resolved in favor of preserving life.⁷¹

Finally, a rational extension of this logic also suggests something further: that many of these statutory schemes reflect the legislative intent, not only to retain the state's interest in preserving life when the patient has not exercised his right to refuse a "life-sustaining procedure" (which, by definition, would merely postpone the moment of an inevitable death without affecting the underlying condition that places the patient on that trajectory), but implicitly to translate that interest into the patient's correlative right to

court employed these tests to find a presumption that the patient would have refused treatment if he were capable of arriving at a reasoned decision. Under the "pure objective" test, treatment may be withheld or withdrawn even in the absence of any evidence that the patient would have refused care as long as he is suffering intolerable and intractable pain, such that treatment would be inhumane. The related "limited objective" test would apply where there exists "some evidence" that the patient would have refused treatment and where the burdens of treatment "clearly and markedly outweigh" the benefits of that treatment. Neither the "pure objective" or "limited objective" test, however, would justify a physician's unilateral decision to withhold or withdraw a "life-sustaining procedure." Rather, these tests would be consistent with the voluntary nature of the patient's decision to refuse treatment, because they merely provide a means of inferring whether the patient would exercise that right if he were capable of expressing a reasoned choice. Further, the objective tests developed in *Conroy* are interesting when applied to a case like *Causey*, because they were devised to address the withholding or withdrawal of life-sustaining treatment from conscious but incompetent patients in a nursing home who tend to be subject to a more significant risk of abuse than patients in the hospital setting. The patient in *Causey*, however, not only was unconscious, but she was in the hospital where regular physician consultations and ethics committee reviews were available. The hospital had submitted the case for review by the ethics committee, which found that treatment should be withdrawn even over the objection of the patient's surrogate decision maker, and the physician defended his decision to withdraw treatment on the grounds that the patient was suffering. To withhold treatment from a patient who is suffering would be justified, however, not on the grounds of "futility," but by the inference that the patient would have refused it.

68. This is not to say that the patient's silence is to be taken either as an implicit acceptance or as a refusal, but that the core issue relates to the determination of whether the patient would have refused or accepted the treatment if he were capable of expressing a reasoned decision. See discussion *supra* note 53 and accompanying text.

69. See *supra* note 31 and accompanying text.

70. See, e.g., URTIA § 11(d).

71. See, e.g., *id.* § 1 cmt. ("[T]he Act intends to err on the side of prolonging life."); see also LA. REV. STAT. ANN. § 40:1299.58(10)(E) (2008). ("It is the policy of the state of Louisiana that human life is of the highest and inestimable value through natural death. When interpreting this Part, any ambiguity shall be interpreted to preserve human life . . .").

insist that such procedures be provided.⁷² In short, it is submitted that the voluntary nature of a patient's "negative" right to refuse treatment that will merely postpone the moment of death implicitly affords a corresponding "positive" right to compel its provision, and that the state's interest in preserving life continues unabated with respect to those interventions until such time as the patient has in fact refused them. To construe the law in any other manner would permit physicians to unilaterally withhold or withdraw treatment, thereby defeating both the voluntary nature of the patient's decision to either accept or refuse such treatment and the very purpose of advance directive statutes.

C. Construing Advance Directive Statutes as Authorizing the Unilateral Withholding or Withdrawal of Life-Sustaining Treatment by Physicians on the Basis of Futility

Notwithstanding the argument set forth above with respect to the appropriate construction of the Louisiana statute at issue in *Causey* and similar schemes in other jurisdictions, there is an increasing view among physicians, health care institutions, and some bioethicists that, as a matter of policy, the law should authorize unilateral decisions to withhold or withdraw life-sustaining treatment even over the insistence by a patient or his surrogate that it be provided. Adherents to this view also have contended that certain existing advance directive statutes reasonably could be construed in that manner.⁷³ Their argument focuses primarily on the perception that it would be meaningless to provide such treatment to unconscious and severely debilitated patients who are not expected to regain capacity.⁷⁴

Some statutes are more amenable to this construction than others.⁷⁵ One of the most interesting is the Uniform Health-Care Decisions Act,⁷⁶ which

72. See, e.g., discussion *infra* at notes 76–97 and accompanying text concerning the Uniform Health Care Decisions Act.

73. See, e.g., Pam Belluck, *Even as Doctors Say Enough, Families Fight to Prolong Life*, N.Y. TIMES (Mar. 27, 2005), http://www.nytimes.com/2005/03/27/national/27death.html?_r=0; see also Report, *Will Your Advance Directive Be Followed?*, ROBERT POWELL CTR. FOR MED. ETHICS (2013), available at <http://www.nrlc.org/uploads/medethics/WillYourAdvanceDirectiveBeFollowed.pdf> [hereinafter Medical Ethics Report].

74. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); see also *In re Quinlan*, 355 A2d 647 (N.J. 1976).

75. See Pope, *supra* note 8 for a comprehensive discussion of this question. See also, Medical Ethics Report, *supra* note 73, at 7–11 (classifying the various state advance directive statutes into groups based upon the degree to which their literal terms expressly protect a patient's affirmative directive for the provision of life-sustaining treatment). In declining order of protection, the Medical Ethics Report categorizes the statutes as either: (1) "unprotective laws," which authorize health care providers not to comply with a patient's advance directive on the basis of "ethics and judgments of medical inappropriateness," and require the unwilling provider to undertake reasonable efforts to effect a transfer to another provider who

has the imprimatur one might associate with any legislative proposal drafted by the National Conference of Commissioners on Uniform State Laws with the purpose of giving consistency among the states concerning significant issues of law.⁷⁷

Some would say that the Uniform Act was drafted not only to clarify the patient's right to refuse life-sustaining treatment, but also to expressly authorize physicians to unilaterally withhold or withdraw treatment that, in their opinion, would be futile to provide.⁷⁸ This argument rests primarily on provisions of the Act that authorize health care providers to disregard patient directives they find objectionable either "for reasons of conscience"⁷⁹ or because they call for "medically ineffective health care or health care contrary to generally accepted health-care standards."⁸⁰

Although certain provisions of the Uniform Act lend credence to this construction, other provisions contradict it, and the force of the argument that the Act favors physician autonomy over patient self-determination be-

is willing to comply with the patient's choice, but without expressly requiring that life-sustaining treatment be provided pending the transfer; (2) "questionable laws," which authorize health care providers not to comply with a patient's directive if they are able to locate another provider who is willing to do so, but nevertheless are silent about the patient's right to receive life-sustaining treatment pending transfer; (3) "laws with time limits for life-preserving measures," which require unwilling health care providers to administer life-sustaining treatment pending transfer of the patient who insists on such treatment, but only for a limited time; and (4) "protective laws," which expressly require the provision of life-sustaining treatment until the patient is actually transferred to a willing provider, with no time limit on that obligation. *Id.*

76. See UHCDA, Prefatory Note.

77. The National Conference of Commissioners on Uniform State Laws drafts model acts in critical areas of state statutory law with the purpose of promoting clarity, stability and consistency among the states. The Uniform Commercial Code is perhaps the most widely-recognized of the Commission's proposed legislation. See generally The National Conference of Commissioners on Uniform State Laws, UNIFORM L. COMMISSION, <http://uniformlaws.org> (last visited Jan. 2, 2015).

78. See, e.g., Pope, *supra* note 8, at 55. Professor Pope explained this argument as follows:

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

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

Id.

79. See UHCDA § 7(e).

80. See *id.* § 7(f).

comes less compelling the more closely one parses the text. These challenges are most directly posed by specific provisions in the Act concerning the form a patient's advance directive might take, the narrow scope of the immunity accorded physicians who decline to comply with a patient's health care directive, and the foundational principles on which advance directive statutes historically were established.⁸¹

First, express provisions of the "model form" advance directive incorporated as part of the Uniform Act suggest that it was intended to recognize the individual's right to compel the provision of certain forms of treatment. Section 4 of the Act specifically provides that patients may direct the provision of artificial nutrition and hydration regardless of their medical condition, and without regard to the decision they might have made either to accept or forego other forms of life-sustaining interventions.⁸² This provision contradicts the view that the Act would authorize physicians to deny requests for such measures.

The limited scope and structural ambiguity of the Uniform Act's immunity provisions also challenge the notion that it was drafted with the intention of transmuting the patient's right to refuse treatment into the physician's authority to deny it. Although Section 9 immunizes providers from civil or criminal liability when they act "in good faith and in accordance with generally accepted health-care standards," the scope of this immunity expressly embraces only three specific circumstances: (1) when the provider *complies with* the "decision of a person apparently having authority to make a health-care decision for a patient, including a decision to withhold or withdraw care";⁸³ (2) when the provider *declines to comply* with "a health-care decision of a person *based on a belief that the person then lacked authority*";⁸⁴ and (3) when the provider *complies with* "an advance health-care directive assuming that the directive was valid."⁸⁵ These terms do not immunize a provider who overrides a patient's decision by withholding or withdrawing treatment on the grounds that it would have been "medically ineffective" or that its provision would be "contrary to generally accepted health care standards."⁸⁶ Thus, like the immunity provisions found in other advance directive schemes, those of the Uniform Act appear to be conditioned upon the physician's compliance with a valid directive that treatment be withheld.

81. Other, less direct challenges relate to the adverse consequences that such a physician-centric construction would portend to the state's interest in preserving the integrity of the medical profession.

82. See UHCDA § 4, ¶7.

83. See UHCDA § 9(a)(1).

84. See *id.* § 9(a)(2) (emphasis added).

85. See *id.* § 9(a)(3).

86. See *id.* § 9(a).

The Act's silence concerning the granting of immunity to physicians who override a patient's choice is difficult to square with a conclusion that the statute was drafted with the intention of conferring any such authority. As a practical matter, this might bring pause to a physician who is considering whether he should deny treatment that a patient or his surrogate has requested. This silence becomes even more disconcerting if one accepts the proposition asserted earlier with respect to the court's decision in *Causey*: the proposition that the voluntary nature of the patient's right either to accept or refuse treatment logically suggests that such measures would be "medically ineffective" or "contrary to generally accepted health care standards" only if the patient has in fact refused them.⁸⁷

Both the model form set forth in the Uniform Act and the limited scope of the Act's immunity provisions muffle any certainty that it could have been drafted with the intention of conferring on physicians the sole authority to decide whether or not life-sustaining treatment will be provided in any particular case. This ambiguity is compounded when the Act is viewed in light of the original purpose these laws were intended to serve. That purpose was to seek a legislative balance between the state's interest in preserving life and the patient's interest in self-determination, both of which the courts have long recognized as matters of constitutional significance.

Perhaps the most widely cited of the cases dealing with this question is *Cruzan v. Director, Missouri Department of Health*.⁸⁸ Addressing the constitutionality of a Missouri statute that required clear and convincing evidence of a patient's decision to decline treatment, the *Cruzan* court noted the inference, readily apparent from previous Supreme Court decisions, that the Fourteenth Amendment affords a constitutionally-protected liberty interest in refusing unwanted medical treatment. The Court then stated that the finding of such an interest was merely the beginning of the inquiry, and that "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interest."⁸⁹ More specifically, the Court indicated that the scope of the patient's

87. See *supra* notes 54–68 and accompanying text. The comments of the various Commissioners about the need for meaningful evidence of the patient's subjective preference appear to be consistent with this argument. See, e.g., Nat'l Conference of Comm'rs on Unif. State Laws, PROCEEDINGS OF COMMITTEE ON THE WHOLE: UNIFORM HEALTH-CARE DECISIONS ACT, p. 57, l. 25 through p. 59, l. 20; p. 60, l. 6 through p. 61, l. 16; p. 64, l. 18 through p. 65, l. 10 (1993).

88. 497 U.S. 261 (1990).

89. *Id.* at 279 & n.7 (citing *Youngblood v. Romeo*, 457 U.S. 307, 321 (1982); *Mills v. Rogers*, 457 U.S. 291, 299 (1982)). In the context of the right to refuse life-sustaining treatment, the New Jersey Supreme Court described those state interests as (1) preserving the life not only of the particular patient, but "preserving the sanctity of all life," (2) preventing suicide, (3) safeguarding the integrity of the medical profession, and (4) protecting innocent

right must be determined by weighing his interest in refusing treatment against the state's interest in preserving life:

We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.

....

[W]e think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.⁹⁰

In seeking to balance these competing interests, advance directive statutes tend to expressly acknowledge only the right of a terminally ill or permanently unconscious patient to refuse treatment that would merely prolong the dying process, thus implicitly waiving the state's otherwise unqualified interest in preserving life in those narrow circumstances.⁹¹ Moreover, in determining whether treatment should be withheld or withdrawn from a patient who lacks decision making capacity but previously issued no clear directive, the law has employed different evidentiary standards to confirm the patient's subjective preference.⁹² Those evidentiary standards vary depending upon whether the patient is conscious, but of uncertain capacity,⁹³ or

third parties who may be harmed by the patient's treatment decision. *In re Conroy*, 486 A.2d 1209, 1223–24 (N.J. 1985).

90. *Cruzan*, 497 U.S. at 280–82. See also *Wash. v. Glucksberg*, 521 U.S. 702, 728 (1997).

91. See generally MEISEL & CERMINARA, *supra* note 2, § 7.04[A][1].

92. See, e.g., *Conroy*, 486 A.2d 1209.

93. See *id.* at 1229–32. In *Conroy*, the New Jersey Supreme Court said as follows: [W]e hold that life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved. The standard we are enunciating is a subjective one, consistent with the notion that *the right that we are seeking to effectuate is a very personal right to control one's own life*. The question is not what a reasonable or average person would have chosen to do under the circumstances, but *what the particular patient would have done if able to choose for himself*.

....

[Where there exists insufficient evidence to establish what the patient would have decided], life-sustaining treatment may also be withheld or withdrawn [from a conscious patient in a nursing home] if either of two "best interests" tests . . . is satisfied.

Under the limited objective test, life-sustaining treatment may be withheld or withdrawn . . . when there is some trustworthy evidence that the patient would have refused the treatment, and the decision maker is satisfied that *it is clear that the burdens of the patient's continued life with the treatment outweigh the bene-*

whether he is permanently unconscious.⁹⁴ Neither consciousness nor capacity, however, has ever been a distinguishing factor in the law for purposes of determining the scope of one's fundamental right to refuse treatment in the abstract. The only relevant distinction goes to the issue of establishing the fact of the patient's subjective preference in any particular case.⁹⁵ Both the

fits of that life for him. By this we mean that the patient is suffering and will continue to suffer throughout the expected duration of his life, unavoidable pain, and that the net burdens of the prolonged life . . . markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the person may still be able to obtain from life.

. . . .

In the absence of trustworthy evidence, or indeed any evidence at all, that the patient would have declined the treatment, life-sustaining treatment may still be withheld or withdrawn . . . if a third, pure objective test is satisfied. Under that test, . . . the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane. Subjective evidence that the patient would not have wanted the treatment is not necessary under this pure-objective standard. *Nevertheless, even in the context of severe pain, life-sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain he might experience.*

Id. (emphasis added).

94. *In re Quinlan*, 355 A.2d 647 (N.J. 1976). In *Quinlan*, the New Jersey Supreme Court said the following:

We have no doubt . . . that if Karen [in a persistent vegetative state] were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, *she could effectively decide* upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death. . . .

. . . We perceive no thread of logic distinguishing between such *a choice on Karen's part* and a similar choice which . . . could be made by a competent patient terminally ill.

Id. at 663 (emphasis added). The approach in *Quinlan* is referred to as the "substituted judgment" standard, in which a surrogate speaks on behalf of the patient, effectuating the decision the patient would have made had she been able to formulate and express it. Substituted judgment necessarily entails consideration of the patient's personal value system, prior statements she might have made about medical care under similar circumstances, her personality, and her philosophical, religious, and ethical values. *See, e.g., In re Jobes*, 529 A.2d 434, 444 (N.J. 1987).

95. *See, e.g., McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990), which involved a 31-year-old man who had been irreversibly quadriplegic and dependent on a ventilator since he was 10 years of age. Kenneth sought permission to terminate his ventilator upon learning that his father's death from cancer was imminent, despairing "over the prospect of life without the attentive care, companionship and love of his devoted father," who had been his only caregiver since his mother died several years before. Uncertain about the legal consequences of acceding to Kenneth's request, his physicians were uncomfortable in terminating the ventilator without the approval of the court. Ironically, as Kenneth's father saw his own death draw nearer, and not knowing what the court would decide, he took it upon himself to terminate

jurisprudence and advance directive statutes have a long and consistent history of confirming the primacy of the patient's subjective preference in these matters.⁹⁶

This well-established history, tradition, and underlying purpose of advance directive statutes would be wholly inverted if the Uniform Act were to be construed as authorizing physicians to unilaterally withhold or withdraw life-sustaining treatment. This fact alone should inform one's inquiry concerning the Act's intended effect, particularly where the patient's life is in the balance.⁹⁷ Moreover, when advance directive statutes are considered

the ventilator as a preemptive measure to ensure that Kenneth's wishes would be respected. Kenneth's father died one week later, and the court issued its opinion approximately three weeks thereafter. *Father Succumbs to Cancer After Fulfilling Son's Death Wish*, SAN DIEGO UNION-TRIB., Oct. 12, 1990 at A15, as cited by HALL ET AL., *supra* note 10, at 537–38. The court found that Kenneth's desire to end his life was driven primarily by his concerns about what his life would be like after the death of his father, and concluded that his right to refuse treatment outweighed the state's interest in preserving his life. Most significantly for purposes of this discussion, the court "attach[ed] great significance to the quality of Kenneth's life as he perceived it under the particular circumstances that were afflicting him." *McKay*, 801 P.2d at 625. *See also* *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986). In *Bouvia*, the court stated the following:

As in all matters lines must be drawn at some point, somewhere, but *that decision must ultimately belong to the one whose life is in issue.*

Here Elizabeth Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. . . . It is not a conditional right subject to approval by ethics committees It is a moral or philosophical decision that, being a competent adult, is hers alone.

Id. at 305 (emphasis added).

96. *See, e.g., In re Estate of Longeway*, 549 N.E.2d 292, 300 (Ill. 1989) ("Illinois has a strong public policy of preserving the sanctity of human life, even if in an imperfect state. . . . [T]he key element in deciding to refuse or withdraw artificial sustenance is determining the patient's intent") (emphasis added); *see also* *Greco v. U.S.*, 893 P.2d 345, 354 (Nev. 1995) (Shearing, J. and Rose, J., concurring in part and dissenting in part) ("this court has also recognized that the value of an impaired life is not always greater than the value of non-life. . . . In addition, the legislature has recognized this fact in setting forth the policy of this state concerning the deprivation of life-sustaining procedures. . . . In these statutes, the legislature made clear that a person may choose not to sustain life. The underlying policy recognizes that, in some situations, non-life may be preferable to an impaired life; further, the policy recognizes that *each individual has the right to make his or her determination as to the relative value of life and non-life.*") (emphasis added); *In re Farrell*, 529 A.2d 404, 408, 411 (N.J. 1987) ("We approach this task with great humility, for we recognize that '[t]o err either way—to keep a person alive under circumstances under which he would rather have been allowed to die, or to allow that person to die when he would have chosen to cling to life—would be deeply unfortunate.' . . . [T]he value of life is desecrated not by a decision to refuse medical treatment but 'by the failure to allow a competent human being the right of choice.'") (quoting *In re Conroy*, 486 A.2d 1206, 1220, 1224 (1985) (emphasis added)).

97. Even those who advocate for a constitutional right to physician-assisted death acknowledge the significance of this traditional focus. As expressed by amici before the United States Supreme Court in the cases of *Washington v. Glucksberg*, 521 U.S. 702 (1997),

in their context as natural corollaries to the law of informed consent, and in light of the consistent jurisprudence that historically has required clear evidence of the patient's decision to refuse treatment, the question might be more informative if it were rephrased to ask what state interests would justify the withholding or withdrawing of treatment from a patient who requested it (or, conversely, what state interests would justify the denial of a patient's right *not* to refuse treatment by authorizing his physician to exercise that right on his behalf).

D. Resolving the Uncertain State of the Law Concerning the Relationship Between Advance Directive Statutes and Medical Futility

The discussion thus far suggests that the law continues to struggle with the notion of medical futility, both in the abstract and in the context of advance directive statutes. The *Causey* court, for example, was understandably reluctant to address the issue from a philosophical perspective, but it found no greater comfort in the specific provisions of the Louisiana statute. As argued above, however, the case might have been resolved with greater certainty had the court considered the definition of "medically inappropriate treatment" as a *sui generis* term, and in light of the specific structure and purpose of the Louisiana Natural Death Act.⁹⁸ In this manner, the court could have concluded as a matter of definition that the treatment at issue was neither futile nor medically inappropriate.⁹⁹

and *Vacco v. Quill*, 521 U.S. 793 (1997), the patient's voluntary choice should be the distinguishing moral factor in these cases.

It is certainly true that when a patient does not wish to die, different acts, each of which foreseeably results in his death, nevertheless have very different moral status. . . . *A doctor violates his patient's rights regardless of whether the doctor acts or refrains from acting, against the patient's wishes, in a way that is designed to cause death.*

Brief for Dworkin et al. as Amici Curiae in Support of Respondents at 11, *Wash. v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110), 1996 WL 708956, at *11 (emphasis added).

98. See generally Pope, *supra* note 8, at 41-42 & n.214-217, 72-74 & n.423-437, 78 & n.466.

99. It might be fair to say that the issue of futility was a red herring in *Causey* that caused the court to lose its focus on the statute's express recognition of both the patient's right to decide whether to accept or refuse life-sustaining treatment and the voluntary nature of that right. See *Causey v. St. Francis Med. Ctr.*, 30732 (La. App. 2 Cir. 8/26/98); 719 So. 2d 1072. Moreover, the court appears to have been further distracted by the question of whether the treatment was "medically inappropriate." See *id.* at pp. 4-5, 719 So. 2d at 1075-76. Ironically, the *Causey* court seems at once to have both invoked and dismissed the relevance of the Louisiana advance directive statute to the issue under consideration in that case. See *id.* at pp. 1-7, 719 So. 2d at 1072-76.

It is important to bear in mind, however, that even statutes that can be construed in a way that effectively defines futile care with reference to the patient's decision to accept or refuse treatment do so more by coincidence than design. The correlation of the patient's choice to the definition is inferential rather than direct, and it follows from the purpose of advance directive statutes. These schemes were drafted, not to provide an express definition of medical futility, but rather, to give effect to a patient's basic right to grant or deny consent to treatment.¹⁰⁰ It would be inconsistent with that purpose, however, to construe the statute in a manner that recognizes a physician's unilateral authority to deny the very treatment the statute places at the patient's discretion. Thus, while a patient's refusal of a particular form of treatment might establish a basis for defining it as both futile and medically inappropriate, it is the exercise of his right to accept or refuse treatment on which those definitions turn. In short, the mere fact that treatment would be considered as futile if the patient were to refuse it does not render it inherently futile and thus beyond his right to accept. It is this subtle point that the *Causey* court overlooked.

Although this construction of the Louisiana statute would have equal merit under similar schemes in other states, the literal terms of some statutes, such as the Uniform Act, do not as readily lend themselves to that view.¹⁰¹ As noted above, some observers strongly contend that the literal terms of the Uniform Act accommodate a physician's unilateral withholding or withdrawal of life-sustaining treatment.

This potential disparity among the states is ironic when one considers the fact that many bioethicists initially were concerned that the complexity and limited immunity provisions found in these schemes might lead physicians to construe them narrowly, thus effectively constraining rather than reinforcing the patient's ability to refuse treatment without first seeking judicial approval. The potential for such mischief in the codification of these schemes was seen, not in the risk that physicians would deny care that a patient had requested, but that they would insist on providing care the patient did not want.¹⁰² The contemporary argument that advance directive statutes should be construed to remove end of life decisions from the subjective preference of patients and place them within the professional discretion of physicians is difficult to reconcile to this history.

Further, while the Uniform Act might appear to resolve the question of medical futility if it were to be construed as conferring unilateral decision making authority on physicians, that construction would not inform the substance of the ongoing futility debate. Nor would it relieve physicians of the

100. See generally MEISEL & CERMINARA, *supra* note 2, § 7.01[C].

101. See discussion *supra* notes 73–87 and accompanying text.

102. See generally MEISEL & CERMINARA, *supra* note 2, § 1.06.

potentially significant legal consequences that would follow a unilateral decision to withhold or withdraw treatment from a patient who has not refused it.¹⁰³ Moreover, to construe the act in that manner would not reduce the likelihood of judicial involvement in these questions that the courts have long regarded as more amenable to resolution in the clinical setting by consensus among physicians, patients, and family members than in the adversarial environment of litigation. To the contrary, it likely would generate litigation in a significant number of cases.

The conflicting arguments about how advance directive statutes should be construed in the context of questions about medical futility suggest that they might not offer a certain resolution to this controversial issue. Perhaps in recognition of that continuing uncertainty, both private and statutory methods have been proposed to resolve, on an *ad hoc* basis, the impasse created when patients or their surrogates request treatment that physicians believe to be inappropriate under the circumstances.

In the private sector, some health care institutions have adopted internal policies that engage their ethics committees in a dispute resolution process. These policies commonly provide an option for physicians to unilaterally terminate treatment if the committee ultimately determines that a dispute about the appropriate course of care will not be resolved.¹⁰⁴ As a practical matter, however, it has been suggested that physicians would be unlikely to follow these policies to their ultimate ends when a dispute proves to be intractable.¹⁰⁵

The other possible solution is found in statutory law. Texas, for example, has enacted a statute under which a physician who opposes a request for life-sustaining treatment may initiate a review of the case by the hospital ethics committee.¹⁰⁶ Perhaps in order to ensure due process and enhance the opportunity of building a consensus about the appropriate course of action, the law confers upon the patient's surrogate the right to attend the meeting.¹⁰⁷ If the committee concludes that it would be inappropriate to continue treatment under the circumstances of the case, the physician would be obligated both to make a reasonable attempt to transfer the patient to another

103. Even the immunity provisions of the UHCDA do not encompass a physician's unilateral withholding or withdrawal of treatment that a patient has not refused. *See supra* notes 83–87 and accompanying text.

104. *See e.g.*, Code of Med. Ethics Op. 2.037, *supra*, note 7.

105. *See Pope, supra* note 8, at 69 (noting that, in Texas, providers decided to unilaterally stop life-sustaining medical treatment, only in two percent of intractable cases); *see also infra* notes 106–10 and accompanying text.

106. TEX. HEALTH & SAFETY CODE ANN. § 166.046(a) (West 2010). The Texas statute does not attempt to define medical futility but to provide a legal process for resolving disputes about the propriety of continued treatment. *See Pope, supra* note 8, at 80.

107. HEALTH & SAFETY § 166.046(b)(2), (4).

facility that is willing to comply with his directive¹⁰⁸ and to continue providing care for ten days after the ethics committee's decision.¹⁰⁹ The statute authorizes the termination of treatment if the patient has not been transferred within the prescribed ten-day window.¹¹⁰

Although this process-based approach appears to have been well received, questions have been raised about certain provisions of the Texas statute. For example, it has been suggested that the ten-day transfer window might not provide a meaningful period of time within which to locate a facility and effect the patient's transfer.¹¹¹ Questions also have been presented about whether the judicial authority¹¹² to extend the transfer deadline is deficient in terms of process.¹¹³ Finally, concerns have been expressed about potential due process implications arising from conflicts of interest posed by the composition of the ethics committee charged with reviewing a physician's denial of treatment.¹¹⁴

These questions aside, a process-based approach would seem to offer a more practical and meaningful way to resolve disputes about medical futility than an advance directive statute that is either ambiguous or leaves decisions about the use of life-sustaining procedures to the physician's sole discretion. Such a scheme arguably would be most meaningful if the body of law it relates to is itself structured in a way that minimizes the potential for disputes at the outset.

In the context of life-sustaining modalities, that potential most likely would arise when a statute purports to accord physicians the unilateral authority to withhold or withdraw treatment from a patient who has not refused it.¹¹⁵ As a preliminary matter, therefore, it is submitted that a dispute

108. *Id.* § 166.046(d).

109. *Id.* § 166.046(e).

110. *Id.* Although commentators report that this scheme appears to have significantly increased ethics consultations in Texas, they also note that providers rarely invoke their authority under the statute to unilaterally withdraw treatment in cases that ultimately prove to be intractable. See Pope, *supra* note 8 at 69 (noting that Texas providers decided to unilaterally stop life-sustaining medical treatment only in two percent of intractable cases).

111. Pope, *supra* note 8 at 80.

112. HEALTH & SAFETY § 166.046(g).

113. One judge has recommended that the statute be clarified with respect to the court's authority to grant an extension by identifying the court in which the petition to extend the time for transfer must be filed and by specifying the process for an appeal when a court refuses to grant an extension. *Nikolouzos v. St. Luke's Episcopal Hosp.*, 162 S.W.3d 678, 684 (Tex. Ct. App. 2005) (Fowler, J., concurring).

114. See Pope, *supra* note 8, at 80.

115. Several amici in the assisted suicide cases of *Washington v. Glucksberg* and *Vacco v. Quill* emphasized the importance of insulating physicians from increasing pressures brought to bear on them by society to assist patients in ending their lives when nothing further can be done for them. See, e.g., Brief for Bioethics Professors Amicus Curiae Supporting Petitioners, *Wash. v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110), 1996 WL 657754;

resolution scheme would be most effective if it were coupled with an advance directive statute that clearly negates any such authority. Having established that foundation, the Texas statute might offer a viable framework for establishing a process to resolve futility-related disputes, but with the following modifications:

(i) the statutory scheme should abate the potential for conflicts of interest due to the composition of the ethics committee by ensuring that it is comprised of persons not affiliated either with the health care facility or the physicians involved in the patient's care in a way that would call their independence into question and, thus, compromise, by perception, the integrity of the review process;

(ii) the statutory scheme should give the committee sufficient flexibility and time either to build a consensus concerning the appropriate course of treatment or to shape a practical compromise when no consensus is possible;¹¹⁶ and

Brief of Family Research Council as Amicus Curiae in Support of Petitioners, *Wash. v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 96-110, 95-1858), 1996 WL 656275. For example, Professors Annas, Glanz, and Mariner stated that, "[P]hysician assisted suicide is recognized, even by the two Circuit Courts of Appeal that have asserted that it is a constitutional right, as far too dangerous a right to be exercised by patients and physicians alone." Brief for Bioethics Professors Amicus Curiae Supporting Petitioners, *supra* at 29. The Family Research Council made a similar point:

[The Hippocratic Oath's proscription against a physician doing harm to patients] . . . is a priceless possession which we cannot afford to tarnish, but society is always attempting to make the physician into a killer—to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient [I]t is the duty of society to protect the physician from such requests.

Brief of Family Research Council as Amicus Curiae in Support of Petitioners, *supra* at 4 (quoting Margaret Mead, Personal Correspondence, *quoted in* MAURICE LEVINE, *PSYCHIATRY & ETHICS* at 324–25 (1972)).

116. One of the most significant ways to enhance the potential for building a consensus is by refusing to charge the physician with the responsibility that inevitably would attend the unilateral authority to deny treatment. Moreover, the very fact that an independent committee would be available to review a proposal to withhold or withdraw care might be likely to avoid the creation of adversarial relationships as the course of treatment progresses. Knowledge that a committee will be available for review might itself either enhance the development of trust or diminish the likelihood of distrust as care progresses.

Like many conflicts, disagreements about the provision of treatment are often based on personal misunderstandings between the parties and distrust. Two of the key factors likely to engender a lack of trust in the medical profession in the context of a physician's denial of life-sustaining treatment are the potential for financial conflicts of interest and the diminished respect perceived by terminally ill, disabled, and elderly patients relative to those who are young and healthy. According to the American Geriatrics Society (speaking of how concerns about physician-assisted suicide were magnified by managed care cost constraints):

Patients nearing death are generally disabled and their care is costly. . . . Decreasing availability and increasing expense in health care and the uncertain impact of managed care may intensify pressure to choose [physician-assisted suicide].

(iii) the statutory scheme should provide for an expedited process for judicial review should the committee be unsuccessful in forging either a consensus or a practical compromise to which both physicians and patient surrogates agree.

A statutory protocol that incorporates these features would recognize that questions about a patient's right either to accept or refuse treatment generally do not directly relate to the exercise of professional medical judgment. Rather, questions of a professional character tend to be more incidental, relating primarily to determinations about whether a particular form of treatment constitutes a life-sustaining procedure within the meaning of the advance directive statute or whether the patient satisfies any relevant clinical standards that might be set forth in the law (such as a diagnosis that he suffers from a terminal and irreversible condition or is in a continual and profound comatose state with no reasonable chance of recovery).

Non-diagnostic questions concerning whether a life-sustaining procedure should be applied in a particular case, on the other hand, pose issues of fact about whether the patient would have accepted or refused treatment had he possessed the capacity to express a reasoned decision about the matter. Because those questions are more subject to legal evidentiary standards than professional medical standards, they are not properly the subject of a physician's professional discretion.

Finally, by subjecting unresolved cases to judicial review, such a statutory process would give effect to the well-established rule of law that a patient's right either to accept or refuse treatment survives the loss of capacity,

. . . [Physician-assisted suicide] may become inherently coercive in a society in which supportive services and medical care are often unavailable. It would be ironic, indeed, to have a constitutional right to [physician-assisted suicide] when there is no guarantee of access to health care.

Brief of the American Geriatrics Society as Amicus Curiae Urging Reversal of the Judgments Below at 24–25, *Wash. v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110), 1996 WL 656290. The National Catholic Office for Persons with Disabilities and the Knights of Columbus raised a similar concern about the compounded risks posed by the inter-working of managed care cost constraints and discrimination based on disabilities:

In the end, a condition-based rule in favor of assisted suicide would pour into the Constitution a poisonous concoction of warm-hearted, misguided pity and cold-hearted utilitarianism. . . . Who stands to benefit most from a constitutional policy by which the right to live of vulnerable persons is reduced to an alienable interest? Is it the person with a terminal condition bent on suicide regardless of what the Constitution holds, or is it a cost-conscience society seeking more ways to ration its generosity?

Brief of the National Catholic Office for Persons with Disabilities and the Knights Of Columbus as Amici Curiae in Support of Petitioners at 22, *Wash. v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110), 1996 WL 656342. Although these arguments related to physician-assisted suicide, the same concerns would seem relevant to the more passive means of inducing death by vesting in physicians the unilateral authority to deny life-sustaining treatment.

thus clearly denying any lawful authority on the part of a physician to unilaterally withhold or withdraw life-sustaining treatment based on the patient's lack of capacity or any other perceived deficit in terms of quality of life.

IV. COUPLING THE WITHHOLDING OF TREATMENT ON THE GROUNDS OF MEDICAL FUTILITY WITH THE PROVISION OF AGGRESSIVE PALLIATIVE INTERVENTIONS

The analysis presented thus far would define, as "futile" care, any life-sustaining treatment that a patient has refused. To so limit the scope of that definition, it is submitted, would be consistent with the legislative balance found in advance directive statutes between the patient's right to self-determination and the state's interest in preserving life.

The moral comfort one might find in this balance, however, begins to dissipate when the withholding or withdrawal of treatment is combined with certain palliative measures. It is true that advance directive statutes tend to expressly exclude comfort care from the scope of a patient's decision to refuse life-sustaining treatment and, thus, from the scope of treatment that physicians have no obligation to provide.¹¹⁷ Yet, determining the appropriate scope of "comfort care" embraced by that exclusion presents its own challenges.

It is arguable that a patient who exercises his right under an advance directive statute to refuse artificial nutrition and hydration also would have the right to be sedated as a palliative measure to relieve the distress that might accompany the withdrawal of sustenance.¹¹⁸ The question becomes much more challenging, however, if the facts are inverted. Assume, for example, that perpetual sedation to unconsciousness is the only possible form of relief for a patient who is experiencing interminable and intractable pain. Realizing that he will be unable naturally to receive nutrition and hydration after being sedated, but recognizing the futility of having that sustenance provided artificially under the circumstances, the patient expresses in advance the decision to refuse it. Within what limits might the law recognize this patient's right to be sedated to unconsciousness in order to relieve suffering caused by his continuing intractable pain and to couple the act of sedation with the withholding of nutrition and hydration, either on the grounds that artificial sustenance would constitute a "life-sustaining procedure" under the governing advance directive statute or that it would be futile to provide sus-

117. See, e.g., LA. REV. STAT. ANN. § 40:1299.58 (2008).

118. This conclusion, however, rests on the assumption either that an advance directive statute would recognize the patient's unconditional right to refuse nutrition and hydration under the circumstances of the particular case or, if not, that the patient's interest in self-determination would override the state's interest in preserving life.

tenance when, once sedated, he is expected to remain in an unconscious state until death?¹¹⁹ Such cases raise a complex combination of questions concerning the scope of a patient's right to refuse treatment, the definition of medical futility, and the existence of a positive right to demand specific clinical interventions that would fall within the range of established professional norms in certain circumstances, but be difficult to distinguish from euthanasia in others.

The term "palliative sedation"¹²⁰ generally refers to the administration of sedatives as a means of relieving the intractable pain and other distressing symptoms that often accompany the latter stages of a terminal illness.¹²¹ When lesser amounts of sedatives are insufficient to relieve the patient's distress, progressively greater doses are administered, even to the point of rendering him unconscious, and sometimes with the understanding that he will be maintained in that state until death. Nutrition and hydration are generally withheld in such cases, and death tends to occur within several days. Palliative sedation tends to be implemented only as a last resort after less intensive interventions have been exhausted.¹²²

119. The clinical cases discussed *infra* at notes 133–155 and related text were developed for a Special Report entitled *At the Intersection of Tax Policy and Bioethics: Considering Tax-Exempt Status in the Context of Palliative Sedation to Unconsciousness*. That work, which was authored by myself and Charles J. Paine, M.D., appeared in Vol. 66, No. 2 of *The Exempt Organization Tax Review*, at p. 121 (a publication of Tax Analysts), addressed the issue of whether a health care facility's tax-exempt status should be conditioned upon its adherence to minimum ethical standards when providing extreme palliative interventions. See Frederick R. Parker, Jr. & Charles J. Paine, *At the Intersection of Tax Policy and Bioethics: Considering Tax-Exempt Status in the Context of Palliative Sedation to Unconsciousness*, 66 EXEMPT ORG. TAX REV. 121, 121–122 (2010). Portions of the clinical basis for the tax policy discussion in that publication are presented here with the permission of Tax Analysts.

120. The practice also is called "terminal sedation," "deep sedation," "sedation for intractable distress in the dying patient" (or "SIDD"), "total sedation," "slow euthanasia," and "sedation to unconsciousness." See Report, Council on Ethical & Judicial Affs., *Sedation to Unconsciousness in End-of-Life Care*, AM. MED. ASS'N (2008), available at https://download.ama-assn.org/resources/doc/ethics/x-pub/ceja_5a08.pdf [hereinafter CEJA Report 5-A-08]; Sjef Gevers, *Terminal Sedation: A Legal Approach*, 10 EUR. J. HEALTH L. 359, 360 (2003); Howard M. Ducharme & Robert J. Kingsbury, *Two Perspectives on Total/Terminal/Palliative Sedation*, CENTER FOR BIOETHICS & HUM. DIGNITY (Jan. 23, 2002), www.cbhd.org/resources/endoflife/kingsbury-ducharme_2002-01-24.htm.

121. These symptoms can include anxiety, agitated depression, insomnia, and vomiting. See, e.g., Dieter Birnbacher, *Terminal Sedation, Euthanasia, and Causal Roles*, 9 MEDSCAPE GEN. MED., no. 2, 2007, at 48, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1994875/?report=classic>.

122. The prevalence of palliative sedation as a means of providing relief to terminally ill patients has been estimated to fall within the range of 21% to 54.5%, and it has been suggested that the average time from sedation to death runs from between two and four days. See Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain*, Post Glucksberg and Quill, 29 AM. J.L. & MED. 45 (2003).

Because palliative sedation can be employed in a manner that closely resembles euthanasia, the process has generated considerable discussion in both law and bioethics.¹²³ In order to better understand the subtle distinctions between the various modalities of palliative sedation, it might be helpful to first identify the characteristics that distinguish palliative sedation from its more controversial alternatives, as well as the circumstances under which the differences between those alternatives can become blurred. We then may consider how the law and bioethical norms inform the use of these measures.

A. Differentiating Palliative Sedation from Physician-Assisted Death and Euthanasia

Palliative sedation entails the use of sedatives in order to relieve pain and suffering.¹²⁴ In contrast with the merely sedative effect of palliative sedation, physician-assisted death involves the prescription of a barbiturate that enables the patient to immediately terminate his life.¹²⁵ Voluntary euthanasia, on the other hand, entails an affirmative act by one person to bring about the death of another at the latter's request (generally by the administration of a lethal concoction).¹²⁶ Thus, for all practical purposes, palliative sedation differs from both physician-assisted death and euthanasia in the sense that it does not seek to achieve its palliative effect by affirmatively causing death. Physician-assisted death and euthanasia differ from each other only in terms of the actor's identity.¹²⁷

Unlike physician-assisted death and euthanasia, the act of sedating a patient in order to relieve suffering does not directly cause death nor does it necessarily accelerate the moment of death.¹²⁸ This is true whether the sedative is administered proportionately with the degree of suffering or rapidly in order to render the patient immediately unresponsive. For this reason, the practice is widely perceived as an appropriate means of last resort to relieve suffering.¹²⁹ The logic that undergirds this acceptance begins to break down, however, when the "active" intervention of sedation is accompanied by the

123. See, e.g., Parker & Paine, *supra* note 119.

124. *Id.*

125. *Id.* at 125 n.20.

126. *Id.*

127. Dr. Jack Kevorkian, for example, initially assisted terminally ill persons in bringing about their own death, and later progressed to directly administering the fatal injection himself, thus crossing the line from physician-assisted death to euthanasia and leading to his conviction for second degree murder. See Dirk Johnson, *Kevorkian Sentenced to 10 to 25 Years in Prison*, N.Y. TIMES, April 14, 1999, at A-1, available at <http://www.nytimes.com/1999/04/14/us/kevorkian-sentenced-to-10-to-25-years-in-prison.html>.

128. See Gevers, *supra* note 120, at 361.

129. See, e.g., Parker & Paine, *supra* note 119, at 121–27.

preplanned “passive” withholding of treatment in the form of nutrition and hydration. It has been argued, in certain cases, that this blending establishes a causal connection between the palliative measure and the patient’s death¹³⁰ sufficient to justify treating the sedation and withholding as integrated parts of a prearranged plan, leading some commentators to argue that the practice is merely a disguised form of euthanasia.¹³¹

B. Clinical Modalities, Bioethical Implications, and Legal Consequences of Palliative Sedation

There are two primary adaptations of sedative-type palliative interventions: “proportionate sedation,” in which the sedative is administered in proportion to the patient’s degree of suffering, and “sedation to unconsciousness,” in which the patient is rendered immediately unconscious.¹³² Of these varieties, proportionate sedation is the more prevalent and less controversial intervention.¹³³

1. *Proportionate Palliative Sedation*

Proportionate sedation entails the progressive administration of the minimum amount of sedative necessary to relieve the patient’s suffering at any given point along the trajectory toward death.¹³⁴ For example, it is not uncommon for physicians to administer morphine and other sedatives to lung cancer patients who are in the terminal stages of their disease process in doses that increase proportionally as the intensity of distress deepens.¹³⁵

130. Notwithstanding the blurring of these procedures in the eyes of observers who occupy both ends of the patient autonomy spectrum, evidence tends to suggest that physicians prefer palliative sedation to physician-assisted death (and, by implication, to voluntary euthanasia). See, e.g., *Studies Reveal Physicians’ Attitudes on End-of-Life Care*, U. IOWA NEWS SERVICES, <http://www.news-releases.uiowa.edu/2004/december/120604terminal.html> (last accessed Feb. 4, 2015). According to Lauris Kaldjian, M.D. (the lead investigator in the studies cited in this article), physician attitudes appear to be related to their experience in caring for terminally ill patients and the frequency with which they attend religious services: “those who had cared for a greater number of terminally ill patients in the preceding year were more opposed to assisted suicide and also more supportive of terminal sedation. . . . [Among those physicians, t]here seemed to be both a greater willingness to be rigorous in end-of-life care but also less willingness to cross that line into actually intending death.” *Id.*; see also CEJA Report 5-A-08, *supra* note 120, at 3.

131. For all practical purposes, palliative sedation cannot be identified with physician-assisted death because the patient would be unable to maintain a sedated state without the assistance of another. For this reason, our discussion concerning the problematic aspects of palliative sedation is limited to the context of voluntary euthanasia.

132. See, e.g., Parker & Paine, *supra* note 119, at 123.

133. *Id.*

134. *Id.* at 123–24.

135. *Id.*

Even though proportionate sedation is employed with the understanding that the dosage necessary to alleviate the patient's symptoms might, at some point, eventuate the loss of consciousness or hasten death by a matter of hours or days, the practice does not purpose either of those consequences; rather, these results are merely the inevitable effect of relieving suffering at the margin of either unconsciousness or death.¹³⁶ For this reason, proportionate sedation generally is considered to be acceptable from both legal and ethical perspectives.

This acceptance is grounded in a fundamental principle known as the rule of double effect.¹³⁷ According to this principle, it is morally acceptable to engage in an affirmative act that inevitably causes harm as long as that harm is merely the unavoidable consequence of an attempt to achieve an identifiable good.¹³⁸ The doctrine serves as an exception to the broader bioethics principle of non-maleficence, which holds that a physician must not intentionally inflict harm.¹³⁹

Now widely employed to justify the use of intense doses of narcotics and sedatives as a palliative measure to relieve suffering at the end of life, the principle of double effect arose out of the Roman Catholic tradition in the context of defining the circumstances under which therapeutic abortions might be considered appropriate from a moral perspective.¹⁴⁰ For example, it is sometimes necessary to treat a pregnant woman's cancer of the cervix by performing a hysterectomy or to remove the fallopian tube from a woman who has an ectopic pregnancy in order to prevent a fatal hemorrhage.¹⁴¹ In each of these cases, a legitimate medical procedure is employed with the intention of saving the mother's life, though inevitably claiming the life of the fetus. Each of these measures would be justified from a moral perspec-

136. *Id.*

137. The rule of double effect is sometimes referred to as the doctrine of double effect or the principle of double effect.

138. The classical formulation of the rule requires that all four of the following elements be satisfied in order for an action to be morally permissible:

1. *The nature of the act.* The act must be good, or at least morally neutral (independent of its consequences).
2. *The agent's intention.* The agent intends only the good effect. The bad effect can be foreseen, tolerated, and permitted, but it must not be intended.
3. *The distinction between means and effects.* The bad effect must not be a means to achieving the good effect. If the good effect were the direct causal result of the bad effect, the agent would intend the bad effect in pursuit of the good effect.
4. *The proportionality between the good effect and the bad effect.* The good effect must outweigh the bad effect. The bad effect is permissible only if a proportionate reason is present that compensates for permitting the foreseen bad effect.

BEAUCHAMP & CHILDRESS, *supra* note 2, at 207.

139. *Id.*

140. *See, e.g.,* Parker & Paine, *supra* note 119, at 124.

141. *Id.*

tive under the doctrine of double effect as long as the fetus's death was an unintended (though foreseen and inevitable) consequence of the procedure. Stated another way, the physician whose actions inevitably lead to the death of the fetus would not violate the principle of non-maleficence where his sole purpose was to save the life of the mother, and if the fetus's death was merely the unintended, though foreseen and inevitable result of that legitimate purpose.¹⁴²

The same logic justifies the now common use of powerful sedatives as a palliative measure when death is near, at least when the sedatives are administered in doses that increase proportionally with the patient's level of distress. Although these interventions may render the patient insensate and even hasten the moment of death (because of the risk of infection that inherently attends a prolonged period of sedation), it is generally accepted in the realms of both bioethics and law that the physician's singular intent in employing the sedative is to relieve suffering. This is true even though the means of achieving that goal will cause a correlative harm (whether that harm is viewed as an eventual unconsciousness, in which state the patient would be expected to remain until death, or death, itself, as an inevitable complication of maintaining him in deep sedation for an extended period of time).¹⁴³ Thus grounded in the principle of double effect, proportionate sedation has gained wide acceptance within the medical profession as an appropriate way to address a patient's intractable pain and distress during the dying process, and these interventions are commonly employed for that purpose.¹⁴⁴

2. *Palliative Sedation to Unconsciousness*

In contrast with the possibility (and perhaps eventuality) that a patient will be rendered unconscious at some point during the course of administering proportionate sedation, the intervention known as "sedation to unconsciousness" is employed with the specific intent of quickly rendering the patient unresponsive and then maintaining him in an unconscious state until death.¹⁴⁵ Moreover, because most candidates for sedation to unconscious-

142. In its classical expression, the doctrine of double effect would not apply to every abortion that might be necessary to save the mother's life. For example, a woman who has serious heart disease might face a significant risk of death unless her pregnancy is terminated. However, an abortion in that case would not satisfy all four elements of the doctrine of double effect because the action of killing the fetus (the bad effect) would serve as the means to save the mother's life (the good effect). See, e.g., BEAUCHAMP & CHILDRESS, *supra* note 2, at 207–08.

143. See, e.g., Parker & Paine, *supra* note 119, at 124.

144. See, e.g., CEJA Report 5-A-08, *supra* note 120; Gevers, *supra* note 120.

145. See, e.g., Mark F. Carr & Gina Jervey Mohr, *Palliative Sedation as Part of a Continuum of Palliative Care*, 11 J. PALLIATIVE MED. 76, 76 (2008); Timothy E. Quill et al.,

ness are unlikely to eat or drink by the time this intervention is considered, it tends not to be accompanied by the administration of artificial nutrition and hydration.¹⁴⁶ This procedure is both less common and more controversial than its proportionate counterpart.¹⁴⁷

The complex blurring of intent created by the union of sedation and the withholding of nutrition and hydration makes sedation to unconsciousness more legally and ethically challenging than proportionate sedation. The pre-planned coupling of these elements incline some observers to view these otherwise unrelated decisions as inseparable components of an integrated procedure that is more analogous to euthanasia than merely a passive means of relieving suffering.¹⁴⁸

This argument is perhaps most compelling when the patient does not suffer from a condition that significantly impairs the ability to ingest food

Last-Resort Options for Palliative Sedation, 151 ANNALS INTERNAL MED. 421 (2009). A third form of sedation, identified by Quill et al. as “ordinary sedation,” is employed both within and outside of the palliative care context and provides relief from symptoms without impairing the patient’s level of consciousness.

146. See Quill et al., *supra* note 145, at 422 (“Except under very unusual circumstances, artificial hydration and nutrition are not provided.”); Gevers, *supra* note 120, at 361 (“Terminal patients are not eating or drinking substantial amounts; the patients that are considered for deep sedation are not likely to eat and will hardly drink. Although artificial hydration and nutrition would seem indicated when the patient is no longer able to eat and drink himself, in some patients—in particular those already dying—it will be contraindicated because it would only lengthen the dying process. In others—apart from the risk of pulmonary edema and other adverse effects—it may be withheld either on the basis of an explicit refusal of the patient, or because in the final analysis the patient—taking into account his intolerable situation and the inevitability of an imminent death—has nothing to gain from it.”); Carr & Mohr, *supra* note 145, at 79 (suggesting that artificial nutrition and hydration are neither palliatively nor medically indicated for patients at the terminal stages of their disease process because they “often feel no hunger and may be unable to utilize nutrients as a healthy body would.”).

147. See, e.g., Parker & Paine, *supra* note 119, at 123–24.

148. See McStay, *supra* note 122. In this sort of case, it is sometimes logically and ethically difficult to distinguish palliative sedation to unconsciousness from physician-assisted death and voluntary euthanasia. Those who challenge the propriety of palliative sedation to unconsciousness draw from legal notions of causation and intent to deny any meaningful distinction between that intervention and voluntary euthanasia, simply because death is equally certain with either measure. As noted by one commentator:

While similar to palliative measures as far as the sedation itself is concerned, withholding of hydration and nutrition brings terminal sedation into the realm of non treatment decisions. At the same time, to the extent that the combination of these two measures may shorten the patient’s life, the practice may be easily associated with euthanasia. It is no surprise, therefore, that terminal sedation has been called . . . ‘slow euthanasia’ or ‘backdoor euthanasia,’ suggesting that it should be dismissed as a covert form of a practice which is by many already considered as unacceptable per se.

Gevers, *supra* note 120, at 360. See also David Orentlicher, *The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947 (1997).

and fluids. For example, the author is aware of one case in which a former cancer patient, though unburdened by intractable pain or other forms of suffering and fully able to ingest nutrition and hydration, requested that she be sedated to unconsciousness and then be allowed to die by withholding nutrition and hydration.¹⁴⁹ Although thought to be in remission at the time of her request, the patient had undergone treatment for several repetitive bouts of cancer throughout her life and had become fearful that the cancer would return.¹⁵⁰ Having fulfilled the responsibility of raising her children, and having grown weary of the pain and other discomfort she had experienced during the prior episodes of illness, the patient decided that she was ready to die, and she was able to locate a facility willing to fulfill her request.¹⁵¹

Whatever reasoning might have been employed to justify the decision in that case, it was not substantiated by the principle of double effect. Moreover, the facts of the case make it difficult to perceive the provider's effort as anything other than the use of sedatives as a thinly-veiled effort to provide a comfortable euthanasia, but without appearing to have crossed the line from inaction to action.

The fact that such cases cannot always be readily justified under either the customary advance directive statute or the doctrine of double effect¹⁵² does not necessarily suggest that sedation to unconsciousness should be universally dismissed as a disguised but unlawful act of euthanasia. Most cases of sedation to unconsciousness tend to be more ambiguous, and it might be premature to universally dismiss the rule of double effect as a meaningful tool for evaluating these interventions. Without question, serious legal and ethical challenges inhere in any palliative intervention that entails a combination of rendering the patient unconscious and then withholding nutrition and hydration until he dies. However, some of these cases can find sanction both in the law and principles of bioethics.

One such circumstance is when the patient's need for artificially-delivered nutrition and hydration is driven by an existing medical condition, so that the need exists whether the patient is conscious or not. Reason suggests that a decision to withhold nutrition and hydration in such a case should be considered on its own, independently of the fact that the patient might have been sedated in order to relieve suffering, thus revealing as the sole cause of death the underlying medical condition that precipitated the need for artificially delivered food and fluids. The act of sedation and the

149. The author became aware of this case during a personal conversation with the bioethicist who was consulted by the facility after the event.

150. *Id.*

151. *Id.*

152. *See* LA. REV. STAT. Ann. §§ 40:1299.58.2-.10 (2005).

withholding of nutrition and hydration in such a case logically could be considered as separate and independent events.

For example, a patient suffering from esophageal cancer who is no longer able to swallow and who wishes no further medical intervention in the form of artificial nutrition and hydration may request deep sedation to the point of unconsciousness in order to relieve the suffering that inevitably accompanies the absence of food and fluids, with death by dehydration to be expected within a few days. The patient's right to decline nutrition and hydration would be statutorily recognized because death would be the natural result of the underlying condition.¹⁵³

Advance directive statutes likewise would sanction the act of sedation under an extension of the same logic. Given the law's express recognition of the patient's right to refuse artificial nutrition and hydration under these circumstances, it would be incongruous to find an intent to cause death when a physician sedates the patient in order to relieve the distress associated with exercising that right. To the contrary, reason would suggest that the sedation was administered as a form of comfort care in order to facilitate the patient's decision, rather than for the purpose of causing death. Logic therefore compels the conclusion, not that the patient was sedated and treatment withheld so that he would die, but that he was sedated in order to mitigate the suffering that otherwise would follow his decision to exercise a choice sanctioned both by the law and accepted bioethics principles.

The factor that justifies this conclusion is the absence of any proximate causal relationship between the act of sedation and the patient's death: since the necessity of sedation as a palliative measure arose out of the patient's irreversible inability to swallow, and since that condition would exist without regard to whether he was conscious, there exists no relationship between the act of sedation and the patient's death and thus no logical ground for finding that the act of sedation was undertaken with the intent to cause death. In such cases, therefore, sedation to unconsciousness can be implemented in a way that denies any resemblance to euthanasia. However, the same reasoning cannot always alleviate concerns about the use of sedation as a means to cause death.

Assume, for example, that a patient who suffers intractable pain as a result of rheumatoid arthritis requests sedation to unconsciousness and refuses nutrition and hydration. The withholding of food and fluids in this case would not be expressly sanctioned by most advance directive statutes because the patient's inability to ingest nutrition and hydration would be caused by the sedation rather than the progression of the underlying disease. By simultaneously creating and refusing to satisfy the patient's need for

153. *Id.* The same result would obtain under the laws of most other states. See, e.g., MEISEL & CERMINARA, *supra* note 2, § 7.07.

artificial nutrition and hydration, this application of palliative sedation, on its face, would appear to be a disguised form of euthanasia.¹⁵⁴

One, however, might envision an argument that this situation can be distinguished from euthanasia. For example, an argument grounded in the doctrine of double effect might rely on the fact that the sedative was employed at the minimum dosage necessary to relieve the patient's pain and suffering. Reason would suggest in such a case that the patient did not intend death, but that the loss of both consciousness and the ability to ingest nutrition and hydration (which eventually led to his death) were merely foreseeable but unintended consequences of a sedative rendered at the minimum dosage necessary to obtain the desired pain relief. In short, those who subscribe to this reasoning would argue that the sedative should be treated in the same manner as if proportionate sedation had been employed, because in either case it would have been administered in the minimum dosage necessary to relieve suffering (even proportionate sedation eventually would render the patient unconscious and unable to receive food and fluids if death did not occur first).

Not everyone who looks to the doctrine of double effect to resolve such a case would subscribe to the same reasoning. Many would view this analysis as a cool utilitarian argument that intentionally distorts the doctrine, taking it beyond reasonable bounds by disguising the act of withholding nutrition and hydration as a passive measure recognized as a lawful right under advance directive statutes. Those who subscribe to this view would construe the law more narrowly, arguing that advance directive statutes would not apply because the patient did not suffer from a "terminal and irreversible condition" within the narrow statutory meaning ascribed to that term.¹⁵⁵ Rather, they would see the withholding of treatment under these circumstances as an affirmative act that is wholly unrelated to the patient's legitimate need for pain relief, and thus as a proximate cause of the patient's death.¹⁵⁶

These ambiguities might be said to inhere in most cases that call for extreme palliative interventions, and they are not easily resolved. Perhaps for that reason, the courts tend to consider the provision of palliative care to be primarily a matter of professional discretion, and it has been suggested that

154. The artificial nutrition and hydration would not constitute a "life-sustaining procedure" in such a case because the patient would not have a "terminal and irreversible condition" as defined in section 40:1299.58.2(14) of the Louisiana Revised Statutes Annotated. *See, e.g.*, MEISEL & CERMINARA, *supra* note 2, § 7.06.

155. *Id.*

156. A wide range of views have been expressed about how to resolve the tension created in cases that implicate both the patient's need for adequate pain relief and societal concerns about euthanasia and the ethical integrity of the medical profession. *See, e.g.*, Roger S. Magnusson, *The Devil's Choice: Re-thinking Law, Ethics, and Symptom Relief in Palliative Care*, 34 J.L. MED. & ETHICS 559, 559–69 (2006); McStay, *supra* note 122; CEJA Report 5-A-08, *supra* note 120.

the risks posed by the most extreme measures are probably more amenable to moderating influence by general clinical policies and guidelines than by specific legislation.¹⁵⁷ Such guidelines, as recommended by the American Medical Association, would both (i) limit the provision of palliative sedation to circumstances of unrelieved, severe physical suffering by patients who are imminently dying and whose clinical symptoms have been unresponsive to other aggressive treatments geared to symptom relief, and (ii) ensure that extreme palliative interventions are employed only as a last resort, with the intent to relieve suffering rather than to cause or hasten death, and in a manner that does not directly cause death.¹⁵⁸

For all practical purposes, the latter of these guidelines incorporates the doctrine of double effect and accommodates the patient's interest in self determination and the state's interest in preserving life in much the same way as advance directive statutes tend to balance these competing interests. The patient's right to demand palliative sedation would thus mirror the scope of his statutory right to receive comfort care after having declined life-sustaining treatment. At the same time, a physician who opposes the most aggressive forms of palliative sedation for reasons of conscience should find sanction in these guidelines, which serve as evidence of the professional standard of care. The reluctant physician also might find relief in the provisions of advance directive statutes that negate any obligation to employ procedures that pose the risk of either causing or accelerating death, or that otherwise would be inconsistent with the physician's role as a healer.

V. CONCLUSION

This Article has considered two instances that give rise to issues of medical futility and the scope of a patient's right to direct the provision of care at the end of life: cases in which a physician invokes the concept of medical futility to justify the denial of life-sustaining treatment that a patient or his surrogate has requested and cases in which the patient has asked to be sedated to unconsciousness in order to relieve unrelenting and intractable

157. See, e.g., Gevers, *supra* note 120, at 366 ("What is needed is not so much specific legislation, but authoritative clinical guidelines providing a workable protocol on how physicians should proceed.").

158. In addition, the AMA recommends (i) that these guideline ensure that patients or their surrogates have provided their explicit informed consent to the use of extreme palliative interventions, (ii) that steps be taken to minimize the risks posed by the measures by ensuring that physicians are educated about the proper clinical context for their use, (iii) that physicians consult with an interdisciplinary team that includes an expert in palliative care before recommending any extreme palliative measure in order to ensure that it is the most appropriate course of treatment, and (iv) that health care facilities establish an internal mechanism to review all cases in which patients request these measures. CEJA Report 5-A-08, *supra* note 120.

pain, and then to be maintained in that state without the provision of nutrition or hydration until he dies (for all practical purposes, a physician who accedes to such a request would create the need for life-sustaining treatment and then not provide it on the grounds that it would be futile to do so). Legal principles of causation would suggest that death was intended in each of these cases, thus exposing the physician to potential criminal liability for homicide in the form of *involuntary* euthanasia in the first instance and *voluntary* euthanasia in the second.¹⁵⁹ Although prosecution might be unlikely in either of these cases as a practical matter, this theoretical risk would exist even in states in which physician-assisted death is lawful.¹⁶⁰

The challenges presented by each of these cases differ from the concerns addressed by courts in customary end-of-life cases and by legislatures in typical advance directive statutes. The law has traditionally recognized that a terminally ill patient does not act with the intent to die when he refuses treatment that will serve only to prolong the dying process.¹⁶¹ Rather, the

159. See generally MEISEL & CERMINARA, *supra* note 2, § 12.04[A].

160. *Id.* The death-inducing agent in physician-assisted death would not be administered by the physician, but by the patient's own hand. In contrast with this practice, euthanasia would be rendered directly at the hand of the physician. In light of this distinction, it might be fair to say that the law considers physician-assisted death more as a form of suicide with the indirect assistance of the physician rather than as a homicide directly at his hand. See *supra* notes 125–127 and accompanying text.

161. The *Glucksberg* Court specifically addressed the distinction between the passive refusal of unwanted medical treatment and the active demand for assistance in committing suicide by relying on its holding in *Quill* for the proposition that “the two acts are widely and reasonably regarded as quite distinct.” *Wash. v. Glucksberg*, 521 U.S. 702, 725 (1997). In *Quill*, the Supreme Court had rejected the view that the two were entitled to be treated the same because the ultimate result in either case was to hasten the patient's death. Rather, the Court found that the distinction between suicide and the refusal of treatment “comports with fundamental legal principles of causation and intent.” *Vacco v. Quill*, 521 U.S. 793, 801 (1997). The Court found the distinction relevant from a causation perspective by noting that a patient who refuses life-sustaining treatment will die from the natural progression of the underlying disease, while a person who ingests a lethal concoction will die from his body's reaction to that substance. *Id.* In terms of intent, the Court found that a physician who complies with a patient's decision to withhold or withdraw treatment does not necessarily intend the patient's death. *Id.* Nor did the Court believe that such an intent could be inferred from a physician's affirmative act of providing aggressive palliative care that unavoidably hastens death. *Id.* at 802. The Court did, however, ascribe a different intent to a physician who assists a patient in committing suicide, finding that they “must, necessarily and indubitably, intend primarily that the patient be made dead.” *Id.* In reaching this conclusion, the Court focused on the different responses that follow when a patient continues to live after the withdrawal of treatment, on the one hand, and after a failed suicide attempt, on the other. At least in the absence of an affirmative attempt to bring about death, the first patient would be allowed to continue living. The only consistent course of action for the second patient, however, would be to try again. Logic would infer the intent to preserve life in the first example and to cause death in the second (where continued life would be deemed a failure). See Brief Amicus Curiae of the American Center for Law & Justice Supporting Petitioners, at 23–28, *Wash. v. Glucksberg*, 520 U.S. 702 (1997) (No. Nos. 95-1858, 96-110), 1996 WL 656340. This would

law considers death in such cases as having resulted from the natural progression of the underlying injury or disease that precipitated the need for treatment.¹⁶² For that reason, the law does not consider a physician who withholds or withdraws life-sustaining treatment pursuant to a patient's request as having acted with the intent to cause death, and advance directive statutes tend to expressly confirm this result.¹⁶³ This rationale breaks down, however, both (i) when a physician *disregards* a patient's affirmative request for treatment, and (ii) when he *accommodates* the patient's affirmative request to be rendered unconscious and then be allowed to die in that state without the provision of artificial nutrition and hydration.

With respect to the first of these alternatives, a physician who withholds or withdraws life-sustaining treatment that either the patient or his surrogate has requested would be hard pressed to deny the specific intent to cause death, without regard either to the benevolence of his motive or the strength of his conviction that the requested treatment would be "futile." Perhaps the most significant impediment to the futility argument in such cases is found in the fact that they tend to involve only patients who are permanently unconscious.¹⁶⁴ A physician who denies such patients the same treatment that he would offer to others who are similarly-situated but not incapacitated would find it difficult to sustain an argument that he considered the treatment to be futile and thus "medically inappropriate" or "medically ineffective" in a physiological sense. The standard of care itself would refute an argument that he based his determination of futility on the exercise of medical judgment, leaving his subjective determination about the patient's quality of life as the only remaining basis for the decision to withhold or withdraw treatment.¹⁶⁵

entail more than the mere toleration of certain adverse but unavoidable risks; it would affirmatively embrace a lethal purpose. *See id.* at 20.

162. *See, e.g., Glucksberg*, 521 U.S. 702; *Quill*, 521 U.S. at 802, 807-08.

163. *See* MEISEL & CERMINARA, *supra* note 2, § 12.03[C][5].

164. *See, e.g., Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Baby K*, 16 F.3d 590 (4th Cir. 1994); *In re Jane Doe*, 418 S.E.2d 3 (Ga. 1992); *In re Wanglie*, No. PX-91-283 (Minn. Prob. Ct. Hennepin Cnty. June 28, 1991), *reprinted in* 7 ISSUES L. & MED. 369 (1991); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

165. The state's interest in preserving life also would directly challenge a physician's reliance on the concept of medical futility to justify the withholding or withdrawal of life-sustaining treatment that either a patient or his surrogate has requested. This conclusion is consistent with the Supreme Court's recognition in *Washington v. Glucksberg* and *Vacco v. Quill* that a state's interest in preserving life is not subject to "judgments about the 'quality' of life that a particular individual may enjoy," and that a state may assert that interest "even for those who are near death." *Glucksberg*, 521 U.S. at 729-30 (quoting *Cruzan*, 497 U.S. at 282). Although a state's advance directive statute might reflect an implicit waiver of its interest in preserving life to the extent the law expressly acknowledges an individual's unqualified right to refuse treatment, reason posits that the state would have retained its interest with

In light of this fundamental problem, it is submitted that advance directive statutes need not and should not be construed to vest in physicians the sole decision-making authority concerning the provision of life-sustaining treatment. This is not to deny the importance of these decisions to physicians and other members of the health care team, but to recognize that entrusting these matters to the sole discretion of the medical profession would merely beg a question of profound significance to a variety of interested parties. In particular, it would be unrealistic to expect such a deference to adequately address the interests of the patient, his family, and society in these matters.

We could take comfort in those interests being properly weighed, however, if the states were to implement a meaningful process designed to forge a consensus about the appropriate treatment regimen when the views of the physician and the patient's (as expressed by his surrogate) diverge. Properly structured, such a process could serve not only to reconcile these conflicts, but to return advance directive statutes to their original legal and ethical moorings. Just as physician-assisted death has been recognized as "far too dangerous a right to be exercised by patients and physicians alone,"¹⁶⁶ it would be even more dangerous to place in a physician's hand the unilateral authority to withhold or withdraw life-sustaining treatment from a patient who has requested it because to do so would effectively condone involuntary euthanasia.

These concerns that attend a physician's refusal to satisfy a patient's affirmative request for treatment are compounded when the issue is placed in the context of the second type of futility case discussed in this Article. This complexity stems from the difficulty of distinguishing palliative sedation to unconsciousness from voluntary euthanasia in certain cases. In light of that potential identity, reason suggests that the law would accommodate the right of a patient to couple the act of sedation with the withholding of nutrition and hydration only when the combination is justified by the doctrine of double effect. In this manner, the law would ensure that the decision reflects the same determination of objective futility that advance directive statutes implicitly recognize when a patient has exercised his right to forego life-sustaining treatment.¹⁶⁷ Moreover, to so limit these interventions would both align the law with professional standards of medical practice,¹⁶⁸ and minimize the risk that they would be exploited as opportunities to engage in voluntary euthanasia under the guise of a legitimate medical procedure.

respect to forms of treatment and circumstances that fall beyond the express scope of the law. See discussion *supra* notes 63–72 and accompanying text.

166. Brief for Bioethics Professors Amicus Curiae Supporting Petitioners, *supra* note 115, at 29.

167. See discussion *supra* note 67 and accompanying text.

168. See *supra* note 158 and accompanying text.

Although we might be inclined to consider these presentations of medical futility as raising merely abstract matters of law, bioethics, and the professional standard of medical care, at the core of these questions lies the very practical and fundamental concerns about the value we should ascribe to each other as human beings: either (i) we consider ourselves as having an inherent and unchanging value that exists independently of any capacity we may possess at any point in time during our lives, or (ii) we perceive ourselves as objects whose worth is derived, not from our nature as human beings, but from the benefit others might find in our continued biological existence in our present state of functional capacity.¹⁶⁹ It is submitted that the rule of law would have meaning only under the first of these premises. By definition, the alternative thesis would define “law” as whatever the majority might prefer from time to time, thereby relegating to their subjective preference one’s right to continue his physical existence. The rule of law would be especially precarious in a world so ordered.

Professor Budziszewski has said that to define any animate being or inanimate thing with reference to its functional capacity would be “appropriate for things that have no inherent nature, whose identity is dependent on our purposes and interests in them—things that do not intrinsically deserve to be regarded in a certain way, but which may be regarded in any way which is most convenient.”¹⁷⁰ C. S. Lewis expressed the same concept in his work entitled *The Abolition of Man*: “when we understand a thing analytically and then dominate and use it for our own convenience, we reduce it to the level of ‘Nature’ in the sense that we suspend our judgements [sic] of value about it, ignore its final cause (if any), and treat it in terms of quantity.”¹⁷¹ As applied to human beings, therefore, both Budziszewski and Lewis would reject the functional, relative view of value. In fact, Lewis went so far as to suggest that when a society comes to regard man as a mere object of relative value, it not only deceives itself, but does so at its peril:

[A]s soon as we . . . reduc[e] our own species to the level of mere Nature
[“nature” being something “of that which knows no values as against

169. By holding that a competent person’s right to refuse medical treatment survives the loss of capacity, the jurisprudence concerning patient rights at the end of life has consistently acknowledged that all persons have an inherent value that exists independently of their decision-making capacity at any point during their biological existence. It follows that a person’s inherent value derives from his nature as a human being rather than from his physical or intellectual capacity. *Glucksberg*, 521 U.S. 702; *Quill*, 521 U.S. 793; *Cruzan*, 497 U.S. 261; *In re Conroy*, 486 A.2d 1209 (N.J. 1985); *In re Quinlan*, 355 A.2d at 664.

170. BUDZISZEWSKI, *supra* note 1, at 76.

171. C.S. LEWIS, *THE ABOLITION OF MAN* 69 (HarperOne 2001).

that which both has and perceives value”], . . . the being who stood to gain and the being who has been sacrificed is one and the same.¹⁷²

Previously in that work Lewis had written the following:

Man’s conquest of Nature turns out, in the moment of its consummation, to be Nature’s conquest of man. Every victory we seemed to win has lead us, step by step, to this conclusion. All Nature’s apparent reverses have been but tactical withdrawals. We thought we were beating her back when she was luring us on. What looked to us like hands held up in surrender was really the opening of arms to enfold us for ever.¹⁷³

Although Lewis penned these thoughts more than 60 years ago, their portent is assuming an increasing reality in the United States as illustrated by decisions in cases such as *Causey*¹⁷⁴ and related legal arguments that advance directive statutes should be construed to vest in physicians the unilateral authority to withhold or withdraw life-sustaining treatment that a patient or his surrogate has requested.¹⁷⁵ These developments suggest the ironic possibility that one’s right to refuse treatment as set forth in advance directive statutes might be transmuted into an obligation to do so, effectively condoning involuntary euthanasia. Likewise, certain applications of extreme palliative interventions, if not constrained by traditional ethical norms and legal principles of causation on which the right to refuse treatment was grounded, could not be logically distinguished from voluntary euthanasia.

The manner in which the law responds to these renditions of medical futility has the potential to influence the future of health care in the United States in ways that we can’t completely foresee, but which Lewis suggests portend consequences that we would both regret and find difficult to reverse. It is submitted that these risks can be avoided if the law remains grounded in the common thread that underlies the principles enunciated by the courts in *In re Quinlan*,¹⁷⁶ *Cruzan*,¹⁷⁷ *In re Conroy*,¹⁷⁸ *Glucksberg*¹⁷⁹ and *Quill*.¹⁸⁰ Each of these cases affirm the law’s recognition of the inherent value of human life as reflected in two prisms: (i) the enduring right of each individual either to accept or refuse medical treatment, whether through his own voice or that of a surrogate who speaks for him, and without regard to his state of functional capacity; and (ii) the corresponding unqualified inter-

172. *Id.* at 71.

173. *Id.* at 68.

174. *Causey v. St. Francis Med. Ctr.*, 719 So.2d 1072 (La. App. 2d Cir. 1998).

175. See discussion *supra* notes 72–87 and accompanying text.

176. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

177. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990).

178. *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

179. *Wash. v. Glucksberg*, 521 U.S. 702 (1997).

180. *Vacco v. Quill*, 521 U.S. 793 (1997).

est of the state in the preservation of life, including the lives of the weakest and most vulnerable among us.¹⁸¹

This body of jurisprudence implicitly recognizes that each member of the species *homo sapiens* is by definition a bearer of rights and a subject to be held in absolute regard, not because of what he can do, but because of what he is by nature. In this way, the law presupposes that one's standing as a person who possesses inherent value is not a function either of his condition, his stage of development at any point in time, or the value that others might ascribe to him in light of those characteristics. In the context of the specific issues addressed in this Article, it would follow that a patient, whether believed to be permanently unconscious or intentionally rendered in that state, would be subject to the same regard as any other person whose capacity is not compromised.

181. *Glucksberg*, 521 U.S. at 732 (stating that the prohibition against assisted suicide “reflects and reinforces [a state’s] policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy.”). See also Frederick R. Parker, Jr., *Washington v. Glucksberg and Vacco v. Quill: An Analysis of the Amicus Curiae Briefs and the Supreme Court’s Majority and Concurring Opinions*, 43 ST. LOUIS U. L.J. 469, 526 n.174 (1999).