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PHYSICIANS LOSE THE TUG OF WAR TO PULL THE PLUG: THE DEBATE ABOUT CONTINUED FUTILE MEDICAL CARE

INTRODUCTION

Jane Doe is a Virginia resident in a permanently vegetative state (PVS).¹ Medical technology can keep her "alive"² for several years through the use of a mechanical ventilator and feeding tube. Jane's physicians will keep her medicated to prevent further pain and suffering. Despite medical efforts which prolong the dying process and alleviate pain, Jane's condition will not improve.³ Eventually she will suffer a protracted decline in her health followed by her inevitable death. Jane's physicians discussed her grave condition with her decision-makers. Her physicians believed that the continuation of Jane's "death-delaying"⁴ treatment is fu-

1. The illustrative medical dilemma of Jane Doe is fictitious. Jane Doe is one of over 14,000 Americans who enter permanent vegetative states (PVSs) annually. See JAMES M. HOEFLER & BRIAN E. KAMOIE, *DEATHRIGHT: CULTURE, MEDICINE, POLITICS, AND THE RIGHT TO DIE* 54 (1994). A person in a PVS suffers extensive brain damage and chronic unconsciousness. *Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support*, 263 *JAMA* 426, 426 (1990). One of the features of PVS is "chronic wakefulness without awareness" which deceptively appears to indicate an alert demeanor, instead of the patient's actual lack of comprehension and coherence. *Id.* at 427. Although health care professionals deem Jane's continued treatment inappropriate, as a Virginia resident, Jane has a right to receive death-delaying medical treatment under the Fourth Circuit Court of Appeals' recent decision *In re Baby K*, 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

2. Although Jane is physically alive, she is "doomed to no more than a biologically vegetative remnant of life." *In re Quinlan*, 355 A.2d 647, 662 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

3. Victor Cohn, *Is It Time for Mercy Killing?*, WASH. POST, Aug. 15, 1989, at Z12. Medical records of the American Medical Association (AMA) indicate that only three patients have ever recovered from PVS. *Id.* The records also indicate that no PVS patient has ever recovered if unconscious for over 22 months. *Id.*

4. Life-sustaining treatment is the most prevalent term used to describe medical treatment that merely maintains a patient's biological existence. See, e.g., *Longeway v. Community Convalescent Ctr.*, 549 N.E.2d 292, 294 (Ill. 1989) (referring to artificial nutrition and hydration treatment as life-sustaining measures); *Quinlan*, 355 A.2d at 663 (describing a mechanical ventilator as an artificial life-sustaining device). However, this Note will use the term "death-delaying treatment" because, regardless of the expression, one can view these treatments as either sustaining a patient's life or prolonging or delaying a patient's death. See, e.g., *J.F.K. Mem. Hosp. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984) (asserting

tile and inappropriate because it only prolongs Jane's death. They requested Jane's decision-makers' consent to the removal of her death-delaying medical care. Instead, the decision-makers demanded that the physicians do everything possible to keep Jane alive.⁵

The hypothetical fact situation about Jane Doe demonstrates an existing conflict between patients and physicians over the continuation of futile death-delaying medical treatment. Patients' decision-makers, wishing for recovery miracles, demand treatment. Physicians, believing such death-delaying treatment futile and inappropriate, seek to discontinue treatment. Recent legal precedent holds that Jane's decision-makers can require health care professionals to continue her death-delaying medical treatment.⁶ This is so even though the protracted care is hopeless.

The legal right to receive death-delaying treatment has arisen from a long evolution of changes in the distribution of medical decision-making power between physicians and patients.⁷ These changes diminished a physician's authority and increased a patient's control over medical decisions.⁸ This final act in the redistribution of medical decision-making power occurred despite physicians' determinations that treatment is futile and inappropriate.⁹ It also disregarded the cost of futile treatment¹⁰ and the

that medical technology which holds a patient on "the threshold of death" is merely "a means of prolonging the dying process rather than a means of continuing life"; *In re Barry*, 445 So. 2d 365, 371 (Fla. Dist. Ct. App. 1984) (stating that life support systems merely prolong a patient's death)

5. Although the demonstrative medical dilemma posed by Jane Doe is fictitious, it resembles recent conflicts between patients and physicians over who should possess the ultimate power to make death-delaying medical treatment decisions. See Ellen H. Moskowitz, *Access to Life-Prolonging Care*, 30 TRIAL 16, 16 (1994) (stating that in death-delaying treatment situations, it is difficult to determine whether patients or physicians should decide when treatment becomes inappropriate).

6. *In re Baby K*, 16 F.3d 590 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994). The Fourth Circuit held that a hospital must provide emergency treatment to a patient even though health care professionals seek to discontinue the treatment because they deem it inappropriate and futile. *Id.* at 594. The Minnesota Probate Court held that health care professionals cannot discontinue death-delaying medical treatment that they deem inappropriate and futile if a patient's guardian demands the continuation of that treatment. *In re Wanglie*, PX-91-283 (Minn. Dist. Ct., P. Div. July 1, 1991), reprinted in 7 ISSUES L. & MED. 369 (1991).

7. See *infra* notes 44-110 and accompanying text for a discussion of the changes in the distribution of medical decision-making power between physicians and patients.

8. See Flora J. Skelly, *Balance of Power*, 36 AM. MED. NEWS 11, 12 (1993) (discussing the distribution of medical decision-making power between physicians and patients).

9. See *supra* note 6 and accompanying text for a discussion of health care professionals refusing to provide death-delaying treatment because they deem it futile

depletion of medical resources.¹¹ By ignoring these important aspects, this distribution may result in greater negative consequences, especially when over 2 million people die annually and approximately 1.6 million of those individuals die in hospitals or long-term health care facilities.¹² This death rate, the increasing age of the population,¹³ advances in medical technology,¹⁴ and increases in debilitating diseases¹⁵ reveal the potential for legal battles between patients and physicians over death-delaying medical treatment.

This Note examines the destructive consequences of recent decisions which allow patients to receive protracted futile treatment and thereby disturb the distribution of medical decision-making power between patients and physicians. Part I traces the shift in decision-making power from physician to patient. Part II analyzes the development of a patient's right to receive death-delaying treatment and its adverse impacts. Part III proposes a three-part solution to restore the appropriate balance of medical decision-making power between patients and physicians and provides a proposed definition of futile medical treatment.

and inappropriate.

10. See *infra* notes 221-37 and accompanying text for a discussion of the costs of futile medical treatment and the adverse effect on insurance policyholders and taxpayers.

11. See *infra* notes 238-42 and accompanying text for a discussion of how futile medical treatment depletes scarce medical resources.

12. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 302-03 (1990) (Brennan, J., dissenting). The dissenting opinion stated that "[o]f the approximately 2 million people who die each year, 80% die in hospitals and long-term care institutions, and perhaps 70% of those after a decision to forgo life-sustaining treatment has been made." *Id.*

13. Nancy S. Jecker & Lawrence J. Schneiderman, *Futility and Rationing*, 92 AM. J. MED. 189, 189 (1992). A factor that encourages a greater focus on futility is the aging of society. *Id.* at 191. The segment of society over the age of 85 is the fastest growing age group in the United States. *Id.* at 191. This segment also represents the heaviest users of health care. *Id.* Although this group comprises 12% of the population, it accounts for approximately one-third of the nation's personal health care expenditures. *Id.*

14. See *Brophy v. New Eng. Sinai Hosp.*, 497 N.E.2d 626, 637 (Mass. 1986) (stating that the longest recorded survival of a patient sustained on artificial nutrition and hydration equipment is 37 years); Moskowitz, *supra* note 5, at 16 (asserting that life-support treatment can maintain a patient's permanent unconsciousness for years); Charles L. Sprung, *Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments*, 263 JAMA 2211, 2211 (1990) (stating that advances in medical technology now allow patients to live longer, although often with considerable suffering and cost).

15. ALAN MEISEL, *THE RIGHT TO DIE* 4 (1989). The AIDS epidemic may be one of the factors substantially increasing the amount of right-to-die litigation, since AIDS patients often endure a prolonged death. *Id.*

I. THE SHIFT FROM PHYSICIAN-CONTROLLED TREATMENT TO A PATIENT'S RIGHT TO PARTICIPATE IN TREATMENT DECISIONS

There is a finite amount of medical decision-making power allocated between physicians and patients.¹⁶ The distribution of this power determines who possesses ultimate control over a patient's medical treatment.¹⁷ This distribution becomes critical when a physician and patient disagree about proper medical treatment.¹⁸ Until fairly recently, a patient did not control medical treatment decisions.¹⁹ Rather, a physician provided medical treatment which he felt was in the patient's best interests, regardless of that patient's wishes.²⁰ The distribution of medical decision-making power eventually shifted away from strict physician control toward patient "self-determination."²¹ Consequently, patients gained the right to refuse death-delaying medical treatment.²² Thus, attainment of the right to refuse treatment signalled the end of an era when physicians possessed by default the absolute control over patient treatment.²³

16. Mark Siegler, *The Progression of Medicine: From Physician Paternalism to Patient Autonomy to Bureaucratic Parsimony*, 145 ARCHIVES OF INTERNAL MED. 713, 714 (1985). A bioethics concern for at least a generation is the proper allocation of medical decision-making power between patients and physicians. *Id.* Such a lengthy evaluation of one aspect in the physician-patient relationship evinces the importance of the distribution of that power.

17. *See id.* (stating that a primary bioethics debate concerns whether physicians or patients should retain medical decision-making power).

18. *See, e.g., In re Quinlan*, 355 A.2d 647, 664 (N.J.), *cert. denied*, 429 U.S. 922 (1976) (allowing a patient to exercise her right of choice and forego death-delaying treatment, even though her physicians sought to continue that treatment).

19. *See infra* notes 24-43 and accompanying text for a discussion of the era of physician paternalism.

20. *See Erol Onel & James G. Adams, Advance Directives*, 267 JAMA 1920, 1920 (1992) (describing medical paternalism as a model in which physicians effectively disregard patients' wishes).

21. Marion Danis & Larry R. Churchill, *Autonomy and the Common Weal*, 21 HASTINGS CENTER REP. 25, 25 (1991). Patients first used the right of self-determination to refuse medical treatment. *Id.*

22. *See Dan W. Brock, Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, 22 HASTINGS CENTER REP. 41, 41 (1992) (book review). *Quinlan* brought public attention to the issue of who decides when to discontinue death-delaying medical treatment. *Id.* at 41. It also set in motion the change from exclusive physician-controlled treatment to shared decision making between physicians and patients. *Id.*; *see Quinlan*, 355 A.2d at 663 (establishing a patient's right to forego death-delaying treatment).

23. Siegler, *supra* note 16, at 714. The Age of Autonomy, characterized by a patient's right to control medical treatment, replaced the historical Age of Paternalism. *Id.*

A. *The Historical Dominance of Physician-Controlled Treatment Decisions*

Historically, physicians made all definitive decisions concerning the proper treatment for their patients.²⁴ Patients readily accepted and trusted their physicians' treatment decisions because their physicians' education, authority, and title as "doctor" meant they knew what was best.²⁵ Physicians made these decisions regardless of a patient's expressed or unexpressed wishes.²⁶ This type of ultimate physician control characterized the era of physician paternalism.²⁷

A line of decisions prior to 1970 which involved a clash between physicians and patients over life-saving blood transfusions illustrates the attempts physicians would make to control a patient's treatment.²⁸ Some patients objected to receiving blood transfusions, but physicians nevertheless sought to administer them.²⁹ Saving a life was the paramount responsibility of a physician³⁰ and the quality of life debate had not yet begun.³¹ This

24. *Id.* Traditional paternalism provided physicians with the authority and discretion to control medical treatment. *Id.*

25. *Id.* The "doctor knows best model [of medicine] was premised on trust in the physician's technical skills and moral stature, was buttressed by an attribution of magical powers to the healer, and was characterized by patient dependency and physician control." *Id.*; see also Peter B. Terry & Martha W. Elliot, *The Pulmonary Physician and the Hospital Ethics Committee*, 96 CHEST 1175, 1175 (1989) (stating that prior to the 1970s, physicians made treatment decisions that they deemed in their patients' best interests).

26. Onel & Adams, *supra* note 20, at 1921 (explaining that under a paternalistic model of medical treatment, physicians disregarded their patients' wishes).

27. Siegler, *supra* note 16, at 714. The physician paternalism era emphasized "patient care rather than patient wishes, patient needs rather than their rights, and physician discretion rather than patient autonomy or self-determination." *Id.*

28. See L.C. Di Stasi, Jr., *Power of Courts or Other Public Agencies, in the Absence of Statutory Authority, to Order Compulsory Medical Care for Adult [sic]*, 9 A.L.R.3D 1391 (1966) (discussing whether courts have the power to order compulsory medical care).

29. See, e.g., *In re Georgetown College*, 331 F.2d 1000, 1001 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) (stating that the hospital petitioned the court for an emergency writ in order to provide a blood transfusion to a patient who refused it); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965) (explaining that the hospital petitioned the court for an order to provide a blood transfusion that the patient refused).

30. See Frank I. Clark, *Withdrawal of Life-Support in the Newborn: Whose Baby Is It?*, 23 SW. U. L. REV. 1, 5 (1993) (stating that for most of the 20th century, "the prevailing medical ethic was to prolong life as long as possible").

31. See *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976). The New Jersey Supreme Court, in the first right-to-die case, brought the quality of life debate to the forefront. *Id.* The court recognized that the patient's irreversible and vegetative condition doomed her to a mere biological existence. *Id.* at 662. This recognition, along with the patient's right to privacy, provided the court with

period predated the time when technology could keep a human body functioning long after cognitive awareness ceased.³² The clash between physician and patient had not fully developed because there was only one view of "life."³³ For instance, in *In re Georgetown College*,³⁴ the Court of Appeals for the District of Columbia in 1964 held that a physician could administer a life-saving blood transfusion to a patient who refused the treatment.³⁵ The *Georgetown* court reasoned that the patient's refusal would be suicide³⁶ and that the state possessed an overriding interest in preserving life.³⁷ In 1965, in *United States v. George*,³⁸ the United States District Court in Connecticut balanced a patient's refusal of a blood transfusion against the state's interest in preserving life and did not allow the patient to refuse a blood transfusion, even though suicide was not illegal in the jurisdiction.³⁹

Initially, physicians won these disputes over life-saving blood transfusions based on prevailing attitudes concerning overriding state interests, such as the preservation of life.⁴⁰ Physicians did not win based on the historical notion of "physician knows best."⁴¹ These decisions indirectly sanctioned a physician's attempt to control a patient's medical treatment.⁴² Although the

the basis to allow the patient's guardian to discontinue her death-delaying medical treatment. *Id.* at 663.

32. See *supra* note 14 and accompanying text for a discussion of how medical technology can keep vegetative patients biologically alive for extended periods of time.

33. Siegler, *supra* note 16, at 713. The common view of life focused on the notion of good health. *Id.* at 714. Both patients and physicians viewed health as a common goal; therefore, patients assumed that their physicians would provide treatment accordingly. *Id.*

34. 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

35. *Id.* at 1009.

36. *Id.* at 1008.

37. *Id.* The state had an interest in preserving the mother's life because, as *parens patriae*, it could not allow the mother to abandon her child. *Id.*

38. 239 F. Supp. 752 (D. Conn. 1965).

39. *Id.* at 754. The court weighed the state's interests and the physician's conscience and professional oath against the patient's refusal of a blood transfusion. *Id.*

40. *Georgetown College*, 331 F.2d at 1008. The patient, who refused a blood transfusion, was the mother of a seven-month-old child. *Id.* The court noted that she "had a responsibility to the community to care for her infant." *Id.* Therefore, the state had a valid interest in preserving the mother's life. *Id.*

41. See, e.g., *id.* (allowing physicians to provide a nonconsensual blood transfusion based on overriding state interests); *George*, 239 F. Supp. at 753, 754 (holding that the state's overriding interest in the preservation of life outweighed the patient's refusal of a blood transfusion); *Raleigh Mem. Hosp. v. Anderson*, 201 A.2d 537, 538 (N.J.), *cert. denied*, 377 U.S. 985 (1964) (providing a hospital with protection from liability for administering a blood transfusion against a patient's wishes in order to protect the dying patient's unborn child).

42. *George*, 239 F. Supp. at 753, 754. The court recognized that both an overrid-

Georgetown and *George* courts' allocation of weight between state interests and patient wishes was not perfectly clear, the outcomes illustrated the disregard for a patient's right to make treatment decisions.⁴³

B. A Patient's Right to Refuse Death-Delaying Medical Treatment Ends the Era of Ultimate Physician Control

A patients' rights movement, centering around a patient's right to participate actively in treatment decisions, initiated a change in the physician-patient relationship and subsequently redistributed medical decision-making power.⁴⁴ A patient's right to participate actively in treatment decisions directly conflicts with a physician's exclusive control over treatment decisions.⁴⁵ Thus, patients could not gain decision-making power without a proportionate loss of this same power by physicians.⁴⁶ Several state supreme courts granted power to patients in the form of a negative right to refuse death-delaying medical treatment.⁴⁷ These decisions are commonly known as the "right-to-die" cas-

ing state interest in the preservation of life and a doctor's conscience and professional oath outweighed the patient's refusal of a blood transfusion. *Id.* at 754. Furthermore, because the patient voluntarily admitted himself into the hospital, he could not suddenly dictate his treatment, especially since his request could result in a charge of malpractice. *Id.*

43. *Id.* In *George*, the patient appeared to be coherent, rational, and strong. *Id.* at 753. He told the judge, at his bedside, that he would not agree to a transfusion but would also not resist a court order. *Id.* The court disregarded the patient's wishes and sanctioned the transfusion based on the state's interest in preserving life. *Id.*

44. See DOUGLAS WALTON, ETHICS OF WITHDRAWAL OF LIFE-SUPPORT SYSTEMS 200 (1983) (stating that the "consumer movement, decline in trust in public institutions, the influence of social sciences and humanities," and "public awareness of abuses of human subject research" all contributed to the trend toward a patient's right to participate in treatment decisions).

45. See *supra* note 8 and accompanying text for a discussion of the conflict between physicians and patients over the distribution of decision-making power.

46. See WALTON, *supra* note 44, at 201. The various distributions of decision-making power between physicians and patients provide the party who gains the power the ultimate control over medical treatment. *Id.*

47. See, e.g., J.F.K. Mem. Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984) (providing patients with the right to discontinue death-delaying treatment); Longeway v. Community Convalescent Ctr., 549 N.E.2d 292, 297 (Ill. 1989) (awarding patients the ability to forego life-sustaining artificial nutrition and hydration); Brophy v. New Eng. Sinai Hosp., 497 N.E.2d 626, 634 (Mass. 1986) (allowing patients to discontinue artificial nutrition and hydration); *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984) (providing, by statute, patients the right to discontinue death-delaying medical treatment); *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985) (granting patients the right to discontinue artificial life-sustaining nutrition and hydration treatment); *In re Quinlan*, 355 A.2d 647, 664 (N.J.), *cert. denied*, 429 U.S. 922 (1976) (providing patients with the right to forego death-delaying respiratory medical treatment).

es.⁴⁸

1. The Atmosphere for Change

The movement from physician-controlled treatment to a patient's active role in medical treatment decisions resulted in some measure from several changes in societal attitudes.⁴⁹ Society's expanding knowledge of various medications and treatment options fostered an atmosphere ripe for a change from the era of paternalism.⁵⁰ This understanding increased patient demands and expectations.⁵¹ Along with expanded patient knowledge, accounts of patient experimentation,⁵² physician negligence,⁵³ and the accompanying outrage contributed to this atmosphere of change. Patients began to question their physicians' authority and the traditional physician-patient relationship.⁵⁴ This atmosphere spawned a new breed of patient who resembled an informed consumer rather than a physician's "guinea pig."⁵⁵

48. MEISEL, *supra* note 15, at 3.

49. See Terry & Elliot, *supra* note 25, at 1175 (emphasizing that "[b]oth medical and cultural factors underlie the shift from paternalism to autonomy").

50. Allan S. Brett & Laurence B. McCullough, *When Patients Request Specific Interventions: Defining the Limits of the Physician's Obligation*, 315 NEW ENG. J. MED. 1347, 1348 (1986). The media fascination with medical advances increased public awareness of medicine. *Id.* The effectiveness of pharmacology and the potential of drug therapy to alleviate symptoms also influenced the behavior of patients. *Id.*

51. *Id.* Society's increased awareness of both medical advances and the effectiveness of drug therapy expanded public knowledge and increased the public expectations of medicine. *Id.*

52. Terry & Elliot, *supra* note 25, at 1175. Patients began to demand rights partially upon discovering abuses of human subjects in medical research. *Id.*; see, e.g., Jabari Asim, *Black Paranoia Far-Fetched? Maybe, but Understandable*, PHOENIX GAZETTE, Feb. 23, 1993, at A13 (discussing the United States Public Health Service's Tuskegee experiment in which 400 black men with syphilis were left untreated); Chris Ison, *A Subtle Test of Ethics*, CHI. TRIB., Mar. 16, 1992, at 7 (describing a class action suit against the United States Government for illegally using 250 Indian children to test an unlicensed hepatitis vaccine); Chris Ison, *A Question of Ethics*, STAR TRIB., Feb. 22, 1992, at 4A (stating that over 30 years ago a doctor at the Willowbrook Institute experimented on retarded children by exposing them to a hepatitis virus).

53. Siegler, *supra* note 16, at 714. The possibility of malpractice and battery suits against physicians for disregarding the doctrine of informed consent encouraged the shift away from the paternalistic patient-physician relationship. *Id.*

54. Terry & Elliot, *supra* note 25, at 1175. Patients became dissatisfied with the impersonalization of the patient-physician relationship. *Id.*; see, e.g., *In re Osborne*, 294 A.2d 372, 375 (D.C. 1972) (allowing a patient "validly and knowingly" to refuse a life-saving blood transfusion).

55. See generally M.H. Pappworth, *Human Guinea Pigs: A History*, 301 BRIT. MED. J. 1456 (1990) (discussing the history of the medical community's improper research on humans); David J. Rothman, *The Government's Guinea Pigs*, BALTIMORE SUN, Jan. 11, 1994, at 9A (discussing the United States Government's histo-

The focal point of this consumer movement was a patient's right to participate in treatment decisions.⁵⁶

This movement was not an isolated rights movement but rather a subset of the "rights movements"⁵⁷ of the 1960s and 1970s.⁵⁸ Although most people interested in patients' rights were those individuals currently seeking medical treatment, the various rights movements created an encompassing atmosphere which recognized general individual rights.⁵⁹ Not only did current patients demand an active role, but society as a whole demanded that individuals have more personal control over various aspects of their lives.⁶⁰ In the medical context, this reflected patient control over the sanctity of one's body.⁶¹

Although the rights movements provided a suitable atmosphere for change, patient rights continued to conflict with physicians' unequivocal control over treatment decisions.⁶² Eventually, the societal change tipped toward patient autonomy⁶³ and, consequently, away from physician paternalism with its time-honored ideology of "doctor knows best."⁶⁴ The right-to-die decisions provided the missing legal precedent which granted patients the right to control crucial aspects of their medical treatment.⁶⁵

ry of human experimentation).

56. See Siegler, *supra* note 16, at 714 (asserting that ethicists, scholars, and consumer advocates sought to empower patients with control over their own treatment decisions).

57. Terry & Elliot, *supra* note 25, at 1175. Examples of the various rights movements include the civil, consumers', women's, and patients' movements. *Id.*

58. *Id.*

59. See, e.g., Siegler, *supra* note 16, at 714 (stating that the various rights movements focused on rights of the individual); Terry & Elliot, *supra* note 25, at 1175 (asserting that the rights movements emphasized individual rights).

60. Siegler, *supra* note 16, at 714. The patients' rights movement and the subsequent autonomy era sought to achieve "equity and equality in the distribution of health services." *Id.*

61. See Brophy v. New Eng. Sinai Hosp., 497 N.E.2d 626, 634 (Mass. 1986). The Brophy court stated that a patient's right to privacy includes the right to be free from a "nonconsensual invasion of one's bodily integrity." *Id.*

62. Tom Tomlinson & Howard Brody, *Futility and the Ethics of Resuscitation*, 264 JAMA 1276, 1280 (1990). One possible model which governs medical decision making presumes that the power in the physician-patient relationship is a "zero-sum game." *Id.* In other words, when one of the parties gains power over treatment decisions, the other party consequently loses power. *Id.*

63. *Decisions near the End of Life*, 267 JAMA 2229, 2231 (1992). Patient autonomy "requires that competent patients have the opportunity to choose among medically indicated treatments and to refuse unwanted treatment." *Id.*

64. Siegler, *supra* note 16, at 714.

65. MEISEL, *supra* note 15, at 45. There is no absolute right to die, but a growing amount of case law and statutory law acknowledges that a limited right does exist. *Id.*

2. The Right-to-Die Decisions Granted Patients Medical Decision-Making Power

The rights movements encouraged the societal demand for change.⁶⁶ This general desire, coupled with the existing struggle between physicians' exclusive control and patients' participation required a legal resolution.⁶⁷ The line of cases which resolved this dispute became known as the right-to-die decisions.⁶⁸

The right-to-die cases capitalized on the societal demand for change in the distribution of medical decision-making power.⁶⁹ This legal precedent addressed the issue of whether an incompetent patient, on life-support apparatus⁷⁰ and with a minimal chance of recovery,⁷¹ could choose to forego death-delaying medical treatment.⁷² Beginning in 1976 with the seminal case⁷³ of *In re Quinlan*,⁷⁴ the New Jersey Supreme Court allowed a patient

66. See *supra* notes 57-60 and accompanying text for a discussion of the rights movements and their impact on society's attitude toward patient autonomy.

67. See HOEFLER & KAMOIE, *supra* note 1, at 128 (stating that "the *Quinlan* case proved to be a legal turning point, the defining moment of the entire right-to-die debate").

68. MEISEL, *supra* note 15, at 3.

69. See *supra* notes 49-65 and accompanying text for a discussion of the reasons for the redistribution of medical decision-making power.

70. See, e.g., *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 265 (1990) (sustaining the patient's life by artificial nutrition and hydration); *J.F.K. Mem. Hosp. v. Bludworth*, 452 So. 2d 921, 922 (Fla. 1984) (maintaining life with a mechanical ventilator); *In re Barry*, 445 So. 2d 365, 366 (Fla. Dist. Ct. App. 1984) (prolonging the patient's death with an artificial ventilator); *Longeway v. Community Convalescent Ctr.*, 549 N.E.2d 292, 293 (Ill. 1989) (sustaining the life of the patient through artificial feeding and hydration); *Brophy v. New Eng. Sinai Hosp.*, 497 N.E.2d 626, 628 (Mass. 1986) (prolonging the patient's life with artificial nutrition and hydration); *In re Conroy*, 486 A.2d 1209, 1216 (N.J. 1985) (sustaining the patient's life by the use of a feeding tube); *In re Quinlan*, 355 A.2d 647, 655 (N.J.), *cert. denied*, 429 U.S. 922 (1976) (maintaining the patient's life with a respirator).

71. See, e.g., *Bludworth*, 452 So. 2d at 923 (stating that "[i]t is now possible to hold such persons on the threshold of death for an indeterminate period of time by utilizing extraordinary mechanical or other artificial means to sustain their vital bodily functions"); *Quinlan*, 355 A.2d at 663 (describing the patient as "probably irreversibly doomed to no more than a biologically vegetative remnant of life").

72. See, e.g., *Longeway*, 549 N.E.2d at 298 (resolving the issue of whether the guardian of an incompetent patient may exercise a right to refuse death-delaying medical treatment within judicial guidelines); *Conroy*, 486 A.2d at 1220 (addressing the issue of whether a health care provider may withhold life-sustaining treatment from an incompetent patient).

73. *Longeway*, 549 N.E.2d at 296. The Illinois Supreme Court stated that *In re Quinlan* was the seminal case which addressed the issue of withdrawing life-sustaining medical procedures. *Id.*

74. 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

to discontinue death-delaying medical treatment.⁷⁵ The court reasoned that the patient's right to privacy outweighed her physicians' decision to continue treatment.⁷⁶ Later decisions held that a patient could forego death-delaying treatment based on the common law doctrine of informed consent.⁷⁷ Thus, the right-to-die decisions instilled patients with the negative right to forego an unwanted death-delaying treatment.⁷⁸

Although the right-to-die line of cases may appear similar to the line of decisions involving blood transfusions, they are factually distinguishable.⁷⁹ Whereas the right-to-die decisions involved sophisticated medical technology which could keep patients alive for an indefinite period of time,⁸⁰ the blood transfusion situations involved patients who would die within hours without a transfusion.⁸¹ In addition, the appropriateness of treatment created another distinguishing feature. Blood transfusions constituted an appropriate treatment because they would return the patient to a normal, active life,⁸² whereas death-delaying treatment merely prolonged biological existence without a chance for recovery.⁸³ Nevertheless, both situations involved the same underlying issue of whether a patient has a right to refuse life-sustaining treatment.⁸⁴

75. *Id.* at 663.

76. *Id.* The New Jersey Supreme Court recognized that the unwritten constitutional right of privacy was broad enough to allow a patient to decline medical treatment. *Id.* at 663. The court found that a patient's right to privacy was strong enough to override the physicians' consensus that removal of life-sustaining treatment would not conform to medical practices, standards, and traditions. *Id.* at 655.

77. See *infra* notes 103-10 and accompanying text for a discussion of a patient's right to forego death-delaying treatment based on the doctrine of informed consent.

78. Brett & McCullough, *supra* note 50, at 1347. A negative right is a right not to have something done, for example, a patient's right to refuse therapy. *Id.*

79. See *infra* notes 80-89 and accompanying text for the differences and similarities between the blood transfusion and the right-to-die decisions.

80. *J.F.K. Mem. Hosp. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984). The Florida Supreme Court asserted that a patient may remain on the "threshold of death for an indeterminate period of time" due to "extraordinary mechanical or other artificial means." *Id.*

81. *United States v. George*, 239 F. Supp. 752, 753 (D. Conn. 1965). Laboratory tests indicated that the patient had already lost 60% to 65% of his red blood cells and any further bleeding "would likely lead to shock and probable death." *Id.*

82. *In re Georgetown College*, 331 F.2d 1000, 1007 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). Several physicians agreed that the patient would have better than a 50% chance of living after the administration of a blood transfusion. *Id.*

83. *In re Quinlan*, 355 A.2d 647, 655 (N.J.), *cert. denied*, 429 U.S. 922 (1976). There was no form of treatment that could cure or improve the patient's permanently vegetative existence. *Id.* The court distinguished this patient from one whose life depended on a blood transfusion because the transfusion patient was "apparently salvable to long and vibrant health." *Id.* at 663. In contrast, in a death-delaying treatment scenario, the patient's irreversible condition precluded returning to a long and vibrant life. *Id.*

84. See *Longeway v. Community Convalescent Ctr.*, 549 N.E.2d 292, 294 (Ill.

These two lines of cases resolved the issue differently. The blood transfusion decisions prevented patients from refusing life-saving medical treatment since the state possessed a compelling interest to preserve life.⁸⁵ However, in the right-to-die cases patients could refuse death-delaying medical treatment because a patient's "right of self-determination"⁸⁶ or "right of choice"⁸⁷ outweighed most state interests.⁸⁸ Thus, the right-to-die decisions provided the crucial legal change in the redistribution of medical decision-making power between physicians and patients.⁸⁹

A patient's right of self-determination derived from the right to privacy⁹⁰ and the common law doctrine of informed consent.⁹¹ This right of choice was not absolute and had to satisfy a state's substituted-judgment test.⁹² Under this examination, the

1989) (providing that the issue was "whether the guardian of an incompetent, seriously ill patient may exercise a right to refuse artificial nutrition and hydration on behalf of his ward"); *In re Conroy*, 486 A.2d 1209, 1221 (N.J. 1985) (stating the issue as "whether life-sustaining treatment may be withheld or withdrawn from an incompetent patient").

85. *Georgetown College*, 331 F.2d at 1000. The court found that the state had an interest in the preservation of the patient's life because not only was she the mother of a seven-year-old child, but her life ultimately hung in the balance. *Id.* at 1008-09.

86. *Conroy*, 486 A.2d at 1221. Self-determination is the right of a person to control his own body. *Id.* In the medical context, this right encompasses a patient's right to accept or reject medical care. *Id.*

87. *Quinlan*, 355 A.2d at 664. The New Jersey Supreme Court recognized that there is a point at which individual rights overcome state interests. *Id.* Thus, the court acknowledged that the patient's right of choice allowed her to refuse death-delaying treatment. *Id.*

88. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977). The four claimed state interests are: (1) the preservation of life; (2) the protection of the interests of third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession. *Id.*

89. *See HOEFLER & KAMOIE, supra* note 1, at 130. *Quinlan* questioned the traditional role of medical professionals and provided patients and their families with the right to make medical decisions about life and death. *See id.*

90. *See infra* notes 97-102 and accompanying text for a discussion of a patient's right of self-determination based on that patient's right to privacy.

91. *See infra* notes 103-10 and accompanying text for a discussion of a patient's right to forego death-delaying treatment based on the common law doctrine of informed consent.

92. *See J.F.K. Mem. Hosp. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984) (defining substituted judgment as a doctrine in which either family members or legal guardians substitute their judgment for what they believe the incompetent patient would do if competent); *Longeway v. Community Convalescent Ctr.*, 549 N.E.2d 292, 299 (Ill. 1989) (defining substituted judgment as a surrogate decision-maker's attempt "to establish, with as much accuracy as possible, what decision the patient would make if he were competent to do so"); *In re Quinlan*, 355 A.2d 647, 664 (N.J.), *cert. denied*, 429 U.S. 922 (1976) (stating that the only way to protect an incompetent patient's right to privacy is to allow a guardian to assert it subject to

patient's decision-makers had to prove that their treatment decision was consistent with that of the patient, if the patient had been competent.⁹³ For instance, the United States Supreme Court in *Cruzan v. Director, Missouri Department of Health*,⁹⁴ upheld Missouri's clear and convincing substituted-judgment standard.⁹⁵ However, in *Cruzan* the patient's decision-makers did not satisfy that clear and convincing standard, and, therefore, could not discontinue the patient's death-delaying treatment.⁹⁶

a. Right to Privacy as a Basis for Refusing Death-Delaying Medical Treatment

The first rationale which justified a patient's right to forego death-delaying medical treatment involved the right to privacy.⁹⁷ The highly intrusive nature of death-delaying medical treatment signifies that a physician who administers such treatment against a patient's wishes violates that patient's right to privacy.⁹⁸ Al-

whether the patient would exercise that right and forego treatment in the particular circumstances).

93. *In re O'Connor*, 531 N.E.2d 607 (N.Y. 1988). The New York Court of Appeals held that there must be clear and convincing evidence that an incompetent patient would not want specific treatment under certain circumstances in order for the patient's guardian to discontinue death-delaying treatment. *Id.* at 613. In *O'Connor*, the court disregarded the patient's statement that she would not want to go on living if she could not take care of herself. *Id.* at 615. The court found that statement to be a mere reaction to a close friend's prolonged death and that the statement was simply consistent with statements that all older people make. *Id.* at 614. Therefore, since the guardians did not meet this clear and convincing standard, they could not refuse the administration of the patient's artificial feeding. *Id.*

94. 497 U.S. 261 (1990).

95. *Id.* The United States Supreme Court upheld the constitutionality of Missouri's substituted-judgment test that required an incompetent patient's decision-makers to show, by clear and convincing evidence, that the patient would, if competent, refuse the treatment. *Id.* at 292.

96. *Id.* The Missouri Supreme Court found that the patient's statements to her roommate about her desire not to live under certain medical conditions were unreliable. *Id.* at 268. Since the patient's guardians were unable to present sufficient evidence to meet Missouri's clear and convincing substituted-judgment standard, they could not discontinue the patient's death-delaying treatment. *Id.*

97. *See, e.g., Brophy v. New Eng. Sinai Hosp.*, 497 N.E.2d 626, 634 (Mass. 1986) (stating that "[a] significant aspect of this right of privacy is the right to be free of non-consensual invasion of one's bodily integrity"); *In re Conroy*, 486 A.2d 1209, 1222 (N.J. 1985) (holding that "[t]he right to make certain decisions concerning one's body is also protected by the federal constitutional right of privacy"); *In re Quinlan*, 355 A.2d 647, 663 (N.J.), *cert. denied*, 429 U.S. 922 (1976) (presuming that an individual's right to privacy is "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances").

98. *Quinlan*, 355 A.2d at 664. The New Jersey Supreme Court found that the patient's bodily invasion was great because she required 24-hour intensive care, antibiotics, a respirator, and a feeding tube. *Id.* Since the patient's bodily invasion was extreme, the patient's right to privacy was much greater than the state's inter-

though a state interest may still override a patient's right to forego death-delaying treatment, the state's interest "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."⁹⁹

Another important aspect of a patient's right to privacy involves the ability to die of natural causes.¹⁰⁰ A patient should not lose this right because of the inability to exercise that choice consciously.¹⁰¹ Allowing a patient's decision-makers to render treatment decisions on behalf of the patient protects this right.¹⁰² Thus, a patient's right to privacy not only yields protection from a violative medical procedure but also safeguards the right to die by natural forces through the discontinuation of death-delaying medical treatment.

b. Informed Consent as a Basis for Refusing Death-Delaying Medical Treatment

Another justification for a patient's right to refuse death-delaying medical treatment derives from the common law doctrine of informed consent.¹⁰³ Under this doctrine, a physician must obtain a patient's consent before administering medical care.¹⁰⁴ Without consent, the doctor commits a battery by providing the treatment.¹⁰⁵ Informed consent is based on a patient's right to refuse an unwanted treatment.¹⁰⁶ A patient's right of self-determination is based on this same justification.¹⁰⁷

est in preserving the patient's life. *Id.*

99. *Id.* at 664.

100. *Id.* A valuable aspect of the patient's right to privacy was her ability to allow her "vegetative existence to terminate by natural forces." *Id.*

101. *Id.*

102. *Id.*

103. *See, e.g., Longeway v. Community Convalescent Ctr.*, 549 N.E.2d 292, 297 (Ill. 1989) (stating that "because a physician must obtain consent from a patient prior to initiating medical treatment, it is logical that the patient has a common law right to withhold consent and thus refuse treatment").

104. *Id.* The Illinois Supreme Court stated that "[l]acking consent, a physician cannot force medical care upon a patient, even in life-threatening situations." *Id.*

105. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914). Justice Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Id.* at 93.

106. *See, e.g., Longeway*, 549 N.E.2d at 297 (stating that the doctrine of informed consent allows a patient to refuse unwanted artificial nutrition and hydration); *In re Conroy*, 486 A.2d 1209, 1222 (N.J. 1985) (asserting that "[t]he patient's ability to control his bodily integrity through informed consent is significant only when one recognizes that this right also encompasses a right to informed refusal").

107. *Conroy*, 486 A.2d at 1221. The New Jersey Supreme Court stated that "[t]he right of a person to control his own body is a basic societal concept, long recognized in the common law." *Id.*

An incapacitated patient cannot express a choice to forego treatment.¹⁰⁸ However, the right to refuse death-delaying medical treatment premised on informed consent does not end merely because the patient cannot sense a violation of that right.¹⁰⁹ Instead, a patient's decision-makers render a treatment decision by exercising the patient's right of choice on the patient's behalf.¹¹⁰

In summary, a patient's right to refuse death-delaying medical treatment reflected society's demand for a change in the distribution of medical decision-making power. Although courts relied on different legal justifications (the right to privacy or informed consent) for this shift, the result created a patient's negative right to refuse death-delaying medical treatment. In *Quinlan*, the New Jersey Supreme Court stated that "the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence."¹¹¹ Thus, the right-to-die decisions provided the legal environment for change in medical decision-making power by empowering patients with the negative right to forego an unwanted death-delaying treatment.

II. PATIENTS GAIN THE RIGHT TO RECEIVE DEATH-DELAYING MEDICAL TREATMENT

The right-to-die decisions properly provided patients with the specific right to refuse unwanted death-delaying medical treatment.¹¹² This negative right of refusal skewed medical decision-making power in favor of patients.¹¹³ However, recent legal precedent has expanded patient control by granting patients the right to receive death-delaying treatment that health care provid-

108. See, e.g., *In re Quinlan*, 355 A.2d 647, 663 (N.J.), cert. denied, 429 U.S. 922 (1976) (stating that if the incompetent patient became lucid for a moment, then she could express her desire about the continuation of her treatment; however, an irreversible condition makes this unlikely, if not impossible).

109. *Longeway*, 549 N.E.2d at 297. The Illinois Supreme Court recognized that although the patient was incapacitated, her common law right to withhold consent did not cease due to her inability to sense a violation of that right. See *id.*

110. See *supra* notes 92-96 and accompanying text for a discussion of how a patient's decision-makers can direct the patient's treatment on behalf of the patient under a substituted-judgment test.

111. *Quinlan*, 355 A.2d at 669.

112. See *supra* notes 66-96 and accompanying text for a discussion of the expansion of patient autonomy in the right-to-die cases.

113. Judith Daar, *A Clash at the Bedside: Patient Autonomy v. a Physician's Professional Conscience*, 44 HASTINGS L.J. 1241 (1993). The *Quinlan* case drew attention to the conflict between physicians' ethical integrity and patients' specific demands for treatment. *Id.* at 1261. The *Quinlan* court resolved this conflict by allowing patients to forego treatment and physicians to accommodate those patients' wishes without liability. *Id.*

ers deem futile¹¹⁴ and inappropriate.¹¹⁵

*In re Wanglie*¹¹⁶ and *In re Baby K*¹¹⁷ demonstrated the legal expansion of a patient's authority in medical decision-making.¹¹⁸ These decisions resolved disputes between representatives of patients who demanded death-delaying medical care and physicians who deemed such treatment futile and inappropriate.¹¹⁹ Although the opinions did not explicitly discuss the futility issue, they indirectly sanctioned a patient's right to receive futile and inappropriate treatment.¹²⁰ These cases indirectly granted patients an expansive right regardless of the adverse impact on physician ethics and morals,¹²¹ the cost of health care,¹²² and medical resources.¹²³

A. Patients' Indirect Right to Receive Death-Delaying Medical Treatment

Wanglie signified the indirect expansion of a patient's medical decision-making power from a negative right to refuse

114. *In re Baby K*, 16 F.3d 590, 593 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994). Baby K's physicians deemed continued treatment medically and ethically inappropriate. *Id.*

115. *Id.* at 596. The physicians treating Baby K asserted that they should only provide warmth, nutrition, and hydration because those treatments were in accord with the prevailing medical standard for anencephalic infants. *Id.* Her physicians deemed treatment of her condition futile. *Id.*; see also Steven H. Miles, *Informed Demand "Non-Beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512, 513 (1991) (discussing Mrs. Wanglie's health care providers' determination that continued death-delaying treatment was inappropriate and non-beneficial).

116. PX-91-283 (Minn. Dist. Ct., P. Div. July 1, 1991), reprinted in 7 ISSUES L. & MED. 369 (1991).

117. 16 F.3d 590 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994).

118. See also Sandra McIntosh, *Judge Sides with Jane's Parents; Says Stopping Life Support Would Be Close to Giving Patient Duty to Die*, ATLANTA J. & CONST., at 1 (stating that a Fulton Superior Court ruled that a hospital may not remove life support from a 13-year-old, irreversibly brain-damaged child).

119. See *infra* notes 124-211 and accompanying text for a discussion of legal disputes between physicians and patients over the continuation of death-delaying medical treatment.

120. There are no decisions that have specifically addressed the futility issue. *In re Baby K* and *In re Wanglie* did not attempt to resolve the issue of whether a patient has a right to treatment that health care providers deem inappropriate and futile. However, these decisions provided patients with a positive right to receive treatment that, in essence, requires health care providers to administer death-delaying treatment regardless of the patient's medical prognosis. *Baby K*, 16 F.3d at 590; *Wanglie*, PX-91-283 (Minn. Dist. Ct., P. Div. July 1, 1991).

121. See *infra* notes 217-20 and accompanying text for a discussion of the effects of futile medical treatment on physicians' ethics and morals.

122. See *infra* notes 221-37 and accompanying text for a discussion of the costs of compulsory futile medical treatment.

123. See *infra* notes 238-41 and accompanying text for a discussion of the depletion of medical resources as a result of futile medical treatments.

treatment to a positive right to receive futile and inappropriate treatment.¹²⁴ It provided the foundation for a patient's eventual express right to receive futile death-delaying medical care.¹²⁵ However, this implicit right to receive treatment did not result from a resolution of the futility debate, but rather from a probate court's appointment of a guardian who subsequently demanded health care professionals continue his wife's death-delaying treatment.¹²⁶

1. In re Wanglie

The Minnesota Probate Court first enunciated a patient's implied right to receive death-delaying medical treatment in *In re Wanglie*.¹²⁷ In *Wanglie*, a conflict arose between health care providers who sought to discontinue a patient's death-delaying treatment and the patient's family, who demanded its continuation.¹²⁸ The patient, Mrs. Wanglie, existed in a persistent vegetative state as a result of oxygen deprivation suffered during a heart attack.¹²⁹ Although medical technology kept her body alive, physicians sought to discontinue her treatment since it would not improve her irreversible condition.¹³⁰

The hospital proposed a two-step legal procedure to resolve the dispute with the Wanglie family.¹³¹ First, it petitioned the

124. Brett & McCullough, *supra* note 50, at 1348. A positive right is a right to have something done, such as a patient's right to select a particular treatment. *Id.*

125. See *In re Baby K*, 16 F.3d 590, 594 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994) (providing patients with an express right to receive emergency treatment).

126. *In re Wanglie*, 7 ISSUES L. & MED. 369 (1991).

127. PX-91-283 (Minn. Dist. Ct., P. Div. July 1, 1991).

128. *Id.*; see Edward Walsh, *County Seeks to Cut Patient's Life Support, Minneapolis Family Won't Say Yes*, TIMES UNION, May 29, 1991, at B8 (stating that medical experts believed this to be the first case in which a hospital sought to discontinue a patient's life-support over the patient's objections).

129. HOEFLER & KAMOIE, *supra* note 1, at 61-63. Mrs. Wanglie experienced respiratory complications and entered the Hennepin County Medical Center where physicians placed her on a respirator. *Id.* She remained aware of her surroundings. *Id.* Her physicians could not successfully wean her from the respirator so they transferred her to a long-term care facility. *Id.* At that facility Mrs. Wanglie had a heart attack. *Id.* Physicians revived her but she suffered oxygen deprivation and, consequently, irreversible brain damage. *Id.* Mrs. Wanglie re-entered the hospital and her physicians diagnosed her condition as PVS. *Id.* She was no longer aware of her surroundings. *Id.* Her physicians concluded that there was no hope of recovery and asked Mrs. Wanglie's family to evaluate the continuation of her death-delaying care. *Id.* Mrs. Wanglie's family opposed the termination of the treatment. *Id.* Thus, the hospital requested that a court appoint an independent guardian to determine whether her treatment was inappropriate. *Id.* The court resolved the dispute by awarding Mr. Wanglie guardianship. *Id.* Three days later, Mrs. Wanglie died of multi-system organ failure. *Id.*

130. Miles, *supra* note 115, at 513.

131. *Id.*

Minnesota Probate Court to appoint an independent guardian to determine the appropriateness of continued medical care.¹³² Next, if the guardian found that treatment inappropriate, the hospital would request a hearing to determine whether it had to continue to provide the inappropriate medical care.¹³³

In *Wanglie* the hospital never reached its second step because the Minnesota Probate Court awarded guardianship to Mr. Wanglie.¹³⁴ The court reasoned that Mr. Wanglie would act in the best interests of Mrs. Wanglie.¹³⁵ Mr. Wanglie demanded that the hospital continue his wife's death-delaying medical treatment.¹³⁶ His request required health care professionals to continue treatment which they found morally and ethically inappropriate.¹³⁷ Thus, the holding in *Wanglie* radically expanded a patient's negative right to refuse death-delaying medical treatment into a positive right-to-receive futile and inappropriate treatment.¹³⁸

2. The Basis for Expanding Patient Rights

The Minnesota Probate Court did not explicitly hold in *Wanglie* that a patient possessed a right to receive death-delaying medical treatment.¹³⁹ Rather, the court merely determined who would make medical treatment decisions for an incapacitated pa-

132. *Id.* If an independent conservator determined that Mrs. Wanglie's respiratory support was without benefit, then the second part of the hospital's legal action would involve a hearing to determine if it had to continue respirator treatment. *Id.* Since the Minnesota Probate Court awarded guardianship to Mr. Wanglie, the hearing was unnecessary. *Id.*

133. *Id.*

134. *In re Wanglie*, PX-91-283 (Minn. Dist. Ct., P. Div. July 1, 1991).

135. Miles, *supra* note 115, at 513. After the court appointed Mr. Wanglie as guardian, the hospital said that it would continue to provide respiratory support to the patient. *Id.*

136. *Brain-Damaged Woman at Center of Lawsuit Over Life-Support Dies*, N.Y. TIMES, July 6, 1991, at A8.

137. Miles, *supra* note 115, at 513. Mrs. Wanglie's physicians deemed her treatment non-beneficial because it could not heal her lungs, palliate her suffering, or enable her to experience life. *Id.*

138. Walsh, *supra* note 128, at B8. The *Wanglie* decision was another milestone in the right-to-die debate, even though it is directly opposite to those cases. *Id.* In the right-to-die decisions, families sought to discontinue death-delaying treatment, whereas Mr. Wanglie sought to continue his wife's treatment. *Id.*; see also *The Right to Live: Doctors Want to Pull the Plug on a Comatose Patient; That's Not Their Choice to Make*, NEWSDAY, Feb. 9, 1991, at 18. The *Wanglie* decision enunciated a right to die for hopeless, comatose patients. *Id.*

139. *In re Wanglie*, 7 ISSUES L. & MED. 369 (1991). The Minnesota Probate Court did not discuss whether a patient has a right to receive treatment. *Id.*; see also Miles, *supra* note 115, at 513 (stating that the Minnesota Probate Court noted that the hospital had not made a request to stop treatment; therefore, the court did not speculate on the legality of such an order).

tient.¹⁴⁰ The possible candidates were either an independent guardian or a family member.¹⁴¹ The court noted that if it awarded the husband guardianship, the husband would most likely require the continuance of death-delaying medical treatment.¹⁴² His close relationship and knowledge of the patient's desires would be in her best interests.¹⁴³ The court observed that an independent guardian would instead order the withdrawal of the patient's respirator.¹⁴⁴ An independent guardian would not have a close enough relationship with the patient to know what treatment was in the patient's best interests.¹⁴⁵ Thus, the Minnesota Probate Court awarded Mr. Wanglie guardianship based on its determination that a close family member would act in the patient's best interests.¹⁴⁶

The *Wanglie* court considered several factors in its best-interests analysis.¹⁴⁷ It inferred that Mr. Wanglie's close relationship to his wife meant he knew her beliefs.¹⁴⁸ In addition, he constantly conferred with other family members about her treatment, followed physicians' recommendations, and considered the quality of her care and the availability of third-party payment.¹⁴⁹ These

140. See Daar, *supra* note 113, at 1243 (stating that the question presented to the trial judge in *Wanglie* was a question about who could best represent the interests of the incompetent patient). But see Walsh, *supra* note 128, at B8 (stating that the issue was whether a patient has a right to medical treatment and whether there are limits to that right).

141. Miles, *supra* note 115, at 513. The hospital asked the court to appoint an independent conservator and Mr. Wanglie subsequently requested guardianship. *Id.*

142. HOEFLER & KAMOIE, *supra* note 1, at 62. During the Probate Court hearing, Mr. Wanglie argued that he was the best possible guardian because he would uphold the couple's shared belief in sustaining life at all costs. *Id.*

143. Miles, *supra* note 115, at 513.

144. HOEFLER & KAMOIE, *supra* note 1, at 62. During the Probate Court hearing the hospital's ethics consultant testified that physicians should not have to provide medical care that cannot serve a patient's personal and medical interests. *Id.* This testimony, plus the hospital's adamant objection to continued treatment, made it clear that the hospital sought appointment of an independent guardian so there could be a determination that the treatment was inappropriate. *Id.*

145. *In re Wanglie*, 7 ISSUES L. & MED. 369 (1991). The Minnesota Probate Court relied on Mr. Wanglie's personal relationship with Mrs. Wanglie when determining that it would be in Mrs. Wanglie's best interests to have Mr. Wanglie as her guardian. *Id.* at 372. For instance, Mr. Wanglie knew Mrs. Wanglie's "conscientious, religious and moral beliefs intimately." *Id.* at 371. Since an independent guardian would not possess such intimate knowledge, it would be difficult for that guardian to act in Mrs. Wanglie's best interests.

146. *Id.* The court granted Mr. Wanglie guardianship of his wife because the court concluded that it was in Mrs. Wanglie's best interests. *Id.* at 372. Mr. Wanglie's status as guardian provided him with the power to act for the Person and Estate of Mrs. Wanglie. *Id.*

147. *Id.* at 371.

148. *Id.*

149. *Id.*

acts demonstrated Mr. Wanglie's understanding of his wife's needs and his dedication to her welfare.¹⁵⁰ These factors assisted the court in determining that awarding guardianship to Mr. Wanglie would be in the patient's best interests.¹⁵¹

3. Best-Interests Basis Contradicts Prior Authority

The Minnesota Probate Court's application of the best-interests analysis contradicts Minnesota precedent¹⁵² and statutory authority.¹⁵³ The Minnesota Supreme Court, in its right-to-die decision *In re Torres*,¹⁵⁴ held that a probate court must act in a patient's best interests during a guardianship proceeding.¹⁵⁵ However, the court also stated that the Minnesota legislature, by enacting the Health Care Bill of Rights,¹⁵⁶ recognized that continued medical treatment does not always serve a patient's best interests.¹⁵⁷ It explained that merely equating continued physical existence of a patient with best interests opposes Minnesota legislation and medical authority.¹⁵⁸

Furthermore, in *Wanglie*, the Minnesota Probate Court based its guardianship decision on Mrs. Wanglie's best interests.¹⁵⁹ It appears that the court, by indirectly sanctioning Mrs. Wanglie's right to receive death-delaying treatment, merely equated Mrs. Wanglie's continued biological existence with her best interests.¹⁶⁰ This improper application of the best-interests test allowed the court to avoid determining whether a decision-maker could force health care professionals to continue futile and inap-

150. *Id.*

151. *Id.*

152. See *In re Torres*, 357 N.W.2d 332 (Minn. 1984) (stating that "simply equating the continued physical existence of the conservatee, who has no chance for recovery, with the conservatee's best interests appears contrary not only to the weight of medical authority, but also to those indications of legislative opinion which exist").

153. See MINN. STAT. § 144.651 (12) (Supp. 1989). The Minnesota Legislature provided patients with the right to refuse medical treatment. *Id.* This demonstrates a recognition by the legislature that a patient's best interests may not be served by continued treatment. *In re Torres*, 357 N.W.2d at 339.

154. 357 N.W.2d 332 (Minn. 1984).

155. *Id.* at 338.

156. MINN. STAT. § 144.651 (12) (Supp. 1989).

157. *Torres*, 357 N.W.2d at 339. The Minnesota Supreme Court stated that the Minnesota Legislature, in providing patients with the right to refuse medical treatment, recognized that continued medical treatment may not serve a patient's best interests. *Id.*

158. *Id.*

159. *In re Wanglie*, 7 ISSUES L. & MED. 369, 372 (1991).

160. See Miles, *supra* note 115, at 514. Mrs. Wanglie's physicians and family did not know her treatment preferences. *Id.* at 513. Without this knowledge, the court based its best-interests determination on Mr. Wanglie's insistence on continued treatment. *Id.*

propriate death-delaying treatment.¹⁶¹

4. *Disregard for Futile and Inappropriate Treatment*

Although the Minnesota Probate Court indirectly determined that death-delaying medical treatment was in a patient's best interests, physicians and the Minnesota medical community regarded such treatment as inappropriate.¹⁶² The probate court's adherence to a best-interests standard avoided the futility issue.¹⁶³ By merely awarding guardianship, the court placed the futility determination with the guardian.¹⁶⁴ In *Wanglie*, Mr. Wanglie, as guardian, deemed his wife's continued treatment appropriate.¹⁶⁵ The court's appointment of Mr. Wanglie as guardian, along with his determination that continued treatment was appropriate, precluded the hospital's request for a hearing on its obligation to provide inappropriate treatment.¹⁶⁶ Thus, without a hearing, the court evaded determining whether the patient possessed an explicit right to receive treatment.¹⁶⁷

On the other hand, if the guardian determined the treatment inappropriate, then a hospital's request to withdraw death-delaying care would require the court to confront directly the futility issue.¹⁶⁸ A futility analysis would demand a resolution between

161. See *supra* notes 152-60 and accompanying text for a discussion of the relationship between best interests and a patient's continued physical existence.

162. Ronald E. Cranford, *Helga Wanglie's Ventilator*, 21 HASTINGS CENTER REP. 23 (1991). The hospital medical director wrote a letter to Mr. Wanglie stating that "[a]ll medical consultants agree with [the attending physician's] conclusion that continued use of mechanical ventilation and other forms of life-sustaining treatment are no longer serving the patient's personal medical interests." *Id.*; see also Miles, *supra* note 115, at 513. The hospital contacted several health care providers in the area but none of them would accept Mrs. Wanglie as a transfer. *Id.* These providers refused the transfer before Mrs. Wanglie's situation became a public controversy, even though there was ample third-party reimbursement for her medical bills. *Id.* This demonstrates a consensus among the Minnesota medical community that respirator support was inappropriate. See *id.*

163. See generally Cranford, *supra* note 162, at 23.

164. See *In re Wanglie*, 7 ISSUES L. & MED. 369 (1991). The court granted Mrs. Wanglie's medical decision-making power to her guardian. *Id.* A consequence of that power was a determination of whether to continue her death-delaying treatment. One of the factors in that determination is a subjective judgment by the guardian of whether the treatment is appropriate. See B.D. Colen, *Take Care: the Cost of Pulling a Plug*, NEWSDAY, Sept. 10, 1991, at 63 (asserting that Mr. Wanglie believed that since the treatment maintained his wife's life, it was appropriate).

165. See Cranford, *supra* note 162, at 23.

166. See *supra* notes 131-32 and accompanying text for a discussion of the hospital's first step in its two-step legal procedure to resolve the Wanglie dispute.

167. See *supra* note 133 for the hospital's second step in its two-step legal procedure to resolve the Wanglie dispute.

168. See *id.* (providing that the determination of the appropriateness of the treatment coincides with the a determination of whether the treatment is futile).

the patient's right to receive treatment and the physician's refusal to continue it.¹⁶⁹ Therefore, a proper legal analysis must consider whether the treatment is futile and inappropriate¹⁷⁰ in order to resolve the decision-making conflict.

Although the medical community continually debates the futility issue, a single, accepted definition remains elusive.¹⁷¹ Under a quantitative analysis, treatment is not futile if it prolongs life.¹⁷² Under a qualitative analysis, treatment is futile if it does not improve the patient's quality of life.¹⁷³ Thus, a resolution of the patient-physician conflict over continuance of death-delaying treatment is unattainable without a universally adopted definition of futility.

B. Patients Expressly Gain the Right to Refuse Death-Delaying Medical Treatment

In re Baby K signified the direct expansion of patient self-determination by providing patients with an explicit right to receive emergency death-delaying medical treatment.¹⁷⁴ The Court of Appeals for the Fourth Circuit provided this right by incorrectly interpreting the Emergency Medical Treatment and Active Labor Act (EMTALA)¹⁷⁵ and by ignoring Virginia's Health Care Decisions Act (HCDA).¹⁷⁶ The disregard for legislative intent along with the avoidance of the futility issue led to an express right to compel health care professionals to provide futile treatment.

169. Miles, *supra* note 115, at 513. Physicians do not have to provide treatment that violates their personal moral views on medical care as long as the physician considers the patient's rights. *Id.* at 513-14. It is common for a physician to discontinue a respirator when it no longer benefits the patient. *Id.* at 513. Thus, health care providers should be able to discontinue inappropriate death-delaying treatment because under common practice, the removal of such medical apparatus does not compromise the patient's rights.

170. See *Guidelines for the Appropriate Use of Do Not Resuscitate Orders*, 265 JAMA 1868, 1870 (1991) (stating that "[a] physician is not ethically obligated to make a specific diagnostic or therapeutic procedure available to a patient, even on specific request, if the use of such a procedure would be futile").

171. See *id.* (stating that physicians are likely to interpret futility in different ways because it encompasses a wide range of possibilities).

172. Morreim E. Haavi, *Profoundly Diminished Life: The Casualties of Coercion*, 24 HASTINGS CENTER REP. 33, 36 (1994). Life support is futile under a quantitative analysis if there is "no credible chance of prolonging a reasonable duration of life." *Id.*

173. *Id.* Life support is futile under a qualitative analysis if there is "no serious possibility of restoring an acceptable quality of life." *Id.*

174. *In re Baby K*, 16 F.3d 590, 594 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

175. See *id.* at 596.

176. See *id.* at 597.

1. In re *Baby K*

Patients gained the explicit right to receive death-delaying emergency treatment in the Fourth Circuit's decision *In re Baby K*.¹⁷⁷ In *Baby K*, a dispute arose between physicians and an infant's mother over continuance of the child's death-delaying medical treatment.¹⁷⁸ Baby K suffered from a condition known as anencephaly.¹⁷⁹ She existed in a permanently unconscious state and could not see, hear, or interact with her environment.¹⁸⁰ The infant's physicians explained to her mother that anencephalic infants die within a few days and that "aggressive treatment would serve no therapeutic or palliative purpose."¹⁸¹ They recommended only supportive care,¹⁸² but the mother insisted that the medical staff provide mechanical ventilation whenever Baby K had breathing difficulty.¹⁸³

Since the hospital and mother disagreed on what constituted appropriate treatment, the physicians attempted to transfer Baby K to another facility.¹⁸⁴ All of the area hospitals refused to accept the infant.¹⁸⁵ After Baby K subsequently re-entered the emergency room three times due to breathing difficulty,¹⁸⁶ the hospital filed an action to determine whether it had to provide emergency medical treatment which it deemed medically and ethically inappropriate.¹⁸⁷ The Court of Appeals for the Fourth Circuit held that under EMTALA,¹⁸⁸ a hospital could not deny

177. 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

178. *Id.* at 592.

179. *Id.* Anencephaly is a "congenital malformation in which a major portion of the brain, skull, and scalp are missing." *Id.*; see also Debra H. Berger, *The Infant with Anencephaly: Moral and Legal Dilemmas*, 5 ISSUES L. & MED. 67, 68 (1989). Anencephaly is also known as "babies born without a brain." *Id.* The facial features of anencephaly include protruding eyeballs, malformed ears, and an extremely short neck. *Id.* The infant's cerebrum and cerebellum are almost completely absent. *Id.*

180. *Baby K*, 16 F.3d at 592.

181. *Id.*

182. *Id.* at 596. Baby K's physicians recommended providing the prevailing standard of care for anencephalic infants which included warmth, nutrition, and hydration. *Id.*

183. *Id.* at 593.

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.* at 592.

188. 42 U.S.C. § 1395dd(a) (1988) states:

In the case of a hospital . . . emergency department, if any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department . . . to determine whether

respiratory treatment to Baby K.¹⁸⁹ The court relied on a literal application of the statute, which enabled the court to avoid determining whether a physician must provide futile treatment upon a patient's demand.¹⁹⁰

2. Inconsistencies in Interpreting the EMTALA

The Fourth Circuit improperly interpreted the EMTALA. The court relied solely on the language of the federal EMTALA statute and not its legislative purpose.¹⁹¹ Broadly construed, the EMTALA applies to "any individual who seeks emergency room assistance."¹⁹² However, Congress intended that the statute prevent the "dumping"¹⁹³ of indigent or uninsured patients.¹⁹⁴ Courts relying on a literal interpretation of the EMTALA have allowed any patient to receive emergency medical care, regardless

or not an emergency medical condition . . . exists.

Section 1395dd(e)(1) defines an emergency medical condition as:

(A) 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.

Section 1395dd(b)(1)(A) provides that once physicians diagnose a patient as presenting an emergency medical condition, the hospital must provide either:

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility

189. *Baby K*, 16 F.3d at 594. The Fourth Circuit determined that once a physician diagnoses a patient as presenting an emergency medical condition, the hospital must provide the necessary treatment to prevent the material deterioration of the patient's condition or provide for a transfer to another medical facility. *Id.*

190. *Id.* at 596. The Fourth Circuit stated that "[w]e recognize the dilemma facing physicians who are requested to provide treatment that they consider morally and ethically inappropriate, but we cannot ignore the plain language of the statute" *Id.* The court also noted that it did not address the moral or ethical issues in this case because it believed that such an analysis was "beyond the limits of [its] judicial function" *Id.* at 598.

191. *Id.* at 596.

192. *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991). See *supra* note 188 for the specific language of the EMTALA.

193. Thomas L. Stricker, *The Emergency Medical Treatment and Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121, 1122 (1992). Hospitals "dump" patients when the hospitals refuse to administer emergency medical care due to "improper economic motives." *Id.* at 1121. These motives stem from a hospital's knowledge or belief that the patient is uninsured, indigent, or unable to pay for emergency medical care. *Id.* at 1121 n.3.

194. 42 U.S.C.A. § 1395dd annotation 1 (1992). The purpose of the EMTALA is to prevent hospitals from dumping patients who are unable to pay for emergency treatment. *Id.*

of economic status or insurance coverage.¹⁹⁵ In contrast, other courts adhere to the legislative history and apply the statute only to patients whom hospitals have refused treatment due to either economic status or lack of insurance coverage.¹⁹⁶ These inconsistent applications of the EMTALA lead to even greater confusion in attempts to resolve the patient-physician futile treatment conflict.¹⁹⁷

The Fourth Circuit in *Baby K* clearly proceeded under the broader, literal interpretation¹⁹⁸ and disregarded congressional intent.¹⁹⁹ Congress did not enact the EMTALA to control situations where family and physicians of a terminally ill patient must make medical treatment decisions.²⁰⁰ Rather, Congress enacted the EMTALA to correct the problem of hospitals dumping indigent and uninsured patients.²⁰¹ Since *Baby K* involved an insured patient,²⁰² the hospital's refusal to treat her did not equate to economic dumping. Thus, according to congressional intent underlying the EMTALA, the statute should not have applied in *In re Baby K*.²⁰³

195. See, e.g., *Gatewood*, 933 F.2d at 1040 (following the express language of EMTALA to allow any person to bring a suit under the statute regardless of their economic status); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990) (following the express language and, therefore, not limiting its application only to situations where a patient is unable to pay for treatment).

196. See, e.g., *Nichols v. Estabrook*, 741 F. Supp. 325, 330 (D.N.H. 1989) (interpreting the EMTALA as merely providing assurances that hospitals will examine and treat patients with emergency medical conditions regardless of their poor financial resources); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 497 (S.D. Ind. 1989) (construing the EMTALA narrowly to apply only when a hospital denies care due to economic factors).

197. See *Stricker*, *supra* note 193, at 1122 (discussing the division among the federal courts in the application of the EMTALA).

198. *In re Baby K*, 16 F.3d 590, 596 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994). The Fourth Circuit stated that it could not disregard the plain language of the statute without transcending its judicial function. *Id.*

199. See *supra* note 194 and accompanying text for a discussion of the purpose of the EMTALA.

200. *Baby K*, 16 F.3d at 598 (Sprouse, J., dissenting). The dissenting opinion asserted that Congress did not enact the EMTALA to "superintend the sensitive decision-making process between family and physicians at the bedside of a helpless and terminally ill patient under the circumstances of this case." *Id.*

201. *Id.* at 598. The dissenting opinion stated that there was no legislative history of the EMTALA that demonstrated Congress' intent to extend the statute to hospital-patient relationships that do not involve "dumping." See *id.*

202. Diane M. Gianelli, *Doctors Argue Futility of Treating Anencephalic Baby*, 37 AM. MED. NEWS 5 (1994).

203. *Id.* The author quotes a physician as stating that:

[t]he anti-dumping law is intended to protect the interests of patients to make sure [they] are not compromised because of financial concerns by the hospitals. If [Baby K] has been correctly diagnosed, no interest of hers is violated by withholding or withdrawing any kind of life-sustaining treatment, including feedings . . . [This] patient is not subject to the anti-

3. The Right to Receive Treatment Avoids the Futility Issue

The Fourth Circuit's adherence to the EMTALA in *Baby K* refuted the argument that state law allows physicians to refuse to provide futile treatment. Under Virginia's Health Care Decisions Act (HCDA),²⁰⁴ medical care providers do not have to administer or continue treatment which they deem medically or ethically inappropriate.²⁰⁵ Although HCDA deals specifically with advance directives,²⁰⁶ the statutory language clearly expresses the Virginia legislature's intent.²⁰⁷ The Fourth Circuit in *Baby K* ignored the legislative purpose behind both EMTALA and HCDA and, subsequently, avoided the issue of whether a patient has a right to receive futile treatment.²⁰⁸ Thus, without addressing the futility issue, the proper balance between a patient's right to receive treatment and a physician's refusal of treatment remains elusive.

Unfortunately, the Fourth Circuit's indirect sanction of a patient's right to receive futile treatment did not confront the futility issue.²⁰⁹ *Baby K*'s physicians, as well as a consensus of the medical community, deemed continued death-delaying treatment inappropriate and futile.²¹⁰ However, the court merely acknowledged the ethical concerns of *Baby K*'s physicians and stated that it could not ignore the plain language of the EMTALA.²¹¹ Thus, the Fourth Circuit's strict adherence to the language of the

dumping law any more than a dead patient would be.

Id.; see also Frances H. Miller, *Infant Resuscitation, A US/UK Divide*, 343 LANCET 1584, 1585 (1994) (stating that the Fourth Circuit extended the EMTALA into the right-to-die controversy by ignoring Congress' economic reasons for enactment).

204. VA. CODE ANN. § 54.1-2990 (Michie 1994).

205. *Id.* This statute states that: "Nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate." *But see Baby K*, 16 F.3d at 597 n.10 (noting that HCDA would not apply to *Baby K* regardless of the EMTALA because HCDA does not apply to infants).

206. *Baby K*, 16 F.3d at 597.

207. See *supra* note 205 for the specific language of HCDA.

208. *Baby K*, 16 F.3d at 596.

209. *Id.* at 596-97. The court did not factor in its analysis whether *Baby K*'s respirator treatment was futile. See *id.* Rather, the Fourth Circuit limited its analysis to whether the EMTALA governed the conflict. See *id.*

210. Gianelli, *supra* note 202, at 5. The consensus among the American Academy of Pediatrics was that continued treatment would not improve *Baby K*'s condition. *Id.* One physician stated that providing continued death-delaying treatment to the baby "deviate[d] sharply from generally accepted medical, ethical and legal standards." *Id.*

211. *Baby K*, 16 F.3d at 596. The court recognized the dilemma that physicians face when a patient requests treatment that they consider inappropriate. *Id.* However, the court stated that it could not ignore the plain language of the EMTALA. *Id.*

statute allowed it to side-step Virginia's HCDA and the futility issue, while expanding a patient's right of self-determination.

C. A Patient's Right to Receive Treatment Adversely Affects Several Interests

The holdings in *Baby K* and *Wanglie* created a radical distribution of medical decision-making power. These decisions signaled a disturbing form of patient self-determination that forces physicians to provide futile treatment.²¹² Forcing health care professionals to provide futile and inappropriate treatment not only compromises their ethics and morals but also adversely affects the economy.²¹³ It places a financial burden on insurance policyholders²¹⁴ and taxpayers,²¹⁵ and depletes medical resources as well.²¹⁶ Thus, the medical and legal communities must recognize these adversely affected interests in order to address fully the futility problem.

1. Compromise of Physician Ethics and Morals

Compelled futile medical treatment compromises physician ethics and morals.²¹⁷ Physicians have the responsibility to abstain from administering or continuing futile treatment.²¹⁸ For example, physicians are not obligated to provide antibiotics for the common cold because antibiotics are not an effective treatment. Prescribing antibiotics merely to satisfy a patient's desire is not a legitimate medical goal.²¹⁹ Continued respiration or artificial nu-

212. See *id.* at 594 (allowing a patient to receive futile and inappropriate death-delaying medical treatment); *In re Wanglie*, PX-91-283 (Minn. Dist. Ct., P. Div. July 1, 1991) (providing a patient the right to receive futile and inappropriate medical treatment based on her best interests).

213. See *infra* notes 217-41 and accompanying text for a discussion of the adverse effects futile medical treatment has on various interests.

214. See Judy Graham, *The High Cost of Healing*, 119 SCHOLASTIC UPDATE 6, 7 (1987) (stating that life-support equipment for a single patient may easily amount to \$2000 per day).

215. See *infra* notes 231-34 and accompanying text for a discussion of the financial burden futile medical treatment places on taxpayers.

216. See, e.g., *Brophy v. New Eng. Sinai Hosp.*, 497 N.E.2d 626, 631 (Mass. 1986) (describing the patient's treatment as requiring seven and one-half hours of nursing care each day).

217. See *In re Baby K*, 16 F.3d 590, 594 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994) (requiring health care professionals to provide treatment regardless of their determination that the treatment was medically and ethically inappropriate); *In re Wanglie*, PX-91-283 (Minn. Dist. Ct., Probate. Ct. Div. July 1, 1991) (allowing a guardian to require health care professionals to provide death-delaying treatment that they deemed inappropriate and non-beneficial).

218. Jecker & Schneiderman, *supra* note 13, at 191.

219. Lawrence J. Schneiderman et al., *Beyond Futility to an Ethic of Care*, 96 AM. J. MED. 110, 112 (1994).

trition treatment for PVS is analogous to antibiotics for the common cold: in both situations the treatment does not improve the patient's condition but merely appeases the patient's or family's wishes. Thus, compelled futile medical treatment forces a physician to abandon his duty to refrain from providing futile treatment and contravenes medical goals and standards.²²⁰

2. Financial Burden Placed on the Economy

Next, futile death-delaying treatment places a great financial burden on society.²²¹ Death-delaying medical treatment for permanently vegetative patients costs approximately \$7 billion in resources annually.²²² A typical PVS patient's medical care costs approximately \$50,000 per year.²²³ Most of these patients cannot afford such death-delaying treatment.²²⁴ Therefore, other sources must fund these expensive futile medical treatments.²²⁵

a. Private Insurance Resources

One major source that funds futile treatment is a patient's insurance company. For instance, private insurance paid a major portion of Mrs. Wanglie's \$800,000 hospital bill²²⁶ and Baby K's care which cost at least \$1450 per day.²²⁷ Insurance companies will not decline payment for death-delaying treatment because they fear negative publicity.²²⁸ Instead, the insurance company recovers these costs through higher deductibles and premiums paid by policyholders.²²⁹ Thus, consumers of health insurance, in addition to patients receiving futile treatment, bear the additional costs of futile and inappropriate treatment.²³⁰

220. John J. Paris et al., *Beyond Autonomy: Physicians' Refusal to Use Life-Prolonging Extracorporeal Membrane Oxygenation*, 329 NEW ENG. J. MED. 354 (1993). The Hippocratic oath requires physicians to act for the benefit of the patient according to the physician's ability and judgment. *Id.* at 357. Thus, physicians should not feel obligated to provide treatment that they deem inappropriate. *Id.*

221. John D. Gorby, *Viewing the "Draft Guidelines for State Court Decision Making in Authorizing or Withdrawing Life-Sustaining Medical Treatment" from the Perspective of Related Areas of Law and Economics: A Critique*, 7 ISSUES L. & MED. 477, 508 (1992).

222. HOEFLER & KAMOIE, *supra* note 1, at 61.

223. *Id.*

224. Graham, *supra* note 214, at 7.

225. See *infra* notes 231-34 and accompanying text for a discussion of insurance company and municipality-funded medical treatment.

226. Walsh, *supra* note 128, at B8.

227. *Baby with No Brain is Key in Fight, Her Mother is Battling a Hospital to Keep the Child Alive*, VIRGINIAN-PILOT, Sept. 26, 1993, at A14.

228. HOEFLER & KAMOIE, *supra* note 1, at 63.

229. Dean Coddington et al., *Factors Driving Costs Must Figure into Reform*, 45 HEALTHCARE FIN. MGMT. 44, 45 (1991).

230. See Miles, *supra* note 115, at 514 (reporting that several Minnesota citizens

b. Taxpayers Burdened by Government Programs

Futile treatment places an increased financial burden on taxpayers through government-funded health care.²³¹ The government finances expensive death-delaying treatment through Medicare, Medicaid, and publicly funded hospitals.²³² For instance, Medicare paid for a portion of Mrs. Wanglie's \$800,000 hospital bill.²³³ The government recovers these costs through higher taxes.²³⁴

The courts in *Wanglie* and *Baby K* did not address treatment costs.²³⁵ Many commentators have suggested that costs were not at issue in these cases.²³⁶ In fact, hospitals do not refuse to provide futile death-delaying treatment based on expenses because this type of medical care generates revenue.²³⁷ Thus, the legal community, health care professionals, several courts, and society do not adequately consider the cost of futile medical treatment. Addressing the financial burden of futile treatment may assist in resolving the physician-patient conflict over the continuation of such treatment.

c. Depletion of Medical Resources

Finally, futile death-delaying treatment depletes medical

complained that "Mrs. Wanglie was receiving expensive treatment paid for by people who had not consented to underwrite a level of medical care whose appropriateness was defined by family demands").

231. See, e.g., Ronald Kotulak, *Doctors Rip "Right-to-Die" Edict, Say More Suicides Could Result*, CHI. TRIB., June 26, 1990, §1, at 11 (stating that Missouri paid for a PVS patient's treatment for the past seven years at a cost of \$130,000 annually and that the patient could live another 30 years with continued treatment).

232. Janet M. Calvo, *Alien Status Restrictions on Eligibility for Federally Funded Assistance Programs*, 16 N.Y.U. REV. L. & SOC. CHANGE 395, 426 (1987). When publicly funded hospitals or Medicaid pay for inappropriate health care, society ultimately bears the financial burden through increased taxes, insurance rates, and costs. *Id.*

233. Miles, *supra* note 115, at 513. Medicare paid for approximately \$200,000 of Mrs. Wanglie's medical treatment. *Id.*

234. See Calvo, *supra* note 232, at 426 (stating that society as a whole pays for inappropriate health care through increased taxes to fund public hospitals, increased health insurance rates, and increased costs of private hospitals).

235. Neither the Fourth Circuit in *Baby K* nor the Minnesota District Court in *Wanglie* mentioned the cost of the patient's treatments.

236. See, e.g., *Baby with No Brain is Key in Fight, Her Mother is Battling a Hospital to Keep the Child Alive*, *supra* note 227, at A14 (stating that despite the high cost of Baby K's treatment, the only issue was who decides what is proper treatment for a patient); Colen, *supra* note 164, at 63 (stating that the conflict between Mrs. Wanglie and her physicians had nothing to do with the cost of her treatment); Walsh, *supra* note 128, at B8 (asserting that money is not an issue in the decision whether to continue Mrs. Wanglie's death-delaying treatment).

237. Colen, *supra* note 164, at 63.

resources.²³⁸ A hospital which provides such treatment must possess expensive life-support equipment²³⁹ and a highly trained staff to administer and monitor the equipment.²⁴⁰ Allocation of medical staff and equipment to provide futile treatment means that these resources are unavailable for other patients.²⁴¹ Therefore, the allocation of medical resources is another important factor in resolving the patient-physician conflict.

III. PROPOSAL

The absence of a universal definition of futile medical treatment contributes to a patient's right to receive inappropriate death-delaying treatment.²⁴² The physicians in *Baby K* and *Wanglie* could not argue that their patients should not be able to force them to provide futile treatment because they did not have a standard definition on which to base their argument.²⁴³ Although the legal community continues to avoid directly addressing the futility debate, it is not solely at fault. The medical community shares some blame since it has failed to adopt a universal definition of futile treatment.²⁴⁴ Thus, without a universal medical standard for futility, courts cannot confront whether a particular death-delaying treatment is futile.²⁴⁵

238. See Giles R. Scofield, *Is Consent Useful When Resuscitation Isn't?*, 21 HASTINGS CENTER REP. 28, 31 (1991) (stating that futility is an important issue because of society's interest in preserving resources); Robert D. Truog et al., *The Problem with Futility*, 326 NEW ENG. J. MED. 1560, 1563 (1992) (adhering to the view that providing death-delaying treatment to patients in a permanently vegetative state is a misuse of resources).

239. See Graham, *supra* note 214, at 7 (stating that life support equipment is "extremely expensive to buy and operate").

240. See, e.g., *Brophy v. New Eng. Sinai Hosp.*, 497 N.E.2d 626, 631 (Mass. 1986) (providing over seven hours of nursing care each day for a PVS patient).

241. See Marcia Angell, *The Case of Helga Wanglie: A New Kind of "Right-to-Die" Case*, 325 NEW ENG. J. MED. 511, 512 (1991) (stating that resources spent on life support could be used to care for patients who would actually benefit from treatment).

242. See Allen J. Bennett, *When Is Medical Treatment "Futile"?*, 9 ISSUES L. & MED. 35, 37 (1993) (noting that the medical predicament of Mrs. Wanglie highlights the problems of what is medical futility and who decides when it exists). *But see* Truog, *supra* note 238, at 1564 (avoiding a rigid formula for futility because "clinical heterogeneity, plurastic values, and the evolutionary nature of social consensus" defies reduction to a universally applicable definition).

243. See *supra* notes 171-73 and accompanying text for a discussion of the lack of a universal definition of futile medical treatment.

244. See Scofield, *supra* note 238, at 31 (stating that "[t]here is no set definition of medical futility, only suggested parameters that vary widely").

245. Daniel Callahan, *Medical Futility, Medical Necessity: the Problem Without a Name*, 21 HASTINGS CENTER REP. 30, 31 (1991) (stating that it is difficult to identify futile treatment because of the elusiveness of a standard definition). *But see* Truog, *supra* note 238, at 1563 (stating that the concept of futility fails to provide

The Fourth Circuit and the Minnesota Probate Court attempted to resolve physician-patient conflicts over futile treatment based on statutory law²⁴⁶ or a best-interests approach.²⁴⁷ However, conflicts still exist because these courts failed to address directly the futility issue. In order to resolve effectively the physician-patient conflict over the appropriateness of futile medical treatment, there must be a three-part solution. First, the medical community must adopt a universally applicable definition of futile medical treatment. Second, a decision must be made regarding who should decide when treatment is futile. Third, a decision must also be made as to who should decide when to discontinue futile treatment.

A. A Universal Definition of Futile Medical Treatment

A physician's ability to withhold death-delaying medical treatment is a vital part of professional responsibility.²⁴⁸ Still, ethicists and the medical community cannot develop a standard definition of futile treatment.²⁴⁹ Proposed definitions include a quantitative determination based on the likelihood of treatment success²⁵⁰ or a qualitative analysis which considers the patient's quality of life.²⁵¹ Although these proposals provide insight into the issues surrounding futile medical treatment, they often lead to conflicting conclusions and thus do not resolve the conflict between patients and physicians over the continuation of death-

an "ethically coherent ground for limiting life-sustaining treatment").

246. See *supra* notes 191-211 and accompanying text for a discussion of how the Fourth Circuit applied EMTALA to resolve a dispute between physicians and patients over the continuation of death-delaying treatment.

247. See *supra* notes 131-61 and accompanying text for a discussion of how the *Wanglie* court applied a best-interests standard to resolve the dispute over who would make the patient's death-delaying treatment decisions.

248. See Edward R. Grant & Cathleen A. Cleaver, *A Line Less Reasonable: Cruzan and the Looming Debate Over Active Euthanasia*, 2 MD. J. CONTEMP. LEGAL ISSUES 99, 119 (1991) (stating that under medical-legal principles, a physician does not have to provide futile medical treatment even if the patient consents to the treatment).

249. See, e.g., Bennett, *supra* note 242, at 40 (stating that even physicians cannot define medical futility); Schneiderman, *supra* note 219, at 110 (asserting that the debate among physicians and ethicists regarding the concept of medical futility is intensifying); Scofield, *supra* note 238, at 31 (providing that "[t]here is no set definition of medical futility, only suggested parameters that vary widely"); Truog, *supra* note 238, at 1560 (stating that most clinicians cannot define futility, but they know it when they see it).

250. Callahan, *supra* note 245, at 31. A quantitative definition "refers to an expectation of success that is either predictably or empirically so unlikely that its exact probability is often incalculable." *Id.*

251. *Id.* A qualitative definition of futility "refers to any treatment that merely preserves permanent unconsciousness or that fails to end total dependence on intensive medical care." *Id.*

delaying treatment.²⁵²

The optimal definition of futile medical treatment is treatment that "merely preserves permanent unconsciousness or cannot end dependence on intensive medical care."²⁵³ This definition focuses on a treatment's effect on a patient's quality of life rather than a treatment's mere biological benefit.²⁵⁴ A key consideration when assessing a patient's quality of life is the irreversible nature of the condition. Treatment that cannot alter the irreversible nature of permanent unconsciousness or dependence on intensive medical care consequently cannot improve a patient's quality of life and therefore is futile. This proposed definition recognizes physician autonomy by requiring an objective determination by a physician of whether the treatment can improve the patient's condition.²⁵⁵ It also takes into account patients' expectations of treatment by considering their quality of life.²⁵⁶ Thus, universal adoption of this definition provides the first step in balancing the current inequality in medical decision-making power.

B. Physicians Must Determine When Medical Treatment is Futile

The proposed futile medical treatment definition allows a physician to make an objective determination of whether treatment will improve a patient's condition.²⁵⁷ A physician who

252. See, e.g., *In re Baby K*, 16 F.3d 590, 592 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994) (demonstrating the conflict between physicians who deemed treatment futile and inappropriate and a patient's guardian who deemed continued treatment beneficial).

253. Lawrence J. Schneiderman et al., *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS OF INTERNAL MED. 949, 951 (1990). Schneiderman's definition also includes an empiric aspect which states that if a physician concludes that in the last 100 cases, a medical treatment has been useless, it is futile. *Id.*

254. See Schneiderman, *supra* note 219, at 110 (discussing how different legal approaches and authors' definitions do not deem treatment futile if the treatment keeps a patient biologically alive, fulfills a patient's previously expressed wishes, or has a physiological effect on the body).

255. Bennett, *supra* note 242, at 39. The AMA partially defines medical futility as physician-oriented, recognizing a physician's inability to restore cardiac function. *Id.*

256. *Id.* The AMA partially defines medical futility as patient-oriented, recognizing the inability of a treatment to achieve the patient's goals. *Id.* This aspect of the definition respects patient autonomy and a patient's right of choice. *Id.*; see also Terese Hudson & Kevin Lumsdom, *Are Futile-Care Policies the Answer?*, 68 HOSP. & HEALTH NETWORKS 26, 27 (1994) (defining futile care by asking whether further treatment can, within a reasonable certainty, cure, ameliorate, improve, or restore the patient's quality of life).

257. Stuart J. Younger, *Who Defines Futility?*, 260 JAMA 2094 (1988). Physicians know most about the empirical facts of futility. *Id.* at 2095. However, a futility determination also requires a value judgment. *Id.* Thus, physicians should frame treatment options in the context of quality of life but should not offer treatment op-

must decide whether the medical treatment improves the patient's condition must inherently consider the treatment's impact on the patient's quality of life.²⁵⁸ If there is no reasonable probability that continued treatment will improve the patient's condition, then, correspondingly, no probability exists that the quality of life will improve.²⁵⁹ Thus, once a physician determines that a treatment will not improve the patient's condition and quality of life, then the physician must deem it futile.

C. Physicians Must Determine Whether Futile Death-Delaying Treatment Should Continue

Physicians must decide either to discontinue or to refuse to initiate death-delaying medical treatment where deemed futile.²⁶⁰ First, they must explain to the patient or decision-makers that the treatment will not improve the patient's condition and will, therefore, not improve the quality of life. Next, they need to request that the family consent to the withdrawal of the treatment, if already started.²⁶¹ Unfortunately, the patient's family may act based on their emotions rather than sound judgment when determining what is best for the patient²⁶² and insist on the continuation of futile treatment.

The courts must provide physicians with a rebuttable presumption to determine when treatment is futile. In order for the patient's decision-makers to rebut this presumption of futility, they must comply with a two-step procedure. First, the patient's representatives must provide the physician with a written objection to the withdrawal of treatment within thirty-six hours of the physician's determination. Upon receipt of this objection, the physician must continue the treatment. Second, the patient's representatives must file an action in probate court within seven days

tions that are futile. *Id.*

258. See *supra* note 253, at 953 (stating that treatment is futile if it does not provide a benefit to the person as a whole, even though it provides an effect on a portion of the patient's body).

259. Hudson & Lumsdom, *supra* note 256, at 27. For example, the Santa Monica Hospital Medical Center's definition of futile care revolves around a quality of life consideration. *Id.* If a treatment does not cure, ameliorate, improve or restore a patient's quality of life, then it is futile. *Id.*

260. See WALTON, *supra* note 44, at 227 (stating that only physicians can determine whether a medical treatment is pointless as a therapeutic effort); Bennett, *supra* note 242, at 45 (asserting that physicians should make futility decisions).

261. Bennett, *supra* note 242, at 45. Physicians should make futility determinations but must also continually communicate with the patient's family about the patient's condition and chances of recovery. *Id.*

262. See *id.* at 42 (noting that expecting a family to make a decision based on futility is asking them to understand this complex topic at a time of great emotional burden).

of the written objection to determine the hospital's responsibility. If the patient's decision-makers do not file an action within seven days, then the physician can discontinue the futile treatment. If the decision-makers file an action, the physician must continue treatment until the court determines whether the decision-makers rebutted the physician's presumption of futility by showing that treatment will improve the patient's condition and correspondingly the patient's quality of life. Upon a finding that the decision-makers did not rebut the futility presumption, the court must authorize the physician to pull the plug on futile treatment.

CONCLUSION

Previously, a permanently vegetative patient could not choose to forego death-delaying medical treatment and remained biologically alive through medical technology. However, the right-to-die decisions provided patients with a negative right to refuse death-delaying treatment.²⁶³ A disturbing new trend allows medical decision-making power to rest with patients in the form of a right to receive futile and inappropriate treatment.²⁶⁴ This is not an explicit promulgation of a patient's right of self-determination but rather an indirect right by default. Some courts implicitly sanctioned a right to futile treatment without addressing the futility issue and its adverse effects.²⁶⁵ A patient's right to receive futile treatment impinges upon on physicians' ethics and morals, disturbs the allocation of scarce medical resources, and imposes added costs on taxpayers and insurance policyholders. These problems, combined with the aging of our society, advances in medical technology, and the increasing incidence of debilitating diseases, will transform the existing situation into a crisis.

Preventing this crisis requires a subtle redistribution of medical decision-making power back to physicians. In order for this change to occur, there must be a universally accepted medical definition of futile treatment. Once the medical community implements that definition, physicians must use their medical knowledge and judgment to determine whether the administration or continuation of treatment is futile. If a physician deems treatment

263. See *supra* notes 69-78 and accompanying text for a discussion of a patient's negative right to refuse treatment.

264. See *supra* notes 127-211 and accompanying text for a discussion of both a patient's indirect and express right to receive futile death-delaying medical treatment.

265. See, e.g., *In re Baby K*, 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994) (providing patients with a right to receive futile emergency treatment without addressing the futility issue); *In re Wanglie*, PX-91-283 (Minn. Dist. Ct., P. Div. July, 1, 1991) (granting patients an implicit right to receive futile treatment by ignoring physicians' determinations that treatment is inappropriate).

futile, the physician must attempt to gain the patient's or family's consent to discontinue it. If unsuccessful, the patient's representatives must rebut the presumption of futility. The courts must not compound the problem by ignoring physicians' futility determinations. A proactive stance by both the medical and legal communities will alleviate this emerging problem.

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