

AN END-OF-LIFE QUANDARY IN NEED OF A STATUTORY RESPONSE: WHEN PATIENTS DEMAND LIFE-SUSTAINING TREATMENT THAT PHYSICIANS ARE UNWILLING TO PROVIDE

Abstract: For decades, the pressing end-of-life treatment issue was whether patients had the right to decline life-sustaining medical treatment. They do, and that right is now firmly established. A significant patient autonomy issue, however, remains unresolved: do patients have the right to demand and receive life-sustaining treatment when such treatment is contrary to the standard of care? Current precedent in the area provides uncertain guidance for health care professionals struggling to ascertain their obligations, as well as for patients wanting to know their rights. Yet, patient-physician disagreement on end-of-life care will continue, especially as medical technology improves. A process-based statute provides the best framework for addressing patient demands for care that are opposed by physicians and hospitals. This Note contends that the Texas Advance Directives Act is an effective model.

INTRODUCTION

The U.S. Supreme Court's landmark decision in 1990 in *Cruzan v. Director, Missouri Department of Health* recognized an implied right of a competent patient to decline life-sustaining medical treatment.¹ The decision was a capstone in the achievement of a national legal consensus that competent adults may refuse any unwanted medical interventions, even when the refusal may result in death.² Incompetent patients

¹ See 497 U.S. 261, 278 (1990). Chief Justice Rehnquist's majority opinion states that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred by our prior decisions" and thus avoids explicit recognition of a Fourteenth Amendment liberty interest in freedom from unwanted medical interventions. See *id.*

² See *id.*; John J. Paris & Michael D. Schrieber, *Physician's Refusal to Provide Life-Prolonging Medical Interventions*, 23 CLINICS IN PERINATOLOGY 563, 563 (1996); see also Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. a Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1241 (1993) (discussing *Cruzan* in the context of other patient autonomy cases in the end-of-life setting); Keith Shiner, Note, *Medical Futility: A Futile Concept?*, 53 WASH. & LEE L. REV. 803, 811-12 (1996) (noting that *Cruzan* was the Supreme Court's recognition of common law-developed patient autonomy). Currently, the right to decline

retain a similar right to be exercised on their behalf by a health care proxy or guardian, although that right is subject to state evidentiary requirements.³

Seventeen years after *Cruzan*, however, a significant patient autonomy issue remains unresolved.⁴ Namely, do patients have the right to demand, and receive, life-sustaining medical treatment when such treatment is contrary to the prevailing standard of medical care?⁵ In other words, does a patient's negative right to decline life-sustaining treatment extend into an affirmative right to receive requested life-sustaining measures?⁶

Take, for example, the case of Barbara Howe.⁷ In December of 1991, Barbara was diagnosed with ALS, and she executed a health care proxy designating her daughter Carol as her health care agent.⁸ Barbara expressed her wish to undergo life-sustaining treatment so long as she could interact with her family.⁹ She was admitted to Massachusetts General Hospital (the "Hospital") in 1999 and, by April 22, 2001, her attending physician stated that, in his best medical judgment, her condition would not improve and that she could no longer communicate

life-sustaining treatment is protected by statute in all fifty states, supported by federal law, and implicitly protected by the Fourteenth Amendment. See Patient Self-Determination Act of 1990, 42 U.S.C. § 1395 (2000); *Cruzan*, 497 U.S. at 273; Alicia R. Ouellete, *When Vitalism Is Dead Wrong: The Discrimination Against and Torture of Incompetent Patients by Compulsory Life-Sustaining Treatment*, 79 IND. L.J. 1, 3-7 & n.7 (2004).

³ See *Cruzan*, 497 U.S. at 283.

⁴ See *id.*; see also Judith F. Daar, *Medical Futility and Implications for Physician Autonomy*, 21 AM. J.L. & MED. 221, 231 (1995) (arguing that there is no legal obligation to provide end-of-life care that is not medically indicated); Paul R. Helft et al., *The Rise and Fall of the Futility Movement*, 343 NEW ENG. J. MED. 293, 296 (2000) (addressing the lack of consensus concerning life-sustaining treatment contrary to the medical standard of care and suggesting that, in the absence of a consensus, such care must be provided); Robert M. Veatch & Carol M. Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15, 36 (1992) (noting that state licensure of physicians gives rise to an affirmative obligation to provide aggressive end-of-life treatment when such treatment is requested).

⁵ See Daar, *supra* note 4, at 231; Helft et al., *supra* note 4, at 296; Veatch & Spicer, *supra* note 4, at 36.

⁶ See Daar, *supra* note 4, at 231; Helft et al., *supra* note 4, at 296; Veatch & Spicer, *supra* note 4, at 36.

⁷ See *In re Howe*, No. 03 P 1255, 2004 WL 1446057, at *1 (Mass. Prob. & Fam. Ct. Mar. 22, 2004).

⁸ *Id.* at *2-3.

⁹ *Id.* at *11.

meaningfully with her family.¹⁰ At Carol's request, though, aggressive treatment continued.¹¹

Beginning in the spring of 2003, Barbara's inability to close—and thereby lubricate—her eyes resulted in a corneal ulcer on her right eye that, in turn, necessitated its surgical removal.¹² Thereafter, Barbara's left eye was taped shut for the majority of the day, untaped only in the presence of her daughters so as to ensure visual contact with her family.¹³ Barbara had become so frail that during the regular course of her treatment to prevent bed sores, she suffered rib and leg fractures.¹⁴ Following Barbara's eye removal, the Hospital's ethics committee, known as the Optimum Care Committee, found that the continued care of Barbara Howe "demands that the entire body of caregivers violate their professional oaths, the standards of medical and nursing practice, the standards of the Massachusetts General Hospital, and the standards of ethics, morality, human decency and common sense."¹⁵ On June 18, 2003, the Hospital filed a petition for declaratory relief, and requested from the Probate and Family Court a determination as to the appropriate level of care that must be afforded to Barbara Howe.¹⁶ Ultimately, the Hospital wanted to discontinue ventilatory support, and sought judicial approval to do so.¹⁷

Unlike the established right to refuse medical treatment, there is no consensus about whether a patient has an affirmative right to demand treatment and compel the provision of that treatment when the physician is unwilling to comply.¹⁸ *In re Howe* and similar cases illustrate the tension between complying with a patient's expressed wishes and allowing health care providers to stop treatment when they are professionally and ethically obligated to do so.¹⁹ The right to refuse

¹⁰ *Id.* at *4. The physician informed Carol Howe that "keeping [her mother] alive by extraordinary means seems only to offer her the opportunity to suffer greatly, and is more like torture than respectful medical care." *Id.* at *5.

¹¹ *Id.* at *11.

¹² See *Howe*, 2004 WL 1446057, at *10–11.

¹³ See *id.* at *12.

¹⁴ See *id.* at *13.

¹⁵ See *id.* at *11–12.

¹⁶ See *id.* at *1.

¹⁷ See *Howe*, 2004 WL 1446057, at *1.

¹⁸ See Paul A. Gomez, Comment, *Promises and Pitfalls: An Analysis of the Shifting Constitutional Interests Involved in the Context of Demanding a Right to Treatment in Health Care*, 64 ALB. L. REV. 361, 383–85 (2000–01) (comparing the right to refuse life-sustaining treatment with the right to demand life-sustaining treatment, and arguing that the former is well-established but the latter is nonexistent).

¹⁹ See *id.*

medical treatment has extensive common law history and its application to the end-of-life context is a logical extension of that history.²⁰ By contrast, there is not a clear legal progression when the issue turns to the patient's right to receive demanded treatment.²¹ State malpractice law holds health care providers to the standard of medical care, and, therefore, patients can effectively demand elements of medical care that are required to meet the malpractice standard.²² Cases like that of Barbara Howe, however, involve requests for treatment that exceed this standard and tread into murky legal precedent.²³

The basic framework of the dispute is simple: a patient requests care that the health care provider is unwilling to give.²⁴ When put in the end-of-life context, though, the consequences become life and death, and questions that were formerly legal and medical in nature become equal parts political, moral, and theological.²⁵ This context, together with the lack of common law history, yields inconsistent precedent.²⁶ Indeed, the current precedent in this area is, at best, conflicting.²⁷ On the one hand, cases indicate that if the hospital or

²⁰ See Jerry Menikoff, *Demanded Medical Care*, 30 ARIZ. ST. L.J. 1091, 1092 (1998).

²¹ See *Howe*, 2004 WL 1446057, at *11-12; Menikoff, *supra* note 20, at 1092.

²² Menikoff, *supra* note 20, at 1093.

²³ See *id.*; see also Daar, *supra* note 4, at 223 (noting that "a review of existing case and statutory law in the area of medical futility shows that courts and lawmakers have promulgated vague and ill-defined policies which have left them susceptible to patient claims for limitless treatment").

²⁴ See Menikoff, *supra* note 20, at 1094. Professor Menikoff argues that, in this instance, "[i]f the appropriate medical standard of care does not otherwise require the physician to offer the care, then the physician cannot be compelled to provide the care merely because the patient asked for it, whether or not it is reasonable to want that care." *Id.*

²⁵ See George J. Annas, "Culture of Life" Politics at the Bedside—The Case of Terri Schiavo, 352 NEW ENG. J. MED. 1710, 1712 (2005) (describing the lengthy judicial process, and subsequent state and federal legislative involvement, that marked the decision concerning the end-of-life medical treatment of Terri Schiavo). Interestingly, the case of Terri Schiavo involved treatment issues "that most lawyers, bioethicists, and physicians believed were well settled," resulted in no changes in the law, "nor involved any arguments that legal changes were necessary." *Id.* at 1710, 1714. The issues in the demand context are not well settled, and, presumably, carry the same potential for a national political saga as the Schiavo case. See *id.* at 1714.

²⁶ Compare *In re Baby K*, 16 F.3d 590, 596 (4th Cir. 1994) (holding that the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") requires continued treatment), with *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (holding that EMTALA does not provide a cause of action when a do-not-resuscitate order is instituted and acted upon against the patient's wishes).

²⁷ Compare *Baby K*, 16 F.3d at 596 (holding that EMTALA requires continued treatment), with *Bryan*, 95 F.3d at 351 (holding that EMTALA does not provide a cause of action when a do-not-resuscitate order is instituted and acted upon against the patient's wishes).

patient seeks declaratory relief before the health care provider's refusal of life-sustaining treatment, the hospital will be compelled to continue the treatment, irrespective of whether the treatment is medically indicated.²⁸ On the other hand, if life-sustaining treatment is withheld without judicial approval, and the patient dies, the hospital may not be liable if it acted pursuant to the standard of care.²⁹

Thus, the legal answers to the questions posed by patient autonomy in the demand context are inconclusive.³⁰ The questions, however, will continue to persist, especially as life-extending medical technology advances and hospitals increasingly become the setting for end-of-life decision making.³¹ The problem is ripe for state statutory response, and the 1999 Texas Advance Directives Act ("the Texas Act" or "the Act") provides an effective model.³² The Texas Act is a response to the issues raised in the conflicting case law, and establishes a process-based resolution to disputes arising from patient or proxy requests for life-sustaining medical treatment that conflict with the standard of care.³³

This Note contends that a statutory remedy is necessary to address patient-physician disagreement over the provision of care demanded by the patient, and that the Texas Act is a worthy model.³⁴ Part I addresses the conflicting judicial responses to patient demands for life-sustaining treatment over the objections of health care providers.³⁵ Part II discusses the ill-fated futility movement, a medical and legal effort to define a class of treatment that physicians were not obligated to provide.³⁶

²⁸ See *Baby K*, 16 F.3d at 596; *In re Wanglie*, No. PX-91-283 (Minn. Prob. Ct. Hennepin County June 28, 1991), reprinted in 7 ISSUES L. & MED. 369, 370-72 (1991).

²⁹ See *Bryan*, 95 F.3d at 351-52; see also *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072, 1075 (La. Ct. App. 1998) (holding that the withdrawal of aggressive life-sustaining treatment is a medical procedure, and that claims brought upon such a withdrawal must establish that the withdrawal did not conform to the standard of care).

³⁰ See Daar, *supra* note 4, at 240.

³¹ See ALAN MEISEL, *THE RIGHT TO DIE* 530 (2d ed. 1995). Professor Meisel argues that "[t]his debate, which is just beginning to be played out in the courts, is likely to occupy as much, if not more, judicial effort in the coming years as conventional right-to-die cases have in the last two decades unless legislation cuts it short." *Id.*

³² See TEX. HEALTH & SAFETY CODE ANN. § 166.052 (Vernon Supp. 2006) (providing for an extrajudicial procedure when the physician recommends against life-sustaining treatment that the patient wishes to continue); see also Robert L. Fine & Thomas W. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANNALS INTERNAL MED. 743, 745-46 (2003) (evaluating Texas's experience with the Act, and recommending the Act as a model for other states).

³³ See § 166.052; Fine & Mayo, *supra* note 32, at 745-46.

³⁴ See § 166.052; Fine & Mayo, *supra* note 32, at 745-46.

³⁵ See *infra* notes 41-165 and accompanying text.

³⁶ See *infra* notes 166-201 and accompanying text.

That movement stalled because of an inability to define futility in a universally accepted fashion.³⁷ Part II further notes the difficulty of attempting to solve the problems associated with demanded care with a one-word catch-all, and demonstrates the ineffectiveness of an imprecise futility statute.³⁸ Then, it summarizes and analyzes various potential resolutions, including a statutory resolution, and summarizes the Texas Act.³⁹ Finally, Part III explains why a process-based statute such as the Texas Act provides the most effective resolution, in part by contrasting the resolution of the 2005 Texas Court of Appeals case of *Hudson v. Texas Children's Hospital*, in which the process-based Texas Act was applicable, with the resolution of *Howe* in the Probate and Family Court of Massachusetts, where there was no applicable statute.⁴⁰

I. LIFE-SUSTAINING INCONSISTENCY

The role of a physician, as suggested by the Hippocratic Corpus, includes an "obligation to abstain from treating those who are overmastered by their diseases, because medicine is powerless in that instance."⁴¹ In the end-of-life context, this obligation often collides with notions of patient autonomy when patients request treatment that will not produce a medical benefit.⁴² These fundamental disagreements about treatment between physicians and patients are a continuing problem, though most disputes never reach the courtroom.⁴³ Of those that do, many are ren-

³⁷ See Helft et al., *supra* note 4, at 293-96 (providing an overview of the futility debate).

³⁸ See *infra* notes 202-212 and accompanying text.

³⁹ See *infra* notes 213-270 and accompanying text.

⁴⁰ See *infra* notes 271-342 and accompanying text.

⁴¹ James J. Murphy, Comment, *Beyond Autonomy: Judicial Restraint and the Legal Limits Necessary to Uphold the Hippocratic Tradition and Preserve the Ethical Integrity of the Medical Profession*, 9 J. CONTEMP. HEALTH L. & POL'Y 451, 466 (1993); see Matthew S. Ferguson, Note, *Ethical Postures of Futility and California's Uniform Health Care Decisions Act*, 75 S. CAL. L. REV. 1217, 1229 (2001-02).

⁴² See Helft et al., *supra* note 4, at 294 (noting that patient-physician conflict in the demand context is, essentially, a debate between patients' autonomy and physicians' autonomy). This conflict may be considered, as it is in this Note, a disagreement between patient requests and provider belief that the requested treatment will result in harm to the patient without a concomitant benefit or provide no benefit at all, and thus would be contrary to the standards of medical practice. See Menikoff, *supra* note 20, at 1124. Other critiques address this issue as a potential area for rationing scarce medical resources. See John D. Lantos & Robert M. Taylor, *The Politics of Medical Futility*, 11 ISSUES L. & MED. 3, 11-12 (1995) (postulating that discussions of medically futile treatments and rationing are often intertwined, though not explicitly so). The resource allocation aspect will not be a focus of this Note.

⁴³ See Helft et al., *supra* note 4, at 294.

dered moot by transfer or death of the patient.⁴⁴ Until the 2005 Texas Court of Appeals case of *Hudson v. Texas Children's Hospital*, each time a patient sought life-sustaining treatment and the health care provider objected, contending that such treatment was contrary to the standard of care, the courts found in favor of the patient.⁴⁵ In each instance, however, the court did not directly rule on the issue of whether a patient has the right to demand and receive life-sustaining treatment that is contrary to the standard of care.⁴⁶

A. *Resolving the Matter Without Resolving the Issue:*⁴⁷

Baby L, In re Wanglie, & In re Baby K

Read together, the cases of *Baby L*, *In re Wanglie*, and *In re Baby K* demonstrate the complexity of the issues involved when patient requests for life-sustaining treatment are met with physician refusal on the grounds that such treatment is contrary to the standard of medical care.⁴⁷ Though the cases each involve substantially similar facts and effectively similar outcomes, they do not constitute a patient's affirmative right to demand and receive life-sustaining treatment.⁴⁸ Instead, the case of *Baby L* illustrates the potential of patient transfer to remedy disputes between physicians and patients over the course of end-of-life treatment in the demand context.⁴⁹ *Wanglie* holds that demanding treatment contrary to the standard of care does not alone constitute

⁴⁴ See *id.* at 296; see also John J. Paris et al., *Physicians' Refusal of Requested Treatment: The Case of Baby L*, 332 NEW ENG. J. MED. 1012, 1013 (1990); *infra* notes 52–65 and accompanying text.

⁴⁵ See Helft et al., *supra* note 4, at 296 (noting, at the time, that no court had approved the withdrawal of life-sustaining treatment over patient objections). Compare *Hudson v. Tex. Children's Hosp.*, 177 S.W.3d 232, 238 (Tex. App. 2005) (setting the stage for the denial of an injunction sought by mother to order the continuance of life-sustaining treatment for her child), with *In re Baby K*, 16 F.3d 590, 596 (4th Cir. 1994) (holding that EMTALA required continued aggressive treatment for an anencephalic infant).

⁴⁶ See *Baby K*, 16 F.3d at 596 (explicitly leaving this issue unresolved, and ruling instead on the application of EMTALA); *In re Wanglie*, No. PX-91-283 (Minn. Prob. Ct. Hennepin County June 28, 1991), reprinted in 7 ISSUES L. & MED. 369, 377 (1991); see also John J. Paris et al., *Beyond Autonomy: Physicians' Refusal to Use Life-Prolonging Extracorporeal Membrane Oxygenation*, 329 NEW ENG. J. MED. 354, 356 (1993) (discussing physician refusal to provide extracorporeal membrane oxygenation to a critically ill five-year-old patient).

⁴⁷ See *Baby K*, 16 F.3d at 596; *Wanglie*, reprinted in 7 ISSUES L. & MED. at 376; Paris et al., *supra* note 44, at 1012–13; see also Helft et al., *supra* note 4, at 296 (noting that the courts did not recognize a right of physicians to act unilaterally in cases in which they thought the care would be futile).

⁴⁸ See *Baby K*, 16 F.3d at 596; *Wanglie*, reprinted in 7 ISSUES L. & MED. at 376; Paris et al., *supra* note 44, at 1012–13; see also Helft et al., *supra* note 4, at 296.

⁴⁹ See Paris et al., *supra* note 44, at 1012–13.

reason to replace a well-qualified guardian, but remains silent on whether the hospital must provide the demanded care.⁵⁰ *Baby K* demonstrates that medical care contrary to prevailing standards of care must be provided when required under federal statute.⁵¹

1. The First Case: Baby L

In 1990, the *New England Journal of Medicine* reported on the case of Baby L, "the first time that physicians—even in the face of judicial intervention—have denied a request for potentially life-prolonging medical treatment for a patient in acute crisis."⁵² Baby L was born prematurely after a complicated pregnancy.⁵³ During the child's first twenty-three months, she suffered recurrent pneumonia, intermittent episodes of uncontrolled seizures, and four cardiopulmonary arrests, and underwent three major surgeries.⁵⁴ In the medical opinion of her attending physicians, Baby L had suffered such extensive neurological defects that she could experience only pain.⁵⁵ Baby L's mother, however, continued to demand that everything possible be done to prolong the child's life.⁵⁶

Faced with the mother's request, the hospital convened an institution-wide meeting, including the chiefs of service, primary care physicians, nurses, hospital counsel, and chairpersons of the institutional ethics committee.⁵⁷ They unanimously agreed that further care was not in the best interests of the child or consistent with standard medical practice, and refused to provide continued mechanical ventilation.⁵⁸ The hospital stabilized the child and actively sought another hospital facility willing to abide by the mother's decision on treatment.⁵⁹ Meanwhile, the mother sought an injunction in probate court to order continued ventilation.⁶⁰

⁵⁰ See Wanglie, reprinted in 7 ISSUES L. & MED. at 376.

⁵¹ See *Baby K*, 16 F.3d at 596.

⁵² Paris et al., *supra* note 44, at 1012-13.

⁵³ See *id.* at 1012.

⁵⁴ See *id.* These surgeries included a gastrostomy and a tracheostomy. See *id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ Paris et al., *supra* note 44, at 1012.

⁵⁸ See *id.* In so doing, the hospital cited *Brophy v. New England Sinai Hospital*, noting that there is nothing in the law "which would justify compelling medical professionals . . . to take active measures which are contrary to their view of their ethical duty toward their patients." *Id.* (quoting 497 N.E.2d 626, 639 (Mass. 1986)).

⁵⁹ *Id.*

⁶⁰ *Id.*

The legal dispute was rendered moot when the guardian ad litem consulted a pediatric neurologist from another institution to assess the patient's condition.⁶¹ The neurologist felt that continued aggressive care was the proper course of treatment for Baby L, and accepted care of the infant.⁶²

The case of Baby L presented the issue of patient demands clashing with a health care institution's refusal to provide aggressive medical care it viewed as contrary to accepted medical standards.⁶³ The resolution did not produce a judicial statement on the best way to resolve this issue.⁶⁴ It did, however, involve a standard extrajudicial solution that is an essential component in any statute—namely, the facilitation of a transfer to a physician willing to provide the care.⁶⁵

2. *In re Wanglie*: The "Right to Life"?

Unlike the case of Baby L, the physician-patient disagreement over the course of Helga Wanglie's end-of-life medical care yielded a court decision.⁶⁶ In 1991, the Hennepin County Probate Court of Minnesota, in *In re Wanglie*, issued the first judicial decision to confront the situation of physicians seeking the withdrawal of life-sustaining care against a patient's wishes.⁶⁷ The court, however, did not directly address the question of an affirmative right of a patient to demand and receive life-sustaining care because the hospital petitioned the court to request a change in guardianship, not for judicial approval of the cessation of treatment.⁶⁸

On May 23, 1990, then-eighty-six-year-old Helga Wanglie suffered a cardiorespiratory arrest that rendered her permanently unconscious.⁶⁹ Over the next several months, Mrs. Wanglie was evaluated by several neurology medical specialists who concurred in the diagnoses

⁶¹ *Id.*

⁶² See Paris et al., *supra* note 44, at 1012–13.

⁶³ See *id.*

⁶⁴ See *id.*

⁶⁵ See *id.*; see also Shiner, *supra* note 2, at 845 (noting that the opportunity to transfer is necessary, and that only upon denial of transfer may consensus within the medical profession show that continued aggressive treatment is contrary to the standard of care, including any viable minority views).

⁶⁶ See *Wanglie*, reprinted in 7 ISSUES L. & MED. at 370–72 (holding that Mr. Oliver Wanglie was the best person to serve as guardian for his gravely ill eighty-seven-year-old wife).

⁶⁷ See *id.* at 377; Daar, *supra* note 2, at 1242–45.

⁶⁸ See *Wanglie*, reprinted in 7 ISSUES L. & MED. at 377.

⁶⁹ See *id.* at 374.

of persistent vegetative state and permanent respirator dependence.⁷⁰ Throughout this time, she was provided aggressive life-sustaining treatment at the Hennepin County Medical Center.⁷¹ Mr. Wanglie was Mrs. Wanglie's husband of fifty-three years and, by Minnesota law, her guardian.⁷² When the hospital informed Mr. Wanglie that continued aggressive care was no longer serving his wife's best interests, and that to continue the course of treatment would be contrary to standard medical practice, Mr. Wanglie disagreed.⁷³ He insisted that all treatment be continued.⁷⁴

The hospital continued the course of Mrs. Wanglie's treatment but filed a probate petition contesting her husband's fitness as her guardian.⁷⁵ After a four-day hearing, the court ruled that decisions concerning Mrs. Wanglie's medical care were better made by her husband of fifty-three years than by a court-appointed third party.⁷⁶ Importantly, the court explicitly stated:

No Court order to continue or stop any medical treatment for Helga Wanglie has been made or requested at this time. Whether such a request will be made, or such an order is proper, or this Court would make such an order . . . are speculative matters not now before the Court.⁷⁷

The hospital chose an indirect path towards its goal of ceasing aggressive care, arguing that Mr. Wanglie should be replaced as guardian, rather than asserting that a patient does not have the right to receive medical treatment contrary to the standard of care.⁷⁸ As a result, the court ruled only on the guardianship matter.⁷⁹

⁷⁰ Daar, *supra* note 2, at 1242 n.4 (quoting Ronald E. Cranford, *Helga Wanglie's Ventilator*, 21 HASTINGS CENTER REP. 23, 23 (1993)).

⁷¹ See Wanglie, *reprinted in* 7 ISSUES L. & MED. at 376.

⁷² See *id.*

⁷³ See *id.* at 377.

⁷⁴ See *id.*

⁷⁵ See *id.* at 369. Some media outlets reported that the hospital asked the court "for permission to let a patient die against the wishes of the next of kin." Daar, *supra* note 2, at 1243 n.14 (quoting *Life in the Balance*, N.Y. TIMES, Jan. 13, 1991, § 4, at 7). In fact, the hospital petitioned the court only to request a change in guardianship. See Wanglie, *reprinted in* 7 ISSUES L. & MED. at 369.

⁷⁶ Wanglie, *reprinted in* 7 ISSUES L. & MED. at 376. The court also held that Mr. Wanglie was in the best position to act upon Helga Wanglie's conscientious, religious, and moral beliefs, and that he had indicated that he would do so. *Id.*

⁷⁷ *Id.* at 377.

⁷⁸ See *id.* at 376.

⁷⁹ See *id.*

Although some characterize *Wanglie* as a "right to life" case or, at least, an implicit recognition of the right to demand treatment in the end-of-life context, this is a mischaracterization of the holding and the issues before the court.⁸⁰ The court specifically declined to address the issue of whether Mrs. Wanglie had the right to demand aggressive life-sustaining treatment.⁸¹ Ultimately, the court held only that a guardian's disagreement with the recommended course of medical care is not sufficient grounds for his replacement.⁸² That holding is limited and rational, especially when the alternative is considered.⁸³ To hold that a hospital may petition the court for the replacement of an incompetent patient's guardian solely because that guardian would not endorse the recommended course of treatment would result in substantial infringement on patient autonomy in the end-of-life setting, and reopen issues that *Cruzan v. Director, Missouri Department of Health* and its predecessors had since resolved.⁸⁴

Wanglie, then, represents the proposition that when physicians and health care decisionmakers disagree, absent extenuating circumstances, replacement of the decisionmaker is not the best course.⁸⁵ Essentially, the case answers the easy half of the question that arises in the demand context: health care decisionmakers *may demand* life-sustaining care that does not conform to the prevailing standard of medical care without being replaced by a third party.⁸⁶ The court, however, was silent on the more difficult question, specifically whether the hospital is *obligated to provide* such care.⁸⁷

⁸⁰ See *id.* at 377; see also Daar, *supra* note 2, at 1244 (comparing *Wanglie* to the U.S. Supreme Court case of *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), to the extent that both cases involved attempted assertions of patient rights that were met with resistance from health care providers, and noting that in the end, both courts looked favorably on the principle of patient self-determination). Professor Daar notes that, given a sufficient level of evidence, patients may have the right to direct their medical care even in the face of physician opposition. See Daar, *supra* note 2, at 1245; see also Veatch & Spicer, *supra* note 4, at 21 (sharing Daar's view).

⁸¹ See *Wanglie*, reprinted in 7 ISSUES L. & MED. at 377.

⁸² See *id.*

⁸³ See Daar, *supra* note 4, at 224 (discussing the purposeful narrow tailoring of the *Wanglie* ruling).

⁸⁴ See *Cruzan*, 497 U.S. at 278; *Wanglie*, reprinted in 7 ISSUES L. & MED. at 377.

⁸⁵ See *Wanglie*, reprinted in 7 ISSUES L. & MED. at 377. Extenuating circumstances would include an instance in which the decisionmaker is acting in a manner clearly harmful to the patient, or demonstrably contrary to the patient's expressed interests. See *id.* at 376-77.

⁸⁶ See *id.*

⁸⁷ See *id.*

3. *In re Baby K* and the Emergency Treatment and Active Labor Act

In 1994, the U.S. Court of Appeals for the Fourth Circuit decided *In re Baby K*, and provided a partial answer to the second half of the demand context question.⁸⁸ The court, citing federal anti-patient "dumping" legislation, found that the hospital was obligated to provide requested mechanical ventilation for an anencephalic infant when that infant was presented to the hospital in respiratory distress, irrespective of the prevailing standard of treatment for anencephaly.⁸⁹

Baby K was born at Fairfax Hospital in October 1992 with anencephaly, a congenital malfunction in which a major portion of the brain, skull, and scalp is missing.⁹⁰ Although Baby K had a brain stem that allowed her to live with the aid of aggressive life-sustaining treatment, she lacked a cerebrum, which resulted in permanent and irreversible unconsciousness.⁹¹ When Baby K had difficulty breathing on her own at birth, the attending physicians placed her on a mechanical ventilator.⁹² Over the next few days, the attending physicians explained to Baby K's mother, Ms. H, that most anencephalic infants die within a few days of birth because of breathing difficulties and never develop the brain they are born without.⁹³ Nevertheless, Ms. H requested aggressive treatment.⁹⁴ Nearly one month after her birth, Baby K was transferred to a nearby nursing home.⁹⁵ Following that transfer, Baby K was readmitted to the hospital three times with breathing difficulties.⁹⁶ After the second admission, the hospital sought declaratory relief as to whether it was obligated to provide aggressive medical treatment that it deemed contrary to the standard of care for Baby K.⁹⁷

The court held that the Emergency Medical Treatment and Active Labor Act ("EMTALA"), a federal statute enacted in response to the practice of hospitals "dumping" patients who were unable to pay by ei-

⁸⁸ See 16 F.3d at 592. The parties in this case are anonymous in the court proceedings. See *id.* Newspaper articles, however, identified the hospital as Fairfax Hospital, located in Falls Church, Virginia. See Daar, *supra* note 4, at 225.

⁸⁹ See *Baby K*, 16 F.3d at 598. The court limited its decision to statutory interpretation, and explicitly stated that "[i]t is beyond the limits of our judicial function to address the moral or ethical propriety of providing emergency stabilizing medical treatment to anencephalic infants." *Id.*

⁹⁰ *Id.* at 592.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ See *Baby K*, 16 F.3d at 593.

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

ther refusing to provide emergency medical treatment or by transferring patients before their emergency conditions were stabilized, required stabilization of Baby K each time she was presented at the hospital with breathing difficulties.⁹⁸ The court found that when Baby K was presented in respiratory distress, a failure to provide immediate medical attention would cause serious impairment of her bodily functions.⁹⁹ Thus, according to the court, Baby K's breathing difficulties constituted an emergency medical condition requiring stabilization in accordance with EMTALA.¹⁰⁰ Although the court recognized the dilemma facing physicians who are requested to provide medical care contrary to the accepted practice of medicine, it found that a plain language reading of EMTALA dictates that such care must be provided.¹⁰¹

In his dissent, Senior Circuit Judge Sprouse argued that the court's application of EMTALA to the treatment of Baby K was improper.¹⁰² EMTALA, he reasoned, was passed to remedy the evil of patient "dumping," and that was not at issue in *Baby K* because the hospital had no economic interest in ceasing aggressive treatment.¹⁰³ Ms. H, Baby K's mother, was insured by Kaiser Permanente, a health maintenance organization that covered the cost of the hospital treatment.¹⁰⁴ Therefore, Judge Sprouse noted, the underlying issue was disagreement between the health decisionmaker and the hospital over the course of end-of-life care, an issue that was outside the scope of EMTALA's anti-dumping provisions.¹⁰⁵

Judge Sprouse argued in the alternative that even if EMTALA was applicable, it was wrongly interpreted by the majority.¹⁰⁶ He recognized anencephaly as a tragic illness that should be regarded as a continuum, not a series of discrete emergency medical conditions to be considered

⁹⁸ See *id.* EMTALA defines "emergency medical condition" as including:

[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Id. at 593–94 (quoting 42 U.S.C. § 1395dd(e)(1)(A) (2000)).

⁹⁹ *Baby K*, 16 F.3d at 594.

¹⁰⁰ See *id.*

¹⁰¹ See *id.* at 596.

¹⁰² See *id.* at 599 (Sprouse, J., dissenting).

¹⁰³ See *id.* at 598.

¹⁰⁴ See *Baby K*, 16 F.3d at 598 (Sprouse, J., dissenting).

¹⁰⁵ See *id.*

¹⁰⁶ See *id.* at 599.

in isolation.¹⁰⁷ He therefore argued that EMTALA would not have triggered the hospital's duty to provide stabilizing treatment for Baby K because there is no known treatment for anencephaly.¹⁰⁸ Moreover, Judge Sprouse argued that if courts are to test the appropriateness of care in this situation, the legal vehicle should be state malpractice law.¹⁰⁹ That area of law is shaped by the prevailing standard of medical care and, as such, would not have required aggressive treatment of Baby K.¹¹⁰

Baby K was roundly criticized, and many commentators extolled Judge Sprouse's dissent.¹¹¹ If the underlying medical condition is not considered, some noted, it would be difficult to imagine any emergency room scenario where a court would not order treatment.¹¹² Others felt that the court's "plain meaning" interpretation of EMTALA stretched the bounds of congressional intent.¹¹³ The statute, conceived to prevent patient "dumping," was read to require the continued aggressive care of an anencephalic infant, a result not within the purview of the statute's founding premise.¹¹⁴ At its core, *Baby K* represents judicial reluctance to endorse the refusal of medical care over the objection of the patient, and includes a controversial reading of a federal statute to that end.¹¹⁵

B. Act First, Question Later?

The outcomes of *Baby K* and *Wanglie* indicate a judicial reluctance to endorse the refusal of life-sustaining medical treatment against the wishes of the patient.¹¹⁶ When litigation arises after the death of the

¹⁰⁷ See *id.*

¹⁰⁸ See *id.*; Daar, *supra* note 4, at 227.

¹⁰⁹ See *Baby K*, 16 F.3d at 599 (Sprouse, J., dissenting).

¹¹⁰ See *id.*

¹¹¹ See George J. Annas, *Asking the Courts to Set the Standard of Emergency Care—The Case of Baby K*, 330 NEW ENG. J. MED. 1542, 1543 (1994); Mark A. Bonanno, *The Case of Baby K: Exploring the Concept of Medical Futility*, 4 ANNALS HEALTH L. 151, 167 (1995); Daar, *supra* note 4, at 227.

¹¹² See Daar, *supra* note 4, at 227; see also Annas, *supra* note 111, at 1543 (indicating that a broad reading of *Baby K* may result in federal law dictating the standard of all emergency treatment).

¹¹³ See Mark Strasser, *The Futility of Futility?: On Life, Death, and Reasoned Public Policy*, 57 MD. L. REV. 505, 509 (1998) (questioning whether EMTALA was properly interpreted, and advocating that Congress pass a clarifying amendment specifying that EMTALA was intended only to apply to indigent care); see also David Zell Meyerberg, Comment, *The Fourth Circuit's Baby K Decision: "Plain Language" Does Not Make Good Law*, 98 W. VA. L. REV. 397, 423–24 (1995).

¹¹⁴ See Strasser, *supra* note 113, at 509.

¹¹⁵ See *Baby K*, 16 F.3d at 596; Daar, *supra* note 4, at 227.

¹¹⁶ See *Baby K*, 16 F.3d at 596; *Wanglie*, reprinted in 7 ISSUES L. & MED. at 376.

patient, however, courts are reluctant to impose liability on the health care provider when it has refused care.¹¹⁷ The precedent and concurrent message to health care providers is thus inconsistent.¹¹⁸ More troubling, though, is that outcomes seem to depend on whether the patient has already died rather than the legally significant facts.¹¹⁹ The divergent strands of cases create a state of affairs in which physicians are likely to get better legal results when they refuse to provide nonbeneficial treatment and then defend their decisions than when they seek advance (legal) permission to withhold treatment.¹²⁰ This may discourage health care providers from seeking guidance from the law, thereby eliminating the safeguards the legal system could provide.¹²¹ That is a troublesome state of the law when the consequences are life and death.¹²²

1. *Bryan v. Rectors & Visitors of the University of Virginia*: Limiting Liability and *In re Baby K*

In the 1996 case of *Bryan v. Rectors & Visitors of the University of Virginia*, the Fourth Circuit faced an issue very similar to the one it had decided two years earlier in *Baby K*.¹²³ In *Bryan*, the University of Virginia Medical Center refused to provide life-sustaining treatment to a

¹¹⁷ See *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996); John J. Paris et al., *Use of a DNR Order over Family Objections: The Case of Gilgunn v. MGH*, 14 J. INTENSIVE CARE MED. 41, 41–45 (1999).

¹¹⁸ Compare *Baby K*, 16 F.3d at 596 (holding that EMTALA requires the provision of life-sustaining treatment to an anencephalic infant regardless of applicable medical standards), and *Wanglie*, reprinted in 7 ISSUES L. & MED. at 376 (holding that the long-time husband of a direly ill wife was not to be replaced as guardian simply because he was requesting medical treatment contrary to the standard of care), with *Bryan*, 95 F.3d at 351 (finding that EMTALA does not require the indefinite provision of life-sustaining treatment), and Paris et al., *supra* note 117, at 41–45 (discussing the *Gilgunn* case, where a malpractice suit stemming from the withdrawal of life-sustaining treatment against the patient's wishes resulted in a jury finding of no negligence).

¹¹⁹ See Ann Alpers & John M. Luce, *Legal Aspects of Withholding and Withdrawing Life Support from Critically Ill Patients in the United States and Providing Palliative Care to Them*, 162 AM. J. RESPIRATORY CRITICAL CARE MED. 2029, 2029 (2000); Paris et al., *supra* note 117, at 44. Compare *Baby K*, 16 F.3d at 596 (holding that EMTALA requires the provision of life-sustaining treatment to an anencephalic infant regardless of applicable medical standards), and *Wanglie*, reprinted in 7 ISSUES L. & MED. at 376 (holding that the long-time husband of a direly ill wife was not to be replaced as guardian simply because he was requesting medical treatment contrary to the standard of care), with *Bryan*, 95 F.3d at 351 (finding that EMTALA does not require the indefinite provision of life-sustaining treatment).

¹²⁰ See Alpers & Luce, *supra* note 119, at 2029.

¹²¹ See *id.*

¹²² See *id.*

¹²³ See *Bryan*, 95 F.3d at 350–51; *Baby K*, 16 F.3d at 596.

critically ill patient.¹²⁴ Unlike *Baby K*, however, the litigation arose after the refusal of treatment and after the death of the patient.¹²⁵ The patient's administratrix brought suit against the hospital for failure to provide emergency stabilizing treatment under EMTALA.¹²⁶

Mrs. Robertson, the patient, was admitted to the University of Virginia Medical Center in critical condition with, most emergently, respiratory distress.¹²⁷ The hospital stabilized the patient and treated her for twelve days.¹²⁸ After that point, because of the patient's dire condition and pursuant to hospital policy, the attending physicians entered a "do not resuscitate order" against the wishes of the patient and her proxy.¹²⁹ Eight days later, Mrs. Robertson suffered cardiac arrest; the attending physicians and hospital staff made no attempt to resuscitate the patient, and she died.¹³⁰

The plaintiff argued that, on the basis of *Baby K*, although Mrs. Robertson suffered underlying respiratory problems, her emergency condition was cardio-pulmonary failure that required stabilization under EMTALA.¹³¹ In failing to provide resuscitation, the plaintiff contended, the hospital did not attempt to stabilize the patient and, therefore, was liable under EMTALA.¹³² The court rejected that reasoning, finding that under the plaintiff's interpretation, every presentation of an emergency patient to a hospital covered by EMTALA would obligate the hospital to do much more than provide immediate, emergency stabilizing treatment with appropriate follow-up.¹³³ According to the court, the plaintiff's reading of EMTALA would require the hospital to provide treatment indefinitely according to a novel federal standard of care derived from the statutory stabilization requirement.¹³⁴ The court was unwilling to accept that contention.¹³⁵

¹²⁴ See 95 F.3d at 350.

¹²⁵ See *Bryan*, 95 F.3d at 350-51; *Baby K*, 16 F.3d at 596.

¹²⁶ *Bryan*, 95 F.3d at 349.

¹²⁷ *Id.* at 350.

¹²⁸ See *id.*

¹²⁹ See *id.*

¹³⁰ See *id.*

¹³¹ See *Bryan*, 95 F.3d at 350-51.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.* at 351.

¹³⁵ See *id.*

In finding for the hospital, the court limited *Baby K* to its facts.¹³⁶ Also, the court warned against misinterpretation of *Baby K*, noting that the case does not require indefinite stabilization for emergency conditions.¹³⁷ EMTALA, the court stated, "cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context [of patient dumping]." ¹³⁸

Therefore, the court found that after the patient is initially stabilized, the patient's care becomes the legal obligation of the physician and the hospital, and the adequacy of that care is governed by state malpractice law.¹³⁹ A prima facie case of medical malpractice under state law includes a showing that the treatment deviated from the standard of medical care.¹⁴⁰ The Fourth Circuit did not have jurisdiction to rule on the matter because it was a state issue, but did note that the hospital's do-not-resuscitate order was consistent with the standard of care.¹⁴¹ Thus, in *Bryan*, the hospital's refusal to provide life-sustaining treatment over the objections of the patient did not give rise to liability under EMTALA, and also likely would not under state malpractice law.¹⁴²

2. *Gilgunn v. Massachusetts General Hospital*: A Message Without Precedent

The 1995 Massachusetts Superior Court case of *Gilgunn v. Massachusetts General Hospital* involved the application of state malpractice law to the refusal of care in the end-of-life context over the objections of the patient, an issue raised but not decided in *Bryan*.¹⁴³ Although

¹³⁶ See *Bryan*, 95 F.3d at 352. The court interpreted *Baby K* as turning "entirely on the substantive nature of the stabilizing treatment that EMTALA required for a particular emergency medical condition." *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ See *id.* at 351-52.

¹⁴⁰ See *id.*

¹⁴¹ See *Bryan*, 95 F.3d at 351-52.

¹⁴² See *id.*

¹⁴³ See *Bryan*, 95 F.3d at 351-52; *Gilgunn v. Mass. Gen. Hosp.*, No. 92-4820 (Mass. Super. Ct. Apr. 21, 1995); Paris et al., *supra* note 117, at 41 (discussing the details of the *Gilgunn* jury trial). Paris's coauthors included: Mrs. Gilgunn's treating physician, G. William Dec, M.D.; the head of the Massachusetts General Hospital's Optimal Care Committee, Edwin H. Cassem, M.D.; and the lawyer representing Massachusetts General, Frank E. Reardon. Paris et al., *supra* note 117, at 41. The case drew widespread attention in the medical and health law communities, but scholarship was delayed by the prospect of an appeal; the plaintiff withdrew her appeal in January 1998, and the article by Paris and his coauthors followed. *Id.* at 45.

Gilgunn was a jury case and did not yield appellate review, the case attracted much attention in the medical community.¹⁴⁴ Indeed, the case was the first in which a jury was asked to assess liability involved in a physician's refusal to provide aggressive life-sustaining treatment against the wishes of the patient.¹⁴⁵ Moreover, the case involved one of the leading medical centers in the country with a standard-setting ethics committee.¹⁴⁶

Gilgunn arose from a dispute over treatment administered to Mrs. Gilgunn, a seventy-two-year-old female who was admitted to Massachusetts General Hospital in early June of 1989 for immediate care of her broken hip.¹⁴⁷ Within nine days of admission, Mrs. Gilgunn suffered a grand mal seizure, and continued to have uncontrollable seizures over the following week.¹⁴⁸ Her condition drastically deteriorated until the end of July, when she lacked any neurological response to stimuli and her prognosis for functional recovery dropped to "nil."¹⁴⁹ The attending physician informed Mrs. Gilgunn's family that aggressive treatment was now "hopeless from a medical point of view," but the family continued to demand that everything possible be done.¹⁵⁰

Following the family meeting, the attending physician consulted with the hospital's ethics committee, known as the Optimal Care Committee (the "OCC").¹⁵¹ The OCC evaluated the patient and her record and concluded that continued medical care was not medically indicated.¹⁵² The family's wishes, according to the notes of the OCC, did not justify mistreating the patient.¹⁵³ First, the intensive care unit team responsible for Mrs. Gilgunn's care entered a do-not-resuscitate order over the strenuous objections of the patient's family.¹⁵⁴ Next, on August 7, the attending physician informed the family that Mrs. Gilgunn would be

¹⁴⁴ See Paris et al., *supra* note 117, at 45.

¹⁴⁵ *Id.* at 41.

¹⁴⁶ See *id.*

¹⁴⁷ *Id.* Unfortunately, Mrs. Gilgunn was also afflicted with debilitating long-term illnesses, including diabetes, cancer, Parkinson's disease, and coronary artery disease. *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ Paris et al., *supra* note 117, at 42.

¹⁵⁰ See *id.* The attending physician especially stressed the danger involved in CPR. *Id.* at 43. Given her condition, attempts at resuscitation would have resulted in multiple broken ribs, hemorrhages, and exsanguinations. *Id.* Such a violent and bloody death, the physician stressed, would not be consistent with the physician's obligation to do no harm. *Id.*

¹⁵¹ *Id.* at 43.

¹⁵² *Id.*

¹⁵³ *Id.* at 42.

¹⁵⁴ Paris et al., *supra* note 117, at 42.

weaned from the ventilator that day.¹⁵⁵ She was, and she died three days later.¹⁵⁶ The family filed suit in response.¹⁵⁷

The result was a two-week Massachusetts Superior Court jury trial held in April 1995.¹⁵⁸ During the trial, the hospital cited the President's Commission for the Study of Ethical Problems in Medicine Report as support for the position that: "A professional has an obligation to allow a patient to choose from among medically acceptable treatment options . . . or to reject all options. No one, however, has an obligation to provide interventions that would, in his or her judgment, be counter-therapeutic."¹⁵⁹ The jury returned a verdict in favor of the hospital.¹⁶⁰ The jury found that, given the circumstances, the hospital's withholding of aggressive treatments did not give rise to liability.¹⁶¹

The five cases discussed in this Part—*Baby L*, *Wanglie*, *Baby K*, *Bryan*, and *Gilgunn*—are the most prominent examples of physician refusal to provide aggressive life-sustaining treatment over the objections of the patient.¹⁶² Together, they send an inconsistent, if not incoherent, message to health care providers about how to handle these end-of-life situations.¹⁶³ The cases may encourage hospitals to cease aggressive treatment first, and defend that action later.¹⁶⁴ The case law does not provide a clear-cut resolution to the patient demands for treatment deemed by physicians to be medically unwarranted.¹⁶⁵

II. A FUTILE DEBATE AND MORE PROMISING RESOLUTIONS

The futility movement—an effort by medical and legal scholars to establish a class of treatment in the end-of-life context that health care institutions and physicians would categorically, and legally, refuse

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *See id.* at 45.

¹⁵⁹ *See* Paris et al., *supra* note 117, at 44 (quoting PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS 44 (1983)).

¹⁶⁰ Paris et al., *supra* note 117, at 45.

¹⁶¹ *Id.*

¹⁶² *See* *Bryan*, 95 F.3d at 350–51; *Baby K*, 16 F.3d at 596; *Wanglie*, reprinted in 7 ISSUES L. & MED. at 376; Paris et al., *supra* note 44, at 1012–13; Paris et al., *supra* note 117, at 45.

¹⁶³ *See* *Bryan*, 95 F.3d at 350–51; *Baby K*, 16 F.3d at 596; *Wanglie*, reprinted in 7 ISSUES L. & MED. at 376; Paris et al., *supra* note 44, at 1012–13; Paris et al., *supra* note 117, at 45.

¹⁶⁴ *See* Alpers & Luce, *supra* note 119, at 2029.

¹⁶⁵ *See* Helft et al., *supra* note 4, at 296 (noting that disputes over end-of-life care will continue and, thus, a process to address them must be developed).

to provide—was an attempt to resolve the issues raised by demanded life-sustaining care.¹⁶⁶ Despite the massive amount of scholarship devoted to the issue, a consensus on the meaning of futile treatment proved to be illusive.¹⁶⁷ The medical community was nearly unanimous in its condemnation as futile of the treatment provided to, for example, Baby K.¹⁶⁸ Yet, the movement failed to achieve a consensus on a general class of treatment that would be considered futile and, thus, never formed an agreement on a substantive definition of futility.¹⁶⁹ As a result, the futility movement did not form a foundation for the refusal of treatment, and ultimately failed at its underlying goal.¹⁷⁰

A. Movement Without a Meaning

The approaches to defining medically futile treatment may be broken down into two not-entirely-distinct groups: the quantitative/physiological-based arguments and the qualitative arguments.¹⁷¹ On the chiefly quantitative side, one prominent medical journal article argued that if care was ineffective in the last one hundred cases, it may be considered futile.¹⁷² The article's authors defined ineffective treatment as "treatment that merely preserves permanent unconsciousness or that fails to end total dependence on intensive medical care."¹⁷³ They concluded that there is no legal or medical obligation to provide such care.¹⁷⁴

This definition of "futile" treatment, however, involves a curious definition of an effect.¹⁷⁵ Aggressive treatment that preserves a per-

¹⁶⁶ See *id.*; Veatch & Spicer, *supra* note 4, at 15; see also Lawrence J. Schneiderman et al., *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 949, 950 (1990) (discussing qualitative and quantitative approaches to defining "futility").

¹⁶⁷ See, e.g., Council on Ethical & Judicial Affairs, Am. Med. Ass'n, *Medical Futility in End-of-Life Care*, 325 J. AM. MED. ASS'N 937, 937-38 (1999); Helft et al., *supra* note 4, at 293-96 (providing an overview of the futility debate); Lawrence J. Schneiderman, *The Futility Debate: Effect Versus Beneficial Intervention*, 42 J. AM. GERIATRIC SOC. 883, 883-86 (1994).

¹⁶⁸ See Lawrence J. Schneiderman & Sharyn Manning, *The Baby K Case: A Search for the Elusive Standard of Medical Care*, 6 CAMBRIDGE Q. HEALTHCARE ETHICS 9, 11 (1997) (publishing the results of an extensive survey of practitioners concerning the treatment provided to Baby K, and indicating nearly unanimous disapproval).

¹⁶⁹ See Helft et al., *supra* note 4, at 296.

¹⁷⁰ See *id.*

¹⁷¹ See Veatch & Spicer, *supra* note 4, at 17-20.

¹⁷² See Schneiderman et al., *supra* note 166, at 951. The authors of this article argue that "when physicians conclude (either through personal experience, experiences shared with colleagues, or consideration of reported empiric data) that in the last 100 cases medical treatment has been useless, they should regard that treatment as futile." *Id.*

¹⁷³ See *id.* at 952-53.

¹⁷⁴ *Id.*

¹⁷⁵ See *id.*

manent state of unconsciousness, or continues dependence on intensive medical care, still has the significant effect of extending the patient's life.¹⁷⁶ Ignoring this effect is an inherently subjective assertion, namely that the permanently unconscious life is not worth living or, correlatively, is not worth preserving.¹⁷⁷

Another less controversial quantitative/physiological definition of futile care is treatment that produces no physiological effect at a given level of probability.¹⁷⁸ An example of this conception of "futile" care would be CPR performed on a patient who last breathed three hours prior to receiving the care.¹⁷⁹ Likewise, the use of antibiotics would be "futile" treatment for the common cold because the treatment ultimately has no effect on a viral condition.¹⁸⁰ Underlying this definition of "futile" care is the relatively straightforward assertion that if the treatment produces no effect, it is not medically appropriate treatment, and its provision is not obligated.¹⁸¹

This conception of "futility," although certainly a viable definition of "futile" care, is not particularly useful in the end-of-life context.¹⁸² Patients generally do not demand CPR three hours after death.¹⁸³ Nor do patients or families typically request treatment that has no demonstrable effect.¹⁸⁴ In the end-of-life context, life-sustaining treatment has one readily apparent effect: prolonging life.¹⁸⁵ Thus, this conception of "futility" is inapplicable in patient-physician disagreements over aggressive life-sustaining treatment.¹⁸⁶

If the "futility" movement was to achieve its goal of providing medical and legal grounds to refuse life-sustaining care, the definition of futile care could not be so limited.¹⁸⁷ As one commentator noted, "even if it is obvious that treatments that produce no effect should be considered futile, that does not establish that *only* such treatments should be considered futile."¹⁸⁸ Expanding the definition involved qualitative as-

¹⁷⁶ See *id.* at 951.

¹⁷⁷ See Schneiderman et al., *supra* note 166, at 951.

¹⁷⁸ See Veatch & Spicer, *supra* note 4, at 18.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ See *id.*; see also Strasser, *supra* note 113, at 515 (discussing the limited applicability of this conception of "futility").

¹⁸² See Veatch & Spicer, *supra* note 4, at 20.

¹⁸³ See *id.*

¹⁸⁴ See *id.*

¹⁸⁵ See *id.*

¹⁸⁶ See *id.*

¹⁸⁷ See Strasser, *supra* note 113, at 515.

¹⁸⁸ *Id.*

sertions.¹⁸⁹ The resultant conception of "futility" was care that had an effect but no benefit.¹⁹⁰ This definition included, for example, aggressive end-of-life treatment that prolonged a terminally ill patient's life but also extended or worsened that patient's pain.¹⁹¹

The qualitative definition of futile care necessarily involves a value judgment.¹⁹² In the previously mentioned example of care that extends life but worsens pain, the value judgment is as follows: extending the life of a terminally ill patient without reducing the pain experienced by that patient is not an end worth pursuing.¹⁹³ To say that a physician is not obligated to provide futile care in this instance is to allow the physician to determine whether prolongation is worthwhile.¹⁹⁴ Some authors suggest that this power rests with the physician in the end-of-life context.¹⁹⁵ Others forcefully argue that physicians have no particular expertise in this area because determining the benefit of extending life, no matter how painful, is not a medical, but a value judgment.¹⁹⁶

In July 2000, the *New England Journal of Medicine* published the futility movement's de facto obituary, entitled "The Rise and Fall of the Futility Movement."¹⁹⁷ The authors, having been participants in the "futility" debate themselves, noted that the "illusion of futility is the mistaken assumption that it is an objective entity."¹⁹⁸ As an inherently subjective classification, the authors argued, designating treatment as futile does not resolve disputes between patients and physicians over aggressive end-of-life care.¹⁹⁹ The futility movement demonstrated the difficulty in clearly delineating a class of care that the medical community is unwilling to provide.²⁰⁰ Although the movement failed, the problem it set out to remedy persists.²⁰¹

¹⁸⁹ See *id.*

¹⁹⁰ See Veatch & Spicer, *supra* note 4, at 17; see also Shiner, *supra* note 2, at 830 (discussing qualitative futility and the "effect but no benefit" definition).

¹⁹¹ See Strasser, *supra* note 113, at 517-20.

¹⁹² See *id.*

¹⁹³ See *id.*

¹⁹⁴ See *id.*

¹⁹⁵ See Daar, *supra* note 2, at 1256-57; Schneiderman et al., *supra* note 166, at 953.

¹⁹⁶ See Veatch & Spicer, *supra* note 4, at 35-36; see also Edmund Pellegrino, *Ethics in AIDS Treatment Decisions*, 19 ORIGINS 539, 544 (1990) (contending that "the physician is neither morally employed nor qualified to make decisions about the quality of life of another person").

¹⁹⁷ See Helft et al., *supra* note 4, at 296.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.* at 294.

²⁰⁰ See *id.*

²⁰¹ See *id.* at 296.

B. An Ineffective Statute

Three states have statutes meant to address patient-physician conflicts in the demand context, but all fall victim to the fallacy of the futility movement.²⁰² The Maryland statute is particularly representative.²⁰³ Section 5-611(a) of the Maryland Health Care Decisions Act states, *inter alia*, that "nothing in this subtitle may be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be ethically inappropriate."²⁰⁴ The subsequent section, 5-611(b), provides that "nothing in this subtitle may be construed to require a physician to prescribe or render medically ineffective treatment."²⁰⁵

The statute fails to define what is meant by "ethically inappropriate treatment" or "medically ineffective" treatment.²⁰⁶ Thus, its application in the end-of-life context is questionable and, to date, has not been tested.²⁰⁷ Section 5-611(b)—specifically addressing "medically ineffective" treatment—may not apply to aggressive life-sustaining treatment because such treatment has a demonstrable effect—the extension of life.²⁰⁸ Section 5-611(a) has a potentially broader construction, although, as the debate surrounding the "futility" movement demonstrated, the precise definition of "ethically inappropriate treatment" may prove illusive.²⁰⁹

The Maryland legislature was cognizant of the potential for continuing patient-physician disputes.²¹⁰ Its statutory response, however, is illustrative of the difficulties in framing the issue.²¹¹ A vaguely phrased statute provides little, if any, guidance.²¹²

²⁰² See MD. CODE ANN., HEALTH-GEN. § 5-611 (West 2005); TEX. HEALTH & SAFETY CODE ANN. § 166.052 (Vernon Supp. 2006); VA. CODE ANN. § 54.1-2990 (West 2004).

²⁰³ See MD. CODE ANN., HEALTH-GEN. § 5-611; *see also* TEX. HEALTH & SAFETY CODE ANN. § 166.052 (providing for an extrajudicial procedure when the physician recommends against life-sustaining treatment that the patient wishes to continue); VA. CODE ANN. § 54.1-2990 (stating that nothing in the Virginia Health Care Decisions Act "shall be construed to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate").

²⁰⁴ MD. CODE ANN., HEALTH-GEN. § 5-611.

²⁰⁵ *Id.* § 5-611(b).

²⁰⁶ *See id.* § 5-611.

²⁰⁷ *See* Ferguson, *supra* note 41, at 1219–20, 1255.

²⁰⁸ *See* MD. CODE ANN., HEALTH-GEN. § 5-611(b) (West 2005).

²⁰⁹ *See id.* § 5-611(a).

²¹⁰ *See id.*

²¹¹ *See id.*

²¹² *See* Ferguson, *supra* note 41, at 1219.

C. Potential Resolutions

Questions about care in the end-of-life context involve a unique confluence of medical, moral, theological, and family issues against the backdrop of the ultimate finality—death.²¹³ As such, they are exceedingly complex issues and ones that, because of their recurrent nature, cannot be ignored.²¹⁴ The questions involve distinct views of what constitutes appropriate medical care in the end-of-life context, and who is best suited to make that determination—physician or patient.²¹⁵

These are difficult issues, as illustrated by the divergent case law and the lack of consensus that marked the futility movement.²¹⁶ Patient-physician disputes over aggressive life-sustaining treatment deemed contrary to the standard of medical care have four plausible resolutions: (1) unilateral physician refusal over objections of the patient; (2) continued provision of care indefinitely, over the objection of the health care provider, but consistent with the wishes of the patient; (3) a judicial, case-by-case approach, initiated by either the patient or the physician; or (4) a well-crafted statute, possibly modeled on the 1999 Texas Advance Care Directives Act.²¹⁷

1. Unilateral Physician Refusal

Unilateral physician refusal to provide care would allow physicians to cease the provision of aggressive life-sustaining care when such care

²¹³ See Annas, *supra* note 25, at 1712–13. This is perhaps best demonstrated by the seven-year litigation stemming from family disagreement over the end-of-life care of Terri Schiavo. See *id.* Determining the course of her life-sustaining treatment involved the judicial, legislative, and executive branches of both the state (Florida) and federal governments. See *id.* See generally ARTHUR L. CAPLAN, JAMES J. MCCARTNEY & DOMIC A. SISTI, *THE CASE OF TERRI SCHIAVO* (2006) (providing comprehensive documentation on the entire legal timeline of the Schiavo cases).

²¹⁴ See Helft et al., *supra* note 4, at 296.

²¹⁵ See Veatch & Spicer, *supra* note 4, at 16.

²¹⁶ See *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 350–51 (4th Cir. 1996); *In re Baby K*, 16 F.3d 590, 596 (4th Cir. 1994); *In re Wanglie*, No. PX-91-283 (Minn. Prob. Ct. Hennepin County June 28, 1991), reprinted in 7 *ISSUES L. & MED.* 369, 376 (1991); Helft et al., *supra* note 4, at 296; Paris et al., *supra* note 44, at 1012–13; Paris et al., *supra* note 117, at 45.

²¹⁷ See *infra* notes 218–240 and accompanying text. The first course of action, for instance, was taken in *Bryan*. See 95 F.3d at 351. The second course of action is vigorously recommended by Veatch and Spicer, *supra* note 4, at 17. The third course of action, for example, was taken in *Baby K*. See 16 F.3d at 596. For the fourth potential resolution, see TEX. HEALTH & SAFETY CODE ANN. § 166.052 (Vernon Supp. 2006) (providing for an extrajudicial procedure when the physician recommends against life-sustaining treatment that the patient wishes to continue).

is contrary to the standard of medical care; an obligation to provide palliative care would still remain.²¹⁸ Medical literature reports that some practitioners believe that this course of action is widely pursued, though infrequently discussed with the patient or his/her health care decisionmaker.²¹⁹ One prominent commentator contends that state medical malpractice statutes allow unilateral refusal, but some physicians are reluctant to refuse treatment over the objections of the patient because of liability fears.²²⁰

The current state of case law arguably incentivizes health care providers to refuse treatment first and defend their actions later, as prerefusal petitions to the courts have been unsuccessful from the perspective of providers wishing to end care, but postrefusal malpractice actions have not given rise to liability.²²¹ Unilateral physician refusal, however, is an unattractive option for two primary reasons.²²² First, it would mark a significant retreat from well-established notions of patient autonomy.²²³ Although an affirmative patient right to demand treatment in the end-of-life context has not been recognized, the wishes of the patients should, at the very least, be considered.²²⁴ Second, given the irreversible consequences of the refusal of life-sustaining treatment, some standardized decision-making process is necessary to prevent rash actions and mistakes.²²⁵

2. Continue Treatment Indefinitely

This option, according to many commentators, is the default position.²²⁶ If the patient requests treatment, they reason, the path of least

²¹⁸ See Paris et al., *supra* note 44, at 1013 (discussing, but not advocating, this option).

²¹⁹ See Schneiderman et al., *supra* note 166, at 952; see also David Cassarett & Mark Siegler, *Unilateral Do-Not-Attempt-Resuscitation Orders & Ethics Consultation: A Case Series*, 27 J. CRITICAL CARE MED. 1116–20 (1999) (studying the frequency of do-not-resuscitate orders unilaterally entered by physicians without patient consultation).

²²⁰ See Howard Brody, *The Physician's Role in Determining Futility*, 42 J. AM. GERIATRIC SOC. 875, 878 (1994).

²²¹ See Alpers & Luce, *supra* note 119, at 2029.

²²² See Veatch & Spicer, *supra* note 4, at 36.

²²³ See *id.* at 29.

²²⁴ See *id.*

²²⁵ See Helft et al., *supra* note 4, at 296.

²²⁶ See *id.*; Veatch & Spicer, *supra* note 4, at 36; see also John J. Paris & Frank E. Reardon, *Physician Refusal of Requests for Futile or Ineffective Interventions*, 2 CAMBRIDGE Q. HEALTH-CARE ETHICS 127, 133 (1992) (discussing the potential effects of this fall-back option and whether policies that insist on doing "whatever the patient wants" undermine the dignity of the patient and the integrity of the medical profession).

resistance is simply to provide that treatment.²²⁷ This, however, results in disregard for professional judgment in the practice of medicine.²²⁸ The provision of aggressive care that is not medically indicated reduces the physician from a professional and moral agent to a servant of the patient's demands.²²⁹ Objections to the indefinite provision of aggressive life-sustaining treatment also come from those who question the allocation of resources in the end-of-life care context.²³⁰

3. Judicial Resolution on a Case-by-Case Basis

Disputes over the continuation of end-of-life treatment may continue to be resolved individually by the courts.²³¹ Yet, without a pertinent statute to apply, courts have taken divergent routes in these cases.²³² It is unlikely that this trend will soon be reversed.²³³ Courts are also ill-equipped for the timely resolution of pressing end-of-life issues, as the timeline and outcome of *In re Howe* demonstrate.²³⁴ Fear of a lengthy judicial process may result in health care providers adopting de facto policies that encourage indefinite provision of treatment or unilateral withdrawal, thus making case-by-case judicial decisions an impotent tool for resolving this debate.²³⁵

4. Statutory Resolution

A well-crafted and process-oriented statutory response at the state level may be the most effective way to resolve these continuing conflicts.²³⁶ Such a statute should take into account the potential, demonstrated in the case of Baby L, for a patient transfer to remedy the disagreement concerning end-of-life care.²³⁷ A statute also should establish a process through which an actionable consensus on the applicable standard of medical care may be achieved.²³⁸ Furthermore, a statute

²²⁷ See Veatch & Spicer, *supra* note 4, at 15–17.

²²⁸ Paris & Reardon, *supra* note 226, at 133.

²²⁹ *Id.*

²³⁰ See Veatch & Spicer, *supra* note 4, at 29 (noting that rationing is inextricable from criticism of indefinitely continued treatment at the patient's request).

²³¹ See Alpers & Luce, *supra* note 119, at 2029.

²³² See *id.*

²³³ See MEISEL, *supra* note 31, at 530.

²³⁴ See No. 03 P 1255, 2004 WL 1446057, at *13–16 (Mass. Prob. & Fam. Ct. Mar. 22, 2004).

²³⁵ See Brody, *supra* note 220, at 878.

²³⁶ See TEX. HEALTH & SAFETY CODE ANN. § 166.052 (Vernon Supp. 2006).

²³⁷ See *id.*

²³⁸ See *id.*

should encourage patient-physician communication, and result in both parties having a greater understanding of the ultimate resolution.²³⁹ The 1999 Texas Advance Directives Act provides a model worthy of imitation.²⁴⁰

D. A Model Statute: The Texas Advance Directives Act

1. The Act Expounded

The Texas Advance Directives Act (the "Texas Act" or the "Act") sets out a straightforward process for instances when "the attending physician refuses to honor an advance directive or treatment decision requesting the provision of life-sustaining treatment."²⁴¹ Importantly, it includes a definition of life-sustaining treatment.²⁴² The Texas legislature eschewed the use of ethereal words, such as "ineffective" or "futile," to describe the requested treatment and, thus, avoided the pitfalls of the Maryland and Virginia legislation.²⁴³

The process established by the Act is initiated when the attending physician recommends against life-sustaining treatment that the patient wishes to continue.²⁴⁴ The physician must inform the patient's health care proxy about this decision.²⁴⁵ Thereafter, treatment will continue pending a review by an institutional ethics committee or medical review board, and the proxy will be given forty-eight hours'

²³⁹ See *id.*; Fine & Mayo, *supra* note 32, at 746.

²⁴⁰ See § 166.052; Fine & Mayo, *supra* note 32, at 746.

²⁴¹ § 166.052(a).

²⁴² See *id.* The Act defines life-sustaining treatment as:

[T]reatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificial nutrition and hydration. The term does not include the administration of pain management medication or the performance of a medical procedure considered to be necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

Id.

²⁴³ Compare TEX. HEALTH & SAFETY CODE ANN. § 166.052(a) (Vernon Supp. 2006), with MD. CODE ANN., HEALTH-GEN. § 5-611 (West 2005), and VA. CODE ANN. § 54.1-2990 (West 2004).

²⁴⁴ TEX. HEALTH & SAFETY CODE ANN. § 166.052(a).

²⁴⁵ See *id.*

notice of the review.²⁴⁶ The proxy and patient, if possible, are invited to attend the meeting and participate in the consultation process.²⁴⁷

If the ethics/medical committee concludes that the attending physician has erred, the hospital will continue to provide aggressive life-sustaining treatment.²⁴⁸ If, however, the ethics/medical committee agrees with the attending physician that further aggressive care is not medically indicated, it must provide the proxy with a written explanation of that decision.²⁴⁹ Then, while continuing to provide aggressive treatment, the physician and the health care provider will assist the proxy in finding a physician and facility willing to provide the requested treatment.²⁵⁰ Moreover, the proxy will be given contact information of health care providers that may provide the demanded care, or further assist in arranging a transfer.²⁵¹ If a willing health care provider is found, then a transfer will be facilitated.²⁵² In that instance, the original hospital will arrange for the transfer and provide the necessary services, but the patient will be responsible for the cost.²⁵³

If, however, the proxy—with the aid of the health care institution—cannot find a provider willing to give the requested treatment within ten days, life-sustaining treatment may be withdrawn.²⁵⁴ This time period may be extended, with the permission of the appropriate court, if there is a reasonable expectation that a willing facility will be found if the extension is granted.²⁵⁵ If aggressive treatment is withdrawn, and the guidelines of the statute have been followed, the law creates a legal safe harbor for both physicians and hospitals by granting immunity from civil and criminal liability.²⁵⁶

2. *Hudson v. Texas Children's Hospital*: Judicial Adherence to the Act

Although multiple end-of-life disputes had been resolved by adherence to the process set forth in the Texas Act, the 2005 case of *Hudson v. Texas Children's Hospital* was the first instance of a hospital seeking

²⁴⁶ See *id.*

²⁴⁷ See *id.*

²⁴⁸ See *id.*

²⁴⁹ See TEX. HEALTH & SAFETY CODE ANN. § 166.052(a) (Vernon Supp. 2006).

²⁵⁰ See *id.* § 166.052(a)(1).

²⁵¹ See *id.* § 166.052(a)(2).

²⁵² See *id.* § 166.052(a)(3).

²⁵³ See *id.* § 166.052(a)(4).

²⁵⁴ See TEX. HEALTH & SAFETY CODE ANN. § 166.052(a)(5).

²⁵⁵ See TEX. HEALTH & SAFETY CODE ANN. § 166.052(a)(6) (Vernon Supp. 2006).

²⁵⁶ See *id.* § 166.046(a).

judicial approbation in accordance with the Act.²⁵⁷ Sun Hudson was born with thanatophoric dysplasia, an extremely rare and fatal form of dwarfism, on September 25, 2004.²⁵⁸ Less than two months later, on November 18, 2004, the Texas Children's Hospital's bioethics committee notified the mother, Ms. Hudson, that it would discontinue care of Sun within ten days, as provided in the Texas Act, unless another physician could be found.²⁵⁹ The hospital found that further care violated applicable medical standards and caused the child excessive pain.²⁶⁰

Texas Children's Hospital followed the process set forth by the Texas Act.²⁶¹ In fact, when Ms. Hudson requested a further extension, until December 6, 2004, the hospital granted that extension.²⁶² When Ms. Hudson expressed her desire for a further extension she was denied, but she filed for an injunction to require the continuance of care; the hospital paid for Ms. Hudson's legal fees.²⁶³ At the outset, the trial court issued a temporary restraining order, preventing the hospital from discontinuing life-sustaining medical treatment.²⁶⁴ By February 16, 2005, the trial court ordered the restraining order lifted.²⁶⁵ A procedural error by the trial judge—specifically, ruling on the timeliness of a recusal motion himself—opened an avenue for appeal.²⁶⁶ The procedural issue was resolved by allowing a probate judge to deny the motion to recuse, and the case returned to the trial court.²⁶⁷ The trial judge again ruled that under the statute, the hospital was authorized to withdraw aggressive treatment.²⁶⁸ On March 15, 2005, four months after the initial ethics determination, Texas Children's Hospital withdrew life-sustaining care from Sun Hudson.²⁶⁹ The child died moments after the withdrawal.²⁷⁰

²⁵⁷ See 177 S.W.3d 232, 233 (Tex. App. 2005); Bruce Nichols, *Hospital Ends Life Support of Baby: 1st Case of Its Kind Is Against Mom's Wish, in Accordance with Law*, DALLAS MORNING NEWS, Mar. 16, 2005, at 1A.

²⁵⁸ See Hudson, 177 S.W.3d at 233.

²⁵⁹ *Id.*

²⁶⁰ See *id.*

²⁶¹ See *id.* at 233–34.

²⁶² See *id.*; Nichols, *supra* note 257.

²⁶³ See Hudson, 177 S.W.3d at 234.

²⁶⁴ See *id.*; Nichols, *supra* note 257.

²⁶⁵ See Hudson, 177 S.W.3d at 235.

²⁶⁶ See *id.*

²⁶⁷ See *id.* at 238; Leigh Hopper & Todd Ackerman, 'Inside of Me, My Son Is Still Alive': Baby Dies After Hospital Removes Feeding Tube; Case Is the First in Which a Judge Allowed a Hospital to Discontinue Care, HOUSTON CHRON., Mar. 16, 2005, at A1.

²⁶⁸ See Hopper & Ackerman, *supra* note 267.

²⁶⁹ See *id.*

²⁷⁰ See *id.*

III. A PROCESS-BASED STATUTE AS AN EFFECTIVE RESOLUTION

When the pertinent issue is patient-physician disagreement over the provision of life-sustaining treatment in the demand context, there is no shortage of scholarship.²⁷¹ Instead, the void is in the law.²⁷² To date, courts have inconsistently addressed the matter, and patients, practitioners, and health care institutions are left to speculate about their respective rights and duties in the demand context.²⁷³ The Texas Act demonstrates that states may effectively fill the void with a statute that establishes a well-crafted extrajudicial process for addressing patient demands and allows for important, but limited, judicial review.²⁷⁴

It is essential that any statute seeking to resolve patient-physician disagreements in the end-of-life context not empower individual physicians to be arbitrators of life-and-death decisions.²⁷⁵ Furthermore, a statute should recognize that there is not universal agreement on medical futility, but also ensure that if no health care providers are willing to provide treatment, none are so obligated.²⁷⁶ The Texas Act meets both requirements and creates a process in which patient involvement and patient-physician communication are central aspects.²⁷⁷ Thus, it preserves respect for both patient autonomy and the medical profession.²⁷⁸

The Texas Act also provides temporal boundaries for resolving disagreements over treatment in the end-of-life context.²⁷⁹ This allows for timely resolution and streamlined judicial appeal if necessary.²⁸⁰ The 2005 Texas Court of Appeals case of *Hudson v. Texas Children's Hospital*

²⁷¹ See Daar, *supra* note 4, at 240 (arguing for a recognition of physician autonomy); Veatch & Spicer, *supra* note 4, at 36 (claiming that physicians' monopoly on end-of-life care services obligates treatment when demanded); see also Menikoff, *supra* note 20, at 1108 (discussing the issues involved when care is demanded); Shiner, *supra* note 2, at 816 (chronicling the futility movement).

²⁷² See Alpers & Luce, *supra* note 119, at 2029.

²⁷³ See *id.* Compare *In re Baby K*, 16 F.3d 590, 596 (4th Cir. 1994) (holding that EMTALA requires a hospital to provide life-sustaining treatment to an anencephalic infant, without regard to medical or ethical standards), with *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 350-51 (4th Cir. 1996) (finding that EMTALA does not require indefinite provision of life-sustaining treatment to critically ill patients).

²⁷⁴ See TEX. HEALTH & SAFETY CODE ANN. § 166.052 (Vernon Supp. 2006); Fine & Mayo, *supra* note 32, at 746.

²⁷⁵ See *In re Wanglie*, No. PX-91-293 (Minn. Prob. Ct. Hennepin County June 28, 1991), reprinted in 7 ISSUES L. & MED. 369, 376 (1991); Veatch & Spicer, *supra* note 4, at 36.

²⁷⁶ See Fine & Mayo, *supra* note 32, at 744; Helft et al., *supra* note 4, at 295.

²⁷⁷ See § 166.052; Fine & Mayo, *supra* note 32, at 744.

²⁷⁸ See § 166.052; Fine & Mayo, *supra* note 32, at 744.

²⁷⁹ See § 166.052; Fine & Mayo, *supra* note 32, at 744.

²⁸⁰ See TEX. HEALTH & SAFETY CODE ANN. § 166.052 (Vernon Supp. 2006); Fine & Mayo, *supra* note 32, at 744.

was decided within four months of an ethics committee determination that the care requested by the patient's mother was not medically indicated, in accordance with the Texas Act.²⁸¹ By contrast, in Massachusetts—a state without a pertinent statute—*In re Howe* involved a two-year protracted legal process *after* the Massachusetts General Hospital Optimum Care Committee found that the treatment provided to Mrs. Howe was in conflict with medical standards and so excessive as to be inhumane.²⁸²

The Texas Act establishes an extrajudicial process that fosters patient-physician communication and agreement.²⁸³ If the disagreement persists, though, the Texas Act provides for effective and timely avenues of resolution.²⁸⁴ In the absence of a statute like the Texas Act, potential resolutions include: (1) the unilateral cessation of treatment by the health care provider on uncertain legal grounds; (2) the indefinite provision of medical care that is contrary to established medical standards and ethics, but consistent with patient demands; or (3) a lengthy resort to the legal process that will most likely—after substantial legal costs—require continued care or end in settlement.²⁸⁵ The Texas Act extracts the potential benefits of each of these solutions while avoiding the pitfalls of each and, therefore, is worthy of imitation.²⁸⁶

A. The Texas Act in Theory

The Texas state legislature addressed the issues presented by patient-physician disagreements over the provision of life-sustaining treatment in the demand context, and did so comprehensively.²⁸⁷ First and foremost, the Texas Act emphasizes patient / health care decisionmaker involvement in the decision-making process.²⁸⁸ The physician is required to inform the decisionmaker of his determination that further

²⁸¹ See *Hudson v. Tex. Children's Hosp.*, 177 S.W.3d 232, 234 (Tex. App. 2005); see also § 166.052.

²⁸² See No. 03 P 1255, 2004 WL 1446057, at *1 (Mass. Prob. & Fam. Ct. Mar. 22, 2005); Liz Kowalczyk, *Woman Dies at MGH After Battle over Care, Daughter Fought for Life Support*, BOSTON GLOBE, June 8, 2005, at A1.

²⁸³ See § 166.052; Fine & Mayo, *supra* note 32, at 744.

²⁸⁴ See § 166.052.

²⁸⁵ See *Baby K*, 16 F.3d at 596; Paris & Reardon, *supra* note 226, at 133; Paris et al., *supra* note 44, at 1012; Schneiderman et al., *supra* note 166, at 951; Veatch & Spicer, *supra* note 4, at 17.

²⁸⁶ See *Baby K*, 16 F.3d at 596; Paris & Reardon, *supra* note 226, at 133; Paris et al., *supra* note 44, at 1012; Schneiderman et al., *supra* note 166, at 951; Veatch & Spicer, *supra* note 4, at 17.

²⁸⁷ See TEX. HEALTH & SAFETY CODE ANN. § 166.052 (Vernon Supp. 2006).

²⁸⁸ See *id.*

treatment is contrary to the standard of care, and the decisionmaker is allowed the opportunity to participate in the subsequent ethics/medical community meeting.²⁸⁹ These lines of communication are important for the patient-physician relationship.²⁹⁰ They also recognize that although patients may not have an absolute right to receive a desired treatment, a patient's request for aggressive life-sustaining treatment must be given substantial deference.²⁹¹

Furthermore, the Texas Act includes the indispensable avenue of resolution via transfer.²⁹² As the first known case of physician refusal of life-sustaining treatment, Baby L, demonstrated, the most logical resolution to these disputes is the transfer of the patient to a willing provider.²⁹³ The Texas Act requires the original hospital to assist actively the patient or proxy in finding a willing provider, so that the proxy is not left to face that task on his or her own.²⁹⁴ If a potential transfer is found, the Texas Act should, but does not, require the original hospital to pay for the transfer if the patient cannot afford it—any appearance of potential financial incentives in this sensitive area should be eliminated.²⁹⁵

The window during which aggressive treatment will be provided by the original hospital while transfer options are explored is set at ten days.²⁹⁶ A line must be drawn to provide an established timeline for resolution, but the exact time period should be determined by each legislature.²⁹⁷ The Texas Act logically allows for an extension of the ten-day time period if a court finds a reasonable likelihood that a willing transfer hospital will be found.²⁹⁸ This form of judicial oversight is worthy of imitation.²⁹⁹

Perhaps the most effective part of the Texas Act is the manner in which it requires a medical consensus to withdraw aggressive life-sustaining treatment.³⁰⁰ The attending physician is not empowered to make this decision unilaterally.³⁰¹ The physician's decision is subject to

²⁸⁹ See *id.*

²⁹⁰ See *id.*

²⁹¹ See *id.*

²⁹² See § 166.052(a)(3).

²⁹³ See Paris et al., *supra* note 44, at 1012–13.

²⁹⁴ See TEX. HEALTH & SAFETY CODE ANN. § 166.052(a)(2) (Vernon Supp. 2006).

²⁹⁵ See *id.* § 166.052(a)(4).

²⁹⁶ See *id.* § 166.052(a)(5).

²⁹⁷ See Fine & Mayo, *supra* note 32, at 746.

²⁹⁸ See § 166.052(a)(5).

²⁹⁹ See *id.* § 166.052(a)(6).

³⁰⁰ See *id.* § 166.052(a).

³⁰¹ See *id.*

review by the hospital, through its ethics or medical review board.³⁰² Even then, though, the hospital cannot withdraw care.³⁰³ Instead, it must actively help the patient/proxy search for an institution that is willing to provide the requested care.³⁰⁴ If it can find a willing provider, the patient is transferred.³⁰⁵ If it cannot, the message is clear: the treatment requested by the patient is contrary to widely accepted standards of medical care.³⁰⁶ Indeed, if treatment is to be withdrawn over patient demands, the Texas Act requires unanimity in the medical community that the treatment is not medically indicated.³⁰⁷

B. *The Texas Act in Practice*

The Texas Act is relatively young, and as such, has not produced extensive review in the literature.³⁰⁸ One prominent early review, however, has been positive.³⁰⁹ The Texas Act has brought clarity and structure to an area of health law that had previously been confounding.³¹⁰

Robert Fine and Thomas Mayo conducted a case study to track the effect of the law at Baylor Medical Center in the statute's first two years of enactment.³¹¹ They reported that ethics consultations in the demand context have increased sixty-seven percent, and concluded that the Texas Act has converted a less visible process into an explicit one.³¹² The new, explicit process provides safeguards against rash decisions and requires health care providers to be accountable for their decisions, both to the Baylor ethics board and to the medical community as a whole because their decisions are effectively reviewed by both.³¹³

The authors also noted the improved communication between physicians and health care decisionmakers in the wake of the Texas Act.³¹⁴ In most cases, both parties are able to outline their stance and the justification for that position.³¹⁵ The result is greater understand-

³⁰² See *id.*

³⁰³ See TEX. HEALTH & SAFETY CODE ANN. § 166.052(a) (Vernon Supp. 2006).

³⁰⁴ See *id.* § 166.052(a)(5).

³⁰⁵ See *id.* § 166.052(a).

³⁰⁶ See *id.*

³⁰⁷ See *id.*

³⁰⁸ See Fine & Mayo, *supra* note 32, at 743.

³⁰⁹ See *id.* at 744.

³¹⁰ See TEX. HEALTH & SAFETY CODE ANN. § 166.052(a) (Vernon Supp. 2006); Alpers & Luce, *supra* note 119, at 2029.

³¹¹ See Fine & Mayo, *supra* note 32, at 743–46.

³¹² See *id.* at 745.

³¹³ See *id.*

³¹⁴ See *id.*

³¹⁵ See *id.*

ing, by both the health care provider and the patient/proxy.³¹⁶ Greater understanding, logically, leads to fewer disagreements, which is a worthy goal in the emotional arena of end-of-life decision making.³¹⁷ In fact, at Baylor during the study, no family member chose to go to court to seek an extension or to challenge the judgment of the ethics consultation.³¹⁸

C. *Two Paths to Resolution: Hudson v. Texas Children's Hospital and In re Howe*

The *Hudson* case was the first in the United States in which a court approved the refusal of life-sustaining treatment over the objections of the patient while that patient was still alive.³¹⁹ Texas Children's Hospital followed the Texas Act, and so too did the Texas courts.³²⁰ Ms. Hudson was able to air her arguments for continued care, and both the courts and the hospital weighed those arguments against unanimous agreement in the medical community that further care was not medically indicated and was unethical.³²¹ The matter was resolved within four months.³²²

The *In re Howe* case, by contrast, involved a substantially different timeline before Ms. Howe's family and Massachusetts General Hospital reached a settlement in March 2005.³²³ In November 2001, the hospital's Optimum Care Committee (the "OCC") recommended against further aggressive medical treatment other than continued medical ventilation, and sought to impose a do-not-resuscitate order.³²⁴ Ms. Howe's daughter, and health care proxy, filed a complaint in the Supe-

³¹⁶ See Fine & Mayo, *supra* note 32, at 745.

³¹⁷ See *id.*

³¹⁸ *Id.*

³¹⁹ Compare 177 S.W.3d at 238 (laying the grounds for the trial court to allow Texas Children's Hospital to follow the Texas Act), with *Bryan*, 95 F.3d at 351-52 (holding that the hospital was not liable in a wrongful death suit under federal law for withholding aggressive life-sustaining treatment from the patient, and implying that state malpractice liability would hinge on adherence to the standard of medical care, which the hospital demonstrated).

³²⁰ See TEX. HEALTH & SAFETY CODE ANN. § 166.052(a) (Vernon Supp. 2006); *Hudson*, 177 S.W.3d at 233-34.

³²¹ See TEX. HEALTH & SAFETY CODE ANN. § 166.052(a); *Hudson*, 177 S.W.3d at 233-34.

³²² See *Hudson*, 177 S.W.3d at 235. Also, this timeline was substantially extended by the procedural error of the trial judge. See Hopper & Ackerman, *supra* note 267. Absent that error, the tragic case would have come to an end in roughly two-and-a-half months. See *id.*

³²³ See *Howe*, 2004 WL 1446057, at *1; see also Liz Kowalczyk, *Hospital, Family Agree to Withdraw Life Support: Deal Ends Long Fight over MGH Patient*, BOSTON GLOBE, Mar. 12, 2005, at B1.

³²⁴ See *Howe*, 2004 WL 1446057, at *10.

rior Court of Suffolk County requesting a temporary restraining order; in response to this action, the hospital agreed not to enact the OCC's recommendations.³²⁵

The hospital continued to provide Ms. Howe aggressive treatment for two-and-one-half more years, until her right eye ruptured and required removal on May 31, 2003.³²⁶ Shortly thereafter, on June 18, 2003, Massachusetts General Hospital filed a petition for declaratory relief, requesting a determination as to the appropriate level of care that must be afforded to Ms. Howe.³²⁷

The case continued for twenty-one months until the parties came to an agreement on the duration of continued treatment in March 2005.³²⁸ Before the hospital filed for declaratory relief, its OCC found that the provision of aggressive care to Ms. Howe required that the caregivers violate their professional oaths, disregard the standard of medical practice, and even compromise accepted standards of human decency.³²⁹ Yet, such care was provided throughout the drawn-out process.³³⁰

The settlement at which the parties arrived also was inconsistent with the stances of both sides.³³¹ Ms. Howe's daughter, and health care proxy, argued that Massachusetts General Hospital was obligated to provide the care she requested on behalf of her mother; the hospital asserted that it was bound by the standard of care, which did not include the aggressive treatments demanded.³³² The result: the parties agreed that Ms. Howe would be provided aggressive life-sustaining treatment for three-and-a-half more months, ending June 30, 2005.³³³ Ms. Howe died less than one month before the cessation of treatment was scheduled.³³⁴ The settlement was a seemingly abstract compromise between no further treatment and indefinite treatment, but, when the applicable law is inconsistent, that may be expected.³³⁵

³²⁵ See *id.*

³²⁶ See *id.* at *11.

³²⁷ See *id.* at *1.

³²⁸ See Kowalczyk, *supra* note 323.

³²⁹ See *Howe*, 2004 WL 1446057, at *11.

³³⁰ See Kowalczyk, *supra* note 323.

³³¹ See *id.*

³³² See *Howe*, 2004 WL 1446057, at *1.

³³³ See Kowalczyk, *supra* note 323.

³³⁴ See Kowalczyk, *supra* note 282.

³³⁵ See Alpers & Luce, *supra* note 119, at 2029 (arguing that medical centers are unsure of their legal obligations when life-sustaining care is demanded); Helft et al., *supra* note 4, at 296 (noting that disputes over the provision of end-of-life care are recurring, and the medical community currently lacks a standard approach to such disputes). Also, the set-

Disputes over end-of-life care are uniquely emotional and often saddening. Unfortunately, they are also inevitable.³³⁶ When the law is unclear as to what is required when patients demand care that is contrary to accepted standards, none of the interested parties benefit.³³⁷ Patients do not understand their rights, and physicians and hospitals do not understand their obligations.³³⁸ Drawn-out disputes may result and, as *Howe* demonstrates, health care providers will be faced with violating professional standards and ethical norms by continuing to provide care or ceasing aggressive treatment with uncertain legal consequences.³³⁹

The Texas Act provides statutory guidance through previously unsettled legal terrain.³⁴⁰ Patients and physicians understand the straightforward extrajudicial process; it often opens lines of communication that result in the avoidance of disputes altogether.³⁴¹ When the disputes persist, it provides for timely avenues of resolution, and judicial appeal if necessary.³⁴²

CONCLUSION

The issues presented when patients request aggressive life-sustaining treatment that physicians are unwilling to provide are complex and trying. They cannot be resolved by invoking a conclusory and ambiguous term such as "futility." Current precedent, reflecting the difficult nature of the issues, provides uncertain guidance for health care providers struggling to ascertain their obligations, as well as for patients wanting to know their rights. Yet, this much is certain: patient-physician disagreement over end-of-life treatment will persist, especially as life-sustaining technology continues to improve.

A process-based state statute provides the best possible resolution to such disputes. The Texas Advance Directives Act provides an effective model. The process outlined in this statute extensively fosters patient-physician agreement about continued care, and, absent such

lement was agreed upon against the backdrop of the sociopolitical drama surrounding the end-of-life issues of Terri Schiavo, and that case may have influenced one or both parties. See Annas, *supra* note 25, at 1710.

³³⁶ See Helft et al., *supra* note 4, at 296.

³³⁷ See Menikoff, *supra* note 20, at 1124.

³³⁸ See Alpers & Luce, *supra* note 119, at 2029.

³³⁹ See Menikoff, *supra* note 20, at 1124.

³⁴⁰ See TEX. HEALTH & SAFETY CODE ANN. § 166.052 (Vernon Supp. 2006).

³⁴¹ See *id.*; Fine & Mayo, *supra* note 32, at 744.

³⁴² See § 166.052.

agreement, allows the patient to seek a transfer to a hospital willing to provide the care sought. It also provides a mechanism for ending treatment when that treatment is inconsistent with the standards of care and medical ethics by sending a clear message: if no physician is willing to provide the aggressive treatment requested, then no physician is obligated to provide that treatment.

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