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A New Predicament for Physicians: The Concept of Medical Futility, the Physician's Obligation to Render Inappropriate Treatment, and the Interplay of the Medical Standard of Care

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A NEW PREDICAMENT FOR PHYSICIANS: THE CONCEPT OF MEDICAL FUTILITY, THE PHYSICIAN'S OBLIGATION TO RENDER INAPPROPRIATE TREATMENT, AND THE INTERPLAY OF THE MEDICAL STANDARD OF CARE

ERIC M. LEVINE¹

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I. INTRODUCTION

It is a well-settled principle that patients have a right to self-determination. Only twenty years ago, courts emphasized that the legal underpinnings of the informed consent requirement are the individual's autonomy and the right to self-determination.² Law and ethics have come to recognize this right of self-determination as embracing a competent person's right to refuse unwanted medical treatment.³ Thus, patient participation in medical decisionmaking is well established.⁴ But how far does this notion of patient participation go? A lively topic in medical literature is the futility of medical treatment, in other words, medical treatment that, in the view of the physician, is nonbeneficial or useless to the patient. Physicians continue to search for a proper definition of futility,⁵ and continue to debate whether the physician or the patient should be the arbiter on whether a given therapy is "futile."⁶ One thing is clear however: if treatment is determined to be futile (whatever that means), then a physician is under no obligation to continue or offer such treatment.⁷

²See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

³See, e.g., *Rasmussen ex rel. Mitchell v. Fleming*, 741 P.2d 674, 681-83 (Ariz. 1987) (en banc); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977); *In re Gardner*, 534 A.2d 947, 951 (Me. 1987); *In re Conroy*, 486 A.2d 1209, 1222 (N.J. 1985); ALAN MEISEL, *THE RIGHT TO DIE* § 3.2, at 45-47 (1989).

⁴Edmund D. Pellegrino, *Ethics*, 270 JAMA 202, 202 (1993).

⁵Compare John D. Lantos et al., *The Illusion of Futility in Clinical Practice*, 87 AM. J. MED. 81, 83 (1989) (suggesting that treatment should be deemed "futile" only after the physician and patient agree that the likelihood of treatment achieving the desired goals of the patient and physician is so low that the expected burdens outweigh any minimal benefits) with Lawrence J. Schneiderman et al., *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 949, 950-53 (1990) (defining "futile" treatment as treatment highly unlikely to produce a desired result based on reasoning, experience, or empirical evidence, or treatment that fails to improve the patient's prognosis, merely preserving the patient in a state of permanent unconsciousness or maintaining the patient's dependence on intensive medical care).

⁶Compare Nancy S. Jecker & Robert A. Pearlman, *Medical Futility: Who Decides?*, 152 ARCHIVES INTERNAL MED. 1140, 1144 (1992) with Stuart J. Youngner, *Who Defines Futility?*, 260 JAMA 2094, 2095 (1988).

⁷See, e.g., Glen C. Griener, *The Physician's Authority to Withhold Futile Treatment*, 20 J. MED. & PHIL. 207, 208 (1995); Lawrence J. Nelson & Robert M. Nelson, *Ethics and the Provision of Futile, Harmful, or Burdensome Treatment to Children*, 20 CRITICAL CARE MED. 427, 428 (1992); Lawrence J. Schneiderman & Nancy Jecker, *Futility in Practice*, 153 ARCHIVES INTERNAL MED. 437, 440 (1993); Lance K. Stell, *Stopping Treatment on Grounds of Futility: A Role for Institutional Policy*, 11 ST. LOUIS U. PUB. L. REV. 481, 492 (1992); see also Council on Ethical and Judicial Affairs, American Med. Ass'n, *Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders*, 265 JAMA 1868, 1870 (1991) [hereinafter AMA GUIDELINES] ("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."). One court, in an earlier right to refuse treatment

The concept of futility has reared its head in some recent court cases, referred to as physician-refusal cases,⁸ in which patients,⁹ or their surrogate decisionmakers, have demanded treatment that physicians refuse to offer or continue because treatment is viewed by physicians as "useless" or "inappropriate." In one well-known case, physicians wished to disconnect an 87 year old woman (Helga Wanglie) in a persistent vegetative state from a respirator.¹⁰ The patient's husband and children objected to the withdrawal of treatment, citing the patient's failure to state her preferences regarding life sustaining treatment.¹¹ Although physicians did not characterize the use of the respirator as "futile" treatment, they believed it was "non-beneficial" because it did nothing to change the patient's prognosis or improve her quality of life.¹² The hospital petitioned a court to appoint an independent conservator to make medical decisions for the patient in lieu of her husband.¹³ The court framed the issue as being "whether it is in the best interest of an elderly woman who is comatose, gravely ill, and ventilator-dependent to have decisions about her medical care made by her husband . . . or by a stranger."¹⁴ Relying on the state's guardian appointment statute, the court held that the patient's husband was the person best suited to make medical decisions for the patient and appointed him as guardian.¹⁵ Although the physicians indicated they would have petitioned the court for a second hearing on whether they were obliged to continue the provision of ventilatory treatment they deemed "non-benefi-

case, ostensibly approved of this view. See *Barber v. Superior Court*, 195 Cal. Rptr. 484, 491 (Ct. App. 1983) ("A physician has no duty to continue treatment, once it has proved to be ineffective. . . . [T]here is no duty to continue [treatment] once it has become futile in the opinion of qualified medical personnel."). Note, however, that in *Barber*, both the physicians and the patient's family agreed that treatment was inappropriate. See *id.* at 486, 492-93.

⁸James J. Murphy, Comment, *Beyond Autonomy: Judicial Restraint and the Legal Limits Necessary to Uphold the Hippocratic Tradition and Preserve the Ethical Integrity of the Medical Profession*, 9 J. CONTEMP. HEALTH L. & POL'Y 451, 454 (1993).

⁹For convenience, throughout this article the term "patient" means either the patient, the patient's surrogate decisionmaker, or the patient's proxy appointed under a durable power of attorney or advance directive. See *infra* notes 166-68.

¹⁰*In re Wanglie*, No. PX-91-283 (Minn. P. Ct. Hennepin County July 1, 1991) (order appointing guardian), reprinted in 2 *Biolaw (Updates)* § 12-6, at U:2161-:2168 (James F. Childress & Ruth D. Gaare eds., 1991).

¹¹Steven H. Miles, *Informed Demand for "Non-Beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512, 513 (1991).

¹²*Id.*

¹³*In re Wanglie*, No. PX-91-283, at 2 (order appointing guardian).

¹⁴*Id.* at 6.

¹⁵*Id.* at 7.

cial," this was unnecessary because the patient died three days after the court appointed the patient's husband as guardian.¹⁶

The underlying contexts in which these physician-refusal cases arise are not limited to the provision of care for elderly patients. *In re Doe*¹⁷ involved a terminally ill thirteen-year-old child.¹⁸ Doctors found that Doe suffered from a degenerative neurological disease, although no particular diagnosis could be confirmed.¹⁹ Doctors placed her on a ventilator and inserted feeding tubes surgically.²⁰ Doctors ultimately suggested to Doe's parents that they permit doctors to enter a do-not-resuscitate (DNR) order, and discussed the possibility of "de-escalating" aggressive treatment.²¹ One parent agreed to a DNR order and the de-escalation of life support while the other did not.²² The hospital filed an action in court seeking a declaration on whether to follow the wishes of Doe's mother or father.²³ The lower court held that both parents must concur in decisions concerning resuscitation and de-escalation of life support, and in the absence of such concurrence, the hospital was not authorized to proceed.²⁴ The court entered an order enjoining the hospital from entering a DNR order and de-escalating life support.²⁵ The Georgia Supreme Court affirmed, relying heavily on state statutes requiring the concurrence of both parents in decisions relating to health care for a child.²⁶ Although neither of these cases directly addressed the issue whether a physician is required to provide treatment deemed futile or inappropriate, it will only be a matter of time before courts undertake to determine the outer limits of patient autonomy and self-determination.

Part II of this article discusses the concept of futility and reviews various proposed approaches to defining "futility." This article then shows how personal value judgments play an integral part in determining futility under virtually all of these approaches. Part II concludes that a decision that treatment is futile should not be based on the individual values of only the patient or physician under the shared decisionmaking model of the physician-patient relationship. Part III tackles the issue whether a physician must offer or

¹⁶Miles, *supra* note 11, at 513.

¹⁷418 S.E.2d 3 (Ga. 1992).

¹⁸*Id.* at 4.

¹⁹*Id.*

²⁰*Id.*

²¹*In re Doe*, 418 S.E.2d at 4.

²²*Id.*

²³*Id.*

²⁴*Id.* at 4-5.

²⁵*In re Doe*, 418 S.E.2d at 4-5.

²⁶*Id.* at 6-7.

continue treatment deemed "medically and ethically inappropriate." Part III first reviews common law doctrines governing the physician-patient relationship and concludes that these doctrines do not require the physician to provide every treatment a patient demands, especially when providing such treatment would force the physician to act contrary to her professional conscience. Part III also discusses the various state statutes affording physicians the right not to render treatment considered medically inappropriate or not to participate in treatment that would violate the physician's professional or personal conscience. Part III then discusses a recent Fourth Circuit case²⁷ holding that physicians are obliged to provide treatment to demanding patients with emergency medical conditions, as defined in the Emergency Medical Treatment and Active Labor Act,²⁸ even though physicians determine that treatment is medically and ethically inappropriate. Part III concludes that, excepting any applicable statute to the contrary, the prevailing standard of medical care is the only thing obliging a physician to continue or offer treatment to a demanding patient, and that the standard of care will rarely, if ever, require a physician to provide medically and ethically inappropriate treatment. Finally, this article concludes that the standard of care ultimately should dictate whether a physician is obliged to prescribe or render treatment deemed medically inappropriate, the provision of which is contrary to the physician's professional conscience. When a physician is faced with a situation in which the patient demands treatment held to be medically inappropriate by a general consensus of health care providers, the provision of which would contravene the physician's conscience, the physician should try to resolve the conflict amicably. The physician should engage in a discussion with the patient and try to come to an agreement. If both the physician and patient cannot come to terms, the physician should, with reasonable diligence, attempt a transfer. If a transfer is not possible, then the physician may refuse to offer or continue such treatment.

II. THE CONCEPT OF FUTILITY

Medical and legal commentators continue to struggle in their search for an acceptable definition of the term "futility."²⁹ To this day, there is no consensus among medical professionals about whether any given medical treatment is futile under a certain set of circumstances.³⁰ Commentators acknowledge the

²⁷*In re Baby K*, 16 F.3d 590 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994).

²⁸42 U.S.C. § 1395dd (1988 & Supp. V 1993).

²⁹See, e.g., J. Randall Curtis et al., *Use of the Medical Futility Rationale in Do-Not-Attempt-Resuscitation Orders*, 273 JAMA 124, 124 (1995) (noting that there is no generally accepted definition of medical futility); see also Thomas A. Raffin, *Withdrawing Life Support: How Is the Decision Made?*, 273 JAMA 738, 738 (1995) (stating that the concept of futility is "ill-defined when applied to the majority of critically ill patients with poor prognoses.").

³⁰Lantos et al., *supra* note 5, at 81; Schneiderman & Jecker, *supra* note 7, at 438; see also *In re Warren*, 858 S.W.2d 263, 266 (Mo. Ct. App. 1993) ("[F]utility can have a different

difficulty in classifying treatments as "futile."³¹ Futility is a nebulous and subjective concept that usually incorporates the different value judgments of physicians and patients.³² I will briefly discuss some of the proposed approaches to defining medical treatment as futile, and then argue that, because of the indeterminate nature of the concept of futility in the context of medical decisionmaking, a search for the meaning of "futility" is unavailing.³³

A. Approaches to Defining Futility

One commentator has noted that "[t]he word 'futile' has a categorical ring that masks a more subtle complexity."³⁴ Futility, according to this commentator, can be defined in various ways. Futility can be defined in physiological terms,³⁵ will the therapy achieve the physiological goal it is expected to achieve? For example, will a blood transfusion raise the recipient's hematocrit level? If, for example, our blood transfusion recipient is hemorrhaging at a rate that exceeds the rate of transfusion, then the transfusion would be physiologically futile. Another example of physiological futility is the use of antibiotics to treat a virus. Antibiotics, which combat bacterial infections, are ineffective in fighting viral infections.³⁶ Other commentators have articulated similar standards that

meaning to different physicians in different circumstances."); Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1258 (1993) ("[I]t seems [that] the medical community is not likely to reach a consensus on how the concept [of futility] should be defined."); Pellegrino, *supra* note 4, at 203 ("The debate about medical futility is far from over."); Murphy, *supra* note 8, at 468 n.122 ("[T]he concept of futility is fraught with numerous interpretations . . .").

³¹ See, e.g., Mildred Solomon, "Futality" as a Criterion in Limiting Treatment, 327 NEW ENG. J. MED. 1239, 1239 (1992); Robert D. Truog et al., *The Problem with Futility*, 326 NEW ENG. J. MED. 1560, 1561 (1992).

³² Kathleen M. Boozang, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 ARIZ. L. REV. 23, 63 (1993); Solomon, *supra* note 31, at 1239; Youngner, *supra* note 6, at 2095.

³³ Some commentators seem to imply this conclusion. See, e.g., Lantos et al., *supra* note 5, at 81 ("[F]utality cannot be defined with precision, but is simply the end of a spectrum of low-efficacy therapies . . ."). Another commentator has expressed a similar view on futility as it relates to life support. E. Haavi Morreim, *Profoundly Diminished Life: The Casualties of Coercion*, HASTINGS CENTER REP., Jan.-Feb. 1994, at 33 ("[The] dispute about whether physicians ethically can, or ought, unilaterally to refuse to provide life support revolves around fundamentally irresolvable moral conflicts concerning our most deeply held beliefs about the value of life, especially profoundly diminished life. Thus the 'futality debate' is itself largely futile.").

³⁴ Younger, *supra* note 6, at 2094.

³⁵ *Id.*

³⁶ See Tom Tomlison & Howard Brody, *Futality and the Ethics of Resuscitation*, 264 JAMA 1276, 1277 (1990).

consider only the physiological effect the treatment will achieve.³⁷ Futility can also be defined in terms of postponing death.³⁸ If death is postponed, then treatment is not futile. Under this definition, maintaining life-sustaining treatment would not be futile even though the prognosis of the patient would never improve. Futility may also be defined in terms of the length or quality of life.³⁹ Under these definitions, if treatment would merely prolong life for an insignificantly short duration, or would not restore cognitive function, then treatment is "futile." Finally, futility may be defined in terms of probability.⁴⁰ Under this definition, treatment is deemed futile when the success rate of a certain procedure is extremely poor, even though the treatment, if successful, could restore the patient to a quality of life she had before incurring the illness.

One group of commentators⁴¹ has suggested an all-encompassing, systematic approach to determining futility. First, they distinguish between "effect" and "benefit."⁴² Treatment that produces an "effect" merely affects a patient's physiology without restoring some undefined quality of life.⁴³ Treatment that produces a benefit improves "the patient's prognosis, comfort, well-being, or general state of health."⁴⁴ "A treatment that fails to provide such a benefit—even though it provides a measurable effect—should be considered futile."⁴⁵ This group of commentators then goes on to define futility in qualitative and quantitative terms.⁴⁶ A determination of quantitative futility requires physicians to conclude that, through their experience or consideration

³⁷See, e.g., Nelson & Nelson, *supra* note 7, at 428 (stating that unless treatment will not "reverse a physiological disturbance that will lead to the [patient's] proximate death," it cannot be considered futile).

³⁸Younger, *supra* note 6, at 2094.

³⁹*Id.*

⁴⁰*Id.*

⁴¹Schneiderman et al., *supra* note 5.

⁴²*Id.* at 950.

⁴³*Id.*

⁴⁴*Id.*

⁴⁵Schneiderman et al., *supra* note 5, at 950; see also Jane M. Trau, *Futility, Autonomy, and Informed Consent*, HEALTH PROGRESS, Mar. 1994, at 40, 41. Dr. Trau sets forth a similar dichotomy for futility determinations. Trau distinguishes between short-term and long-term therapeutic benefits. *Id.* Short-term benefits relate to the immediate physiological effect the patient experiences from treatment while long-term benefits relate to the positive long-term effect the treatment has on the patient's overall quality-of-life. *Id.* Under the Trau model, a short-term benefit is akin to an "effect" and a long-term "benefit" is akin to a benefit under the Schneiderman et al. model. *Id.*; see Schneiderman et al., *supra* note 5, at 950. Trau then proposes that "[t]he goal of medicine is to restore patients to a state in which they can pursue a life plan," Trau, *supra*, at 41-42, and thus treatment that fails to provide a long-term benefit (i.e., preserving quality-of-life) is futile. *Id.* at 44.

⁴⁶Schneiderman et al., *supra* note 5, at 951-53.

of reported studies, a given treatment has not worked in the last 100 cases.⁴⁷ Qualitatively futile treatment, on the other hand, includes those "treatment[s] that merely preserve[] permanent unconsciousness or . . . fail[] to end total dependence on intensive medical care"⁴⁸ A determination of qualitative futility therefore requires a physician to predict a patient's inability to escape from the embrace of intensive medical care and achieve "life goals" post-treatment.⁴⁹ Treatment found to be either qualitatively or quantitatively futile fails to provide a "benefit," even though it may produce an incidental physiological "effect."⁵⁰ This approach therefore views futility as a broader concept than mere physiological futility,⁵¹ and incorporates probability⁵² and quality-of-life⁵³ considerations. It implicitly rejects the definition of futility in terms of postponing death.⁵⁴

Another commentator, in urging hospitals to develop institutional policies governing futility determinations,⁵⁵ has propounded a four-part test for determinations of futility.⁵⁶ Under this test, a treatment is futile if it:

- (a) fails to hold a reasonable promise for bringing about the patient's recovery as verified by current medical knowledge and experience, (b) imposes burdens grossly disproportionate to any expectable patient benefit, (c) plays no effective role in mitigating the patient's discomfort, and (d) serves only to artificially postpone the moment of the patient's death by sustaining, supplanting or restoring a vital function⁵⁷

Part (a) of this approach incorporates a determination of probability; specifically, it asks how probable it is that the treatment will bring about the patient's recovery. Part (b) weighs the general burdens and benefits of the

⁴⁷*Id.* at 951.

⁴⁸*Id.* at 952. The commentators note that a "patient has no right to be sustained in a state in which he or she has no purpose other than mere vegetative survival" *Id.*

⁴⁹*Id.* at 952-53.

⁵⁰Schneiderman et al., *supra* note 5, at 950-51.

⁵¹See *supra* text accompanying notes 35-36.

⁵²See *supra* text accompanying note 40.

⁵³See *supra* text accompanying note 39.

⁵⁴See Schneiderman et al., *supra* note 5 at 952 (noting that treatment preserving life without consciousness and requiring "constant monitoring, ventilatory support, and intensive care nursing" is futile); see also William A. Knaus et al., *Do Objective Estimates of Chances for Survival Influence Decisions to Withhold or Withdraw Treatment?*, 10 MED. DECISION MAKING 163, 163 (1990) (stating that "treatment that [merely] prolongs the process of dying but offers no realistic chance of improvement" is futile).

⁵⁵Stell, *supra* note 7, at 484, 493.

⁵⁶*Id.* at 495.

⁵⁷*Id.*

treatment, while part (c) looks at whether the treatment achieves the particular benefit of diminishing patient discomfort. Part (b) potentially includes quality-of-life considerations; could it not be argued that the burdens of a therapy are grossly disproportionate to the expected benefits if the therapy, for example, involves very costly and invasive measures that would merely preserve the patient in a state of permanent unconsciousness?

Assuming "discomfort" in part (c) means physical discomfort, part (c) potentially embraces the concept of physiological futility by focusing on the treatment's "effectiveness" in alleviating patient discomfort. The question in many cases will be whether the treatment will mitigate, by physiological means, the patient's discomfort or pain.

Part (d) of this commentator's approach, like the approach articulated by other commentators,⁵⁸ implicitly rejects the definition of futility in terms of postponing death.⁵⁹ Part (d), however, implicitly draws on quality-of-life considerations. Applying part (d), if an individual were unable to carry out a vital life-sustaining function (e.g., respiration), necessary intensive interventions (e.g., ventilatory treatment) would merely postpone death and, by their nature, would inevitably have a significant impact on the patient's quality of life.⁶⁰

All of these approaches to defining futility fail to expressly consider patient values or goals. Instead, they all rely on a physician's assessment whether, for example, the treatment would achieve any physiological effect, or whether the probability of success is high enough to characterize the treatment as effective. One commentator suggests that the definition of futility should expressly consider the goals of the patient, and to some degree, the probability that the patient's goals will be achieved through the provision of medical treatment.⁶¹ Under this standard, only if the "treatment will not produce [the] benefit sought by the patient, [can it] be considered futile."⁶² The American Medical Association (AMA) has proposed a similar standard for defining futility in the realm of cardiopulmonary resuscitation (CPR).⁶³ The AMA stated that "[r]esuscitative efforts . . . would be considered futile if they could not be expected to achieve the goals expressed by the informed patient."⁶⁴

Thus, definitions of futile treatment have generally incorporated one or more of three considerations:

⁵⁸ See *supra* notes 41-50, 54 and accompanying text.

⁵⁹ See *supra* text accompanying note 38.

⁶⁰ For an example of how a respirator can adversely affect a patient's quality-of-life, see *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 222 (Ct. App. 1984) or *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 716-17 (Conn. Super. Ct. 1984).

⁶¹ Daar, *supra* note 30, at 1255.

⁶² *Id.*

⁶³ AMA *Guidelines*, *supra* note 7.

⁶⁴ *Id.* at 1870.

(1) the *benefit* that the treatment will produce (e.g., purely *physiological* benefits—administering levodopa to patients afflicted with Parkinson's disease to increase synaptic dopamine; restoring *quality of life*—performing kidney transplantation in a patient previously dialysis dependent; preserving *length of life* or *postponing death*—administering AZT to an AIDS patient to control viral replication; and *mitigating patient discomfort*—administering analgesic medication, such as morphine, to a patient with terminal cancer);

(2) the treatment's *probability of success*; and

(3) the *patient's goals* in receiving the treatment.

B. *Personal Value Judgments Inhere in Futility Determinations*

"[V]alue judgments add an interpretation of the facts [of a case] in terms of what is 'good' or 'bad,' or what 'ought' or 'ought not' be done."⁶⁵ Value judgments, in the context of medical decisionmaking, are personal and embrace an individual's views about risk taking, the significance of a benefit, quality of life, and the importance of a therapy's probability of success.⁶⁶ Definitions of futility that embody any one of the three considerations noted above generally require value judgments.⁶⁷

Determining whether a benefit will be gained from a certain medical procedure, the first of three major considerations noted above, involves a value judgment. While postponing death for one week may seem worthless to some, others may find it a noble cause.⁶⁸ For example, consider the elderly patient nearing death who wants to see the grandchild she was never able to meet.⁶⁹ One person may value life even if it is limited by extreme pain and handicap.⁷⁰ Others may have a lower tolerance for pain and would rather die than live a debilitating life.

⁶⁵Tomlinson & Brody, *supra* note 36, at 1277.

⁶⁶*See id.*

⁶⁷E.g., Youngner, *supra* note 6, at 2095 (observing that all definitions except those that consider only the physiological effect on the patient involve value judgments). In the *Wanglie* case, *see* discussion *supra* part I, for example, value judgments played a significant part in the surrogate's decision to have Mrs. Wanglie's ventilatory support maintained and the physician's objection to the continuation of such treatment. *See* Felicia Ackerman, *The Significance of a Wish*, HASTINGS CENTER REP., July-Aug. 1991, at 27, 28 (noting that the doctors and Mrs. Wanglie's husband did not "disagree about whether maintaining Mrs. Wanglie on a respirator [was] likely to prolong her life[, but rather,] whether her life [was] worth prolonging"); *see also supra* text accompanying note 12.

⁶⁸*See* Younger, *supra* note 6, at 2095.

⁶⁹*Id.*

⁷⁰*Id.*

Certain physicians may think that because very few terminally ill patients eventually leave the hospital after receiving CPR,⁷¹ CPR on these patients is ineffective and thus futile.⁷² Some of these physicians may believe that prolonging life for a brief duration is not a worthy objective. When a patient believes that prolonging life, albeit for a short duration, is a goal worth pursuing, there exists a rivalry of values.⁷³ In sum, patients and physicians may perceive the objectives and benefits of treatment and quality of life differently,⁷⁴ and whether a certain therapy provides the recipient with a "benefit" is a matter of opinion rooted in personal mores.

Physiological futility appears to be value-free⁷⁵ because it merely involves a question of medical science.⁷⁶ But this assertion does not always hold true.⁷⁷ For example, if a physiological effect through a given treatment occurs between 0% and .01% of the time, virtually all patients and physicians would agree, based on their values concerning the probability of success, that this treatment would be useless in achieving the desired physiological effect. It could be argued, however, that the treatment is not physiologically futile because of the possibility, albeit extremely slight, of the treatment achieving the desired physiological effect. Characterizing a treatment as "useless" based on the extremely low chance that a physiological effect will occur requires an opinion that this low probability is not worth pursuing, not a scientific determination that the physiological effect sought is scientifically impossible.⁷⁸ However, when it is *certain* that a therapy will provide no physiological effect, then it cannot be argued that values play a role in determining the therapy's usefulness.⁷⁹

⁷¹ See, e.g., Paul C. Sorum, *Limiting Cardiopulmonary Resuscitation*, 57 ALB. L. REV. 617, 618 (1994) (noting that approximately 10% of those patients who receive CPR "live long enough to leave the hospital"); see also Boozang, *supra* note 32, at 24 (noting that "CPR is a . . . medical intervention which for many patients has a remote chance of success").

⁷² Sorum, *supra* note 71, at 620.

⁷³ Truog et al., *supra* note 31, at 1561.

⁷⁴ Daar, *supra* note 30, at 1254.

⁷⁵ See *id.*

⁷⁶ Robert M. Veatch & Carol M. Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15, 18 (1992); see *supra* text accompanying notes 35-37.

⁷⁷ See Veatch & Spicer, *supra* note 76, at 19 (arguing that values sometimes play a role in questions of physiological futility).

⁷⁸ *Id.* ("[I]f the patient and clinician simply disagree over whether an agreed upon one-in-one-thousand chance is worth it, the dispute is not scientific, but valuative.")

⁷⁹ See Youngner, *supra* note 6, at 2095. A treatment that certainly yields no physiological effect will be referred to throughout this article as strictly physiologically futile treatment. Almost everything in clinical medicine is based on probability, not certainty. Griener, *supra* note 7, at 211; see Tomlinson & Brody, *supra* note 36, at 1276. Thus, the instances in which *strict* physiological futility could apply are very limited

Having individual physicians decide statistical cutoff points at which treatment is deemed futile also involves value judgments. Physicians frequently disagree about the weight to be placed on the probability of a therapy's outcome.⁸⁰ For example, while one physician may believe that a 2% probability of success constitutes the point at which a given treatment becomes futile, another physician may believe that a 9% probability of success is the critical cutoff point.⁸¹ This difference of opinion can be explained not in terms of medical science, but in terms of the personal values that underlie such conclusions; a physician may ask whether it is worth pursuing a treatment that has an x% probability of therapeutic success in light of the time, effort, and resources that will be expended, the risks to the patient, and the benefit to be gained from the treatment.⁸² The physician's answer will depend on her values concerning risk taking and the worth of the outcome that is sought. Patients also weigh probability differently depending on their condition, the risks of the treatment, and their inclination toward pessimism or optimism. Thus, whether a given rate of success fares favorably in a risk-benefit analysis depends on the value judgments of the individual physician and patient.

Additionally, social and psychological considerations may influence a physician's expectations of success.⁸³ For example, a physician may determine that a liver transplant would be futile in an alcoholic patient who is unlikely to

and not helpful for most cases in which the physician and patient experience a conflict of values.

⁸⁰Lantos et al., *supra* note 5, at 82.

⁸¹*Id.* (noting that while some physicians will find that a treatment is futile only if its success rate is 0%, other physicians will characterize treatment as futile in cases in which the success rate approaches 13%); see also Curtis et al., *supra* note 29, at 127 (reporting that a group of internal medicine residents each considered CPR futile at different points along a spectrum of probabilities concerning patient survival and ultimate discharge from the hospital, ranging from less than 1% to more than 20%).

⁸²This implies that futility determinations based on probability are never based on probability alone, but include consideration of other factors, such as the risks and benefits of a given therapy. For example, certain patients diagnosed with pancreatic cancer are eligible for a potentially curative surgical procedure known as the Whipple procedure or a pancreaticoduodenectomy. See Robert J. Mayer, *Pancreatic Cancer*, in HARRISONS PRINCIPLES OF INTERNAL MEDICINE 1532, 1533 (Kurt J. Isselbacher et al. eds., 13th ed. 1994). The purpose of this procedure is to remove the pancreatic tumor. See *id.* The procedure is associated with a high mortality rate and its probability of success is low. *Id.* In addition, length of life after complete surgical excision of the tumor is generally short in duration. *Id.* While a physician would not necessarily view this treatment as futile on its low probability of success alone, this low probability in combination with the short length of life the patient will experience after successful treatment may make the treatment a more compelling candidate for a futility determination.

⁸³Lantos et al., *supra* note 5, at 82.

practice abstinence, and who would thereby subvert the operation's therapeutic goals.⁸⁴

Finally, value judgments are intrinsic to both the patient's and physician's determination of therapeutic goals. Definitions of futility based on whether a given treatment will achieve the goals of the patient involve value judgments. While a physician may be able to provide the therapy that will ensure the outcome sought by the patient, the physician may not deem that outcome worthwhile. As noted above, the achievement of physiological results may be considered "beneficial" by the patient, but not by the physician. Thus, value judgments are invariably present in efforts to define futility, as demonstrated by the preceding evaluation of the three considerations generally embodied in futility definitions.

C. *A Decision that a Therapy Is Futile Should Not Be Based on Individual Values*

So what's wrong with value judgments? They are a part of life. For example, when one goes to the supermarket, value judgments abound in a decision to buy a certain type of orange juice: Do I prefer fresh-squeezed or juice from concentrate? Can I afford to buy premium brand or only the store brand? Which one tastes the best? Physicians are trained in the medical arts and their value judgments can be very helpful to patients. For example, a surgeon may believe the risks of a certain surgical procedure outweigh the benefits to be gained. If the patient is offered the surgical procedure, under the doctrine of informed consent, the physician must inform the patient of the procedure's concomitant benefits and risks.⁸⁵ However, nothing in the law of informed consent requires the physician to state her opinion that a certain risk is worth taking. The decision whether a risk is worth taking rests with the patient.⁸⁶ Nonetheless, a patient will often seek a physician's opinion on whether a proposed course of treatment is worth pursuing based on the risks and expected benefits.⁸⁷ It is here that a physician's value judgment plays a significant role. The patient will decide whether to undergo surgery by weighing the physician's opinion—or

⁸⁴*Id.*

⁸⁵FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* § 1.12.1, at 45 (2d ed. 1990).

⁸⁶The patient ultimately determines whether to undergo a proposed treatment or procedure. Failure to obtain the patient's consent before administering a treatment is an intentional tort for which the patient may recover for any damages thereby incurred. *See, e.g.,* *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every 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."), *overruled on other grounds by* *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

⁸⁷*See* David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 *JAMA* 2101, 2102 (1992); Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 *J. CONTEMP. HEALTH L. & POL'Y* 47, 54 (1994).

the physician's expressed values in the form of an opinion—and the patient's own values.

While value judgments are a necessary part of medical decisionmaking,⁸⁸ they should not be the basis for classifying a therapy as futile:

The claim that a treatment is futile has serious ethical consequences for both physicians and patients. It may apparently justify decisions to withhold or withdraw therapy, including life-prolonging therapy. It may seem to lessen the physician's obligation to discuss therapies with patients and thus decrease patients' participation in decisions about their care. Some even argue that physicians are obliged to withhold futile therapies⁸⁹

Value judgments in medical decisionmaking pose no problem, and are helpful to the patient, when both physician and patient values are harmonious, and both the physician and patient can agree on a course of treatment. But what if both the physician and patient disagree on the "usefulness" of a medical treatment? The physician-patient relationship has evolved from one in which physicians received deference for primary decisionmaking for the patient to one in which patients, along with physicians, play a key role in determining the course of their medical care.⁹⁰ Based on this contemporary notion of shared decisionmaking, both the physician's recommendations and the patient's ultimate decision on a proposed course of treatment are essential to any medical decision.⁹¹ Thus, neither a patient's nor a physician's value judgment alone should shape a futility determination. A treatment should not be designated as "futile" or "non-futile" based on one person's mores. With the exception of strict physiological futility,⁹² designations of futility are primarily

⁸⁸Jecker & Pearlman, *supra* note 6, at 1140; Tomlinson & Brody, *supra* note 36, at 1277; see also Murphy, *supra* note 8, at 479-80 ("[T]he ability to make value judgments is essential to the physician's fulfilling his duty to protect and benefit his patients.").

⁸⁹Lantos et al., *supra* note 5, at 81 (footnotes omitted); accord Ronald Cranford & Lawrence Gostin, *Futility: A Concept in Search of Definition*, 20 L. MED. & HEALTH CARE 307, 308 (1992) ("Once a decision is framed by the term, 'futility,' it provides a justification for physicians to either 1) override the wishes of the patient . . . or . . . surrogate[], or 2) make a non-treatment decision without even obtaining informed consent . . .").

⁹⁰Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 CONN. L. REV. 349, 355 (1993); see also Pellegrino, *supra* note 4, at 202 ("The right of patients . . . to participate in medical decisions is now firmly established in law and ethics.").

⁹¹MEISEL, *supra* note 3, § 2.3, at 19-20.

⁹²Truog et al., *supra* note 31, at 1561. Treatment is strictly physiologically futile only when it is *certain* that the physiological effect sought from the treatment cannot be achieved. As noted above, *supra* note 79, since the success or non-success of almost all treatments is based on probability, not certainty, most treatments will not be strictly physiologically futile.

based on personal values, and a physician is no more qualified than a patient⁹³ to determine whether, for example, living in a state of permanent unconsciousness is an acceptable quality of life, or whether a one-in-one-hundred chance is worth taking. Thus, futility determinations that embrace value judgments can "plausibly be viewed as not purely medical,"⁹⁴ and should not be relegated exclusively to the medical profession.

Nor should the determination of futility be assigned exclusively to the patient. While the value judgments of the patient are important, a physician's clinical recommendations are not insignificant.⁹⁵ Physicians treat patients every day and come to learn of a therapy's general efficacy for certain classes of persons and illnesses. Their clinical experiences can provide invaluable insight to desperate patients, who may have unrealistic expectations about the likelihood of success or the benefits to be gained from a certain therapy. By giving the patient sole authority to determine whether treatment is futile, the shared decisionmaking model of the physician-patient relationship is reduced to little more than "vending machine medicine."⁹⁶ Unlike some commentators, who suggest that the goals of a patient should control determinations of futility,⁹⁷ this article argues that patient goals are not the only relevant considerations in making futility determinations.

Value judgments, which are inevitably entangled with futility determinations,⁹⁸ leave room for subjectivity and render the establishment of some touchstone to guide physicians in making futility determinations virtually impossible. The patient's eligibility for a certain treatment would be left to chance. For example, the administration of treatment that would do no more than prolong life in a state of permanent unconsciousness could depend on the fortuity of arriving at a hospital at which physicians do not regard such treatment as futile.⁹⁹ Futility determinations are usually made near the end of

⁹³See Boozang, *supra* note 32, at 66 (contending that "physicians have neither the skill nor knowledge to exercise authority over value-based patient treatment decisions").

⁹⁴Orentlicher, *supra* note 87, at 2103.

⁹⁵See Murphy, *supra* note 8, at 479-82; see also Pellegrino, *supra* note 87, at 50-51 ("Physicians are needed to provide information and to discuss this information with patients to enable and empower them to use their autonomy wisely.").

⁹⁶Nelson & Nelson, *supra* note 7, at 431; see also Morreim, *supra* note 33, at 37 ("The physician-patient relationship is not an irrevocable indentured servitude, but a commitment to bring one's best knowledge and skill to help the patient meet important needs."); Pellegrino, *supra* note 87, at 59 (arguing that to allow patients to demand any medical procedure they want "depreciates [the physician's] expertise [and] makes him a technical instrument of another person's wishes").

⁹⁷See, e.g., Daar, *supra* note 30, at 1254-55.

⁹⁸See *supra* part II.B.

⁹⁹See Griener, *supra* note 7, at 212. Dr. Griener notes that by allowing individual physicians to make futility decisions based upon their own personal values, patients may or may not receive treatment depending upon "who their physician happens to be, rather than upon their medical condition." One study has found that, in Canada,

life,¹⁰⁰ when a decision that a treatment is futile means the withholding or withdrawal of treatment and eventual death.¹⁰¹ Such decisions should not be grounded in the subjective views of individual physicians.

In sum, the determination that a treatment is "futile," except when grounded in a finding of strict physiological futility,¹⁰² involves value judgments. Because value judgments embrace a person's own views concerning quality of life and risk taking, decisions involving value judgments tend to be subjective. Under the current model of medical decisionmaking (i.e., shared decisionmaking), value judgments of either the patient or physician alone should not be the basis for a futility determination. A determination of futility should be made by the patient and physician together, only after careful consideration of the views of both parties. A corollary to this assertion is that futility determinations will not be possible unless both patient and physician values are consonant. But a determination that a treatment is futile is only consequential when patient and physician values diverge. This discord is "best seen as involving a conflict of values rather than a question of futility."¹⁰³ Thus, searching for a definition of futility in cases involving physician-patient disagreement is, in and of itself, *futile*. But this does not end the inquiry. It still must be determined whether a physician must provide treatment deemed "medically"¹⁰⁴ and "ethically"¹⁰⁵

patients and their families can expect to face substantially different viewpoints among health care workers on the appropriateness of withdrawing life support from a critically ill patient under the same or similar circumstances. Deborah J. Cook et al., *Determinants in Canadian Health Care Workers of the Decision to Withdraw Life Support from the Critically Ill*, 273 JAMA 703, 706-07 (1995).

¹⁰⁰See Orentlicher, *supra* note 87, at 2102.

¹⁰¹Lantos et al., *supra* note 5, at 81. *But see* David K. Lee et al., *Withdrawing Care: Experience in a Medical Intensive Care Unit*, 271 JAMA 1358, 1358 (1994) (noting the potential long-term survival of some patients after the withdrawal of life-sustaining measures regarded as futile).

¹⁰²See *supra* notes 79, 92 and accompanying text.

¹⁰³Truog et al., *supra* note 31, at 1561; *see also* Veatch & Spicer, *supra* note 76, at 20 (noting that a disagreement between physician and patient as to whether a treatment is beneficial constitutes a "value disagreement"). When this disagreement arises, it is the result of the physician and patient "draw[ing] on [their] own sources of values—religion, family, ethnic identity and culture—to decide whether, for example, extra days in end-stage renal disease, in full-blown AIDS crisis, or in a permanent vegetative state are worth the burdens and costs of the intervention." *Id.*

¹⁰⁴Because this article argues that determining futility is an unavailing labor when patient and physician values conflict, I will hereinafter refer to treatment that physicians deem "futile" or "useless" as "medically inappropriate" to avoid the futility label. Treatment is "medically inappropriate" when an individual physician determines that treatment should not be provided because doing so would contravene the medical standard of care under the circumstances. This definition assumes an established standard of care which is derived from customary practice or a general consensus among physicians in a particular field of medicine.

¹⁰⁵Ethically inappropriate treatment is referred to throughout this article as treatment that an individual physician regards as medically inappropriate, the provision of which

inappropriate in the face of patient demands. The issue whether a *patient* who deems medical treatment inappropriate is required to accept that treatment per the demand of a physician has been resolved by many courts.¹⁰⁶ Most jurisdictions agree that competent patients, and to some extent incompetent patients, have a right to refuse treatment that provides a slight chance for meaningful recovery, even when physicians view such treatment as beneficial.¹⁰⁷ The next section will focus on the former question: whether a physician *must* provide treatment viewed as medically and ethically inappropriate to the demanding patient.

III. THE PHYSICIAN'S OBLIGATION TO PROVIDE TREATMENT DEEMED MEDICALLY AND ETHICALLY INAPPROPRIATE

There appears to be general agreement among medical professionals that health care providers are not ethically obliged to render medically inappropriate treatment, even when patients demand such treatment.¹⁰⁸ This principle is said to have historical roots.¹⁰⁹ Under the Hippocratic tradition, physicians have an "affirmative obligation to refuse to provide medical treatment when medicine cannot cure the disease or improve the patient's condition."¹¹⁰ The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research noted:

Although competent patients . . . have the legal and ethical authority to forego some or all care, this does not mean that patients may insist on particular treatments. . . . A health care professional has an obligation to allow a patient to choose from among medically acceptable treatment options . . . or to reject all options. *No one, however, has an obligation to provide interventions that would, in his or her judgment, be countertherapeutic.*¹¹¹

would contravene that individual physician's conscience or sense of medical ethics.

¹⁰⁶MEISEL, *supra* note 3, § 3.2, at 27 (Supp. 1994); *see also* Thor v. Superior Court, 855 P.2d 375, 386 (Cal. 1993) (en banc) ("[T]he patient's choice must be respected regardless of the doctors judgment . . .").

¹⁰⁷MEISEL, *supra* note 3, § 3.2, at 27 (Supp. 1994). The medical profession has come to accept this view as well. Michael A. Rie, *The Limits of a Wish*, HASTINGS CENTER REP., July-Aug. 1991, at 24, 24.

¹⁰⁸*See, e.g.*, Schneiderman & Jecker, *supra* note 7, at 440.

¹⁰⁹*See* Nancy S. Jecker, *Knowing When to Stop: The Limits of Medicine*, HASTINGS CENTER REP., May-June 1991, at 5, 6-7; Jecker & Pearlman, *supra* note 6, at 1140; Lantos et al., *supra* note 5, at 81 ("The prudent Greek physician had an obligation not to treat 'incurable' diseases.").

¹¹⁰Murphy, *supra* note 8, at 466; *accord* Pellegrino, *supra* note 4, at 202.

¹¹¹PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 44 (1983) [hereinafter PRESIDENT'S COMM'N] (emphasis added) (footnote

The medical profession is experiencing a 180-degree turnaround in medical ethics.¹¹² The patient and physician have switched roles. In the 1970s and 1980s, it was the patient who sought to avoid treatment that physicians felt ethically obligated to provide.¹¹³ Now, it is the physician who is "refusing" to provide medically inappropriate treatment to the patient who demands it. Courts have only recently begun to deal with these "physician-refusal" cases.¹¹⁴ However, these courts have not yet directly confronted the issue whether a patient has a right to medically inappropriate treatment, the provision of which is contrary to the physician's conscience.¹¹⁵ At first glance, it appears that these courts have upheld a patient's right to receive treatment; but a closer look reveals that they did not hold outright that patients can demand medically inappropriate treatment. Rather, their holdings were grounded on federal or state statutes that either assign the patient or her surrogate, and not the physician, the right to make all health care decisions,¹¹⁶ or require that physicians provide treatment under certain emergency circumstances.¹¹⁷ This article will now discuss how the common law and statutory law tend to preserve the right of physicians to decline to provide treatment that would contravene their professional or personal consciences. This article will conclude that, excepting a statute to the contrary,¹¹⁸ the only thing obliging a health care provider to

omitted); *see also id.* at 219 ("[A] decision . . . not to try predictably futile endeavors is ethically . . . justifiable.").

¹¹²*See Veatch & Spicer, supra note 76, at 15.*

¹¹³*See, e.g., In re Quinlan, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976).*

¹¹⁴*E.g., In re Baby K, 16 F.3d 590 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994); In re Doe, 418 S.E.2d 3 (Ga. 1992); In re Wanglie, No. PX-91-283 (Minn. P. Ct. Hennepin County July 1, 1991) (order appointing guardian), reprinted in 2 Biolaw (Updates), supra note 9, § 12-6, at U:2161-:2168; see also Alexander M. Capron, *Baby Ryan and Virtual Futility*, HASTINGS CENTER REP., Mar.-Apr. 1995, at 20, 20-21 (discussing a case in which physicians wanted to discontinue what was projected to be long-term dialysis for an infant apparently born with severe brain damage and kidney problems despite the parents' request to continue treatment).*

¹¹⁵*See Boozang, supra note 32, at 62.* In England, though, one court has addressed this issue. An appellate court held that physicians are under no obligation to render treatment judged inappropriate. *In re Baby J* (C.A. June 3, 1992), *discussed in* Ross Kessel, *British Judges Cannot Order Doctors to Treat*, HASTINGS CENTER REP., July-Aug. 1992, at 3.

¹¹⁶*E.g., In re Doe, 418 S.E.2d at 7* (holding that under a Georgia statute, both parents of a terminally ill child must consent before a hospital can enter a do-not-resuscitate (DNR) order); *In re Wanglie, No. PX-91-283, at 7-8* (order appointing guardian) (determining that under a Minnesota guardianship statute, it was in the patient's best interest that her husband make her health care decisions).

¹¹⁷*See In re Baby K, 16 F.3d at 594-95* (holding that a hospital is required to provide care for an anencephalic infant brought in for respiratory distress, which constitutes an emergency medical condition under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1988 & Supp. V 1993)).

¹¹⁸Although this article discusses one contrary statute, *see infra* part III.D.2 (discussing a case in which the Fourth Circuit held that the Emergency Medical Treatment and

provide treatment is the standard of care, and that the standard of care should rarely, if ever, require a health care giver to provide medically inappropriate treatment to a demanding patient.

A. Common Law Abandonment

The law of abandonment is relevant when a physician, after beginning treatment of a patient, decides to withdraw treatment because the physician believes that it no longer provides a benefit or is unlikely to produce any measurable effect. It may also be relevant when a physician commences a physician-patient relationship and withholds treatment demanded by the patient.¹¹⁹ The law of abandonment provides that once a patient engages a physician to treat a condition, the physician is under an obligation to "give [the] patient all necessary and continued attention as long as the case requires."¹²⁰ But the law of abandonment does not require that a physician continue the professional relationship if, for example, the patient is persistently noncompliant.¹²¹ Once a physician-patient relationship is initiated, and the patient requires medical attention, the physician may leave the relationship by acquiring the consent of the patient or by giving reasonable notice and affording the patient a reasonable opportunity to procure another competent health care provider to continue care.¹²²

Active Labor Act, 42 U.S.C. § 1395dd, requires a health care provider receiving federal funds to provide ventilatory treatment to an anencephalic baby who arrives at the provider's emergency room with respiratory distress, even though such treatment is arguably medically inappropriate, *In re Baby K*, 16 F.3d at 594-95); it is beyond the scope of this article to discuss other statutes, such as the Americans with Disabilities Act (ADA), that could potentially require health care providers to render arguably inappropriate treatment. See *In re Baby K*, 832 F. Supp. 1022, 1029 (E.D. Va. 1993) (holding that physicians violate the ADA by withholding ventilatory treatment from an anencephalic infant suffering from respiratory distress based on her anencephaly), *aff'd on other grounds*, 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994); David Orentlicher, *Rationing and the Americans with Disabilities Act*, 271 JAMA 308, 311 (1994) (observing the potential for physicians to violate the ADA by withholding "marginally beneficial care" from a patient based on the patient's particular disability).

¹¹⁹Physicians have no obligation to commence a professional relationship with everyone who seeks their services, e.g., *Watson v. Sharp Air Freight Servs., Inc.*, 788 F. Supp. 722, 724 (E.D.N.Y. 1992); *Findlay v. Board Of Supervisors*, 230 P.2d 526, 531 (Ariz. 1951); *Lyons v. Grether*, 239 S.E.2d 103, 105 (Va. 1977), but once the professional relationship is commenced, the physician may not exit the relationship absent consent or without giving the patient a reasonable opportunity to procure another health care provider, *infra* text accompanying note 122.

¹²⁰*Johnson v. Vaughn*, 370 S.W.2d 591, 596 (Ky. 1963); *accord Vann v. Harden*, 47 S.E.2d 314, 319 (Va. 1948) ("After a physician has accepted employment . . . , it is his duty to continue his services so long as they are necessary.").

¹²¹See *Payton v. Weaver*, 182 Cal. Rptr. 225, 229 (Ct. App. 1982).

¹²²E.g., *Katsetos v. Nolan*, 368 A.2d 172, 182 (Conn. 1976); *Miller v. Greater Southeast Community Hosp.*, 508 A.2d 927, 929 (D.C. 1986); *Capps v. Valk*, 369 P.2d 238, 240 (Kan. 1962); *Johnson*, 370 S.W.2d at 596; *Johnston v. Ward*, 344 S.E.2d 166, 170 (S.C. Ct. App.

The doctrine of abandonment does not mandate that a physician offer or provide medically inappropriate treatment to a patient. It requires only that a physician render care until her services are no longer necessary.¹²³ A physician's services are not necessary if the treatment is medically inappropriate, that is, if the provision of treatment would violate the medical standard of care.¹²⁴ But if there is a dispute about whether a certain treatment is medically inappropriate by virtue of the absence of an established standard of care, then under the doctrine of abandonment, a physician cannot unilaterally terminate the professional relationship without giving the patient reasonable notice of withdrawal and affording the patient a reasonable opportunity to seek treatment from another health care provider.¹²⁵ Once reasonable notice and opportunity are provided, however, the physician is no longer obligated to provide treatment.

Thus, the doctrine of abandonment, in addition to safeguarding patient welfare, incidentally preserves the right of a physician not to participate in treatment that would violate her sense of ethics by allowing the physician to leave the relationship merely by giving notice and a reasonable opportunity to find another health care provider. The law of abandonment does not support a patient's right to demand continued treatment from a refusing physician, at least once reasonable notice and opportunity are given.

B. Informed Consent and the Competent Patient's Right to Refuse Treatment

A person's interest in bodily integrity and self-determination is deeply entrenched in our common law.¹²⁶ "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint and interference of others"¹²⁷ A physician's obligation to obtain informed consent from the patient is derived from the principles of bodily integrity and self-determination.¹²⁸ The obligation to obtain informed consent is both an ethical requirement and a legal "standard of care" owed to the patient.¹²⁹ The law of informed consent requires that a physician obtain consent before treating

1986); *Ricks v. Budge*, 64 P.2d 208, 211-12 (Utah 1937); *Lee v. Dewbre*, 362 S.W.2d 900, 902 (Tex. Ct. App. 1962); 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 236 (1981).

¹²³See C.T. Drechsler, Annotation, *Liability of Physician Who Abandons Case*, 57 A.L.R.2d 432, 437 (1958).

¹²⁴See *supra* note 104 and accompanying text.

¹²⁵See *Miller*, 508 A.2d at 929; *Capps*, 369 P.2d at 240.

¹²⁶*In re Conroy*, 486 A.2d 1209, 1221 (N.J. 1985).

¹²⁷*Union Pac. Ry. v. Bostford*, 141 U.S. 250, 251 (1891).

¹²⁸*Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (plurality opinion).

¹²⁹*Boozang*, *supra* note 32, at 42.

a patient,¹³⁰ and that consent be based on the physician's disclosure and explanation of all information material to the patient's decision:¹³¹ the nature and purpose of the treatment,¹³² its expected benefits,¹³³ the foreseeable material risks,¹³⁴ the reasonable alternatives to the treatment,¹³⁵ and the foreseeable risks of foregoing the treatment.¹³⁶ The United States Supreme Court just five years ago observed that "the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment."¹³⁷

But do these principles of patient autonomy embrace a right to demand medically inappropriate treatment?¹³⁸ The right to refuse treatment and the informed consent doctrine require that the patient make the ultimate decision whether to undergo a proposed course of treatment that the physician has offered the patient. These rights do not, as a corollary, allow a patient to *demand* medically inappropriate treatment from a health care provider when providing

¹³⁰E.g., *Mims v. Boland*, 138 S.E.2d 902, 906 (Ga. 1964); *Pizzalotto v. Wilson*, 444 So. 2d 143, 143-44 (La. Ct. App. 1983); *Pugsley v. Privette*, 263 S.E.2d 69, 74 (Va. 1980).

¹³¹E.g., *Truman v. Thomas*, 611 P.2d 902, 905 (Cal. 1980) (en banc).

¹³²See, e.g., *Corn v. French*, 289 P.2d 173, 175-76 (Nev. 1955).

¹³³ROZOVSKY, *supra* note 85, § 1.12, at 45.

¹³⁴E.g., *Truman*, 611 P.2d at 906; *Driers v. Gregor*, 424 N.Y.S.2d 561, 564 (App. Div. 1980); *Holt v. Nelson*, 523 P.2d 211, 216 (Wash. 1974). The physician, however, is not required to disclose risks that are likely to be known by the average patient or which the patient actually knows. See *Wilkinson v. Vessey*, 295 A.2d 676, 689 (R.I. 1972).

¹³⁵See, e.g., *Logan v. Greenwich Hosp. Ass'n*, 465 A.2d 294, 301 (Conn. 1983); *Sard v. Hardy*, 379 A.2d 1014, 1020 (Md. 1977).

¹³⁶E.g., *Truman*, 611 P.2d at 906; *Holt*, 523 P.2d at 216.

¹³⁷*Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 277 (1990) (plurality opinion). The Court also stated that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278.

¹³⁸Many commentators argue no. See, e.g., *Cranford & Costin, supra* note 89, at 309; John J. Paris et al., *Physician's Refusal of Requested Treatment: The Case of Baby L*, 322 NEW ENG. J. MED. 1012, 1014 (1990) (noting that the doctrine of informed consent does not endorse a patient's right to treatment that a physician views as futile or harmful); *Murphy, supra* note 8, at 477 ("[N]one of the major health care cases from *Quinlan* to *Brophy* to . . . *Cruzan* . . . supports the right of a patient to demand a specific intervention from a physician." (footnote omitted)). But see *Marcia Angell, The Case of Helga Wanglie: A New Kind of Right to Die Case*, 325 NEW ENG. J. MED. 511, 511 (1991) (commenting on the correctness of the decision by the court in *In re Wanglie* to appoint Mrs. Wanglie's husband as the decisionmaker and noting that "any other decision by the court would have been inimical to patient autonomy and would have undermined the consensus on the right to die that has been carefully crafted since the *Quinlan* case"); *Boozang, supra* note 32, at 69 ("A patient's right to demand futile treatment implicates the same legal rights as those at issue in 'right-to-die' cases and consequently should be governed by that jurisprudence.").

treatment would violate the provider's conscience.¹³⁹ The informed consent doctrine and the right to refuse treatment do not imply a *right* to any treatment the patient wants.¹⁴⁰

That a physician is not obliged to act contrary to her professional conscience under the auspices of patient autonomy is illustrated by the results in several cases. For example, in *Conservatorship of Morrison v. Abramovice*,¹⁴¹ physicians raised personal objections to complying with the request of a permanently unconscious patient's conservator that the patient's nasogastric tube be removed.¹⁴² The court held that the conservator had authority to make that decision,¹⁴³ but could not compel the physicians to carry it out.¹⁴⁴ The court noted that if the physicians refused, however, they must be willing to transfer the patient to a health care provider who would comply with the conservator's request.¹⁴⁵ Similarly, in *Brophy v. New England Sinai Hospital, Inc.*,¹⁴⁶ the court, utilizing a substituted judgment standard, found that the patient would have wanted life-sustaining treatment withdrawn.¹⁴⁷ The court held that the request of the patient's family that the patient's gastrostomy tube be removed should be honored, but that medical professionals could not be forced to act contrary to their ethical principles:¹⁴⁸

Neither . . . the doctrine of informed consent nor any other provision of law requires the hospital to cease [treatment] upon request of the guardian. There is nothing in [the right to refuse treatment cases] which would justify compelling medical professionals . . . to take active measures which are contrary to their view of their ethical duty toward their patients.¹⁴⁹

¹³⁹See Veatch & Spicer, *supra* note 76, at 23 ("Autonomy gives the patient a right to refuse treatment—that is, to leave the medical relationship. . . . But that principle cannot imply that autonomy can give the patient or surrogate a right of access to care.")

¹⁴⁰See Stell, *supra* note 7, at 487.

¹⁴¹253 Cal. Rptr. 530 (Ct. App. 1988).

¹⁴²*Id.* at 534.

¹⁴³*Id.* at 533.

¹⁴⁴*Id.* at 534.

¹⁴⁵253 Cal. Rptr. at 534.

¹⁴⁶497 N.E.2d 626 (Mass. 1986).

¹⁴⁷*Id.* at 631-32.

¹⁴⁸*Id.* at 639-40; *accord In re Estate of Longway*, 549 N.E.2d 292, 299 (Ill. 1989).

¹⁴⁹*Brophy*, 497 N.E.2d at 639. *But see Gray ex rel. Gray v. Romeo*, 697 F. Supp. 580, 591 (D.R.I. 1988) (holding that a hospital and its physicians are required to withdraw life-sustaining treatment over ethical objections unless the patient can be transferred to another health care facility where physicians would assent to the patient's request); *In re Jobs*, 529 A.2d 434, 450 (N.J. 1987) (requiring a nursing home to participate in the withdrawal of life-sustaining treatment because of the inability to transfer the patient elsewhere); *see also Elbaum ex rel. Elbaum v. Grace Plaza of Great Neck, Inc.*, 544

The court ordered the hospital and its physicians to assist in a transfer to another health care provider, or to the patient's own home, where the gastrostomy tube could be withdrawn without offending the professional consciences of the physicians.¹⁵⁰

C. Preserving the Ethical Integrity of the Medical Profession

Amid the emergence of the right to refuse treatment cases, courts articulated four state interests that could potentially override an individual's decision to refuse medical treatment: the interests in preserving life, preventing suicide, protecting innocent third parties, and preserving the ethical integrity of the medical profession.¹⁵¹ The interest in preserving the ethical integrity of the medical profession is implicated when physicians are compelled to act in a manner that would expose them to criminal or civil liability or, more importantly, in a manner that would violate prevailing medical ethics.¹⁵² This interest takes priority when a physician refuses to render medically inappropriate treatment because doing so would violate her sense of professional ethics.

As one court noted in one of the earlier right to refuse treatment cases, *Superintendent of Belchertown State School v. Saikewicz*,

[p]revailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all

N.Y.S.2d 840, 847-48 (App. Div. 1989) (per curiam) (holding that physicians must, absent a transfer to a willing health care provider, withdraw life support over ethical objections, in part because the physicians and the nursing home where the patient remained failed to inform the patient's family upon the patient's admission of its policy against removing life support). These cases, nevertheless, do not bolster a patient's right to obtain nonbeneficial treatment from a physician. Paris et al., *supra* note 138, at 1014. The courts in *Gray* and *Jobes*, for example, based their decisions on the well-established right of the patient to refuse treatment. See *Gray*, 697 F. Supp. at 591; *In re Jobes*, 529 A.2d at 450. In the physician refusal context, however, there is no well-established right to receive medically inappropriate treatment, see *infra* text accompanying note 159, and thus there is no basis for violating the health care provider's conscience.

¹⁵⁰*Brophy*, 497 N.E.2d at 640.

¹⁵¹The first court to expressly articulate all four interests was the Supreme Judicial Court of Massachusetts in *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977), but courts had previously alluded to one or more of these interests in deciding cases. E.g., *In re Osborne*, 294 A.2d 372, 374 (D.C. 1972) (alluding to the interest in protecting innocent third parties); *In re Quinlan*, 355 A.2d 647, 663 (N.J.) (referring to the preservation of life and ethical integrity of the medical profession interests), *cert. denied*, 429 U.S. 922 (1976). Other courts soon followed the *Saikewicz* court, and the four interest balancing approach has "become almost a catechismic aspect of judicial right to [refuse treatment] opinions." MEISEL, *supra* note 3, § 4.12, at 99; see, e.g., *Satz v. Permuter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) (en banc).

¹⁵²Martha A. Matthews, Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CAL. L. REV. 707, 733 n.178 (1987).

circumstances. . . . Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same.¹⁵³

The proposition that medical ethics are not threatened by allowing a competent patient to refuse treatment has come to be generally accepted by both the courts¹⁵⁴ and the medical profession.¹⁵⁵ Since the prevailing view is that a physician's assent to a patient's refusal of treatment does not violate medical ethics, rarely does the interest in preserving the ethical integrity of the medical profession override the patient's interest in refusing unwanted treatment.¹⁵⁶

When it is the physician who declines to render medically inappropriate treatment to the demanding patient, however, a different analysis ensues. There is support for the proposition that a physician may not be compelled to provide medically inappropriate treatment¹⁵⁷ (i.e., treatment that contravenes

¹⁵³*Saikewicz*, 370 N.E. at 426-27.

¹⁵⁴*See, e.g.*, *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452, 1455 n.8 (D.D.C. 1985) ("[M]edical ethics incorporates [sic] the duties owed the patient, including . . . administering treatment only with consent [of the patient]."); *Thor v. Superior Court*, 855 P.2d 375, 386 (Cal. 1993) (en banc) ("Our conclusion that the patient's choice must be respected regardless of the doctor's judgment does not denigrate professional standards of care."); *In re Storar*, 420 N.E.2d 64, 71 (N.Y.) ("[A] doctor cannot be held to have violated his legal or professional responsibilities when he honors the right of a competent . . . patient to decline medical treatment."), *cert. denied*, 454 U.S. 858 (1981); *see also In re L.W.*, 482 N.W.2d 60, 75 (Wisc. 1992) ("[T]he existence of a protected right to refuse treatment . . . may in a sense protect the ethical integrity of the medical profession. In the absence of such a protected right, physicians may be discouraged from attempting certain life-sustaining procedures in the first place, knowing that once connected they may never be removed.").

¹⁵⁵*See, e.g.*, *Report of the Judicial Council of the American Medical Association*, 253 JAMA 2424, 2424 (1985) ("The preference of the [patient] should prevail when determining whether extraordinary life-prolonging measures should be undertaken in the event of terminal illness.").

¹⁵⁶*See Saikewicz*, 370 N.E. at 426-27; *In re Quinlan*, 355 A.2d 647, 664-69 (N.J.), *cert. denied*, 429 U.S. 922 (1976); *Matthews, supra* note 152, at 734; Patricia A. Unz, Note, *Euthanasia: A Constitutionally Protected Peaceful Death*, 37 N.Y.L. SCH. L. REV. 439, 462 (1992).

¹⁵⁷*See, e.g.*, *United States v. George*, 239 F. Supp. 752, 754 (D. Conn. 1965) ("[T]he doctor's conscience and professional oath must . . . be respected. . . . [T]he patient [in this case] sought to dictate to treating physicians a course of treatment amounting to medical malpractice. . . . The patient may knowingly decline treatment, but he may not demand mistreatment."); *In re Farrell*, 529 A.2d 404, 412 (N.J. 1987) ("Even as patients enjoy control over their medical treatment, health-care professionals remain bound to act in consonance with specific ethical criteria. We realize that these criteria may conflict with some concepts of self-determination. In the case of such a conflict, a patient has no right to compel a health care provider to violate generally accepted professional standards."); *see also Rie, supra* note 107, at 24 (declaring that patients have no "right to

the standard of care).¹⁵⁸ As a corollary, there is general agreement that patients do not have a right to every therapy they desire.¹⁵⁹ Moreover, commentators have noted that to compel a physician to provide medically inappropriate treatment would violate well-established medical ethics.¹⁶⁰ The court in the *Brophy* case approved of the view that a "hospital and its medical staff 'should not be compelled . . . to [act] contrary to its [sic] moral and ethical principles, when [these] principles are recognized and accepted within a significant segment of the medical profession and the hospital community.'"¹⁶¹ Thus, there is a strong argument that the interest in preserving the ethical integrity of the medical profession is implicated in these physician-refusal cases based on the theory that medical professionals may not be compelled to render medically inappropriate treatment, that to compel them to render medically inappropriate treatment would violate well-established medical ethics, and that there is no established right of a patient to receive treatment that is deemed medically inappropriate.¹⁶² In physician-refusal cases, the interest in preserving the ethical integrity of the medical profession is weighty and appears to transcend whatever interest a patient has—if he has one at all—in receiving medically inappropriate treatment.

make claims against the physician to dispense any medical . . . treatment that [the physician] believes offers no medical benefit to the patient"; Rosemarie Tong, *Towards a Just, Courageous, and Honest Resolution of the Futility Debate*, 20 J. MED. & PHIL. 165, 170 (1995) ("[P]hysicians have a right to refuse a patient treatment . . . if it is medically inappropriate." (alteration in original)).

¹⁵⁸ See *supra* note 104.

¹⁵⁹ See Pellegrino, *supra* note 4, at 202; Paris et al., *supra* note 138, at 1013 ("[Patients] are not free . . . to design their own treatment."); PRESIDENT'S COMM'TN, *supra* note 111, at 44 ("The care available from health care professionals is generally limited to what is consistent with role-related professional standards and conscientiously held personal beliefs.").

¹⁶⁰ See, e.g., Erich H. Loewy & Richard A. Carlson, *Futility and Its Wider Implications: A Concept in Need of Further Examination*, 153 ARCHIVES INTERNAL MED. 429, 429 (1993); see also Trau, *supra* note 45, at 44 (noting that the provision of medically inappropriate treatment "would be the equivalent to practicing irrational or bad medicine and would thus be unethical").

¹⁶¹ *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 639 (Mass. 1986) (quoting with approval the lower court decision).

¹⁶² Of course, the assertion of this interest would have to be made by the state and not by individual health care providers. See *In re Dubreuil*, 629 So.2d 819, 823 (Fla. 1993) (holding that a health care provider cannot assert the countervailing state interests on behalf of the state).

D. Statutory Law and the Physician's Right Not to Participate in Medically and Ethically Inappropriate Treatment

1. State Statutory Law and the Physician's Conscience

The view that a physician should not be compelled to provide treatment, when providing such treatment would offend her personal or professional conscience, is manifest in state statutory law. For example, many states permit physicians to decline to participate in abortions.¹⁶³ Some statutes provide an unqualified right not to participate in an abortion,¹⁶⁴ while others require an explicit moral or religious objection.¹⁶⁵ Outside the abortion context, states over the past several years have enacted legislation toward preventing physicians from being compelled to act contrary to their consciences. State statutes that affirm the right of a patient to refuse treatment through advance directives,¹⁶⁶ proxies,¹⁶⁷ or surrogate decisionmakers¹⁶⁸ provide that health care providers need not accede to a patient's, proxy's, or surrogate's request to withdraw or withhold treatment, but must attempt to or successfully effect a

¹⁶³E.g., ARIZ. REV. STAT. ANN. § 36-2151 (1993); CAL. HEALTH & SAFETY CODE § 25955 (West 1984); FLA. STAT. ANN. § 390.001(8) (West 1993); MINN. STAT. ANN. § 145.414 (West 1989); MONT. CODE ANN. § 50-20-111 (1995); N.Y. CIV. RIGHTS LAW § 79-i (McKinney 1992); S.D. CODIFIED LAWS ANN. § 34-23A-12 (1986); WYO. STAT. § 35-6-106 (1994); see also 42 U.S.C. § 300a-7(b) (1988) (maintaining the right of federally funded health care providers not to participate in abortions if such participation would offend the provider's religious or moral beliefs).

¹⁶⁴See, e.g., N.Y. CIV. RIGHTS LAW § 79-i (allowing a refusal for *any* reason).

¹⁶⁵E.g., CAL. HEALTH & SAFETY CODE § 25955(a).

¹⁶⁶An advance directive is a witnessed written document or oral statement in which a competent person (declarant) expresses his wishes or instructions on the administration or avoidance of medical treatment under particular circumstances so that they may be honored upon the declarant's subsequent inability to make health care decisions. See MEISEL, *supra* note 3, § 10.1, at 312-13. Additionally, the declarant can sometimes use an advance directive to appoint another person to make health care decisions for the declarant should the declarant become incapacitated. *Id.* at 313. For purposes of this article, "living wills" are synonymous with advance directives.

¹⁶⁷A proxy is a person appointed in an advance directive to make health care decisions on behalf of the patient should the patient become incapable of medical decisionmaking. *Id.* § 10.4, at 319. "Health care agents" or "attorneys-in-fact" are individuals appointed by a "principal" in a (health care) durable power of attorney to make health care decisions for the principal in the event the principal loses decisionmaking capacity. *Id.* For purposes of this article, the terms "proxy," "health care agent," and "attorney-in-fact" are synonymous.

¹⁶⁸For purposes of this article, a surrogate decisionmaker is a person that, although not expressly designated by the patient, may be authorized by statute or judicially appointed to make health care decisions on behalf of the patient should the patient lose decisionmaking capacity and fail to formulate an advance directive, designate a proxy, or express his wishes to physicians or others before losing decisionmaking capacity.

transfer to another health care provider willing to comply with the request.¹⁶⁹ Of greater import are those state statutes explicitly recognizing that a physician cannot be compelled to provide treatment viewed as medically or ethically inappropriate.¹⁷⁰ Unfortunately, none of these statutes defines

¹⁶⁹Some statutes require the health care provider declining to comply with the treatment request of the patient, proxy, or surrogate decisionmaker to transfer the patient to a health care provider willing to comply with the request. See Appendix A, Part A. Some statutes merely require the physician declining to comply with the treatment request of the patient or decisionmaker to make a reasonable effort to transfer the patient, but do not necessarily require a successful transfer. See Appendix A, Part B. Some statutes merely require the unwilling physician to permit, not impede, or assist in the transfer of the patient. See Appendix A, Part C. See Appendix A, Part D for statutes not expressly requiring unwilling physicians to attempt a transfer or to assist in or permit a transfer. Some statutes are ambiguous about what they require of a physician unwilling to comply with the patient's or decisionmaker's request. See Appendix A, Part E. Finally, some statutes are silent as to the physician's obligation to transfer, but do give immunity to the physician who refuses to carry out a *proxy's* decision to withdraw or withhold life support. See Appendix A, Part F.

Some of these statutes expressly aim to prevent patients, proxies, or surrogates from requiring a health care provider to act contrary to her personal or professional conscience. *E.g.*, IDAHO CODE § 39-4508 ("Any physician or other health care provider who for ethical or professional reasons is incapable or unwilling to conform to the desires of the patient [or decisionmaker] may withdraw without incurring any civil or criminal liability provided the physician or other health care provider makes a good faith effort to assist the patient in obtaining the services of another physician or other health care provider before withdrawal."); ILL. ANN. STAT. ch. 755, para. 40/35 ("A health care provider who *because of personal views or beliefs or his or her conscience* is unable to comply with the terms of a decision to forgo life-sustaining treatment shall . . . assist . . . in effectuating the timely transfer of the patient to another health care provider willing to comply with the [patient's or decisionmaker's] wishes . . ." (emphasis added)); N.H. REV. STAT. ANN. § 137-J:8(II) ("When the direction of an agent requires an act or omission *contrary to the moral or ethical principles or other standards of a health . . . care provider . . .*, the care provider shall allow for the transfer of the patient to another facility . . ." (emphasis added)).

¹⁷⁰COLO. REV. STAT. ANN. § 15-14-506(5)(b) (West Supp. 1994) (health care providers cannot be compelled to administer "medically inappropriate" treatment at the request of a health care agent appointed under a medical durable power of attorney); LA. REV. STAT. ANN. § 40:1299.58.1(A)(4) (providing that a physician cannot be required to provide "medically inappropriate treatment . . . to any patient [and that a physician's] medical judgment with respect to the application of medical treatment or life-sustaining procedures" may not be interfered with); MD. HEALTH-GEN. CODE ANN. § 5-611(a)-(b) (physicians cannot be required to prescribe or render "medical treatment [they] determine[] to be ethically inappropriate" or "medically ineffective . . . under generally accepted medical practices"); VA. CODE ANN. § 54.1-2990 ("[A physician cannot be required to] prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate. However, . . . if the physician's determination is contrary to the terms of an advance directive of a qualified patient or the treatment decision of a person designated to make the decision . . ., the physician shall make a reasonable effort to transfer the patient to another physician."); *cf.* OHIO REV. CODE ANN. § 1337.16(B)(2)(b) ("If the instruction of a [health care agent] is to use or continue life-sustaining treatment [for a patient suffering from] a terminal condition or in a permanently unconscious state, . . . the attending physician . . . who . . . is not willing . . . to comply or allow compliance with that instruction, [presumably because

"medically inappropriate" or "ethically inappropriate" treatment. In sum, a sizable majority of the states recognize the right of a physician to decline to provide medically inappropriate treatment or treatment that would offend the physician's conscience.

2. The Emergency Medical Treatment and Active Labor Act and the *Baby K* Case

Not all statutes, however, are read to adopt this view. In *In re Baby K*,¹⁷¹ the Fourth Circuit held that the Emergency Medical Treatment and Active Labor Act (EMTALA)¹⁷² "does not provide an exception for stabilizing treatment physicians may deem medically and ethically inappropriate."¹⁷³

EMTALA provides that hospitals or other health care facilities having emergency departments and receiving funds under Medicare or Medicaid,¹⁷⁴ that are presented with persons suffering from an emergency medical condition,¹⁷⁵ must either provide treatment that would stabilize the condition,¹⁷⁶ or effect a transfer¹⁷⁷ to another hospital after meeting several conditions.¹⁷⁸ The purpose of EMTALA, also known as the Patient

the physician deems life-sustaining treatment inappropriate,] shall use or continue the life-sustaining treatment . . . until a transfer . . . is made.").

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

¹⁷²42 U.S.C. § 1395dd (1988 & Supp. V 1993).

¹⁷³*In re Baby K*, 16 F.3d at 598. The lower court held that the hospital was obligated to provide treatment under EMTALA, The Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794 (1988 & Supp. V. 1993), The Americans with Disabilities Act of 1990 (ADA) §§ 3(2), 302, 42 U.S.C. §§ 12102(2), 12182 (Supp. V 1993), and on common law grounds. See *In re Baby K*, 832 F. Supp. 1022, 1027-31 (E.D. Va. 1993), aff'd on narrower grounds, 16 F.3d 590 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994). The Fourth Circuit found it unnecessary to review the district court's reliance on the Rehabilitation Act, the ADA, and common law because the hospital was required to provide treatment under EMTALA. *In re Baby K*, 16 F.3d at 592 n.2.

¹⁷⁴This is what is known under the statute as a "participating hospital." 42 U.S.C. § 1395dd(e)(2) (Supp. V 1993).

¹⁷⁵An emergency medical condition is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual . . . in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part . . ." *Id.* § 1395dd(e)(1)(A) (Supp. V 1993). This provision has been interpreted to mean any condition posing an "imminent danger of death or serious disability." *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990).

¹⁷⁶42 U.S.C. § 1395dd(b)(1)(A) (Supp. V 1993).

¹⁷⁷*Id.* § 1395dd(b)(1)(B) (1988).

¹⁷⁸*Id.* § 1395dd(c) (1988 & Supp. V 1993). The main conditions require: (1) that the transferring hospital inform the person of the hospital's obligation and risks of the transfer, *id.* § 1395dd(c)(1)(A)(i); (2) that a physician from the transferring hospital certify that the benefits to be gained from the transfer outweigh the risks, *id.*

Anti-Dumping Act,¹⁷⁹ is to prevent hospitals from refusing emergency medical care to individuals who lack insurance or financial resources.¹⁸⁰ The *Baby K* decision made it clear, though, that EMTALA applies to *all* individuals, regardless of their ability to pay for emergency medical care.¹⁸¹

Baby K was placed on a ventilator immediately after birth, and a diagnosis of anencephaly¹⁸² was later confirmed.¹⁸³ Physicians encouraged Baby K's mother to agree to the provision of palliative care, but discouraged aggressive treatment, explaining that Baby K would be permanently unconscious and would probably die very soon.¹⁸⁴ Baby K's mother insisted on aggressive treatment, which included the provision of breathing assistance with a mechanical ventilator whenever Baby K had difficulty breathing.¹⁸⁵ Physicians contended that "such care was inappropriate";¹⁸⁶ the prevailing standard of care for anencephalics, the hospital argued, is to provide palliative care until death.¹⁸⁷ The hospital attempted to transfer Baby K, but no nearby hospitals

§ 1395dd(c)(1)(A)(ii)-(iii); (3) that the transferring hospital provide medical treatment to minimize the risk of transfer, *id.* § 1395dd(c)(2)(A); (4) that the transferring hospital confirm that the transferee, which has accepted the transfer, has available space and qualified personnel, *id.* § 1395dd(c)(2)(B); and (5) that the transfer be effected with qualified personnel and appropriate equipment, *id.* § 1395dd(c)(2)(D).

¹⁷⁹*Anadumaka ex rel. Anadumaka v. Edgewater Operating Co.*, 823 F. Supp. 507, 510 (N.D. Ill. 1993).

¹⁸⁰*See, e.g., Holcomb v. Monahan*, 30 F.3d 116, 117 n.2 (11th Cir. 1994); *Miller v. Medical Ctr.*, 22 F.3d 626, 628 (5th Cir. 1994); *Brooks v. Maryland General Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993); *Carodenuto v. New York City Health & Hosps. Corp.*, 593 N.Y.S.2d 442, 444 (Sup. Ct. 1992).

¹⁸¹*In re Baby K*, 16 F.3d 590, 593 (4th Cir.) (citing *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992); *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990)), *cert. denied*, 115 S. Ct. 91 (1994).

¹⁸²Anencephaly is a congenital malformation of the brain whereby the cerebral hemispheres and cerebellum are absent. *See* Robert H. Haslam, *The Nervous System*, in NELSON TEXTBOOK OF PEDIATRICS 1473, 1485 (Richard E. Behrman et al. eds., 14th ed. 1992). The anencephalic infant's brainstem is capable of sustaining vital bodily functions for a short duration (i.e., a few days), but the infant possesses no potential for cognitive function or consciousness. Beth Brandon, Note, *Anencephalic Infants as Organ Donors: A Question of Life or Death*, 40 CASE W. RES. L. REV. 781, 784 (1990); *see also In re Baby K*, 16 F.3d at 592 (observing that Baby K, an anencephalic infant, is permanently unconscious, has no cognitive abilities, and is unable to interact with her environment).

¹⁸³*In re Baby K*, 16 F.3d at 592.

¹⁸⁴*Id.*

¹⁸⁵*Id.* at 593.

¹⁸⁶*Id.*

¹⁸⁷*In re Baby K*, 16 F.3d at 596.

were willing to accept a transfer.¹⁸⁸ When Baby K no longer needed the resources of a pediatric intensive care unit, she was transferred to a nursing home.¹⁸⁹ A cycle developed whereby Baby K would be readmitted to the hospital for acute respiratory problems, put on a ventilator, and sent back to the nursing home once the respiratory condition subsided.¹⁹⁰

After Baby K's second readmission, the hospital brought an action in the federal court "to resolve the issue . . . whether it [wa]s obligated to provide emergency medical treatment to [an anencephalic infant] that it deem[ed] medically and ethically inappropriate."¹⁹¹ The court held that under EMTALA, the hospital was required to provide Baby K with treatment upon arriving at the hospital in respiratory distress.¹⁹² The court found that respiratory distress qualifies as an emergency medical condition under EMTALA because "a failure to provide 'immediate medical attention' would reasonably be expected to cause serious impairment of [Baby K's] bodily functions."¹⁹³ The court concluded that because a transfer could not be arranged, the hospital was required to stabilize Baby K's respiratory condition.¹⁹⁴ A "straightforward" application of EMTALA "requires the Hospital to provide respiratory support through the use of a respirator or other means necessary to ensure adequate ventilation."¹⁹⁵

The hospital argued that Congress, in enacting EMTALA, did not intend to require physicians to act outside the prevailing standard of medical care, and that putting an anencephalic infant on a respirator exceeded this standard of care.¹⁹⁶ The court replied that the unambiguous language of EMTALA does not provide for such an exception.¹⁹⁷ The hospital also relied on a Virginia statute,¹⁹⁸ which permits a physician to decline to offer treatment viewed as medically or ethically inappropriate,¹⁹⁹ to argue that EMTALA did not require

¹⁸⁸*Id.* at 593.

¹⁸⁹*Id.*

¹⁹⁰*Id.*

¹⁹¹*In re Baby K*, 16 F.3d at 593.

¹⁹²*Id.* at 594-95.

¹⁹³*Id.* at 594; *see* 42 U.S.C. § 1395dd(e)(1)(A)(ii).

¹⁹⁴*In re Baby K*, 16 F.3d at 594.

¹⁹⁵*Id.*

¹⁹⁶*Id.* at 596.

¹⁹⁷*Id.* The court "recognize[d] the dilemma facing physicians who are requested to provide treatment they consider medically and ethically inappropriate," but noted that the "appropriate branch to redress the[se] policy concerns . . . is Congress." *In re Baby K*, 16 F.3d at 596.

¹⁹⁸VA. CODE ANN. § 54.1-2990.

¹⁹⁹*See supra* note 170 and accompanying text.

physicians to provide the treatment sought by Baby K's mother.²⁰⁰ The court proclaimed:

EMTALA does not provide an exception for stabilizing treatment physicians may deem medically or ethically inappropriate. Consequently, to the extent that [the state statute] exempts physicians from providing care they consider medically or ethically inappropriate, it directly conflicts with the provisions of EMTALA that require stabilizing treatment to be provided.²⁰¹

Consequently, the Virginia statute was preempted by EMTALA.²⁰² The court refused to address the moral or ethical implications of providing aggressive treatment to anencephalics.²⁰³ The court only concluded that there was no exception for treating anencephalics under EMTALA, just as EMTALA admits no exception for "those with lung cancer, or those with muscular dystrophy—all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death."²⁰⁴

The *Baby K* decision was heavily criticized.²⁰⁵ The American Academy of Pediatrics declared that providing treatment to Baby K would "deviate sharply" from generally accepted standards of ethics and medical care.²⁰⁶ Nevertheless, EMTALA apparently does not provide an exception for cases like *Baby K*, in which physicians believe that the provision of treatment, although effective in

²⁰⁰*In re Baby K*, 16 F.3d at 597. The district court stated that EMTALA "does not admit of any 'futility' or 'inhuman' exceptions." *In re Baby K*, 832 F. Supp. 1022, 1027 (E.D. Va. 1993), *aff'd on narrower grounds*, 16 F.3d 590 (4th Cir.), *cert. denied* 115 S. Ct. 91 (1994). The district court noted that even if it did contain these exceptions, they would not apply here. *Id.* The court found that using a ventilator to assist Baby K's respiratory functions was not futile or inhumane. *Id.*

²⁰¹*In re Baby K*, 16 F.3d at 597. The court also suggested that the Virginia statute did not apply to medical decisionmaking for infants because it was part of an Act that dealt with advance directives and surrogate decisionmaking on behalf of adult patients. *Id.* n.10.

²⁰²*Id.* at 597. Under the Supremacy Clause of the U.S. Constitution, U.S. CONST. art. VI, cl. 2, state law that conflicts with federal law such that compliance with both would be impossible is preempted. 2 RONALD D. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE AND PROCEDURE § 12.1, at 62-63 (2d ed. 1992); *see, e.g.*, *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984); *Free v. Bland*, 369 U.S. 663, 666 (1962).

²⁰³*In re Baby K*, 16 F.3d at 598.

²⁰⁴*Id.*

²⁰⁵*See generally* George J. Annas, *Asking the Courts to Set the Standards of Emergency Care—The Case of Baby K*, 330 NEW ENG. J. MED. 1542 (1994); Diane M. Gianelli, *Doctors Argue Futility of Treating Anencephalic Baby*, AM. MED. NEWS, Mar. 21, 1994, at 5 (citing the criticism of various experts); *When Care Is Futile, Let Go*, USA TODAY, Oct. 17, 1994, at 10A.

²⁰⁶Gianelli, *supra* note 205, at 5.

stabilizing the patient's condition, is medically and ethically inappropriate.²⁰⁷ This article argues that *Baby K* was correctly decided to the extent that the court declined to read an exception into EMTALA that was not already there.²⁰⁸ Furthermore, *Baby K* was correctly decided to the extent that individual physicians, or a group of physicians at a particular hospital, should not deny treatment on the basis that such treatment is medically inappropriate in their view. To allow such unilateral decisions would be tantamount to pushing the EMTALA mandates down the slippery slope.

EMTALA should be amended, however, to exempt physicians from providing treatment when providing such treatment would force physicians to act "contrary to [their] moral and ethical principles, when [those] principles [are] recognized and accepted within a significant segment of the medical profession"²⁰⁹ The exemption should apply when providing treatment under the circumstances would go beyond the prevailing standard of care, and would consequently violate the health care provider's conscience. This would have meant inevitable death for Baby K since, consistent with such an exemption, the hospital could have withheld respiratory support from Baby K under the prevailing standard of care for anencephalic infants.²¹⁰ Unfortunate as this may be, it should be the very rare case in which treatment can be denied if this proposed exemption were to make its way into EMTALA. Prevailing standards of medical care should rarely call for the denial of treatment. Placing such an exemption in EMTALA would bring it up to speed with the prevailing policy, reflected in case law²¹¹ and statutory law,²¹² that physicians should not be obliged to render medically inappropriate treatment or participate in treatment that violates their consciences. Thus, this article suggests that EMTALA should embrace an exception whereby a physician would not be required to provide treatment defined as medically inappropriate by the general population of health care providers (i.e., an established standard of care) when providing such treatment would violate that individual physician's sense of medical ethics.

E. The Standard of Medical Care

Principles of medical malpractice dictate that physicians must act with the degree of skill and care ordinarily possessed by a reasonable and prudent physician in the same medical specialty acting under the same or similar

²⁰⁷See *In re Baby K*, 16 F.3d at 597.

²⁰⁸See *id.*

²⁰⁹*Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 639 (Mass. 1986) (emphasis added) (internal quotation marks omitted).

²¹⁰*In re Baby K*, 16 F.3d at 596 (observing that the prevailing standard of medical care for anencephalics is the provision of palliative treatment).

²¹¹See *supra* notes 141-150 and accompanying text.

²¹²See *supra* part III.D.1.

circumstances.²¹³ Departure from this prevailing standard of care may result in professional malpractice liability²¹⁴ or disciplinary action by state licensing authorities.²¹⁵ Departure may also constitute a breach of professional ethics.²¹⁶

When the standard of care demands that a treatment be provided for a certain medical condition under a certain set of circumstances, barring any reasonable alternative or a transfer of the patient, the physician must provide that treatment or face the consequences of a breach of his professional duty.²¹⁷ The physician must provide treatment even though the provision of treatment would violate the physician's conscience.²¹⁸ A finding that a treatment is medically inappropriate by a consensus of physicians, on the other hand, also translates into a standard of care that individual physicians should follow. Assuming there is a general consensus among physicians that a certain therapy under certain circumstances is medically inappropriate, then physicians have a professional duty not to offer the treatment.²¹⁹ To do otherwise would result in a violation of the standard of care²²⁰ and a potential breach of ethics.²²¹

²¹³E.g., *Walls v. Boyett*, 226 S.W.2d 552, 556 (Ark. 1950); *Munro v. Regents of the Univ. of Cal.*, 263 Cal. Rptr. 878, 882 (Ct. App. 1989); *Marchlewski v. Casella*, 106 A.2d 466, 467 (Conn. 1954); *Hill v. Boughton*, 1 So. 2d 610, 612 (Fla. 1941); *Mitchell v. Hadl*, 816 S.W.2d 183, 185 (Ky. 1991); *Hood v. Phillips*, 554 S.W.2d 160, 165 (Tex. 1977); *Johnson v. Misericordia Community Hosp.*, 294 N.W.2d 501, 518 (Wisc. 1980).

²¹⁴E.g., *Pepe v. United States*, 599 F. Supp. 798, 802 (E.D.N.Y. 1984); *Scardina v. Colletti*, 211 N.E.2d 762, 765 (Ill. App. Ct. 1965); *Wood v. Posthuma*, 310 N.W.2d 341, 343 (Mich. Ct. App. 1981); *Mozingo ex rel. Thomas v. Pitt County Memorial Hosp., Inc.*, 415 S.E.2d 341, 345 (N.C. 1992).

²¹⁵Andrew L. Hyams & Louis M. Dyll, *Professional Practice: Licensure and Discipline*, in *LEGAL MEDICINE: LEGAL DYNAMICS OF MEDICAL ENCOUNTERS* 101, 104 (Kathryn H. Falk & Ellen B. Geisel eds., 2d ed. 1991). See generally *McKay v. State Bd. of Medical Examiners*, 86 P.2d 232 (Colo. 1938); *Jaffe v. State Dep't of Health*, 64 A.2d 330 (Conn. 1949); *Krueger v. Board of Professional Discipline*, 836 P.2d 523 (Idaho 1992), cert. denied, 113 S. Ct. 1277 (1993).

²¹⁶See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 125 (3d ed. 1989) (noting that by falling below the standard of care, a physician can violate her obligation of nonmaleficence).

²¹⁷See Morreim, *supra* note 33, at 36; see also Andrea J. Lairson, Comment, *Reexamining the Physician's Duty of Care in Response to Medicare's Prospective Payment System*, 62 WASH. L. REV. 791, 794 (1987) (declaring that a physician must act in accordance with the standard of care when determining when and whether to discontinue treatment).

²¹⁸See Daar, *supra* note 30, at 1246 ("Assertion of a physician's professional conscience will not mean that a doctor can offer a quality and degree of medical care that is below accepted standards . . .").

²¹⁹See Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L. REV. 1809, 1831 (1992) ("[T]he standard of care is the ultimate test for physicians . . . when evaluating whether care should be provided or withheld from a patient.").

²²⁰Mere violation of the standard of care will not necessarily result in malpractice liability. The patient must incur harm as a result of the physician's breach of the standard of care. E.g., *Central Dispensary & Emergency Hosp., Inc. v. Harbaugh*, 174 F.2d 507,

Under the model this article proposes, medical inappropriateness is a determination made by the general population of physicians,²²² not by individual physicians on a case-by-case basis. Under this model, a physician should rarely, if ever, be required to offer medically inappropriate treatment because the standard of care—the general consensus among physicians on the appropriateness of the treatment—dictates that the treatment not be offered or continued.

Generally, the standard of care is determined with reference to the customary practice of physicians in their field of medicine.²²³ The standard of care is typically established by expert testimony on the customary practice in the profession or specialty.²²⁴ Medical literature, textbooks, institutional policies, and guidelines established by accrediting agencies and professional groups all play a significant role in establishing custom and thus in developing the standard of care.²²⁵ Because the physician-refusal case is a fairly new phenomenon in the medical community, customary practice would appear to favor the provision of arguably inappropriate treatment.²²⁶ Over time, however, after many more of these physician-refusal cases begin to surface, customary practice may change. Medical literature and institutional policy, for example, could be very influential in changing the way health care providers approach situations in which patients demand potentially inappropriate medical care. Hopefully, sometime in the near future, the medical profession will reach some accord on the appropriateness of certain therapies under

508 (D.C. Cir. 1949); *Custodio v. Bauer*, 59 Cal. Rptr. 463, 472 (Ct. App. 1967); *Fall v. White*, 449 N.E.2d 628, 636 (Ind. Ct. App. 1983); *Paige v. Manuzak*, 471 A.2d 758, 766-67 (Md. Ct. Spec. App.), *cert. denied*, 476 A.2d 722 (Md. 1984).

²²¹ See *supra* note 216 and accompanying text.

²²² See *supra* note 104.

²²³ JAMES A. HENDERSON, JR. & RICHARD N. PEARSON, *THE TORTS PROCESS* 405 (3d ed. 1988); Barry R. Furrow, *Malpractice Revisited: Of Medical Errors, Social Transformations, and Tort Standards*, 63 NEB. L. REV. 810, 816 (1984); see, e.g., *Campbell v. Palmer*, 568 A.2d 1064, 1067 (Conn. App. Ct. 1990); *Hood v. Phillips*, 554 S.W.2d 160, 165 (Tex. 1977). Some courts hold that customary practice is only evidence of the standard of care and is not conclusive. E.g., *Spears v. McKinnon*, 270 S.W. 524, 526-27 (Ark. 1925); *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966); *Toth v. Community Hosp.*, 239 N.E.2d 368, 373 (N.Y. 1968); *Vassos v. Roussalis*, 625 P.2d 768, 772 (Wyo. 1981). The consequence of this principle is that customary practice will sometimes amount to negligence. See, e.g., *Ludahl v. Rockford Memorial Hosp. Ass'n*, 235 N.E.2d 671, 674 (Ill. App. Ct. 1968); *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974), *legislatively overruled by* WASH. REV. CODE ANN. § 4.24.290 (West 1988).

²²⁴ Hirshfeld, *supra* note 219, at 1832.

²²⁵ See generally MICHAEL G. MACDONALD ET AL., *HEALTH CARE LAW: A PRACTICAL GUIDE* § 11.02[3][a] (1993).

²²⁶ See, e.g., *Morreim*, *supra* note 33, at 36 (noting that physicians ordinarily provide life support to patients experiencing "profoundly diminished life").

particular circumstances,²²⁷ thereby providing the individual practitioner with a standard of care to which she may refer when administering or withdrawing inappropriate treatment.

IV. CONCLUSION

The subjectivity inherent in futility determinations dictates that a physician's unilateral conclusion that a treatment is futile should not determine the withholding or withdrawal of treatment when the values of the patient and physician conflict.²²⁸ One commentator befittingly suggests that "[t]he rapid advance of the language of futility into the jargon of bioethics should be followed by an equally rapid retreat."²²⁹ The focus, instead, should be on whether a physician is obliged to offer or provide to a demanding patient treatment deemed "medically and ethically inappropriate." Physicians typically object to providing medically inappropriate treatment because providing such treatment, in their view, would offend their personal or professional consciences.²³⁰ Generally, the law has tended to uphold the physician's right to refuse to act contrary to his sense of medical ethics.²³¹

This article concludes that the standard of medical care should govern decisions not to offer treatment deemed medically inappropriate. If through customary practice, the consensus of the general population of physicians is that a *certain therapy under a certain set of circumstances* is medically inappropriate, then a physician should not be obliged to offer that therapy, even when the patient demands it. By forcing a physician to render medically inappropriate treatment to the demanding patient, where such treatment would violate the physician's sense of ethics and exceed the standard of care, the physician is put into a position which the courts and legislatures have generally sought to avoid. Although this model of medical decisionmaking deviates somewhat from the shared decisionmaking model of the physician-patient relationship, this modification is necessary to avoid the erosion of medical professionalism.

This recommendation prevents abuse by precluding a physician's refusal to treat when no established standard of care concerning the treatment at issue exists. In other words, if only one physician or an indistinct group of physicians deems treatment medically inappropriate, but there is no customary practice among the general population of physicians, then a physician should not

²²⁷Some groups have begun drafting guidelines on inappropriate care in hopes of attaining a consensus among health care providers. Diane M. Gianelli, *Getting a Better Fix on Futility: More Providers Seeking Consensus on How to Set Limits*, AM. MED. NEWS, Dec. 5, 1994, at 3. This process, however, is in its early stages. See *id.*

²²⁸See Lantos et al., *supra* note 5, at 82; *supra* part II.

²²⁹Truog et al., *supra* note 31, at 1563.

²³⁰See Loewy & Carlson, *supra* note 160, at 429.

²³¹See *supra* part III.

unilaterally decide to withhold or withdraw treatment, even if doing so would violate her own sense of medical ethics. This eliminates inter-physician variability of health care delivery in clinical situations in which value judgments abound.²³²

When a physician is presented with a situation in which the patient demands medically inappropriate treatment, the provision of which contravenes the physician's conscience, the physician should try to resolve the conflict amicably. "Resolving the conflict" means explaining to the patient the physician's opposition to the provision of treatment, stating the reasons why the physician believes the treatment is inappropriate, and informing the patient of the probable outcome. Of course, the inappropriate treatment might not be offered in the first place, but the standard of care will dictate whether it should be offered. If the physician and patient cannot come to terms after discussion, then the physician should, with reasonable diligence, attempt to seek a transfer. If a health care provider willing to administer the treatment is found, this will avoid the dilemma for the physician. Finally, if a transfer is not feasible, then whether the physician is obliged to render the treatment will depend on an established standard of care.²³³

Under the model proposed in this article, if an established standard of care contemplates that a given therapy under the circumstances is medically inappropriate, and a reasonable transfer cannot be effectuated, then an individual physician may unilaterally withdraw or withhold treatment despite patient, proxy, or surrogate demands to the contrary. If, however, there is no established standard of care, and if a reasonable transfer cannot be effectuated, then the unilateral withdrawal or withholding of treatment by a physician should not be sanctioned. To do otherwise would allow an individual physician's value judgments about the appropriateness of medical treatment to dictate the outcome in individual cases, resulting in widespread inconsistencies in the delivery of health care. While adherence to the model proposed in this article may sometimes result in a unilateral decision by a

²³²One commentator observed this potential variability. See Boozang, *supra* note 32, at 42 ("[I]t is uncertain [whether] physicians can make futility judgments accurately, reliably, and consistently." (emphasis added)).

²³³*Cf.* Jecker & Pearlman, *supra* note 6, at 1144. Jecker and Pearlman recommend that futility determinations be guided by "broad professional and community standards." *Id.* They suggest that if a physician determines that a treatment is futile under these standards, they need not obtain permission from the patient to withdraw or withhold such treatment. *Id.* This is somewhat comparable to the recommendation set forth in this article. However, this article argues that futility determinations should play no part in a decision whether to withdraw or withhold treatment unless both the physician and patient agree on a course of treatment. Furthermore, under the recommendation set forth in this article, physicians have an obligation to discuss with the patient why they believe the treatment they wish to withdraw or withhold is medically inappropriate. If after discussion, the physician and patient cannot come to terms, then the physician should, with reasonable diligence, attempt a transfer. Under Jecker and Pearlman's recommendation, once the physician determines that treatment is futile, then the physician has no further obligation to the patient. *See id.*

physician to withhold or withdraw life-sustaining treatment, such instances will be rare, and in any event, such decisions are vital to the preservation of the ethical integrity of the medical profession.

APPENDIX A

Part A - Statutes Compelling Transfer

- ALASKA STAT. § 18.12.050(a) (1994) (advance directives)
 ARIZ. REV. STAT. ANN. § 36-3205(C)(1) (1993) (advance directives, proxies, surrogate decisionmakers)
 COLO. REV. STAT. ANN. §§ 15-14-507(1)-(2), -18-113(5), -18.5-102(2) (West 1987 & Supp. 1994) (proxies, advance directives, surrogate decisionmakers)
 D.C. CODE ANN. § 6-2427(b) (1995) (advance directives)
 IND. CODE ANN. § 16-36-4-13(e) (Burns 1993) (advance directives)
 KAN. STAT. ANN. § 65-28,107(a) (1992) (advance directives)
 UTAH CODE ANN. § 75-2-1112(2) (1993) (advance directives, proxies, surrogate decisionmakers)
 W. VA. CODE §§ 16-30-7(b), -30A-10(b) (1995) (advance directives, proxies)

See also FLA. STAT. ANN. § 765.308(2) (West Supp. 1995) (advance directives, proxies)(health care provider must either transfer the patient or carry out the instructions of the patient or proxy); MASS. GEN. LAWS ANN. ch. 201D, § 14 (West Supp. 1995) (proxies) (health care provider must either effect a transfer, carry out the wishes of the proxy, or seek judicial relief).

Part B - Statutes Requiring Reasonable Effort to Transfer

- ARK. CODE ANN. § 20-17-207 (Michie Supp. 1991) (advance directives, proxies, surrogate decisionmakers)
 CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1995) (advance directives)
 CONN. GEN. STAT. ANN. § 19a-580a (West Supp. 1995) (advance directives, proxies)
 HAW. REV. STAT. § 327D-11(b) (Supp. 1992) (advance directives)
 IDAHO CODE § 39-4508 (1993) (advance directives, proxies)
 IOWA CODE ANN. § 144A.8(1) (West 1989) (advance directives, surrogate decisionmakers)
 LA. REV. STAT. ANN. § 40:1299.58.7(B) (West 1992) (advance directives, proxies, surrogate decisionmakers)
 ME. REV. STAT. ANN. tit. 18-A, § 5-708 (West Supp. 1994) (advance directives, proxies, surrogate decisionmakers)
 MINN. STAT. ANN. § 145C.11(2)(b) (West Supp. 1995) (proxies)
 MO. ANN. STAT. § 459.030(1) (Vernon 1992) (advance directives)
 MONT. CODE ANN. § 50-9-203 (1995) (advance directives, proxies, surrogate decisionmakers); *id.* § 50-10-103(2) (DNR orders)
 NEB. REV. STAT. § 20-409 (Supp. 1994) (advance directives)
 NEV. REV. STAT. ANN. § 449.628 (Michie 1991) (advance directives, proxies, surrogate decisionmakers)
 N.M. STAT. ANN. § 24-7-5(B) (Michie 1994) (advance directives)
 N.D. CENT. CODE §§ 23-06.4-08, -06.5-09(2) (1991) (advance directives, proxies)
 OKLA. STAT. ANN. tit. 63, § 3101.9 (West Supp. 1995) (advance directives, proxies)

OR. REV. STAT. § 127.625(2)(d) (Supp. 1994) (advance directives)

20 PA. CONS. STAT. ANN. § 5409(a) (Supp. 1995) (advance directives)

R.I. GEN. LAWS § 23-4.11-7 (Supp. 1994) (advance directives)

S.D. CODIFIED LAWS ANN. § 34-12D-11 (1994) (advance directives)

TEX. HEALTH & SAFETY CODE ANN. § 672.016(c) (West 1992) (advance directives, surrogate decisionmakers)

VA. CODE ANN. § 54.1-2987 (Michie 1994) (advance directives, proxies, surrogate decisionmakers)

WIS. STAT. ANN. §§ 154.07(1)(a)(3), 155.50(1)(b) (West Supp. 1994) (advance directives, proxies)

WYO. STAT. § 35-22-104(b) (1994) (advance directives)

See also GA. CODE ANN. § 31-32-8(b) (Harrison 1994) (advance directives) (physician who declines to follow the patient's living will must, at the election of the patient's next of kin or legal guardian, either attempt a transfer or allow the patient's next of kin or guardian to find another physician willing to give effect to the patient's directive); S.C. CODE ANN. §§ 44-77-100, 62-5-504(R) (Law. Co-op. Supp. 1994) (advance directives, proxies) (physician who declines to carry out the instructions of the patient or proxy must make a reasonable effort to find another physician willing to give effect to those instructions, and, upon finding a willing physician, must transfer the patient).

Part C - Statutes Requiring Permission or Assistance with Transfer

ALA. CODE § 22-8A-8(a) (1990) (advance directives)

Ill. ANN. STAT. ch. 755, paras. 40/35, 45/4-8(b)-(c) (Smith-Hurd 1992) (proxies, surrogate decisionmakers)

KY. REV. STAT. ANN. §§ 311.634(1)-(2), .982(1)-(2) (Baldwin 1991) (advance directives, proxies)

MD. HEALTH-GEN. CODE ANN. § 5-613(a)(2) (1994) (proxies, surrogate decisionmakers)

MISS. CODE ANN. § 41-41-115(2) (1993) (advance directives)

MO. ANN. STAT. § 404.830(1), (3) (Vernon Supp. 1995) (proxies)

NEB. REV. STAT. §§ 30-3428(2), -3432(3) (Supp. 1994) (proxies)

N.H. REV. STAT. ANN. § 137-J:8(II) (Supp. 1994) (proxies)

N.Y. PUB. HEALTH LAW § 2984(4) (McKinney 1993) (proxies)

OHIO REV. CODE ANN. § 1337.16(B) (Anderson 1993) (proxies); *id.* §§ 2133.02(D)(2), .10(A) (Anderson 1994) (advance directives)

TEX. CIV. PRAC. & REM. CODE ANN. § 135.008(c) (West Supp. 1995) (proxies)

VT. STAT. ANN. tit. 14, § 3459(b) (1989) (proxies); *id.* tit. 18, § 5256 (1987) (advance directives)

W. VA. CODE §§ 16-30B-10(b), -30C-9(c) (1995) (surrogate decisionmakers, DNR orders)

See also TENN. CODE ANN. § 32-11-108(a) (Supp. 1994) (advance directives) (physician who is unwilling to give effect to the provisions of the patient's living will shall, at the option of the patient or patient's next of kin or legal guardian, "make every reasonable effort to assist in the transfer of the patient to another physician . . . [willing to] comply with the [patient's] declaration").

The aforementioned statutes essentially codify the view taken in *Abrmovice* and *Brophy*. See *supra* notes 141-50 and accompanying text.

Part D - Statutes Not Expressly Requiring Physicians to Attempt a Transfer

ILL. ANN. STAT. ch. 755, para. 35/3(d) (advance directives)
MINN. STAT. ANN. § 145B.06(1)(a) (advance directives)
OR. REV. STAT. § 127.625(2)(c) (proxies, surrogate decisionmakers)
WASH. REV. CODE ANN. § 70.122.060(2)-(4) (West Supp. 1995) (advance directives)

Part E - Ambiguous Statutes

GA. CODE ANN. § 31-36-8(2)-(3) (proxies) (physician must make *necessary arrangements* to effect the patient's transfer)

IND. CODE ANN. § 30-5-7-4(b) (Burns Supp. 1995) (proxies) (physician must take *all steps necessary* to effect a transfer)

N.H. REV. STAT. ANN. § 137-H:6(II) (1990) (advance directives) (physician who declines to give effect to the patient's declaration "shall . . . *make the necessary arrangements* to effect the transfer of the . . . patient . . . to another physician who has been chosen by the . . . patient or by the [patient's] family" (emphasis added))

N.J. STAT. ANN. § 26:2H-62(b) (West Supp. 1995) (advance directives, proxies) (physician declining to follow the patient's advance directive or the proxy's instructions "*shall act in good faith* . . . to effect an appropriate, respectful, and timely transfer of care" (emphasis added))

R.I. GEN. LAWS § 23-4.10-6 (proxies) (physician must make *necessary arrangements* to effect the patient's transfer)

Part F - Silent Statutes

CAL. PROB. CODE § 4750(c) (West Supp. 1995)
IOWA CODE ANN. § 144B.9(2) (West Supp. 1995)
MISS. CODE ANN. § 41-41-173(2)
TENN. CODE ANN. § 34-6-208(c) (1991)
WYO. STAT. § 3-5-208(b) (Supp. 1995)