

## MEDICAL TORTURE: END OF LIFE DECISION-MAKING IN THE UNITED KINGDOM AND UNITED STATES

*Jon D. Feldhammer\**

- *Now death is not the worst that can happen to men . . . .*<sup>1</sup>

MR. SMITH IS A 54-year-old man with non-small-cell lung cancer [in his oncologists' office] following restaging evaluation after his latest round of chemotherapy. He is now on his third different chemotherapy regimen after two brief partial remissions followed by the inevitable progressions. His performance status is declining as the toxicities of chemotherapy mount. The [tests] show that once again his liver metastases have grown. After he is told this news, he is not surprised. When he is told his likelihood of responding to yet another chemotherapy regimen are slim, he replies, "But doctor, what have I got to lose?"<sup>2</sup>

Mr. Smith is going to die of cancer;<sup>3</sup> how he dies will depend on the treatment he chooses. There are two treatment options available; one of aggressive life-prolonging therapy, the other palliative pain treatment. If Mr. Smith chooses aggressive treatment, he will continue to undergo chemotherapy that will cause vomiting, diarrhea, loss of hair, and permanent hospitalization. His liver will stop working and he will suffer dementia,<sup>4</sup> jaundice,<sup>5</sup> kidney failure, a diminished immune system, rapid gastrointestinal bleeding,<sup>6</sup>

---

\* Editor in Chief, *Cardozo Journal of International & Comparative Law*. Candidate for Juris Doctorate, Benjamin N. Cardozo School of Law, June 2007. I would like to thank my wife, Rachel Kuperman, M.D. for all her help and support.

<sup>1</sup> PLATO, *LAWS*, BOOK IX, available at <http://www.gutenberg.org/dirs/etext99/plaws11.txt>

<sup>2</sup> Paul R. Harnett & Timothy J. Moynihan, *But Doctor, What Have I Got to Lose . . . ?*, 19 *J. CLINICAL ONCOLOGY* 3294, 3294 (2001).

<sup>3</sup> *Id.* (citing statistics that indicate the odds of any drugs shrinking the cancer are less than 5 percent and even if the cancer does shrink, there is no evidence that the treatment will allow Mr. Smith to live any longer; and there is a 90 percent chance of further treatment making Mr. Smith sick enough to require hospitalization).

<sup>4</sup> This is known as hepatic encephalopathy, "a condition usually occurring secondarily to advanced liver disease, marked by disturbances of consciousness that may progress to deep coma, psychiatric changes of varying degree, flapping tremor, and fetor hepaticus." DORLAND'S POCKET MEDICAL DICTIONARY 283 (25th ed. 1995).

<sup>5</sup> Jaundice will make Mr. Smith's skin turn yellow and itch. This is caused by a build-up of the body's natural toxins that the dying liver can no longer process.

<sup>6</sup> This condition is life threatening and will cause his stomach to become extremely distended and bloated.

an inability to breakdown proteins,<sup>7</sup> and a loss of clotting factors.<sup>8</sup> To combat these illnesses, Mr. Smith will be treated with dialysis, artificial nutrition, blood transfusions, antibiotics, biopsies to test the advancement of the cancer, and constant blood tests to monitor his blood levels.<sup>9</sup> Eventually Mr. Smith may need intubation to help him breathe and restraints because of his dementia.<sup>10</sup> He will probably develop bed sores from being bed-bound that will bleed uncontrollably and may become infected, despite the regular doses of antibiotics. His condition will continue to deteriorate until he wastes away and dies alone in a hospital intensive care unit (ICU), or with two family members, as limited by ICU rules.<sup>11</sup>

Mr. Smith's other option is palliative treatment. This therapy will focus on easing his pain, and will allow Mr. Smith to say good-bye to his loved ones and die at home, surrounded by family. Under this alternative, Mr. Smith will be treated primarily with pain prevention and will die comfortably before most of the symptoms described above have progressed.

In an ideal world, Mr. Smith's question, "What have I got to lose?" would be the beginning of a conversation between the doctor and the patient. The doctor would propose possible treatments, give the probability of success and side effects, steering the conversation to palliative care and the fact that the patient is going to die. In reality, this conversation rarely happens and the patient receives aggressive care as the de facto treatment. The end result is that patients die in hospitals while undergoing futile and painful procedures. This result is a violation of both the physician's duty to act ethically and the patient's right to be free of cruel and degrading treatment.

The United States and the United Kingdom have failed to effectuate their citizens' end-of-life plans. 38.3 percent of Americans die in a hospital,<sup>12</sup> a striking statistic in a country where 90 percent of the people would like to die at home.<sup>13</sup> In the United Kingdom,

---

<sup>7</sup> The inability to breakdown proteins is what contributes to encephalopathy.

<sup>8</sup> See generally Gary Newman, *Cirrhosis and Liver Failure*, in *MEDICINE* 289 (Mark C. Fishman, M.D. et al. eds., 4th ed. 1996).

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

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> Angus et al., *Use of Intensive Care at the End of Life in the United States: An Epidemiologic Study*, 32 *CRITICAL CARE MED.* 638, 638 (2004) (using statistics from 1999).

<sup>13</sup> *Id.* at 642.

up to 70 percent of cancer patients would prefer to die at home and only 26.5 percent of them do.<sup>14</sup>

Keeping someone with a terminal prognosis alive by extraordinary medical means is tantamount to torture and degrades that person's dignity. The large number of patients with terminal prognoses, such as cancer or multi-organ system failure, dying in intensive care settings<sup>15</sup> as opposed to hospice care, indicates that there is a systemic failure in meeting patients' expectations.<sup>16</sup> As a result, it is the duty of the legislature to act for the good of the people and put clear laws into effect. These laws must redirect the system to meet patients' expectations, allow physicians to adhere to their duty to act ethically, and maintain patients' right to dignity.

A comparative study between the United Kingdom and the United States offers the opportunity to explore how a privatized medical system differs from a socialized one in dealing with end of life issues. In addition, an analysis between a European and an American country provides an opportunity to explore why endless aggressive medical treatment raises human rights violations under any Western standard. The United Kingdom's common law and adoption of the European Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention)<sup>17</sup> provide a strong basis for an argument that continued futile care raises human rights issues. The United States does not have a common law right that protects patients from futile treatment, but its broad-based, substantive due process law gives rise to a similar argument that such treatment violates its citizens' human rights.<sup>18</sup>

---

<sup>14</sup> Irene J. Higginson et al., *Do Social Factors Affect Where Patients Die: An Analysis of 10 Years of Cancer Deaths in England*, 21 J. PUB. HEALTH MED. 22 (1999) (using statistics from 1994).

<sup>15</sup> See Angus et al., *supra* note 12, at 642 ("One in five Americans die using intensive care services.").

<sup>16</sup> Craig C. Earle et al., *Trends in the Aggressiveness of Cancer Care Near the End of Life*, 22 J. CLINICAL ONCOLOGY 315, 320 (2004) (concluding that "the treatment of advanced cancer patients is becoming increasingly aggressive and that aggressive treatment is continuing later in life," based on the statistics of chemotherapy use).

<sup>17</sup> European Convention on Human Rights and Fundamental Freedoms, Rome (Nov. 4, 1950), T.S. 71 (1953) (Cmd. 8969), available at <http://www.pfc.org.uk/legal/echrtext.htm>.

<sup>18</sup> U.S. CONST. amend. XIV, § 1; *Rochin v. California*, 342 U.S. 165, 172-74 (1952) (holding that where police officers saw the petitioner swallow capsules suspected to contain illegal drugs, and subsequently attempted to forcibly extract the capsules from the petitioner's mouth, and then later had petitioner's stomach pumped against his will, shocks the conscience of the court and is a due process violation). *But see Breithaupt v. Abram*, 352 U.S. 432 (1957) (holding that drawing blood against the defendant's will does not

Focusing on a hypothetical, terminally ill cancer patient provides a clear picture of the legal obligations and patient-physician decision-making in end of life situations that exist in both countries today. There are four reasons to focus on cancer patients. First, in order to use hospice benefits under Medicare or other insurance coverage in the United States, the patient's physician and the hospice medical director must certify that "the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course."<sup>19</sup> Determining a six month life expectancy for many terminal diseases is impossible.<sup>20</sup> However, physicians can more accurately identify the final stage of illness in many cancers.<sup>21</sup> As a result, palliative hospice care is a viable option available to most cancer patients. In 1996, 58 percent of all hospice patients in the United States had a primary cancer diagnosis.<sup>22</sup> In the United Kingdom, 95 percent of palliative care patients suffered from cancer.<sup>23</sup>

Second, physiological medical futility is most readily identifiable in cases of cancer, in part because of the reliability of diagnosis. Physiological futile treatment means that the treatment is "clearly futile in achieving its physiological objective and so offers no physiological benefit to the patient."<sup>24</sup> Physiological medical futility determinations have been accepted as a legitimate reason for

---

shock the conscience because it is a highly effective and routine procedure carried out in accordance with accepted medical standards).

<sup>19</sup> 42 C.F.R. § 418.22 (2005); see also Judy Zerzan et al., *Access to Palliative Care and Hospice in Nursing Homes*, 284 JAMA 2489, 2492 (2000).

<sup>20</sup> Ellen Fox et al., *Evaluation of Prognostic Criteria for Determining Hospice Eligibility in Patients with Advanced Lung, Heart, or Liver Disease*, 282 JAMA 1638, 1644 (1999) ("[I]f a high degree of predictive accuracy is demanded by those who interpret the 6-month prognostic requirement for hospice enrollment, few patients who die of [chronic obstructive pulmonary disease, congestive heart failure, and end-stage liver disease] will be eligible for hospice care."); see also Zerzan et al., *supra* note 19, at 2492 ("the 6-month prognosis requirement for hospice services may limit access to hospice care even when the resident prefers a palliative approach to care.").

<sup>21</sup> See Zerzan et al., *supra* note 19, at 2492.

<sup>22</sup> Barbara J. Haupt, *Characteristics of Hospice Care Users: Data from the 1996 National Home and Hospice Care Survey*, ADVANCE DATA FROM VITAL & HEALTH STAT., Aug. 28, 1998, at 10.

<sup>23</sup> Hospice Information, *Hospice and Palliative Care Facts and Figures 2005*, available at [http://www.hospiceinformation.info/uploads/documents/hospice\\_&\\_palliative\\_care\\_facts\\_&\\_figures\\_2005.pdf](http://www.hospiceinformation.info/uploads/documents/hospice_&_palliative_care_facts_&_figures_2005.pdf) (last visited Nov. 15, 2006).

<sup>24</sup> Ronald Cranford & Lawrence Gostin, *Futility: A Concept in Search of a Definition*, 20 L., MED. & HEALTH CARE 307, 307 (1992) (quoting HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE SUSTAINING TREATMENT AND THE CARE OF THE DYING (1987)).

R

R

withdrawing care in both the United States<sup>25</sup> and the United Kingdom.<sup>26</sup> Physicians in both countries are under no obligation to provide treatment that is determined to be futile. However, recent studies show that aggressive medical treatment for cancer is increasing, indicating that physicians persist in futile treatment, despite the lack of legal constraint.<sup>27</sup>

Third, cancer patients' general ability to plan for their last days in advance calls into question the limits and veracity of patient autonomy. Unlike most times where the difference between dying quickly and peacefully and dying slowly and painfully is a split-second decision made at the time of treatment,<sup>28</sup> cancer patients die slowly, giving the patient time to create an advanced directive and to inform their physicians about it. Patient autonomy is fatally flawed, mainly because it cannot exist without informed consent, and while the United States and United Kingdom protect the doctrine of informed consent, it is not clear what it is.<sup>29</sup> In fact, in-

---

<sup>25</sup> See, e.g., Child Abuse Prevention and Treatment and Adoption Reform Act (CAPTA), 42 U.S.C. § 5101 *et seq.* (2005), in particular see 42 U.S.C. §§ 5106g(6), 5106a(b) (funding under CAPTA conditioned on state procedure for responding to medical neglect, except in the case of medical futility or virtual medical futility); *Barber v. Super. Ct.*, 195 Cal. Rptr. 484, 491 (1983) (stating that a physician has no duty to continue life-sustaining treatment once it becomes futile); 45 C.F.R. § 1340.15(b)(2) (2005); 2003 Ops Atty Gen F 2003-1 *interpreting* N.Y. PUB. HEALTH LAW § 2973 (2005); AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS 14 (2004-2005); Eric M. Levine, *A New Predicament for Physicians: The Concept of Medical Futility, the Physician's Obligation to Render Inappropriate Treatment, and the Interplay of the Medical Standard of Care*, 9 J.L. & HEALTH 69, 70 (1995).

<sup>26</sup> *Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L.) (holding no duty to continue futile treatment); *Re Wyatt (a child)* (medical treatment: continuation of order), [2005] EWCA (Civ) 1181, [2005] All E.R. (D) 107 (Oct); British Medical Association, *Withholding And Withdrawing Life-Prolonging Treatment: Guidance For Decision Making* (British Medical Association 2d ed., 2001); General Medical Council, *Withholding and Withdrawing Life-Prolonging Treatments: Good Practice in Decision-Making* (General Medical Council 2002), available at [http://www.gmcuk.org/guidance/library/standards/withholding\\_lifeprolonging\\_guidance.asp](http://www.gmcuk.org/guidance/library/standards/withholding_lifeprolonging_guidance.asp) [hereinafter GMC Guidelines]. *But see* *Glass v. United Kingdom*, [2004] 1 F.L.R. 1019.

<sup>27</sup> See Earle et al., *supra* note 16.

<sup>28</sup> These are situations in which the patient chooses nothing. Even if the patient has an advanced directive, unless the attending physician knows about it, there will be no time to reference it.

<sup>29</sup> In the United Kingdom, see *Re M.B. (Medical Treatment)* [1997] 2 F.L.R. 426, 432 (“[I]n general it is a criminal and tortious assault to perform physically invasive medical treatment, however minimal the invasion might be, without the patient's consent.”). In the United States, see *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129-30 (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.”).

formed consent is merely a mythical concept,<sup>30</sup> especially in the face of overly aggressive behavior by doctors who view death as defeat, patients' lack of understanding of statistics and medical science, doctors' fear of damaging their patient-doctor relationship by introducing death planning, and doctors being human and not wanting to give bad news.<sup>31</sup>

Finally, the painful treatments for cancer and the marked decline in weight and functioning near the end of life makes cancer a clear illustration of when aggressive medical treatment near the end of life violates human rights and becomes an instrument of torture rather than cure.<sup>32</sup>

Despite the lack of either an ethical or legal obligation to continue care in situations that meet the criterion for medical futility in both the United States and the United Kingdom, these patients are still being aggressively treated.<sup>33</sup> However, there is an ethical obligation to discontinue care when the treatment will not affect the patient's prognosis but will inflict severe pain. The fact that the law does not obligate a shift from curative measures to palliative in these instances highlights an egregious gap between legal and ethical obligations. This gap is due in large part to the extremely narrow definition of medical futility, the over-expansive reach of patient autonomy, the virtual non-existence of physician autonomy, and the litigious nature of health care.<sup>34</sup> This gap rises to the

---

<sup>30</sup> Roger B. Dworkin, *Getting What We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship*, 13 HEALTH MATRIX 235, 246 (2003) ("If patient autonomy were really the dominant value in patient health care law, then doctors and patients would be free to bargain about the quality of care the doctor would provide to the patient. Malpractice law would be contract law, not torts, as one of the leading proponents of individual autonomy in many aspects of society advocated long ago.")

<sup>31</sup> *Id.*; Susan Adler Channick, *The Myth of Autonomy at the End-Of-Life: Questioning the Paradigm of Rights*, 44 VILL. L. REV. 577 (1999) (proposing moving away from patient autonomy as paradigm for all medical decision making).

<sup>32</sup> The English court in *Portsmouth NHS Trust v. Wyatt and Wyatt*, [2004] EWHC 2247 (Fam), [2005] 1 F.L.R. 21, *aff'd* *Re Wyatt* (a child) (medical treatment: continuation of order), [2005] EWCA (Civ) 1181, [2005] All E.R. (D) 107 (Oct) (approved judgment), confronted this issue because doctors described the patient's quality of life as terrible and the continued aggressive treatment intolerable. The court ultimately decided that it was in the patient's best interests to discontinue medical treatment. *Id.* at ¶ 38. *See also* *NHS Trust A v. M; NHS Trust B v. H*, [2001] 1 All E.R. 801, [2001] 1 F.C.R. 406, [2001] 2 W.L.R. 942 (rejecting continuing futile treatment as torture in dicta, while holding that it is in the best interests of the patients not to continue artificial nutrition and hydration and that it is lawful to withdraw such care).

<sup>33</sup> Earle et al., *supra* note 16.

<sup>34</sup> In the United States, see Norman L. Cantor, *Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182 (2001); Mark

level of a substantive due process claim in the United States, and a human rights violation in the United Kingdom under the European Convention as adopted by the Human Rights Act of 1998.<sup>35</sup>

Part I of this note will explore the current state of the law in the United States and the United Kingdom for patients with a diagnosed terminal illness. The primary focus is on the issues of autonomy, surrogate decision-making, and the interplay between death and dying jurisprudence and human rights law. Part II will compare and contrast the law in the United States and United Kingdom with a focus on determining whether current medical practices are tantamount to human rights violations. This examination will focus on the causes for the disparity between legal and ethical obligations in end of life decision-making. Finally, Part III will propose a new model statute that will guide patients to the most appropriate care and remove the human rights violations from the current treatment structure.

## I. BACKGROUND: THE STATE OF THE LAW IN THE UNITED STATES AND THE UNITED KINGDOM

### A. *United States*

There are few legal certainties in the U.S. laws regarding end-of-life treatment, and the few beacons of clarity often contradict each other. It is this legal morass that gives rise to human rights violations in the form of forcing patients to undergo painful, futile treatments and forcing physicians to administer them. Both the patients' and the medical practitioners' rights are being violated under today's regime in the United States. Part I.A is divided into three parts: an examination of futility, the background of physician and patient autonomy, and an analysis of substantive due process law and how it is being applied to end of life decision-making.

#### 1. *Futility*

It is the general rule that doctors may discontinue care regardless of the patient's choice if it is "medically futile," subject to two

---

Strasser, *The Futility of Futility?: On Life, Death, and Reasoned Public Policy*, 57 MD. L. REV. 505 (1998); Kristi E. Schrode, *Life in Limbo: Revising Policies for Permanently Unconscious Patients*, 31 HOUS. L. REV. 1609 (1995). In the United Kingdom, see Richard Huxtable, *Glass v. United Kingdom: Maternal Instinct v. Medical Opinion*, CFAM 16.3(339) (2004); Anne Morris, *Easing the Passing: End Of Life Decisions and the Medical Treatment (Prevention of Euthanasia) Bill*, MED. L. REV. 2000.8(300) (2000).

<sup>35</sup> Human Rights Act, 1988, c.42 (Eng.).

constraints.<sup>36</sup> First, “[t]o avoid malpractice, the physician must meet professional standards of skill in judging treatment effects . . . .”<sup>37</sup> Second, “the physician ought to inform the patient about the treatment modality and the physician’s judgment of futility; this way the patient has an opportunity to obtain a second opinion.”<sup>38</sup> The legal certainty of futility determinations provides a seductively simple test for drawing a clear line when curative treatment should end. Unfortunately, there is little consensus among medical professionals as to what medical futility means under a given set of circumstances.<sup>39</sup> In addition, few judges and legislatures have attempted to define medical futility,<sup>40</sup> or to address patients’ requests for futile care.<sup>41</sup>

An attractive definition that the United States Supreme Court has suggested for futility is treatment that has no beneficial effect.<sup>42</sup> The beneficial effect definition will capture treatment that has absolutely no chance of prolonging life or curing the illness, but beyond that, the question of what is beneficial is a value judgment. Arguably if the treatment would cause the patient to live one min-

<sup>36</sup> See Cantor, *supra* note 34, at 185; see also sources cited *supra* note 25. But see, sources cited *infra* note 50.

<sup>37</sup> Cantor, *supra* note 34, at 185 (footnotes omitted).

<sup>38</sup> *Id.*

<sup>39</sup> Levine, *supra* note 25, at 73; see also Matthew S. Ferguson, *Ethical Postures of Futility and California’s Uniform Health Care Decisions Act*, 75 S. CAL. L. REV. 1217, 1222 (2002) (“Given equally autonomous agents with different perspectives, a patient and physician can disagree about futility and both be on firm ethical and legal footing.”); Strasser, *supra* note 34, at 514 (“There is no consensus about how to define futile medical care.”); Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician’s Professional Conscience*, 44 HASTINGS L.J. 1241, 1246 (1993) (“[T]here is a general lack of consensus in defining what constitutes medically futile treatment.”).

<sup>40</sup> New York is the only state to statutorily define medical futility. It has done so in the context of do-not-resuscitate (DNR) orders. “‘Medically futile’ means that cardiopulmonary resuscitation will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest in a short time period before death occurs.” N.Y. PUB. HEALTH LAW § 2961(12) (2005).

<sup>41</sup> There are only four exceptions. See California’s Uniform Health Care Decision Act (UHCDA), CAL. PROB. CODE §§ 4600-4740 (2006); Maryland’s Health Care Decisions Act, MD. CODE ANN., HEALTH-GEN. §§ 5-601 to 5-608 (2005); Texas’ Advance Directives Act, TEX. HEALTH & SAFETY CODE ANN. §§ 166.001-166.166 (2006); Virginia’s Health Care Decisions Act, VA. CODE ANN. § 54.1-2990 (2005).

<sup>42</sup> *United States v. Rutherford*, 442 U.S. 544, 555 (1979) (“In the treatment of any illness, terminal or otherwise, a drug is effective if it fulfills, by objective indices, its sponsor’s claims of prolonged life, improved physical condition, or reduced pain.”).

R  
R  
R  
  
R  
  
R

ute longer, it might be considered beneficial.<sup>43</sup> In general, the courts choose to refrain from making any value judgments and err on the side of life.<sup>44</sup>

Commentators and physicians have also tried to define medical futility. In general, they use three main categories: physiological, qualitative, and quantitative.<sup>45</sup> The first category, physiological futility, addresses the question: would treatment lead to the medical goal sought? The Hastings Center guidelines define “physiological futility” as treatment which is “clearly futile in achieving its physiological objective and so offers no physiological benefit to the patient.”<sup>46</sup> An example is prescribing antibiotics for a viral infection, since antibiotics have absolutely no effect on viruses and cannot lead to the medical goal of defeating the infection with absolute certainty.<sup>47</sup> While this definition enjoys nearly universal acceptance,<sup>48</sup> it is so narrow that it is nearly useless in end-of-life determinations.<sup>49</sup> Few end-of-life treatments offer no physiological benefits; as in the “beneficial effect” test, a treatment that offers a few more minutes of life escapes being categorized as physiologically futile. Furthermore, courts have been reluctant to enforce even this definition of futility when any family members are in disagreement about the discontinuation of curative medical treatment.<sup>50</sup>

---

<sup>43</sup> See *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072 (La. Ct. App. 1998) (holding medical treatment that could prolong the terminal patient’s life is not futile despite the patients 1 to 5 percent chance of regaining consciousness before death).

<sup>44</sup> See, e.g., *In re Conroy*, 98 N.J. 321, 368 (1985) (“When evidence of a person’s wishes or physical or mental condition is equivocal, it is best to err, if at all, in favor of preserving life.”); *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 273 (1990) (citing *Conroy* for same proposition).

<sup>45</sup> See Jerry Menikoff, *Demanded Medical Care*, 30 ARIZ. ST. L.J. 1091, 1095 (1998); Keith Shiner, *Medical Futility: A Futile Concept?*, 53 WASH & LEE L. REV. 803 (1996).

<sup>46</sup> Cranford & Gostin, *supra* note 24, at 307.

R

<sup>47</sup> See Tom Tomlison & Howard Brody, *Futility and the Ethics of Resuscitation*, 264 JAMA 1276, 1277 (1990).

<sup>48</sup> Shiner, *supra* note 45, at 829-30. See also Robert M. Veatch & Carol M. Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15, 20 (1992).

R

<sup>49</sup> Cf. Levine, *supra* note 25, at 79 (stating that physiological futility is only useful if it is certain that the therapy will not offer any physiological effect).

R

<sup>50</sup> See *In re Doe*, 262 Ga. 389 (1992) (enjoining hospital from entering DNR order or de-escalating treatment unless both parents agree to withdraw life-sustaining care, even when continued care is futile); *In re Conservatorship of Wanglie*, No. PX-91-283 (Minn. Dist. Ct. Hennepin Co. July 1991) (holding that the patient’s husband can demand treatment without even considering its futility); *In Re Baby K*, 16 F.3d 590 (4th Cir. 1994)

The second category, qualitative futility, “refers to any treatment that merely preserves permanent unconsciousness or fails to end total dependence on intensive medical care.”<sup>51</sup> Qualitative futility has also been articulated as a situation in which the outcome of the proposed therapy is poor.<sup>52</sup> One attack of this definition is that a treatment that may extend the patient’s life by a few days is considered futile, even if the patient is awaiting the arrival of family and friends to be at their side before they die.<sup>53</sup> This scenario is not uncommon and is an ethical issue any law or futility definition must take into account.<sup>54</sup>

Lastly, “[q]uantitative futility involves situations where the benefit of the treatment, should it succeed, would clearly be worthwhile, but the probability of the treatment succeeding is extremely low.”<sup>55</sup> There are many problems with this definition. It is not clear who decides what probability of success is too low, or what standard of success should be used. For example, success could be defined as self-regulated breathing, or it could be consciousness. Another problem is that statistics can accurately predict success rates in the general population, but are extremely unreliable at the individual level.

A declaration of medical futility is useful when there is a disagreement between the patient and the health care providers because it allows the health care providers to unilaterally stop treatment. Ultimately, at the heart of the futility debate is an attempt to resolve the conflict caused by a patient or his proxy seeking medical treatment that the physician believes is ethically and medically inappropriate and refuses to administer.<sup>56</sup> These cases

---

(holding hospital physicians are obligated under EMTALA to provide treatment even if care is deemed to be futile) *cert. denied*, 513 U.S. 825 (1994).

<sup>51</sup> John B. Oldershaw et al., *Persistent Vegetative State: Medical, Ethical, Religious, Economic and Legal Perspectives*, 1 DEPAUL J. HEALTH CARE L. 495, 503 (1997).

<sup>52</sup> Lawrence J. Schneiderman et al., *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 949, 952 (1990).

<sup>53</sup> Stephen N. Nelson, “*Do Everything!*”—*Encountering Futility in Medical Practice*, 19 ETHICS & MED. 103 (2003).

<sup>54</sup> In an interview with the author, an oncologist recounted such a tale with tears in his eyes. He diagnosed a patient, a young mother who had just adopted a baby, with terminal cancer. Under the State’s adoption law, the parents had to stay together for a year in order to finalize the adoption. If the mother died before the end of the year this requirement would be violated and the baby would be taken away from its family. In accordance with the patient’s wishes, the doctor kept her alive beyond any medically reasonable point until the year passed. The mother died one day after the year ended.

<sup>55</sup> Menikoff, *supra* note 45, at 1098.

<sup>56</sup> Ferguson, *supra* note 39, at 1235.

are referred to as physician-refusal cases.<sup>57</sup> In a disturbing trend, nearly every court to consider futility in this context has determined that the aggressive medical treatment should be continued.<sup>58</sup> The only case to decide otherwise is *Gilgunn v. Massachusetts General Hospital*, in which the court allowed physicians to override the patient's and family's undisputed requests for continued treatment.<sup>59</sup> The issue in *Gilgunn* was whether the physician properly entered a Do Not Resuscitate order (DNR) against the patient's and surrogate's wishes.<sup>60</sup> The courts have been more prone to allow physicians to enter DNR orders than withdraw life-prolonging treatment.<sup>61</sup> The courts' refusal to allow physicians to stop futile treatment raises serious questions about the interplay of patient and physician autonomy.

## 2. Autonomy

In the middle of the twentieth century, Western medicine shifted from a paternalistic approach in which the physician was

---

<sup>57</sup> See Levine, *supra* note 25, at 71; James J. Murphy, *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).

<sup>58</sup> See, e.g., *In Re Baby K*, 16 F.3d 590 (4th Cir. 1994) (holding hospital physicians are obligated under EMTALA to provide treatment to an anencephalic infant, even if care is deemed to be futile) *cert. denied*, 513 U.S. 825 (1994); *In re Conservatorship of Wanglie*, No. PX-91-283 (Minn. Dist. Ct. Hennepin Co. July 28, 1991), *reprinted in* 7 ISSUES L. & MED. 369 (1991) (holding that the patient's husband can demand treatment without even considering its futility); *In re Jane Doe*, No. D-93064 (Sup. Ct. Fulton County, Ga. Oct. 17, 1991) (denying hospital's request to allow de-escalation of treatment and entry of Do Not Resuscitate order without consent of both parents for 13-year-old girl in severe pain with no chance of recovery), *aff'd*, 418 S.E.2d 3 (Ga. 1992); Benjamin Weiser, *The Case of Baby Rena: Who Decides When Care is Futile?*, WASH. POST, July 14, 1991, pt. 1, at A1; *Id.* July 15, 1991, pt. 2, at A1 (describing the case of a baby born with AIDS slowly deteriorating and dying despite the doctors requests to stop aggressive "curative" treatment).

<sup>59</sup> See John Ellement, *Jury Sides with Doctors on Ending Woman's Life Support*, BOSTON GLOBE, April 22, 1995, at 18 ("The jury then found that [the patient] would have wanted medical care extended, but they also found that it would have been 'futile' and of no medical benefit."); see also Kathleen M. Boozang, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. PITT. L. REV. 549, 588-590 (1999).

<sup>60</sup> See *supra* note 59.

<sup>61</sup> This may in part have to do with the high probability of causing pain and suffering when administering cardiopulmonary resuscitation (CPR) such as broken ribs and punctured lungs, as well as much better statistical data about its efficacy. See *infra* note 75. Another explanation is that it is very difficult to prove medical malpractice because of the low success rates with CPR. Marshall B. Kapp, *Treating Medical Charts Near the End of Life: How Legal Anxieties Inhibit Good Patient Deaths*, 28 U. TOL. L. REV. 521, 526-27 (1997).

R

R

R

the decision-maker for patient care, to a model of giving patients, or their surrogates, the right to autonomous self-determination.<sup>62</sup> A determination of futility is often viewed by the medical community as a way for physicians to reclaim the ability to make decisions in situations where they believe that what is happening is neither in the best interests of the patient, nor in the best interest of society as a whole.<sup>63</sup>

#### a. Patient Autonomy

Patients have the right to control the course of their medical treatment.<sup>64</sup> The recognition of this right gave rise to the law of informed consent where a doctor must get a patient's consent to administer treatment, outside of an emergency.<sup>65</sup> In *Cruzan v. Director, Missouri Department of Health*,<sup>66</sup> the United States Supreme Court recognized a constitutional right for patients to make the medical decision to withdraw life-sustaining treatment.<sup>67</sup> The main issue presented in *Cruzan* was whether the Due Process Clause allowed Missouri to require "clear and convincing" evidence of the patient's desire to have life-sustaining treatment withdrawn.<sup>68</sup> The majority held that state interest in the protection of life allowed Missouri to require a strict evidentiary standard.<sup>69</sup> The majority upheld the lower court's determination that the parents had failed to meet this standard and that their request to withdraw life-sustaining treatment was appropriately denied.<sup>70</sup> Justice Bren-

---

<sup>62</sup> Shiner, *supra* note 45, at 812 n.45.

<sup>63</sup> *Id.*

<sup>64</sup> See Schloendorff v. Soc'y of N.Y. Hosp., 211 N.Y. 125, 129-30 (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.").

<sup>65</sup> See Dworkin, *supra* note 30, at 239-41 (informed consent in the context of end of life decision-making); *In re Farrell*, 529 A.2d 404, 413-14 (N.J. 1987) ("[S]ociety must ensure that a patient who has decided to forego life-sustaining treatment is competent; is informed about his or her prognosis, the medical alternatives available, and the risk involved; and has not been coerced.").

<sup>66</sup> 497 U.S. 261 (1990).

<sup>67</sup> *Id.* The constitutional right to refuse medical treatment does not give rise to a right to assisted suicide. *Washington v. Glucksberg*, 521 U.S. 702 (1997) (reaffirming the constitutional right of a patient or his proxy to withdraw care and holding there is no constitutional right to euthanasia); *Vacco v. Quill*, 521 U.S. 793 (1997) (upholding New York's statute banning physician assisted suicide).

<sup>68</sup> *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

R

R

nan, dissenting, argued that allowing a state interest to curb the patient's fundamental right to refuse treatment violated the Due Process Clause because it stripped away the patient's right to die with dignity.<sup>71</sup>

The right to control one's own medical treatment is not lost merely because the patient is incompetent.<sup>72</sup> However, when the patient is incompetent, a host of new complexities arise regarding who will make future medical determinations and under what standards.<sup>73</sup>

When the patient is incompetent, most states use a "substituted judgment" approach, which requires the surrogate to make decisions as the patient would if he were competent.<sup>74</sup> Other states apply a "best interests" rule in which the surrogate is to determine what would be in the best interests of the patient, weighing the patient's wishes as a factor, if they are known.<sup>75</sup> Some other objective factors are relevant as well, such as "the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options."<sup>76</sup> Other

---

<sup>71</sup> *Id.* at 301-02 (Brennan, J., dissenting).

<sup>72</sup> See *In re Quinlan*, 70 N.J. 10 (1976) (holding that patients have the right to withdraw medical care that can be executed by a surrogate), *cert. denied*, 429 U.S. 922 (1976).

<sup>73</sup> See Cantor, *supra* note 34, at 188-93.

<sup>74</sup> See, e.g., FLA. STAT. § 765.401(2) (2005); 755 ILCS 5/11a-17 (2005); *In re Lawrance*, 579 N.E.2d 32 (Ind. 1991); *In re Guardianship of Browning*, 568 So. 2d 4 (Fl. 1990); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986); *In re Welfare of Colyer*, 99 Wn. 2d 114 (1983); *Burgess v. Burgess (In re Burgess)*, 189 Ill. 2d 270 (2000); *In re Quinlan*, 70 N.J. 10 (1976). See also Boozang, *supra* note 59, at 572-73.

<sup>75</sup> See, e.g., *Conservatorship of Wendland*, 26 Cal. 4th 519 (2001) (upholding the trial court's determination that there was no clear and convincing evidence that withholding treatment is what the patient would have wanted or what would have been in his best interests); *In re Guardianship of L.W.*, 167 Wis. 2d 53 (1992) (holding that the guardian of a ward can consent to withdraw artificial nutrition and hydration where it is in the best interests of the ward to do so); *In re Conservatorship of Torres*, 357 N.W.2d 332 (Minn. 1984) (applying the best interests test); *Rasmussen v. Fleming*, 154 Ariz. 207 (1987) (applying the best interests test). In the context of DNR, courts have applied futility determinations under the "best interests" standard, but have not applied that standard in de-escalation of care situations. See *In re K.I.*, 735 A.2d 448 (D.C. Cir. 1999) (overriding mother's wishes to continue aggressive medical treatment and entering DNR in accordance with medical guardian ad litem's decision); *People ex rel. Yeager*, 93 P.3d 589 (Colo. 2004) (upholding trial court's authorization of a state agency's DNR order after the court determined the DNR was in the patient's best interests).

<sup>76</sup> *In re Guardianship of L.W.*, 167 Wis. 2d 53, 86 (1992) (quoting *In re Conroy*, 98 N.J. 321, 363 (1985)).

R

R

states have adopted a combined approach, applying both rules.<sup>77</sup> At least one court has refused to make any determination at all, leaving it for the state legislature to address.<sup>78</sup> Regardless of what standard a court uses, overall, most courts generally require that life-prolonging treatment be continued.<sup>79</sup> In the few, exceptional cases, courts have allowed health care providers to withdraw treatment if they can show it is not in the patient's best interests.<sup>80</sup>

In understanding patient autonomy, it is important to distinguish the patient's right to choose or refuse treatment from the right to request a treatment not offered.<sup>81</sup> The principal patient autonomy cases involve the negative right to refuse unwanted treatment,<sup>82</sup> not the positive right to demand a particular course of treatment.<sup>83</sup> This is because physicians are only obligated to offer and administer treatments indicated by the medical community's standard of care. Physicians are open to liability only if they deviate from that standard.<sup>84</sup> As a result, the medical standard of care serves as a direct limitation on patient autonomy.

The dichotomy between negative and positive rights gives rise to the question of what is the physician's duty to treat, and when may a doctor refuse to administer futile care. Under the common law, physicians had no duty to accept or treat a patient.<sup>85</sup> How-

---

<sup>77</sup> *In re Conroy*, 98 N.J. 321 (1985).

<sup>78</sup> *In re Infant C.*, 37 Va. Cir. 351 (1995) (holding the court does not have the authority to consent to withholding life-prolonging medical treatment from an infant).

<sup>79</sup> Alan Meisel, *Managed Care, Autonomy, and Decisionmaking at the End of Life*, 35 HOUS. L. REV. 1393, 1428-29 (1999).

<sup>80</sup> *Id.* See, e.g., *In re Guardianship of L.W.*, 167 Wis. 2d at 82 (1992) (“[W]here it is in the best interests of the ward to withhold or withdraw treatment, the guardian has not only the authority to but a duty to consent to the withholding or withdrawal of treatment.”).

<sup>81</sup> Steven H. Miles, *Medical Futility*, 20 LAW MED. & HEALTH CARE 310, 312 (1992).

<sup>82</sup> See, e.g., *In re Quinlan*, 70 N.J. 10 (1976); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

<sup>83</sup> See Shiner, *supra* note 45, at 837-38.

<sup>84</sup> Not offering an appropriate treatment to a patient would violate informed consent. There are two standards that jurisdictions use to determine whether a treatment must be offered: “customary practice” and “materiality.” *Harrison v. United States*, 284 F.3d 293, 298 (1st Cir. 2002). The customary practice standard requires a physician to disclose whatever information a reasonable physician would customarily disclose under the circumstances. *Id.* The materiality standard requires disclosure of information that the physician should reasonably recognize as material to the patient's decision. *Id.*

<sup>85</sup> See, e.g., *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993) (“Under traditional state tort law, hospitals are under no legal duty to provide [emergency care.]”); Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173 (2002); Eleanor D. Kinney, *Tapping*

ever, once a physician began treatment the physician was obligated to continue treatment unless the physician could transfer the patient.<sup>86</sup> In the 1980s, Congress began addressing deficiencies in this common law doctrine. The Emergency Medical Treatment and Active Labor Act (EMTALA),<sup>87</sup> a federal law enacted in 1986, imposes upon hospitals the duty to provide emergency stabilization for all patients.<sup>88</sup> The statute's sole purpose was to deal with "patient dumping," the problem of patients being turned away from emergency rooms for non-medical reasons.<sup>89</sup> Congress also sought to stop possible discrimination against disabled patients, and passed the Americans with Disabilities Act of 1990 (ADA).<sup>90</sup> With these two pieces of legislation, Congress created the right to emergency treatment and the right for disabled individuals to receive medical attention. These two rights conflict directly with physician autonomy in the context of futility.

#### b. Physician Autonomy

Beginning in 1976, with the decision of *In re Quinlan*,<sup>91</sup> patients were given the power to make the decision to refuse life-prolonging treatment. Karen Ann Quinlan's father sought judicial appointment to remove his daughter from a ventilator and artificial nutrition and hydration which kept her alive in a permanent vegetative state.<sup>92</sup> The court unanimously upheld the father's petition.<sup>93</sup> As a result, patients began refusing treatment at times when their physicians believed it inappropriate. The courts began dealing with the issue of forcing physicians to administer or withhold treatment,

---

*and Resolving Consumer Concerns About Health Care*, 26 AM. J. L. & MED. 335, 375 (2000).

<sup>86</sup> See sources cited *supra* note 85.

<sup>87</sup> 42 U.S.C.S. § 1395dd (2005).

<sup>88</sup> See *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d at 710 ("[C]ongress enacted EMTALA to require hospitals to continue to provide [emergency care]. . . . EMTALA imposes two duties on every hospital that has both a medicare provider agreement with the Secretary of Health and Human Services and an emergency room or department: (1) to provide to anyone presented for treatment 'an appropriate medical screening . . . to determine whether or not an emergency medical condition . . . exists,' and (2) to stabilize the condition or, if medically warranted, to transfer the person to another facility if the benefits of transfer outweigh its risks." (quoting 42 U.S.C. § 1395dd(a)-(c) (2005)).

<sup>89</sup> *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (citing legislative history and case law).

<sup>90</sup> 42 U.S.C.S. § 12112 (2005).

<sup>91</sup> 355 A.2d 647 (N.J. 1976)

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

even when the physician considered the course of conduct unethical,<sup>94</sup> and recognized a state interest in “maintaining the ethical integrity of the medical profession.”<sup>95</sup> In *Cruzan*,<sup>96</sup> the United States Supreme Court cited this state interest, but decided that it must give way to a patient’s right to refuse medical treatment. The Court’s decision makes sense in the setting of patient refusal because the patient has set the threshold of how much pain and suffering he is willing to endure. In the context of a patient’s positive requests for futile medical treatment, the state interest in maintaining the integrity of the medical profession is much higher because doctors are being asked to *act* in unethical ways, rather than to refrain from acting.

The distinction between acting and the omission to act is well-recognized in criminal law and has been applied to the physician’s situation in futility determinations. In order to commit a crime of omission, an actor must have a duty to act and fail to do so.<sup>97</sup> In *Barber v. Superior Court*,<sup>98</sup> the court considered whether withdrawing life sustaining care is a crime, and determined that withdrawing care is an omission, not an affirmative act.<sup>99</sup> Furthermore, the court held that the doctor had no duty to act, and therefore committed no crime.<sup>100</sup> Even for civil liability in a medical malpractice suit, a physician must owe a patient a duty of care, and have breached that duty in order to be held liable.<sup>101</sup> Thus, the central question becomes: what is a physician’s duty of care?

---

<sup>94</sup> Even the *In re Quinlan* court recognized this tension; “there must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients.” 70 N.J. 10, 49-51 (1976).

<sup>95</sup> Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977). This proposition has been repeatedly cited by courts throughout the country. See, e.g., Polk County Sheriff v. Iowa Dist. Ct., 594 N.W.2d 421, 428-29 (1999) (discussing in dicta that the state interest in ethical integrity of the medical profession could justify a health care practitioner’s discontinuance of care); Thor v. Sup. Ct., 5 Cal. 4th 725, 738 (1993); *In re Conroy*, 98 N.J. 321, 355 (1983) (holding patient interest in preventing nonconsensual invasion of her bodily integrity above the state interest in the integrity of the medical profession).

<sup>96</sup> 497 U.S. 261, 278 (1990).

<sup>97</sup> MODEL PENAL CODE § 2.01 (1962).

<sup>98</sup> 147 Cal. App. 3d 1006 (Ct. App. 1983).

<sup>99</sup> *Barber v. Super. Ct.*, 147 Cal. App. 3d 1006, 1016 (1983) (“[W]e conclude that the cessation of ‘heroic’ life support measures is not an affirmative act but rather a withdrawal or omission of further treatment.”).

<sup>100</sup> *Id.*

<sup>101</sup> Each state’s medical malpractice law varies slightly, but generally, “[t]he requisite elements of proof in a medical malpractice case are (1) a deviation or departure from

Under the common law, a physician could stop treating a patient provided he gave proper notice, otherwise known as the common law right of abandonment.<sup>102</sup> In *Conservatorship of Morrison*,<sup>103</sup> the patient was a ninety-year-old woman in a persistent vegetative state. The conservator requested that the doctor withdraw her nasogastric tube and the doctor refused, offering instead to transfer the patient to a facility that would comply with the conservator's wishes.<sup>104</sup> The court held: "In such cases as this [sic] no physician should be forced to act against his or her personal moral beliefs if the patient can be transferred to the care of another physician who will follow the conservator's direction."<sup>105</sup> The legal ability to transfer patients does not offer a solution when a physician concludes further treatment is both futile and unethical, yet the patients themselves think otherwise. The practical reality is that in these cases, no one will accept the patient. In *Wanglie*,<sup>106</sup> even though the patient's present and future health care costs were fully provided for, her doctors were unable to find anyone willing to take care of her after looking for five weeks.<sup>107</sup> In forty-nine states, the rule is when a physician is unable to transfer the patient, the physician is required to continue treatment.<sup>108</sup> Texas is the only exception.<sup>109</sup>

---

accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage." *Amsler v. Verrilli*, 119 A.D.2d 786, 786 (N.Y. App. Div. 1986).

<sup>102</sup> See *Payton v. Weaver*, 182 Cal. Rptr. 225, 229 (1982) (stating the general proposition that a physician may abandon a patient, but "only . . . after due notice, and an ample opportunity afforded to secure the presence of other medical attendance," quoting *Lathrope v. Flood*, 63 P. 1007, 1008 (1901) *rev'd on other grounds*, 67 P. 683 (Cal. 1902)); see also *Levine*, *supra* note 25.

<sup>103</sup> *Conservatorship of Morrison*, 206 Cal. App. 3d 304 (1988).

<sup>104</sup> *Id.* at 307.

<sup>105</sup> *Id.* at 311. *Morrison* did not consider what would happen if the physician was unable to transfer the patient since a facility was willing to accept transfer of the patient. *Id.* at 310-11.

<sup>106</sup> *In re Conservatorship of Wanglie*, No. PX-91-283 (Minn. Dist. Ct. Hennepin Co. July 1991).

<sup>107</sup> See Steven H. Miles, *Interpersonal Issues in the Wanglie Case*, 2 KENNEDY INST. OF ETHICS J. 61, 69 n. 1 (1992).

<sup>108</sup> See, e.g., *Gray v. Romeo*, 697 F. Supp. 580, 590-91 (D.R.I. 1988) (concluding that if patient cannot be transferred to facility willing to comply with patient's wishes, hospital must comply); *In re Jobes*, 529 A.2d 434, 450 (N.J. 1987) (concluding that nursing home could not refuse to participate in patient's withdrawal of artificial nutrition by continuing to treat patient until patient was transferred); *In re Requena*, 517 A.2d 886, 891-93 (N.J. Ch. 1986) (determining that right of patient to refuse life-sustaining treatment superseded hospital's policy against withholding food and water from patients and denying hospital's request to compel patient to leave), *aff'd*, 517 A.2d 869 (N.J. Super. Ct. Law Div. 1986).

Generally, in the United States, there is no requirement to seek out judicial approval before withdrawing or withholding life-prolonging treatments.<sup>110</sup> The reality is that in the face of medical malpractice, physicians are unlikely to act without approval from the court—even if court approval is not strictly necessary.<sup>111</sup>

c. Texas

In 1999, Texas enacted the Advance Directives Act.<sup>112</sup> Under this act, Texas provides a statutory extrajudicial process to allow physicians to withdraw or withhold life-prolonging treatments even with a clear contrary directive from the patient. The process is triggered upon a physician's refusal to carry out the patient's treatment decisions, at which point an ethics or medical committee reviews the physician's refusal.<sup>113</sup> The patient must "be informed of the committee review process not less than 48 hours before the meeting," and is entitled to attend the meeting and receive a written report detailing the committee's findings.<sup>114</sup> If the dispute over the patient's treatment isn't resolved by the ethics consultation committee, the physician must make a reasonable effort to transfer the patient.<sup>115</sup> After ten days of looking for a transferee, the physician may stop life-prolonging treatment.<sup>116</sup> So long as the physi-

---

<sup>109</sup> TEX. HEALTH & SAFETY CODE ANN. § 166.046 (2006). See also Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANNALS INTERNAL MED. 743 (2003).

<sup>110</sup> The *Quinlan* court stated:

We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome . . . . This is not to say that in the case of an otherwise justiciable controversy access to the courts would be foreclosed; we speak rather of a general practice and procedure.

355 A.2d 647, 669 (N.J. 1976). See also *Barber v. Super. Ct.*, 147 Cal. App. 3d 1006 (1983) (holding there is no requirement for judicial approval before the decision to withdraw treatment is made); *In re Dinnerstein*, 380 N.E.2d 134, 139 (Mass. App. 1978) (declaring that law does not require prior judicial approval in order to withdraw resuscitation in appropriate cases).

<sup>111</sup> Kapp, *supra* note 61, at 523.

<sup>112</sup> Texas' Advance Directives Act, TEX. HEALTH & SAFETY CODE ANN. §§ 166.001-166.166 (2006).

<sup>113</sup> *Id.* § 166.046(a).

<sup>114</sup> *Id.* § 166.046(b)(1)-(3).

<sup>115</sup> *Id.* § 166.046(d).

<sup>116</sup> *Id.* § 166.046(e). The patient may request an extension to the 10 day period from a state court. *Id.* § 166.046(g). However, the court may only grant the extension "if the court finds, by a preponderance of the evidence, that there is a reasonable expectation that

cian complies with these steps, the physician is immune to both civil and criminal liability.<sup>117</sup>

While there have not been any statewide studies of the impact of this law, Robert Fine and Thomas Mayo conducted a study of the law's impact at the Baylor University Medical Center.<sup>118</sup> Interestingly, the study did not show a marked change in the percentage of patients that had their life-sustaining treatment withdrawn after the futility consultation process began.<sup>119</sup> Instead, the study demonstrated a 67 percent increase in the number of futility consultations that were requested, indicating physicians felt more comfortable in confronting possible futile-treatment situations.<sup>120</sup> In addition, before the law was enacted it took days to weeks to obtain the family's agreement to withdraw life-prolonging treatment; after the law, it only took hours to days.<sup>121</sup> This drastic change indicates the psychological pressure that families go under in deciding whether to withdraw life-prolonging treatment. During the study families would say, "If you are asking us to agree with the recommendation to remove life support from our loved one, we cannot. However, we do not wish to fight the recommendation in court, and if the law says it is OK to stop life support, then that is what should happen."<sup>122</sup> Often times futile treatment is continued because the surrogate decision makers, the patient's *family* are unable bear the responsibility of "killing" their loved one.

### 3. *Substantive Due Process*

Doctors in the United States must provide emergency treatment for unstable patients, and once they begin care, they establish a patient-physician relationship that cannot be severed unless the doctor can find a facility to which to transfer the patient.<sup>123</sup> Any future determination of the appropriateness of withdrawing or withholding aggressive medical care falls entirely on the patient or his decision-maker so long as he wants to continue aggressive treatment, no matter how damaging and grotesque the treatment may

---

a physician or health care facility that will honor the patient's directive will be found if the time extension is granted." *Id.*

<sup>117</sup> *Id.* § 166.044.

<sup>118</sup> Fine & Mayo, *supra* note 109.

<sup>119</sup> *Id.* at 745.

<sup>120</sup> *Id.*

<sup>121</sup> *Id.* at 745, table 3.

<sup>122</sup> *Id.* at 745 (paraphrasing conversations with families).

<sup>123</sup> This is true, except for the narrow exception of physiological futility.

be for the patient.<sup>124</sup> Physicians take an oath to “do no harm,”<sup>125</sup> a promise which has been a longstanding and fundamental principle of medical ethics.<sup>126</sup> Yet the existing legal paradigm forces doctors to harm patients by administering treatment that is neither curative or palliative, or face the consequences of civil and criminal liability. This is a result which should “shock the conscience of the court,” violating the Fourteenth Amendment’s substantive due process clause.<sup>127</sup>

In *Washington v. Glucksberg*,<sup>128</sup> the latest substantive due process decision by the United States Supreme Court dealing with end of life decision-making, the Court explained how courts should approach substantive due process issues. Substantive due process “protects those fundamental rights and liberties which are, objectively, ‘deeply rooted in this Nation’s history and tradition . . . .’”<sup>129</sup> Therefore, in order to make a substantive due process claim there must be a tradition and history behind protecting the alleged right or liberty. Furthermore, after identifying the fundamental interest, it must be narrowly defined and balanced against legitimate state interests.<sup>130</sup> The Court ultimately weighed the long history of the state prohibiting suicide and the strong state interest in preserving life, and determined that there is no fundamental right to assisted suicide.<sup>131</sup>

Recently, the Second Circuit rejected a substantive due process claim in *Blouin v. Spitzer*, when the state refused to allow an incompetent patient’s care to switch from aggressive treatment to palliative care even when the family, physicians, surrogate and clergy all demanded it.<sup>132</sup>

Sheila Pouliot, the patient in *Blouin*, was born severely retarded and was at no point competent.<sup>133</sup> At the time of the case,

---

<sup>124</sup> This is true, except for the narrow exception of *Gilgunn*, the only court to hold that aggressive curative treatment could be withdrawn over the objection of the health care decision-maker.

<sup>125</sup> The Hippocratic Oath, available at [http://www.nlm.nih.gov/hmd/greek/greek\\_oath.html](http://www.nlm.nih.gov/hmd/greek/greek_oath.html).

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

<sup>127</sup> U.S. CONST. amend. XIV, § 1.

<sup>128</sup> 521 U.S. 702 (1997).

<sup>129</sup> *Id.* at 720-21 (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (plurality opinion)).

<sup>130</sup> *Id.*

<sup>131</sup> *Id.* at 728.

<sup>132</sup> 356 F.3d 348 (2d Cir. 2004).

<sup>133</sup> *Id.*

she suffered from seizures, osteoporosis, dislocated joints and widespread flexion contractures involving her elbows, knees and hips. Her gut had begun to fail which caused “recurrent aspiration pneumonia, episodes of gastrointestinal bleeding, and chronic, severe constipation. . . . When she was admitted to the hospital she was suffering from hypotension, aspiration pneumonia, internal bleeding, severe abdominal pain, and a non-functioning intestine.”<sup>134</sup> All the involved parties met and decided that switching to palliative care would be both appropriate and in Sheila’s best interests. A few days later, the Attorney General’s office advised the hospital officials that they were in violation of New York law. As a result, Sheila was kept alive for two more months of intense suffering before a court order could be obtained to overrule the Attorney General’s decision.<sup>135</sup>

The plaintiff, Sheila’s sister, sued the Attorney General under § 1983,<sup>136</sup> arguing that even a “never-competent person has constitutional interests in avoiding medical intrusions that would needlessly prolong the dying process.”<sup>137</sup> The Second Circuit held that the Constitution does not prohibit the state from prolonging the life of one of its citizens, no matter what quality of life that is.<sup>138</sup> In making this decision, the Second Circuit relied heavily on the *Cruzan* decision, and in particular the language that “a State may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life.”<sup>139</sup> Interestingly, the rest of the Supreme Court’s quote that the Second Circuit omitted is: “to be weighed against the constitutionally protected interests of the individual.”<sup>140</sup> Since the plaintiff’s claim was that a constitutionally protected interest of Ms. Pouliot’s was violated, the Second Circuit only begged the question in its holding. No other court has followed the Second Circuit’s position.

The current legal quagmire leaves the following treatment path in the United States. At the beginning, a physician begins

---

<sup>134</sup> *Id.* at 352.

<sup>135</sup> *Id.* at 351-52.

<sup>136</sup> 42 U.S.C.S. § 1983 (2006).

<sup>137</sup> *Blouin v. Spitzer*, 356 F.3d at 359 (quoting Brief for Petitioner, *Blouin v. Spitzer*, 356 F.3d (No. 02-7997)).

<sup>138</sup> *Id.* at 360-61.

<sup>139</sup> *Blouin v. Spitzer*, 356 F.3d at 360-61 (quoting *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 282 (1990)).

<sup>140</sup> *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 282 (1990).

treating a patient (i.e., Mr. Smith) without knowing what is wrong with him, or is compelled to treat him under EMTALA. The physician gives Mr. Smith a terminal diagnosis. The physician can continue aggressive medical care free of liability so long as Mr. Smith does not ask for care to be withdrawn or withheld. The physician only faces legal difficulties if the physician would like to discontinue aggressive treatment and switch to palliative care, and cannot get Mr. Smith's consent. If this happens, the first step for the doctor is to go to the hospital's medical ethics committee.<sup>141</sup> However, except for in Texas, the ethics committee's decision has no binding authority unless a determination of physiological medical futility is reached.<sup>142</sup> If the treatment does not meet the narrow definition of physiological futility and the ethics committee is unsuccessful in convincing Mr. Smith that their recommended course of action is the correct one, the aggressive care will continue until Mr. Smith dies a slow painful death that the physician is forced to administer. This path is the default route for patients in the United States unless they make it clear through "clear and convincing" evidence that their wishes are otherwise.

### B. *United Kingdom*

The United Kingdom began developing its death and dying jurisprudence in the early 1980s.<sup>143</sup> The United Kingdom's death and dying jurisprudence was not fully developed until the early 1990's, when the House of Lords held in *Airedale NHS Trust v. Bland*<sup>144</sup> that medical treatment may be lawfully withheld from an incompetent patient who has no hope of recovery, provided it was in the patient's best interests not to prolong his life.<sup>145</sup>

---

<sup>141</sup> See American Medical Association, *CODE OF MEDICAL ETHICS* 280 (2004-2005). The committee is comprised of health practitioners and ethicists who look at the patient's prognosis, come to a determination about the appropriate course of medical treatment, and subsequently speak to the decision-maker. *Id.*

<sup>142</sup> *Id.* at 14. See *supra* Part I.A.2.b.

<sup>143</sup> See *Re B (a minor)* (wardship: medical treatment), [1990] 3 All E.R. 927, [1981] 1 W.L.R. 1421 (C.A. 1981).

<sup>144</sup> [1993] A.C. 789 (H.L. 1993).

<sup>145</sup> See also *Re J (a minor)* (wardship: medical treatment), [1991] Fam. 33 (C.A. 1990) (holding life sustaining treatment could be stopped for a baby whose future and current quality of life was intolerable); *Re J (a minor)* (wardship: medical treatment), [1993] Fam. 15 (C.A. 1992) (reversing lower court's order to continue life-prolonging treatment for a baby suffering from mental retardation and cerebral palsy without any developmental milestones and lack of capacity to breathe regularly without medical intervention).

When the United Kingdom solidified what would be its approach to end of life decision making in *Airedale NHS Trust v. Bland*, the court reviewed the American cases. The judges expressly rejected the majority approach in the United States and expressly accepted that of the dissenters:

The best interests of the patient in my judgment embrace not only recovery or the avoidance of pain (neither of which apply to this case) but also a dignified death. On this issue I respectfully agree with the dissenting judgments of Handler J in *Re Conroy* (1985) 98 NJ 321 and Brennan and Stevens JJ in *Cruzan v Director, Missouri Dept of Health* (1990) 497 US 261.<sup>146</sup>

In the United Kingdom, competent adults have the right to accept or reject medical treatment; this is called the right of self-determination.<sup>147</sup> This right exists whether or not the patient's decision is rational,<sup>148</sup> and has been extended to a competent patient to refuse medical treatment, even when it means his or her death.<sup>149</sup> While the United Kingdom has adopted the right to refuse treatment, the courts have explicitly not extended patient autonomy to the right to demand a particular treatment.<sup>150</sup> It is the providence of the patient's physician to decide which treatments are medically indicated and the physician is under no obligation to offer any other treatment.<sup>151</sup> If the patient requests a treatment that the physician has not offered, the physician's only obligation is

---

<sup>146</sup> *Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L. 1993) (Hoffman, L.J.).

<sup>147</sup> See *Sidaway v. Bethlem Royal Hospital Governors*, [1985] A.C. 871, 904-05 (H.L. 1985).

<sup>148</sup> See *Id.*

<sup>149</sup> See, e.g., *Re B* (consent to treatment: capacity) [2002] EWHC (Fam) 429 (Eng.) (holding a paralyzed patient could refuse life-sustaining medical treatment despite the fact her physicians believed they had not exhausted the possible treatments); *Re AK* (medical treatment: consent), [2001] 1 F.L.R. 129 (Fam. 2000) (holding a competent adult's refusal to consent to treatment must be observed).

<sup>150</sup> In a recent Court of Appeals decision, *R (Burke) v. General Medical Council*, the court in assessing the limits of patient autonomy said:

The proposition that the patient has a paramount right to refuse treatment is amply demonstrated by the authorities cited by Munby J in paras [54]-[56] of his judgment under the heading 'Autonomy and self-determination'. The corollary does not, however, follow, at least as a general proposition. Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. Insofar as a doctor has a legal obligation to provide treatment, this cannot be founded simply upon the fact that the patient demands it.

[2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223 at ¶ 31.

<sup>151</sup> See GMC Guidelines, *supra* note 26; *R (Burke) v. General Medical Council*, [2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223 [50].

to offer the patient the opportunity to obtain a second opinion.<sup>152</sup> However, if a competent patient demands life-prolonging treatment, the physician must continue care or transfer the patient, even if the physician believes that the patient's life should come to an end.<sup>153</sup> If the physician does not provide the treatment in such a situation, the physician may be criminally liable and violates Article 2 of the European Convention.<sup>154</sup>

The United Kingdom recognizes the sanctity of life and preciously guards it. Lord Donaldson MR in *Re J*<sup>155</sup> is often cited for this proposition:

We know that the instinct and desire for survival is very strong. We all believe in and assert the sanctity of human life. As explained, this formulation takes account of this and also underlines the need to avoid looking at the problem from the point of view of the decider, but instead requires him to look at it from the assumed point of view of the patient. This gives effect, as it should, to the fact that even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intolerable. People have an amazing adaptability. But in the end there will be cases in which the answer must be that it is not in the interests of the child to subject it to treatment which will cause increased suffering and produce no commensurate benefit, giving the fullest possible weight to the child's, and mankind's, desire to survive.

Lord Donaldson made it clear that there should be a strong presumption in favor of prolonging life. It is not the court's role to determine what quality of life and treatments *it* would find intolerable. Rather, its only role is to decide what the *patient* would deem intolerable.<sup>156</sup> It is important to recognize that this is not a subjective standard or a substituted judgment approach; it is a protection

---

<sup>152</sup> R (Burke) v. General Medical Council, [2005] EWCA Civ 1003, [2005] 2 FLR 1223 [55] ("Ultimately, however, a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to the patient's clinical needs.").

<sup>153</sup> *Id.* at [39, 53].

<sup>154</sup> R (Burke) v. General Medical Council, [2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223 [34, 39].

<sup>155</sup> *In Re J* (a minor) (wardship: medical treatment), [1991] Fam 33 at 46-47.

<sup>156</sup> Judge Hedley echoed this point in *Portsmouth NHS Trust v. Wyatt and Wyatt*, when determining the premature baby before him should not be given artificial ventilation if she stopped breathing on her own, despite the parent's wishes to continue all aggressive treatment. [2004] EWHC (Fam) 2247, [30], [2005] 1 F.L.R. 21, *aff'd Re Wyatt* (a child) (medical treatment: continuation of order), [2005] EWCA (Civ) 1181, [2005] All E.R. (D) 107 (Oct.) (approved judgment).

for competent disabled individuals to be able to choose to live in an extremely disabled state.<sup>157</sup> It means that the only relevant factors to consider are the patient's interests; the interests of family and others are not relevant.<sup>158</sup>

The strong state interest in preserving life gives rise to a presumption of prolonging life. Physicians can rebut that presumption by strictly following the carefully circumscribed best interests test.<sup>159</sup> The English common law recognizes two patient's rights capable of rebutting the presumption of life: the right of self-determination<sup>160</sup> and the right to dignity of the human body.<sup>161</sup> Conflicts between what is in the patient's best interests, the right of self-determination, and the sanctity of life have been resolved by giving the patient a right to consent, and the power to rebut the state's interest in life. As a result, the patient can choose not to undergo life saving medical treatment.<sup>162</sup>

The patient's right to dignity is not diminished if the patient is incompetent.<sup>163</sup> This right often necessitates a quality of life assess-

---

<sup>157</sup> "Best interests is not a test of 'substituted judgement' (what the person would have wanted), but rather it requires a determination made by applying an objective test as to what would be in the person's best interests." DEPARTMENT FOR CONSTITUTIONAL AFFAIRS, MENTAL CAPACITY BILL: EXPLANATORY NOTES ¶ 25 (2004), available at <http://www.publications.parliament.uk/pa/ld200405/ldbills/013/en/05013x.htm>.

<sup>158</sup> See DEPARTMENT OF HEALTH, SEEKING CONSENT: WORKING WITH OLDER PEOPLE 10-11 (Dec. 16, 2001), <http://www.dh.gov.uk/assetRoot/04/06/70/20/04067020.pdf>.

<sup>159</sup> In *Re J*, Lord Donaldson also made it clear that

[t]he decision on life and death must and does remain in other hands. What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which as a side effect will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so.

[1991] Fam 33, 46-47.

<sup>160</sup> See, e.g., *Re B* (consent to treatment: capacity) [2002] EWHC (Fam) 429 (Eng.) (holding a paralyzed patient could refuse life-sustaining medical treatment despite the fact her physicians believed they had not exhausted the possible treatments); *Re AK* (medical treatment: consent), [2001] 1 F.L.R. 129 (Fam. 2000) (holding a competent adult's refusal to consent to treatment must be observed).

<sup>161</sup> See *Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L.). The right to dignity of the human body also means the right to be free of extreme pain and suffering, and to be free from humiliation and degrading invasions of the body for no good purpose.

<sup>162</sup> See *supra* note 160. The right of an individual in the U.K. to end his own life has been extended to all situations, not only in the arena of medical decision-making. As of the Suicide Act of 1961, active suicide in the U.K. is legal.

<sup>163</sup> See *Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L.).

ment.<sup>164</sup> In *Re J*, the court recognized that the infant's injuries were so severe that life, from the infant's point of view, would be so intolerable that if capable of making a competent decision, he would choose to die.<sup>165</sup> Baby J was born after twenty-seven weeks of gestation and suffered recurrent convulsions and apnea.<sup>166</sup> When Baby J would cry, he would become cyanosed and need artificial ventilation, and on one occasion, doctors had to paralyze him in order to stabilize his oxygen levels.<sup>167</sup> Baby J's head was filled with fluid where brain tissue should be; as a result, he would never see, talk, or move his arms or legs. Over time he *might* develop the ability to smile and cry.<sup>168</sup> The court held that a mechanical ventilator should be withheld in the event that the infant stopped breathing.<sup>169</sup>

For patients in a persistent vegetative state, the courts have determined that it is in the patient's best interests to withdraw life-sustaining care because of the patient's poor quality of life.<sup>170</sup> Courts have agreed with physicians' determinations that it is not in the patient's best interests to continue life-sustaining care, even where the family of the patient has disagreed.<sup>171</sup> England codified this common law right to dignity by adopting the European Convention in 1998.<sup>172</sup> Specifically, Article 3, which states, "No one shall be subjected to . . . inhuman or degrading treatment . . ." <sup>173</sup>

---

<sup>164</sup> *Re Wyatt* (a child) (medical treatment: parents' consent), [2004] EWHC (Fam) 2247, 84 BMLR 206 ("account has to be taken of the pain and suffering and quality of life which the child will experience if life is prolonged. Account has also to be taken of the pain and suffering involved in the proposed treatment itself" (citing *In Re J* (a minor) (wardship: medical treatment), [1991] Fam 33, 46)).

<sup>165</sup> This has also become known as the "intolerability test." The court has come to the same conclusion in other cases as well, *see, e.g., Re Wyatt* (a child) (medical treatment: parents' consent), [2004] EWHC 2247 (Fam), 84 BMLR 206.

<sup>166</sup> *Re J* (a minor) (wardship: medical treatment), [1991] Fam 33 (C.A. 1990). DORLAND'S POCKET MEDICAL DICTIONARY 56 (25th ed. 1995) defines apnea as "cessation of breathing."

<sup>167</sup> *Re J* (a minor) (wardship: medical treatment), [1991] Fam 33 (C.A. 1990).

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> *See Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L.); *NHS Trust A v. M; NHS Trust B v. H*, [2001] 1 All E.R.(Fam) 801 (2000).

<sup>171</sup> *See An NHS Trust v. D and others*, [2005] EWHC (Fam) 2439 (holding that invasive procedures that only detract from the baby patient's dignity and add nothing to her physiological state may be stopped despite objections by the family).

<sup>172</sup> *See infra* note 188.

<sup>173</sup> European Convention on Human Rights and Fundamental Freedoms, Rome (Nov. 4, 1950), T.S. 71 (1953) (Cmd. 8969) available at <http://www.pfc.org.uk/node/328>. *But see NHS Trust A v. M; NHS Trust B v. H*, [2001] 1 All E.R. (Fam) 801 [43] (2000) ("Clearly the

refers to the right to dignity in a medical setting. It is this right to dignity that operates as the second way in which patients may rebut the state's presumption in favor of life.

The United Kingdom recognizes a doctor's right to make a decision that will cause the patient's death.<sup>174</sup> The general medical practitioner's duty of care is to act in accordance with the standards of reasonably competent doctors.<sup>175</sup> A fundamental aspect of this duty of care is the duty to keep the patient alive.<sup>176</sup> The duty to keep the patient alive is not without exception, however, as the Court of Appeals recently said:

Insofar as the law has recognised that the duty to keep a patient alive by administering [artificial nutrition and hydration] or other life-prolonging treatment is not absolute, the exceptions have been restricted to the following situations: (1) where the competent patient refuses to receive [life-prolonging treatment]; and (2) where the patient is not competent and it is not considered to be in the best interests of the patient to be artificially kept alive.<sup>177</sup>

If an adult patient is not competent and has not pre-arranged the course of treatment they desire (through advanced medical directives such as a living will), no one, including the court, can give consent to a medical treatment for that patient.<sup>178</sup> This absence of substituted judgment in the English system is replaced by the medical practitioner's duty of care and the best interests standard.<sup>179</sup> The best interests standard means that the doctor's duty is to give or withhold treatment according to what appears to be in the best interests of the patient.<sup>180</sup> In the case of a minor, the court is to

---

continuation of futile treatment or the withdrawal of such treatment cannot be described either as torture or as punishment.”).

<sup>174</sup> Such as the withdrawal of life-prolonging treatments when such treatment is determined to not be in the patient's best interests. *See, e.g., Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L. 1993); *NHS Trust A v. M*; *NHS Trust B v. H*, [2001] 1 All E.R. (Fam) 801 (2000).

<sup>175</sup> *See Bolam v. Friern Hosp. Mgmt. Comm.* [1957] 2 All ER (QB) 118 (1957).

<sup>176</sup> *R (Burke) v. Gen. Med. Council*, [2005] EWCA (Civ) 1003, [32-33].

<sup>177</sup> *Id.* at [33].

<sup>178</sup> *See F v. West Berkshire Health Auth. (Mental Health Act Commission intervening)* [1989] 2 All ER 545, sub nom *Re F (mental patient: sterilisation)* [1990] 2 AC 1, (H.L.).

<sup>179</sup> *Id.* This proposition is also directly addressed by Lord Justice Hoffman in *Airedale NHS v. Bland*, [1993] A.C. 789 (H.L. 1993): “I think that what the American courts have called ‘substituted judgment’ may be subsumed within the English concept of best interests.”

<sup>180</sup> *See Re J (a minor) (wardship: medical treatment)*, [1993] Fam 15 (C.A. 1992).

decide the best interests of the child.<sup>181</sup> Many factors are weighed in best interests determinations. As Dame Elizabeth Butler-Sloss said in *Re A (Male Sterilisation)*, “best interests encompasses medical, emotional and all other welfare issues.”<sup>182</sup> Best interests involves a complicated weighing of the sanctity of life, the patient’s right to self-determination, and the right to a dignified death.<sup>183</sup> Ultimately, the best interests test is fact intensive and varies case by case.<sup>184</sup>

The United Kingdom has recently codified its common law best interests test as applied to insensate patients in the Mental Capacity Act of 2005.<sup>185</sup> Section 26 of the Act requires compliance with a valid and applicable advanced medical directive to withdraw or withhold treatment.<sup>186</sup> However, if a valid and applicable advanced medical directive requests that treatment be continued, it is only a factor to be considered under Section 4.<sup>187</sup>

The United Kingdom adopted the European Convention into the United Kingdom domestic law in the Human Rights Act of 1998.<sup>188</sup> The common law principles set in *Airedale NHS Trust v. Bland* had to be reexamined to see if they comported to the Convention. In *National Health Service Trust A. v. M.; N.H.S. Trust B. v. H.*,<sup>189</sup> the High Court of Justice reaffirmed the reasoning of the House of Lords in *Bland* and decided that the European Convention does not require the United Kingdom to continue life-prolonging care in all situations.

---

<sup>181</sup> *Re B (a minor) (wardship: medical treatment)*, [1990] 3 All E.R. 927, [1981] 1 W.L.R. 1421 (C.A. 1981) (authorizing doctors to perform surgery to fix an intestinal blockage in a child with down syndrome because the surgery would allow the child to live a normal life span of a child with down syndrome, despite the parent’s refusal to give consent for the surgery); *Re Wyatt (a child) (medical treatment: parents’ consent)*, [2004] EWHC (Fam) 2247 (holding that the doctor’s determination that withholding artificial ventilation or similar aggressive treatment is in the best interests of the infant, despite the parent’s determination that such treatment would be in the infant’s best interests).

<sup>182</sup> [2000] 1 F.L.R. 549, 555.

<sup>183</sup> See *Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L. 1993).

<sup>184</sup> *R (Burke) v. Gen. Med. Council*, [2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223 [63].

<sup>185</sup> Mental Capacity Act, 2005, C. 9, s. 4 (Eng.), available at <http://www.opsi.gov.uk/acts/acts2005/20050009.htm>.

<sup>186</sup> *Id.* at s. 26.

<sup>187</sup> *Id.* at s. 4. See also *R (Burke) v. Gen. Med. Council*, [2005] EWCA (Civ) 1003, [2005] 2 FLR 1223 [57].

<sup>188</sup> Human Rights Act, 1988, c.42 (Eng.).

<sup>189</sup> [2001] 1 All E.R. (Fam) 801 (2000).

The role of the courts in end of life decision-making is of an advisory nature.<sup>190</sup> Over time, less end of life cases have come to the courts and are instead resolved in the field by medical practitioners.<sup>191</sup> In one recent case of particular note, *Glass v. United Kingdom*, the European Court of Human Rights created great confusion as to what the role of a court should actually be.<sup>192</sup> The Court appeared to hold that judicial intervention is not just advisory but *required* by the European Convention under Article 8 ¶ 2, when there is a disagreement between the patient's parents and the doctors.<sup>193</sup> However, the United Kingdom Court of Appeals clarified the *Glass* decision, and held that the courts cannot authorize treatment that would otherwise be illegal.<sup>194</sup> Courts can make declarations of whether a proposed course of treatment will be lawful and medical practitioners *may* want to seek such a declaration.<sup>195</sup> "This is not however, something that they are required to do as a matter of law."<sup>196</sup>

The last place physicians and the law must look for rules and guidance for end of life determinations is the General Medical Council's Withholding and Withdrawing Life-Prolonging Treatments: Good Practice in Decision-Making (GMC Guidelines).<sup>197</sup> While the GMC Guidelines have come under attack,<sup>198</sup> they have been upheld and suggested as a model of best practices for physicians to follow.<sup>199</sup> The GMC Guidelines do not change the com-

---

<sup>190</sup> Lord Goff of Chieveley in *Airedale NHS Trust v. Bland* recommended that physicians seek out the Family Division courts until a body of experience and practice were built up and the guidelines more clear. [1993] A.C. 789, 865 (H.L. 1993)

<sup>191</sup> See *R (Burke) v. Gen. Med. Council*, [2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223 [69] (citing statistics given to the court by the Intensive Care Society, approximately 15,000 patients a year die due to the decision to withdraw or withhold life-prolonging care).

<sup>192</sup> [2004] 1 F.L.R. 1019 (Eur. Ct. H.R.).

<sup>193</sup> *Glass v. United Kingdom*, [2004] 1 F.L.R. 1019 [75-76] (Eur. Ct. H.R.). This interpretation was followed by the U.K. courts in *R (Burke) v. General Medical Council*. [2004] EWHC (Admin) 1879, [2004] 2 F.L.R. 1121, *rev'd*, [2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223.

<sup>194</sup> *R (Burke) v. General Medical Council*, [2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223 [80].

<sup>195</sup> *Id.*

<sup>196</sup> *Id.*

<sup>197</sup> GMC Guidelines, *supra* note 26.

<sup>198</sup> *R (Burke) v. Gen. Med. Council* [2004] EWHC (Admin) 1879, [2004] 2 F.L.R. 1121 (holding that the GMC Guidelines did not comport with the European Convention) *set aside* by *R (Burke) v. Gen. Med. Council*, [2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223.

<sup>199</sup> *R (Burke) v. Gen. Med. Council*, [2005] EWCA (Civ) 1003, [2005] 2 F.L.R. 1223 [83] ("It is, in our view, of the utmost importance that the Guidance should be understood and

mon law but they do provide an accessible version of the common law for medical practitioners to follow.

If Mr. Smith were in the United Kingdom, he would still have the choice to continue with aggressive medical treatment. The cancer would spread and his liver would stop functioning properly. When dementia set in, he would lose the ability to continue to make his own decisions. The physicians would then ask themselves,<sup>200</sup> is it in the patient's best interests to continue aggressive medical care? If the physician decides the answer is no, then Mr. Smith's care would be switched to palliative care, and the physicians would not need to appeal to the courts for guidance. Mr. Smith would then die with some semblance of human dignity remaining.

## II. COMPARING AND CONTRASTING THE UNITED KINGDOM TO THE UNITED STATES

The law in the United States and the United Kingdom differs in three major ways. First, the two countries offer different levels of protection for the fundamental right to life. In addition, the United Kingdom has great concern about the dignity of human life and limiting highly degrading treatments that cannot serve a legitimate medical end. Second, the majority of jurisdictions in the United States make use of substituted judgment whereas the United Kingdom has explicitly ruled that no one can act as the incompetent patient. As a result, the United Kingdom has arguably come to a more honest and objective standard in determining the course of action with the terminally ill. Third, the United Kingdom and United States share subtle differences in their views and applications of patient and physician autonomy. These differences are important to the legal landscape of each country's death and dying jurisprudence.

### A. *Protection of Life*

The United States has a constitutional "interest" in life.<sup>201</sup> This interest is far from a fundamental right to life. Instead it is a constitutional right that waxes and wanes depending on the circum-

---

implemented at every level throughout the National Health Service and throughout the medical profession.").

<sup>200</sup> Applying the Mental Capacity Act, 2005, C. 9 (Eng.).

<sup>201</sup> In *Cruzan v. Dir., Mo. Dept. of Health*, the court found that "the Due Process Clause protects an interest in life." 497 U.S. 261, 281 (1990).

stances.<sup>202</sup> In contrast, the United Kingdom has a clearly written fundamental right to life stated in Article 2 of the European Convention: “[E]veryone’s right to life shall be protected by law.”<sup>203</sup> This difference has led to two rifts in the death and dying jurisprudence between the United States and the United Kingdom with profound impact. The first difference is that, while the United Kingdom has unequivocally declared that physician-assisted suicide is a criminal offense,<sup>204</sup> the picture is much murkier in the United States.<sup>205</sup> The second difference is that in the United Kingdom, patients have complete dominion over the personal decision to die. They can refuse treatment in any situation and can even choose to actively end their own lives.<sup>206</sup> In the United States, the prevention of suicide is considered a legitimate state interest.<sup>207</sup> The United States’ approach is inconsistent; it does not necessarily stop others from participating in euthanasia, but it does stop people from killing themselves.

It would not be unreasonable to theorize that the United Kingdom is more comfortable with determining that withdrawal of life-prolonging treatment is in the best interests of some patients because there is a well-defined and consistent right to life. Furthermore, the criminalization of physician assisted suicide serves to quell worries about a slippery slope of best interests determinations becoming euthanasia decisions. Without this backdrop in the United States, anytime a doctor tries to act in a way that will hasten death, it is viewed with great suspicion and generally deemed unlawful because of worries about euthanasia. At least one commentator has argued that the United States has turned to vitalism out of confusion about the state of the law and the line

---

<sup>202</sup> *Id.*

<sup>203</sup> European Convention on Human Rights, *supra* note 17, at Article 2.

<sup>204</sup> See Suicide Act, 1961, C. 60, s. 2 (Eng.). The House of Lords has ruled that all types of euthanasia are illegal in the U.K. *R (Pretty) v. Dir. of Pub. Prosecutions*, [2001] UKHL 61, [2002] 1 A.C. 800 (H.L. 2001). This ruling was upheld by the European Court of Human Rights in *Pretty v. United Kingdom*. [2002] 2 F.L.R. 45, [2002] 2 F.C.R. 97 (E.C.H.R. 2002).

<sup>205</sup> See, e.g., Oregon Death With Dignity Act, OR. REV. STAT. § 127.805(1) (2003) (“An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner . . .”). A further examination of this act and the euthanasia movement is beyond the scope of this note.

<sup>206</sup> See Suicide Act, 1961, C. 60, s. 1 (Eng.)

<sup>207</sup> See *Cruzan v. Dir. Mo. Dep’t of Health*, 497 U.S. at 271.

between euthanasia and best interests determinations.<sup>208</sup> Vitalism is the belief that “the preservation of individual human life is an end in itself, irrespective of the social, economic, or personal cost.”<sup>209</sup> The brutal result of vitalism is that patients are forced to receive painful contraindicated medical treatment without a hope of cure.<sup>210</sup> In order to treat people better, their rights need to be more precisely defined.

Lord Justice Hoffman, in *Airedale NHS Trust v. Bland*,<sup>211</sup> recognized that “[t]o continue treatment is as much a choice as to discontinue it.” The United States seems to ignore this distinction, preferring instead to believe that continuing treatment is what will happen if the choice to discontinue it does not happen.

### B. *Substituted Judgment*

In the United Kingdom, no one, including the court, can give consent to a medical treatment for an adult, even if that adult is incapable of giving his consent.<sup>212</sup> The presence of substituted judgment in the United States offers another explanation for the difference between English and American law. When a court uses substituted judgment, it is less likely to be forced to confront the issue of whether the continuation of aggressive treatment is in the patient’s best interests. This is because the court only tackles the issue of what the patient himself would have chosen, instead of contemplating the ethical result.

In order to prove the patient’s wishes to the court in the United States, the non-patient decision maker is generally saddled with a clear and convincing standard of evidence,<sup>213</sup> while being placed in the untenable position of trying to imagine and prove a hypothetical based upon a hypothetical. The first hypothetical is,

---

<sup>208</sup> See Alicia R. Ouellette, *When Vitalism is Dead Wrong: The Discrimination Against and Torture of Incompetent Patients by Compulsory Life-Sustaining Treatment*, 79 *IND. L.J.* 1 (2004).

<sup>209</sup> *Id.* at 21 (citing Laurence O. Gostin, *A Moment in Human Development: Legal Protection, Ethical Standards and Social Policy on the Selective Non-Treatment of Handicapped Neonates*, 11 *AM. J.L. & MED.* 31, 37 (1985)).

<sup>210</sup> *Id.*

<sup>211</sup> [1993] A.C. 789 (H.L. 1993).

<sup>212</sup> See *F v. West Berkshire Health Auth. (Mental Health Act Commission intervening)* [1989] 2 All ER 545, *sub nom Re F* (mental patient: sterilisation) [1990] 2 AC 1, (H.L.).

<sup>213</sup> See, e.g., *Grace Plaza v. Elbaum*, 82 N.Y.2d 10 (1993) (holding that the patient’s husband would have to continue to pay for support of his wife who is in a persistent vegetative state despite the fact that he asked for withdrawal of life-prolonging treatment and that he believed his wife would make that decision).

what would the patient have wanted under these circumstances? The second, what is the patient's current condition? Since the patient cannot communicate, what the patient wants is unknowable and even in the rare instance of a pertinent advanced medical directive, it does not necessarily reflect what the patient currently wants, just what the patient thought he might want under these circumstances. The United Kingdom's best interests test eliminates this type of two-tiered conjecture and makes a pragmatic decision based on the objective observer's consideration of the condition of the patient.

### C. Patient and Physician Autonomy

#### 1. Attorney-Client Relationship vs. Physician-Patient Relationship

Some commentators have asserted that there is no battle between physician and patient autonomy.<sup>214</sup> Nevertheless, the fact that Maryland, Virginia, and California have passed laws to preserve physicians' ethical integrity further indicates there is a conflict going on, and that physicians are on the losing side.<sup>215</sup> All three laws were designed to ensure that physicians only need to provide care that they determine is ethical and in accordance with their conscience.<sup>216</sup> However, the efficacy of these provisions is far from clear, as the Fourth Circuit has already held that EMTALA provides no exception for treatment that physicians deem medically or ethically inappropriate.<sup>217</sup>

The provisions that Maryland, Virginia, and California have created are strikingly similar to the Model Rules of Professional Conduct that the American Bar Association (ABA) uses to govern

---

<sup>214</sup> Strasser, *supra* note 34; Schrode, *supra* note 34.

<sup>215</sup> California's Uniform Health Care Decision Act (UHCDA), CAL. PROB. CODE §§ 4600-4740 (2006); MD. CODE ANN., HEALTH-GEN. I 5-601 to 5-608 (2006); VA. CODE ANN. § 54.1-2990 (2005).

<sup>216</sup> In California: "A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience." CAL. PROB. CODE § 4734(a) (2006). In Maryland: "[N]othing in this subtitle may be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be ethically inappropriate." MD. HEALTH-GEN. CODE ANN. § 5-611 (2006). In Virginia: "Nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate." VA. CODE ANN. § 54.1-2990 (2005).

<sup>217</sup> *In re Baby "K,"* 16 F.3d 590, 597 (4th Cir.). Virginia's law is not the only one under attack. See Martha Minow, *Who's the Patient*, 53 MD. L. REV. 1173, 1183 (1994); Ferguson, *supra* note 39, at 1254-56.

the conduct of attorneys in the United States.<sup>218</sup> Model Rule 1.16 allows lawyers to withdraw from representing a client *at any time* if:

. . . .

(4) the client insists upon taking action that the lawyer considers repugnant or with which the lawyer has a fundamental disagreement;

. . . .

(7) other good cause for withdrawal exists.<sup>219</sup>

Allowing lawyers to withdraw from representing their client maintains both the lawyer's autonomy and the lawyer's ethical beliefs. The United States Supreme Court in *Jones v. Barnes*,<sup>220</sup> reversed the Second Circuit's decision that the client should always be able to determine which issues to press in a criminal defense because it would undermine the lawyer's ability to conduct the case in accordance with his professional judgment.<sup>221</sup> It is striking that physicians are not allowed to conduct their patient's treatment in accordance with their professional judgment.

The position of offering lawyers greater protection of their autonomy than physicians is indefensible. The treatment of a physician's professional judgment in end of life decisions should be indistinguishable from a lawyer's judgment of legal representation in criminal cases. In both instances, the appropriate professional is using his expertise to make informed decisions regarding the future of the client's life and freedom. The fact that lawyers and doctors are treated differently in these situations is a reflection of the court's institutional competence. Judges are uniquely equipped to understand and balance issues in an attorney-client relationship; it is an arena they deal with daily. However, judges lack both the necessary medical training and experience to understand the physician-patient relationship. Judges generally only have the experience of being a patient, and approach these cases with a patient's biases and lack of understanding of the physician's position. A

---

<sup>218</sup> "The ABA is a private organization that has no power to impose rules on lawyers directly. Instead, the ABA indirectly regulates the conduct of lawyers through the promulgation of the Model Rules of Professional Conduct. The Rules were adopted by the ABA House of Delegates on August 2, 1983, and have since been adopted by thirty-four states and incorporated into law in significant portion by six others." Daar, *supra* note 39, at 1281 n.169.

<sup>219</sup> MODEL RULES OF PROF'L. CONDUCT R. 1.16(b)(4), (7) (2002), available at [http://www.abanet.org/cpr/mrpc/rule\\_1\\_16.html](http://www.abanet.org/cpr/mrpc/rule_1_16.html).

<sup>220</sup> 463 U.S. 745 (1983).

<sup>221</sup> *Id.* at 751.

judge by definition should be unbiased and be able to adequately weigh both the plaintiff's and defendant's arguments. The courts have long recognized this limitation of their institutional competence and have regularly called upon the legislature for help.<sup>222</sup>

## 2. Human Rights

Patients in both countries have the right to be informed and to choose from all "medically appropriate" treatments.<sup>223</sup> In the United Kingdom, the line separating physician and patient autonomy is determined by what treatments are medically appropriate. Physicians are the arbiters of what is in the patient's best interests when it comes to what treatments to offer and the courts are loath to try to correct them.<sup>224</sup> It is logical that a *medical* doctor should choose which *medical* treatments are appropriate to a patient's condition. However, in the United States, life-prolonging care has been taken out of the physician's collection of discretionary treatments and has been made the required standard of care. As a result, the only way in most states for a patient to opt out of medically inappropriate life-prolonging care is if the patient is competent and demands the end of such treatment.<sup>225</sup>

Both physician autonomy and patient dignity are commanded by the U.S. Constitution. In *Washington v. Glucksberg*, the Supreme Court set forth its two prong method of testing whether a

---

<sup>222</sup> See *Barber v. Super. Ct.*, 147 Cal. App. 3d 1006, 1014 (1983) ("Of course, the only long-term solution to this problem is necessarily legislative in nature. It is that body which must address the moral, social, ethical, medical and legal issues raised by cases such as the one at bench."); *In re Welfare of Colyer*, 99 Wn. 2d 114, 129 (1983) ("While we hold that courts need not be involved in individual decisions, we recognize that the court, or the Legislature, must establish guidelines to be followed to ensure that the rights of all parties are adequately protected."); *In re Quinlan*, 70 N.J. 10, 50 (1976) ("We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome.").

<sup>223</sup> See *Sidaway v. Bethlem Royal Hosp. Governors*, [1985] A.C. 871, 904-905 (H.L. 1985).

<sup>224</sup> See *R (Burke) v. Gen. Med. Council*, [2005] EWCA (Civ) 1003, [2005] 2 FLR 1223.

<sup>225</sup> By not making life-prolonging care mandatory, the United Kingdom's process can handle the problem of most patients being incompetent by the time the decision to stop life-prolonging care is needed. The physician decides if that treatment is in the patient's best interests, and the mental state of the patient is only one component of that decision. In the United States, many states prohibit the surrogate from making the decision to withdraw care, or only allow withdrawal by a showing of "clear and convincing" evidence that had the patient been competent, it is what he would have wanted. Oullette, *supra* note 208, at 9-10.

right is a protected liberty interest.<sup>226</sup> First, substantive due process “protects those fundamental rights and liberties which are, objectively, ‘deeply rooted in this Nation’s history and tradition.’”<sup>227</sup> There is a long tradition of preserving the ethical integrity of a professional field by permitting the professionals to cease their duties when it leads them to areas that they find to be ethically repugnant.<sup>228</sup> In particular, there is a well-recognized state interest in maintaining the integrity of the medical profession.<sup>229</sup> One method for maintaining the integrity of the medical profession is the law of abandonment, which under the common law allowed doctors to discontinue care when they wanted, provided they gave notice. The law of abandonment is embedded in the history and legal traditions of the United States,<sup>230</sup> and should be relevant when a physician determines that treatment no longer provides a benefit to the patient. Similarly, the patient’s right to dignity has already been accepted by the Supreme Court as a legitimate fundamental right.<sup>231</sup>

Second, the Court has required a careful description of the asserted fundamental liberty interest in substantive due process cases.<sup>232</sup> The physician’s liberty interest is in maintaining their own ethical beliefs without unduly impinging upon the liberty interests of the patient. The physician’s duty to act ethically and the patient’s right to dignity overlap when the physician is required to infringe upon the patient’s dignity, against the physician’s profes-

---

<sup>226</sup> See *supra* Part I.A.3. The result of which is the continuation of life-prolonging treatment.

<sup>227</sup> *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997) (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1976) (plurality opinion)).

<sup>228</sup> For the legal profession, see MODEL RULES OF PROF’L CONDUCT R. 1.16(b)(4), (7) (2002), available at [http://www.abanet.org/cpr/mrpc/rule\\_1\\_16.html](http://www.abanet.org/cpr/mrpc/rule_1_16.html). For the medical profession, thirty years ago the physician made end-of-life determinations. See *supra* Part II. However, thirty years ago medical technology lacked the ability to preserve the lives of the patients being discussed herein. *Cruzan v. Dir. Mo. Dep’t of Health*, 497 U.S. 261, 270 (1990).

<sup>229</sup> *Id.* at 271; *Washington v. Glucksberg*, 521 U.S. at 731 (1997).

<sup>230</sup> Levine, *supra* note 25, at 87-88.

<sup>231</sup> See *Vacco v. Quill*, 521 U.S. 793, 809 (1997) (Stevens, J., concurring) (“Avoiding intolerable pain and the indignity of living one’s final days incapacitated and in agony is certainly ‘at the heart of [the] liberty . . . to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.’” (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992))). See also *Washington v. Glucksberg*, 521 U.S. at 721, 752 (1997) (Stevens, J., concurring) (stating that there is a liberty interest in a patient’s dignity that may outweigh a state’s interest in the preservation of human life).

<sup>232</sup> *Washington v. Glucksberg*, 521 U.S. at 721.

sional ethical judgment. An example of this is when, in *Blouin v. Spitzer*, the physician was forced to continue aggressive medical treatment despite everyone's judgment that the patient's dignity would be best served by switching to palliative treatment.<sup>233</sup> The liberty interest that comes into play when the physician's ethical decision is aligned with a patient's right to dignity offers a narrow and precise description, satisfying the second prong of the substantive due process inquiry.

The countervailing state interest is the preservation of life.<sup>234</sup> The courts in the United States have acknowledged that this interest is strongest when it is possible to cure the illness.<sup>235</sup> However, when it is possible to cure the illness, the dignity of the patient is not being violated by applying the treatment because it may have a legitimate result rather than merely causing pain and suffering. No court has ever held that there is a fundamental right to unlimited life-sustaining treatment in the face of physiologically futile care. The core question is, when does the treatment justify a futility determination? Again, this is an area outside of the institutional competence of the court, and should be determined by doctors in accordance with the best interests of the patient; to do otherwise would violate physicians' substantive due process right to act in accordance with their medical and ethical judgment.

The United Kingdom's approach to death and dying jurisprudence is much better at avoiding human rights violations than the United States'. The United Kingdom preserves patient dignity and physician autonomy by allowing its physicians to make the medical determination of when life-prolonging treatment is no longer appropriate. One of the considerations taken into account in the United Kingdom's approach is economic distributive justice.<sup>236</sup> This is its greatest failure. Discontinuing life-prolonging treatment is clearly a form of resource management. However, it does not seem appropriate to base ethical decisions on cost, unless providing ineffective treatment interferes with the ability to provide useful treatment to someone with a better prognosis. There is no reason

---

<sup>233</sup> *Blouin v. Spitzer*, 356 F.3d 348, 351-52 (2d Cir. 2004).

<sup>234</sup> *Id.*

<sup>235</sup> *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977). See also *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 313 (1990) ("[T]he State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life.").

<sup>236</sup> *Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L.).

to believe that maintaining life-prolonging care indefinitely for all patients would outstrip the United Kingdom's capacity to take care of patients. But as a result of the United Kingdom being under a socialized health care regime, there is a hyper-sensitivity towards the fact that medical resources are not infinite. Lord Justice Hoffman pointed out in *Bland* that "the resources of the national health service are not limitless and choices have to be made."<sup>237</sup> Economic analysis in the United Kingdom, without empirically establishing actual resource limitations, has weakened its ethical position. It cannot definitively claim that its patients are sometimes unable to receive life-prolonging treatment, not because they are unable to pay for it, but because the patients' physicians believe the course of treatment being sought is unethical.

### III. PROPOSED LEGISLATION

Courts in the United States have been asking for legislative action in the area of end of life decision-making since death and dying jurisprudence began.<sup>238</sup> The courts do not have the investigative resources or the institutional competence to make general guidelines regarding end of life decision-making.<sup>239</sup> The following is my proposal for a model statute that does not violate patients' rights and leads to both ethical and medically appropriate outcomes. Both the United Kingdom and the United States would benefit from its enactment.

---

<sup>237</sup> *Id.* (Hoffman, L.J.).

<sup>238</sup> The Florida Supreme Court became one of many voices calling for legislative involvement:

Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type [of] issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.

Satz v. Perlmutter, 379 So. 2d 359, 360 (1980). See also *In re Conroy*, 98 N.J. 321, 344 (1985) (suggesting it would be best if legislature, a body of elected officials with broad investigatory resources, would come up with guidelines for the courts and physicians to follow); *Rasmussen v. Fleming*, 154 Ariz. 207 (1987) (urging legislative involvement); *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 822 (1984).

<sup>239</sup> See *supra* note 238.

2006]

*MEDICAL TORTURE*

549

**§ 1. Definitions**

- a) “physician” means a medical doctor authorized under applicable law to practice public medicine;
- b) “patient” means the person undergoing medical care or that person’s legally appointed decision-maker;
- c) “health care provider” means a physician or health care facility that provides health care for the patient;
- d) “health care facility” means any facility that is legally capable of administering medical treatment to an individual. This includes hospitals, nursing homes, and palliative treatment centers;
- e) “physiological futility” means treatment that offers no physiological benefit to the patient;
- f) “life-sustaining treatment” means treatment which, in the view of the health care provider, is necessary to sustain the patient’s life.

**§ 2. Prerequisites for the health care provider to unilaterally withdraw life-sustaining treatment**

- a) The following prerequisites shall be met before unilaterally withdrawing life-sustaining medical treatment:
  - 1) the patient’s health care provider has made a reasonable effort to transfer care of the patient to another health care provider;
  - 2) the patient has been informed of the health care provider’s decision to invoke this provision and has been given a reasonable amount of time to seek transfer to another health care provider;
  - 3) a medical ethics board of independent physicians and ethicists has been consulted and concurs with the primary physician’s determination to withdraw or withhold life-sustaining treatment;
  - 4) the medical determination review board created under this Act must receive notification forty-eight hours before life-sustaining treatment is withdrawn or withheld; and
  - 5) if the patient is incompetent, the withdrawal or withholding of life-sustaining treatment must be in the patient’s best interests as determined by section three.

- b) If the requirements of subsection (a) are met, reasonable notice must be given to the patient that the physician is going to withdraw or withhold life-sustaining treatment;
- c) If the requirements in subsections (a) and (b) are met, and the medical determination review board has not issued a disagreement with the determination:
  - 1) the health care provider may withdraw or withhold life-sustaining treatment from the patient; and
  - 2) reasonable notice shall be given to the medical determination board after the life-sustaining treatment is withdrawn or withheld.
- d) In the event life-sustaining treatment is withheld or withdrawn, palliative treatment shall be made available to maintain the patient's comfort and dignity.

*Comments.*

This section allows a radical change from the common law termination of medical care that will cause the patient to die faster without the patient's consent. If the patient and his physician cannot find a health care provider to assume care, it means the medical standard is that it is in the patient's best interests to be treated with pain relief instead of curative medicine. Patient transfer allows the patient to appeal to physician's ethics in ways other possible solutions, such as a broadened medical futility standard, do not.

The severity of this decision is heightened in two ways. First, this section requires that both the hospital's ethics committee and an independent tribunal of physicians (the medical determination review board) review the primary physician's determination. Second, these review boards are considering whether withholding or withdrawing life-sustaining treatment is appropriate, not whether patient transfer is appropriate.

Subsections (a)(1) and (a)(2) do not precisely define the amount of time a health care provider must give a patient to seek transfer, nor the amount of effort they need to expend to find a health care provider for the patient. These details are extremely fact dependent, and should be made on a case by case basis.

**§ 3. The best interests test**

- a) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of
  - 1) the person's age or appearance, or

2006]

*MEDICAL TORTURE*

551

- 2) a condition of his, or an aspect of his behavior, which might lead others to make unjustified assumptions about what might be in his best interests.
- b) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
  - 1) He must consider:
    - a. whether it is likely that the person will at some time have capacity in relation to the matter in question, and
    - b. if it appears likely that he will, when that is likely to be.
  - c) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
  - d) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
  - e) He must consider, so far as is reasonably ascertainable:
    - 1) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
    - 2) the beliefs and values that would be likely to influence his decision if he had capacity, and
    - 3) the other factors that he would be likely to consider if he were able to do so.
  - f) He must take into account, if it is practicable and appropriate to consult them, the views of:
    - 1) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
    - 2) anyone engaged in caring for the person or interested in his welfare,
    - 3) any donee of a lasting power of attorney granted by the person, and
    - 4) any deputy appointed for the person by the court,

as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

- g) The duties imposed by subsections (a) to (f) also apply in relation to the exercise of any powers which:
- 1) are exercisable under a lasting power of attorney, or
  - 2) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.
- h) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (a) to (f)) he reasonably believes that what he does or decides is in the best interests of the person concerned.

...

[i] "Relevant circumstances" are those—

- (1) of which the person making the determination is aware, and
- (2) which it would be reasonable to regard as relevant.<sup>240</sup>

*Comments.*

This test is taken from the United Kingdom's Mental Capacity Act.<sup>241</sup> All relevant pre-enactment interpretations by the courts in the United Kingdom should be considered when applying the best interests test under this section.

**§ 4. Presumption of assisted-suicide.** For purposes of civil liability, if the health care provider intentionally disregards the prerequisites under Section 2(a) and withdraws life-sustaining care, it shall be presumed that the health care provider assisted in the patient's death.

**§ 5. Medical determination review board**

- a) The board:
- 1) shall be comprised of nine physicians; and
  - 2) shall be appointed by the state governor for a term of four years.

---

<sup>240</sup> Mental Capacity Act, 2005, c.9, § 4 (Eng.).

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

2006]

*MEDICAL TORTURE*

553

- b) Upon receipt of a withdrawal determination the board shall:
- 1) review the determination within forty-eight hours;
  - 2) independently determine if the withdrawal or withholding of life-sustaining treatment is medically indicated; and
  - 3) vote on the validity of the determination. If a majority of board members vote that the determination is not medically indicated, notice shall be sent immediately to the requesting health care provider. Such a vote shall not foreclose future appeals to the medical determination board if the facts of the patient's case materially change.
- c) "medically indicated" for purposes of this section means that the patient's quality of life would make the treatment not worth the outcome. "This means offering those treatments where the possible benefits outweigh any burdens or risks associated with the treatment, and avoiding those treatments where there is no net benefit to the patient."<sup>242</sup>

*Comments.*

The medical determination board is only responsible for making *medical* determinations. For that reason, its members must be physicians. The board's function is to stop a court from trying to conjure what is considered to be the medical standard of care. What the board determines should be considered to be the prevailing medical standard.

**§ 6. Patient transfers**

- a) The patient may, at any time, seek to transfer his care to another health care provider.
- b) A physician may, at any time, seek to transfer the patient to another health care provider.
- c) If at anytime a health care provider that will accept transfer of the patient is located, all life-sustaining treatment shall be continued and administered until the transfer is complete.
- d) If the requirements under Section 2 have been met, a patient may be transferred due to reasons including lack of

---

<sup>242</sup> GMC Guidelines, *supra* note 26, at ¶ 9.

554 *CARDOZO J. OF INT'L & COMP. LAW* [Vol. 14:511

patient stability, even if the transfer is not medically indicated.

- e) Transfer of patient care under this Act shall not affect the pre-transfer obligations to pay for treatment. All transfer expenses shall be paid by the transferring party. This section cannot be modified by agreement.

*Comments.*

Subsections (a) and (b) state the common law doctrine of transfer. They should not be construed to alter the common law.

Subsection (d) is necessary because normal requirements for patient transfer (i.e. patient stability) may not be fulfilled by the patient in question, and therefore this Act could be effectively nullified by any remote health care provider agreeing to accept transfer. However, patients may be transferred from their current health care provider to another without moving locations, and in the case of an unstable patient, this should be the preferred transfer. A different physician within the hospital may take over treatment, or a physician from another health care facility may travel to the current health care facility to take over treatment.

Subsection (e) prevents the withdrawal of care under this Act from being used as a form of cost control. Patients who are dependent on life-sustaining treatment may have already exhausted their insurance, if they ever had any, and the health care facility has been forced to pay the bill. This creates a huge incentive for "patient dumping," which under this Act would become a roundabout euthanasia program. Subsection (e) is vital in taking economic considerations out of end of life decisions. Furthermore, insurance companies often contract to pay for treatment only at certain hospitals; this subsection overrides this contractual limitation.

**§ 7. Medically futile treatment**

- a) Sections 1-6 do not apply to decisions in which treatment has been determined to be physiologically futile.
- b) If treatment, or a course of treatment, has been determined to be medically futile, the patient's physician may refuse to administer, or withdraw such treatment after informing the patient of the physician's determination and giving the patient a reasonable amount of time to obtain a second opinion.

*Comments.*

The only purpose of this section is to preserve the limited doctrine of medical futility.

**§ 8. Jurisdiction of the courts.**

- a) The court shall have jurisdiction over whether the procedures of this Act have been complied with.
- b) The court shall review determinations made by the medical review board under a clear and erroneous standard of proof.

*Comments*

The court's role is to prevent abuse of the termination of care procedure in this Act.

**§ 9. Private cause of action.** A health care provider that causes life-sustaining treatment to be withdrawn or withheld in compliance with this Act, is not civilly or criminally liable for that action. If the procedure under this Act is negligently followed or intentionally not followed and life-sustaining treatment is terminated, patients shall have a private cause of action against the health care provider.

*Comments*

In a jurisdiction that has adopted the proposed legislation, Mr. Smith's outcome will be similar to the outcome under the United Kingdom's current legal system. The primary difference in the outcome is that the proposed legislation will allow the withdrawal of aggressive treatment without a consideration of how much money it will save. If Mr. Smith is switched to palliative treatment, it is only out of consideration of Mr. Smith's right to dignity and the physician's right not to torture patients.

#### IV. CONCLUSION

The current state of the law in the United States forces physicians to practice defensive medicine.<sup>243</sup> Under the current legal regime, if a physician switches the patient from aggressive curative care, the physician could, and often does, face litigation.<sup>244</sup> The practical consequence of this is that physicians are put in the position of either following requests for inappropriate treatment, or continuing to administer aggressive curative care until the patient dies. The inappropriate use of curative treatment deprives patients

---

<sup>243</sup> Kapp, *supra* note 61.

<sup>244</sup> *Id.*

556 *CARDOZO J. OF INT'L & COMP. LAW* [Vol. 14:511

of their fundamental right to dignity and humane treatment, and instead leaves patients to meet death alone in a hospital after being poked, prodded, skewered and cut, sometimes for years on end. This is an area in which the conversation must change from how to cure the patient to deciding how people should die.

The United Kingdom should teach us that limiting the use of aggressive curative treatment does not translate to euthanasia. In fact, we learn that it increases patients' dignity and allows the medical community to abide by its duty to "do no harm." If these decisions are not guided by ethical reasoning, they will ultimately be made for economic ones. Considering the rise of Medicare, HMO's and other socialized institutions in the United States in connection with medical technology's ability to prolong near-death life longer and longer, it is only a matter of time before courts use economic reasoning to stop treatment, as their counterparts in the United Kingdom have already done.<sup>245</sup>

The United States' failure in this arena is reflected in its statistics.<sup>246</sup> Legislative action is desperately needed. The courts themselves have repeatedly asked for legislative guidance recognizing their own limitations. As medical technology progresses, some people currently thought to be hopeless may be cured, but many more will be maintained in limbo, living only due to the technology pumping their heart, and expanding their lungs. It is time to end the suffering and allow physicians to give dignity back to the dying.

---

<sup>245</sup> See *supra* note 236.

<sup>246</sup> See *supra* note 12.