1993

Beyond Autonomy: Judicial Restraint and the Legal Limits Necessary to Uphold the Hippocratic Tradition and Preserve the Ethical Integrity of the Medical Profession

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Available at: http://scholarship.law.edu/jchlp/vol9/iss1/25
The judge, even when he is free, is still not wholly free. He is not to innovate at pleasure. He is not a knight-errant, roaming at will in pursuit of his own ideal of beauty or of goodness. He is to draw his inspiration from consecrated principles. He is not to yield to spasmodic sentiment, to vague and unregulated benevolence. He is to exercise a discretion informed by tradition, methodized by analogy, disciplined by system, and subordinated to "the primordial necessity of order in the social life." Wide enough in all conscience is the field of discretion that remains.1

There are limits to what medicine can achieve. However, this is a reality that some people, when faced with a relative's death, refuse to accept. Even when experienced physicians diagnose an unconscious and severely brain-damaged patient's condition as medically irreversible and beyond any beneficial treatment, patients' families hold out hope for miracles.2 This is understandable. The controversy arises, however, when relatives demand that doctors continue to do everything possible to sustain the patient's life, regardless of the financial cost, the medical benefit, or the ethics of further...

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2. Members of both the Wanglie and "Doe" families, the families in the two illustrative cases hereinafter discussed, conceded that their insistence on continued aggressive treatment was based at least in part on their holding out hope for miracles. See infra notes 30, 51, 52 and accompanying text.
Demands that a physician provide treatment that he believes to be medically contraindicated put the physician in a difficult ethical, legal, and professional position. Employing the courts to force physicians to do so gravely threatens the foundations on which the practice of medicine is founded. To compel a doctor to act contrary to medical judgment undermines the physician's duty to profession and patient alike. It also may violate the physician's personal conscience and sense of morality. As one scholar has described this problem:

Any doctor who . . . is compelled by law to make any decision he would not otherwise have made, is being forced to act against his own mind, which means forced to act against his own life. He is also being forced to violate his most fundamental professional commitment, that of using his own best judgment at all times for the greatest benefit of his patient.

Nevertheless, because of the ascendant statutory recognition and judicial enforcement of patients' claims to autonomy in medical decision-making,
doctors commonly fear the legal ramifications of terminating, or refusing to provide, the treatment demanded. The unfortunate result has been "the fear of litigation that now paralyzes health care providers and administrators," which, in turn, results in the provision of costly but futile care in hospitals across the country. Situations such as this, in which the physician objects to continuing the life-sustaining medical treatment that the patient or her family demands, have surfaced only recently in the bioethical literature. Presently, American courts are beginning to adjudicate these "physi-

7. "In the last 25 years autonomy has superseded beneficence as the first principle of medical ethics. This is the most radical reorientation in the long history of the Hippocratic tradition." Edmund D. Pellegrino, The Relationship of Autonomy and Integrity in Medical Ethics, 24 BULL. PAN AM. HEALTH ORG. 361, 361 (1990).

8. These fears are not without historical, legal substantiation. See John J. Paris et al., Ethical Context for Physician Refusal of Requested Treatment, 11 J. PERINATOLOGY 273, 274 (1991) ("[T]he Child Abuse Prevention and Treatment Act . . . to this day frighten[s] many physicians into believing that the law requires them to do everything possible to save every seriously ill newborn."). Popularized accounts of criminal prosecution of physicians may also instill this fear in physicians when they consider withdrawing nutritional fluids or other means of life support. See, e.g., Judith Cummings, Doctors Accused of Starving Comatose Patient, N.Y. TIMES, Feb. 7, 1983, at A10 (reporting that two doctors faced murder charges for withdrawing a patient's life support); Judith Cummings, 2 California Prosecutors Challenging a Decision on Artificial Life Support, N.Y. TIMES, Nov. 24, 1983, at B18 (reporting that the court barred the district attorney's office from prosecuting the two doctors on murder charges). Contra COUNCIL ON SCIENTIFIC AFFAIRS & COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MEDICAL ASS'N, PERSISTENT VEGETATIVE STATE AND THE DECISION TO WITHDRAW OR WITHHOLD LIFE SUPPORT 1 (1989), reprinted in 263 JAMA 426 (1990). "The suggestion that ending treatment in this circumstance is a form of criminal homicide has been firmly rejected." Id.


An enthusiastic 'Hear! Hear!' to the physicians who refused treatment of Baby L. It is about time neonatologists stopped being manipulated by fear of litigation, government regulations, and other outside pressures and stood up for our own principles. How often have we continued in a futile attempt at life prolongation without hope of survival or of any reasonable quality of life potential only because of nonmedical intrusions into our province? Id. See Nelson & Nelson, supra note 3, at 427 (discussing the analogous scenario in which parents insist on continued aggressive treatment for their children when the physician objects to the treatment as medically or ethically wrong).

10. The case of Baby L, reported in the New England Journal of Medicine in 1990, see infra note 11, was the first of such cases to be reported. See Murphy, supra note 9, at 1148 (noting that the case of Baby L "appears to be the first time a health care team . . . was willing to defend in court their decision to deny a request for life-sustaining therapy that they thought was futile").
Physician-refusal cases with precious little precedent. Although the cases of Baby L and Baby E.T. were rendered moot before courts could reach decisions on their merits, trial courts in Minnesota and Georgia did confront this issue in two well-publicized 1991 cases: In Re Wanglie and In re Doe ("Scottish Rite").

As the Wanglie, Scottish Rite, Baby L, and Baby E.T. cases demonstrate, American courts are just beginning to encounter what have been termed "physician-refusal" cases. Given the depth and breadth of the roots of the physician-refusal dilemma, the issue is not likely to disappear. Faced with

13. Before the probate court in Massachusetts could make a final decision, Baby L was transferred to the care of a pediatric neurologist (from another institution) who was willing to accommodate the family's demand for aggressive treatment. With this transfer, the legal dispute ended. Paris, supra note 11, at 1013. Similarly, in the case of Baby E.T., the infant died while the case was pending in the Chicago Juvenile Court. Paris, supra note 8, at 273.
16. See Paris, supra note 8, at 1012; Paris, supra note 11, at 273.
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the legal elevation of patients' claims to autonomous decision-making, American courts now must determine just how far autonomy goes. Does it encompass an affirmative right of the patient to demand or design medical treatment? Is it limited to the refusal of unwanted or nonconsensual treatment? How does the concept of autonomy relate to the physician's moral agency and judgment in light of the ethical obligations imposed on her by the medical profession and its Hippocratic tradition?

This Comment examines the legal, medical, and ethical issues involved in such a case. Part I presents the Wanglie and Scottish Rite decisions as illustrative both of the problem and the inadequate judicial response thereto. This part then explores the scope and the roots of the physician-refusal dilemma. In Part II, this Comment discusses the opposing positions, the conflict of which animates the bioethical debate over physician-refusal. Part III traces the current ethical standards of the medical profession to their roots in the Hippocratic tradition; it then illustrates the manner in which the articulated policies of the medical profession demonstrate contemporary adherence to these ancient principles. In Part IV, this Comment examines the present state of the decisional law at issue, with special emphasis on (A) the judicial development and protection of the state's interest in preserving the ethical integrity of the medical profession; and (B) the nature and extent of the legal rights of patients to control the medical care provided to them. Part V analyzes the implications of absolutizing patients' right to control medical treatment and illustrates the mischief and imperilment that such a policy would bring to the historic mission of the medical profession. In Part VI, this Comment concludes that when presented with a physician-refusal case, a court should employ judicial restraint by refusing to yield to what Justice Cardozo labeled "spasmodic sentiment... or... unregulated benevolence." The court should draw its inspiration from the "consecrated" and established principles of ethical medical practice rooted in the Hippocratic tradition and clearly articulated in the extant standards of the medical profession.

17. See supra notes 5-7 and accompanying text.
19. CARDozo, supra note 1.
20. Id.
I. THE PHYSICIAN-REFUSAL DILEMMA: WAITING FOR THE MIRACLE

A. The Wanglie Case

The first judicial decision in a physician-refusal case is that of Helga M. Wanglie, an eighty-seven-year-old retired schoolteacher who lay in an irreversible persistent vegetative state ("PVS") in the intensive care unit of a Minneapolis hospital. After transfer from a nursing home to Hennepin County Medical Center for emergency treatment in January 1990, she was placed on a respirator. When attempts to wean her from the respirator failed, she was released to a chronic care hospital; when a subsequent weaning attempt also failed, she had to be resuscitated and was taken to another hospital for intensive care. When she remained unconscious, her family transferred her back to Hennepin County Medical Center in May 1990. There, her physicians concluded that she was in a persistent vegetative state as a result of severe anoxic encephalopathy. She was kept on a respirator and treated with repeated courses of antibiotics, frequent airway suctioning, tube feedings, an air flotation bed, and biochemical monitoring. In June and July of 1990, Mrs. Wanglie's doctors suggested that life-sustaining treatment should be withdrawn because it was not benefiting her. However,
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Mrs. Wanglie's husband, son, and daughter insisted on continued treatment, at least in part because they felt "a miracle could occur."\(^3\)

In October 1990, a new attending physician concluded that Mrs. Wanglie "was at the end of her life and that the respirator was 'non-beneficial,' in that it could not heal her lungs, palliate her suffering, or enable this unconscious and permanently respirator-dependent woman to experience the benefit of the life afforded by respirator support."\(^3\) Shortly thereafter, this doctor told the Wanglie family that he was no longer willing to prescribe the respirator.\(^3\) Mrs. Wanglie's husband, Oliver, refused to consent to terminating treatment.\(^3\) He also refused to have his wife transferred to another facility whose medical staff might agree to continue aggressive treatment.\(^3\) The Medical Center sought the appointment of an independent conservator to make this decision for Mrs. Wanglie.\(^3\) Finding no reason to remove Mr. Wanglie as his wife's conservator, the trial court ruled that he should continue in that role.\(^3\) Helga Wanglie died three days after that decision.\(^3\) It is particularly noteworthy that shortly thereafter, the Wanglies' lawyer stated that "the family never doubted the doctors' prognosis; they just continued to hold out hope for a miracle."\(^3\)

B. The In re Doe ("Scottish Rite") Case:

A second case involved a thirteen-year-old girl, who was a patient at Scottish Rite Hospital for Crippled Children in Atlanta.\(^3\) She suffered from a neurological degenerative disorder, with substantial brain damage and "no judgment based on medical science. It is grounded in beliefs and values about which people inevitably disagree. In such situations, clinicians' judgments cannot be decisive.")\(^3\)

31. Miles, supra note 24, at 513.
32. Id. See Joseph S. Alpert, Persistent Vegetative State: Where Do We Go From Here?, 151 ARCHIVES INTERNAL MED. 855 (1991). "Prolonged survival of patients with PVS has created a very difficult moral and ethical dilemma for the health care profession. Should these patients receive intense, life-prolonging therapy? . . . Can we as a society afford to pay the high costs for maintaining patients with PVS?" Id. Particularly vexing is the fact that PVS, a "new" disease of the late twentieth century, is the result of the application of modern medical technology. Id. "Patients with this devastating neurological entity rarely, if ever, survived for long. Before the advent of modern medical interventions, such as intravenous antibiotics and intravenous and/or enteral nutritional support." Id.
33. Miles, supra note 24, at 513.
34. Id.
38. Id.
reasonable possibility of a 'meaningful recovery,' due to the fact that substantial portions of her brain [were] irreversibly damaged, including the areas which [controlled] her cognitive functions, her ability to eat, swallow and breathe.'\textsuperscript{40} Her doctor testified that she had "no self-awareness, self control, capacity to relate to others, or capacity to communicate or control her existence."\textsuperscript{41}

Accordingly, the physicians and the Bioethics Committee at Scottish Rite were of the opinion that all extraordinary life-sustaining medical procedures should be discontinued.\textsuperscript{42} Because both parents did not consent to discontinuance, Scottish Rite sought declaratory relief and an order directing it to deescalate all artificial and extraordinary medical measures that its physicians were providing to the child.\textsuperscript{43} Dr. Edward M. Goldstein, the pediatric neurologist who treated "Jane Doe" since her admission to Scottish Rite, stated, "It's to the point the patient is being abused through medical technology."\textsuperscript{44} The attending physicians, including the doctor who had treated the child for the preceding six years, believed the girl was in pain and told the Judge it would be in the best interest of the patient to disconnect her respirator.\textsuperscript{45} At trial, Dr. Goldstein testified that he found it "ethically and morally unconscionable" to continue treatment.\textsuperscript{46}

Notwithstanding the physicians' testimony, the trial court ruled in favor of the family and enjoined the hospital from deescalating treatment without the consent of both parents.\textsuperscript{47} It did so despite its awareness that the lingering death of the patient was "having a disastrous effect on the Hospital personnel, and [was] demoralizing to the nursing and house staff."\textsuperscript{48} While the court claimed to "empathize[] with their extraordinary burden," it concluded that "such factors cannot be considered by the Court in this case."\textsuperscript{49} Undermining the court's professed concern for the medical staff is its analytical view of the case, which identified only three competing interests: "the fundamental rights of each of the parents; the responsibilities of the state; and the best interests of the child."\textsuperscript{50} Herein lies the basic conceptual failure
of the trial court's decision: it gave no legal weight to the rights or concerns of the doctors, nurses, or staff at Scottish Rite—an interest which the courts must, and regularly do, address in order to preserve the ethical integrity of the medical profession.

As in Wanglie, "Jane Doe's" family seemed unable to accept the fact that there was no medical treatment that could improve the child's condition. On the day following the trial court's decision, The Washington Post reported that "[t]he father of the girl holds out hope for a miracle, but doctors say she will never recover."51 Newsday reported that the child's father refused to permit physicians to withdraw treatment because "he believes in miracles."52 "I don't believe there's such a thing as no hope," he said.53 The miracle never came; "Jane Doe" died within a few weeks after the trial court's decision.54

C. The Scope and Roots of the Dilemma:

The demands of the Wanglie family and "Jane Doe's" family are not unique. Indeed, "considerable numbers of patients with terminal illnesses or hopeless prognoses maintain a desire for intensive life-supportive care."55 One study demonstrates that the majority of patients and families "unconditionally desire[s] intensive care even toward the end of life."56 The results of this study indicate that elderly patients with previous intensive care unit hospitalizations are "generally extremely willing to undergo intensive care regardless of their age, functional status, perceived quality of life, hypothetical life expectancy, or the nature of their previous intensive care unit experience."57 Likewise, family members generally expressed a "similar eagerness to have their relatives undergo intensive care."58

The Wanglie and Scottish Rite cases illustrate the manner in which these wishes can conflict with the ethical standards and professional obligations of physicians. The roots of this conflict can be traced to three distinct yet coalescent sources. The first, and most obvious, is the emergence in the last four decades of new medical technology, which has given us the power to fore-

53. Id.
56. Marion Danis et al., Patients' and Families' Preferences for Medical Intensive Care, 260 JAMA 797, 802 (1988).
57. Id. at 801.
58. Id.
stall death and thus prolong indefinitely the lives of critically ill patients. Such technology has transformed both the causes of death and the process of dying. Where patients would have died from the natural course of a disease in the past, almost no disease can be said to have a “natural history” today. As one court has noted, “Hopelessly or terminally ill patients who in the past would have met with a swift end, now find that medical science can sustain them, near the threshold of death, but not yet across it.” Another court has concluded, “The procedures used can be accurately described as a means of prolonging the dying process rather than a means of continuing life.” Thus, today’s physicians regularly face the issues of how long a life must be extended, and under what conditions is it humane and ethically acceptable to do so.

Professor Nancy Jecker has identified a second source of the present dilemma. It lies in the substitution of the Hippocratic medical tradition with the “value-free” imperatives of Baconian science, which “infects medical decisionmaking” today. While the Hippocratic physician sought to support and lend assistance to human nature, and thus restore a natural balance to a person’s health, the Baconian tradition of the seventeenth century advanced the idea of controlling, conquering, and mastering nature. The legacy of this tradition, which colonial physicians transported to America, is the “presumption in favor of aggressive treatment” that today characterizes demands for continued life support against extremely poor odds.


60. President’s Comm’n, supra note 59, at 16-18.


62. In re Estate of Longeway, 549 N.E.2d 292, 294 (Ill. 1989). Accord John F. Kennedy Hosp. v. Bludworth, 452 So. 2d 921, 923 (Fla. 1984) (stating that “[i]t is now possible to hold such persons on the threshold of death for an indeterminate period of time by utilizing extraordinary mechanical or other artificial means to sustain their vital bodily functions”).

63. Bludworth, 452 So. 2d at 923.

64. Nancy S. Jecker is an Assistant Professor in the Department of Medical History and Ethics and an Adjunct Assistant Professor in the Department of Philosophy at the University of Washington, Seattle, Washington.


66. Id.

67. Id. at 6.

68. Id. at 6-7.
Dr. Edmund Pellegrino articulates a third source of the present dilemma in his observation that "[i]n the last 25 years autonomy has superseded beneficence as the first principle of medical ethics." Dr. Pellegrino sees this radical transformation in the Hippocratic tradition as "a response to the coalescence of sociopolitical, legal, and ethical forces that make it well-nigh irreversible." In reaction to the paternalism of the medical profession, these forces bring demands for self-determination and require the informed consent of the patient in medical decisions. Adding legal weight to these claims of autonomy, American courts since 1976 have grounded the right to refuse treatment in a constitutional right of privacy and the common law right to informed consent. Recently, however, the conceptual momentum of autonomy has been so potent that there now exists what Dr. Pellegrino calls a "tendency to absolutize autonomy." Separated from its theoretical roots, autonomy is thus misconstrued and elevated as a right, not merely a claim, of the patient. One danger in absolutizing autonomy is that doing so misperceives autonomy as a primary objective in medical decisions rather than as a vehicle for ensuring the patient's participation in them. In terms of its impact on the effectiveness of the physician's clinical judgment, this tendency is especially problematic because it shifts the locus of decisionmaking.

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69. Edmund D. Pellegrino, M.D., is Senior Research Scholar, Kennedy Institute of Ethics, Georgetown University, Washington, D.C.
70. Edmund D. Pellegrino, supra note 7, at 361.
71. Id.
72. Id. at 363.
73. Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2847 (1990). See e.g., Gray v. Romeo, 697 F. Supp. 580, 586 (D.R.I. 1988) (holding that right to privacy encompasses right to refuse life-sustaining medical treatment); Rasmussen ex rel. Mitchell v. Fleming, 741 P.2d 674, 682-83 (Ariz. 1987) (finding that individual's right to refuse medical treatment is supported by the doctrine of informed consent and by the right to privacy under the state constitution); Satz v. Perlmutter, 379 So. 2d 359, 360-61 (Fla. 1980) (affirming patient's right to refuse treatment on grounds of his constitutional right of privacy); In re Estate of Longeway, 549 N.E.2d 292, 297 (Ill. 1989) (recognizing common law right of patient to withhold consent and thus refuse treatment); In re Gardner, 534 A.2d 947, 951 (Me. 1987) (finding personal right to refuse life-sustaining medical treatment to be firmly anchored in the common law doctrine of informed consent); Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 633 (Mass. 1986) (basing right to refuse on common law right and penumbral constitutional right to privacy); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977) (basing decision on common law's recognition of right to be free from nonconsensual invasion of bodily integrity); In re Conroy, 486 A.2d 1209, 1223 (N.J. 1985) (holding that right to decline medical treatment is "embraced within the common law right to self-determination"); In re Quinlan, 355 A.2d 647, 662-64 (N.J.) (holding right to refuse medical treatment to be supported by right to privacy and right to be free from unwanted bodily invasion), cert. denied, 429 U.S. 922 (1976).
74. Pellegrino, supra note 7, at 361.
from the physician to the patient.\textsuperscript{75}

The physician-refusal dilemma is the natural and inevitable product of the convergence of these forces. Medical technology can forestall death. The Baconian tradition calls physicians to control nature and conquer death. Under the claim of autonomy, patients and their families prefer and demand that physicians postpone death. The issue at stake, then, is the physician’s responsibility to oblige these demands. Is he legally, professionally, or ethically bound to obey these commands when the treatment requested is, in the physician’s judgment, medically or ethically wrong?

II. THE BIOETHICAL DEBATE

A. The Patient/Surrogate as the Sole Decision-Maker

Dr. Marcia Angell has articulated the argument on one side of the physician-refusal debate.\textsuperscript{76} She contends that, regardless of the physician’s judgment as to the usefulness of treatment, the proper decision-making authority in the case of an incompetent patient can rest only in the patient’s family.\textsuperscript{77} Dr. Angell concludes that when the court granted conservatorship of Helga Wanglie to her husband (who demanded further aggressive treatment), it correctly implied that the most important consideration was who made the decision, not what the decision was.\textsuperscript{78} Her argument continues that “any other decision by the court would have been inimical to patient autonomy and would have undermined the consensus on the right to die that has been carefully crafted since the Quinlan case.”\textsuperscript{79}

By Dr. Angell’s own admission, this position does not propose that patients have the right to demand any treatment they choose; rather, this right is limited to (1) refusing treatment or (2) choosing among effective ones.\textsuperscript{80} Applying this reasoning in the case of Mrs. Wanglie, the hospital was bound to maintain her on the respirator because it was “effective” in achieving the family’s goal of keeping her alive.\textsuperscript{81} Although the hospital disagreed with the effectiveness of continued life support, it was bound by the patient’s right

\begin{itemize}
\item \textsuperscript{75} Edmund D. Pellegrino & David C. Thomasma, \textit{For the Patient’s Good: The Restoration of Beneficence in Health Care} 11 (1988).
\item \textsuperscript{77} Id. at 512.
\item \textsuperscript{78} Id. at 511.
\item \textsuperscript{79} Id.
\item \textsuperscript{80} Id. at 512.
\item \textsuperscript{81} Id. This, however, would be the exception that swallows the rule. As respirators are, by nature, “effective” in keeping patients alive indefinitely, this approach would, in effect, give the patient an unfettered and limitless right to demand continued aggressive treatment by any means of intervention that could extend life.
\end{itemize}
of self-determination to accept her decision and to provide the treatment demanded. The only conceivable basis for a hospital or physician to interfere with the patient's right of self-determination would occur when the decision violates the best interest of the patient.\(^8\) Otherwise, according to Dr. Angell, "[i]nstitutions lie outside this . . . decision-making and should intervene by going to court only if they believe a decision violates these standards."\(^8\)

Echoing similar sentiments, Professors Robert M. Veatch\(^8\) and Carol M. Spicer\(^8\) assert that because a physician's clinical judgment about the effectiveness or benefit of a given course of treatment incorporates the physician's own beliefs and values, "clinicians' judgments cannot be decisive."\(^8\) Although they concede that autonomy does not give the patient or his surrogate decision-maker a right of access to care, Veatch and Spicer conclude that because the medical profession is "a licensed professional monopoly . . . an obligation to treat even against the conscience of the physician seems the only course, until we can train professionals who will approve of such interventions."\(^8\)

**B. The Duty of Physicians to Provide Non-Beneficial Treatment**

On the other side of the debate is the position that the doctor is not obligated to provide treatment that is not beneficial to the patient. "The moral basis of the physician-patient relationship is the obligation of the physician to attempt to do the patient some good. Actions that do not contribute to this end are not morally required."\(^8\) Recent policy statements by the American Medical Association,\(^9\) the Society for Critical Care Medicine,\(^9\) and the

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82. Id.
83. Id.
84. Robert M. Veatch is Director and Professor of Medical Ethics, Kennedy Institute of Ethics, and Professor, Philosophy Department and Medical Center, Georgetown University, Washington, D.C.
85. Carol Mason Spicer is Managing Editor of *Kennedy Institute of Ethics Journal* and Lecturer, Department of Philosophy, Georgetown University, Washington, D.C.
87. Id. This statement begs the more fundamental question of whether we want physicians that act against, or without considering, their consciences. The prospect of relieving physicians of their responsibility as independent moral agents is a perilous one. See Gordon B. Avery, *Point-Counterpoint: Physicians' Refusal of Requested Treatment* (Views from the Journal's Editorial Board), 10 J. PERINATOLOGY 407, 410 (1990) (noting that physicians must have moral authority over their own actions if they are to be held responsible for those actions).
89. See infra notes 117-122 and accompanying text.
American Thoracic Society\textsuperscript{91} support this position.

Moreover, in the opinion of Dr. Pellegrino, deference to the argument that one must focus on the decision-maker, rather than on the medical decision itself is flawed for two reasons.\textsuperscript{92} First, it ignores the criteria involved in deciding what treatment is to be provided.\textsuperscript{93} Second, it fails to propose a resolution of the conflict between the patient and the physician.\textsuperscript{94}

Admittedly, a decision not to provide a specific type of medical intervention rests on two inherent value judgments. First, usefulness or futility can be judged only in relation to the selection of a goal to be achieved. Because the goals of a type of medical intervention are "open-ended," a decision that a certain procedure does no good, or offers no benefit, implicitly makes a value judgment as to which of those goals are acceptable or worth pursuing.\textsuperscript{95} Second, an assertion that a treatment is not beneficial is a matter of probability, not certainty.\textsuperscript{96}

That doctors' decisions involve value judgments and are not grounded in absolute metaphysical certainty is an insufficient predicate upon which to deny physicians the right to adhere to those decisions. Indeed, if we required physicians' medical judgments to be value-free, we would undermine the fundamental role of the physician, and likely diminish the quality of medical care provided. Because of the physician's Hippocratic duty to employ proactively his professional judgment to benefit and protect the sick,\textsuperscript{97} and thus to weigh the consequences of alternative treatments,\textsuperscript{98} physicians' judgments cannot, and should not, be value-free. In essence, "to admit that physicians should have the power to refrain from doing harm is to concede that they have the moral authority to judge not just the harms, but also the benefits, of medical interventions."\textsuperscript{99}

\begin{enumerate}
\item See infra notes 123-26 and accompanying text.
\item See infra note 127 and accompanying text.
\item Interview with Edmund D. Pellegrino, M.D., Senior Research Scholar, Kennedy Institute of Ethics, Georgetown University, in Washington, D.C. (Nov. 11, 1991) [hereinafter Pellegrino Interview].
\item Id.
\item Id.
\item Id.
\item Id.
\item Id.
\item Id.
\item The Hippocratic Oath contains the vow: "I will apply dietetic measures for the benefit of the sick according to my . . . judgment; I will keep them from harm and injustice." The Hippocratic Oath, in BIOMEDICAL ETHICS 54, 54 (Thomas A. Mappes & Jane S. Zembaty, eds., 2d ed. 1986) (emphasis added).
\item If physicians cannot employ their value judgments to restrict the wide range of alternatives made available to patients, patient autonomy can be undermined. Tomlinson & Brody, supra note 88, at 1279.
\item Id. at 1278.
\end{enumerate}
III. The Principles and Traditions of Medicine

As former Chief Justice Warren Burger once noted, "The law always lags behind the most advanced thinking in every area. It must wait until the theologians and the moral leaders and events have created some common ground, some consensus." While consensus has been established regarding the right of a patient to decline life-sustaining medical treatment, there is as yet no consensus on the right of the patient to compel the provision or continuation of such treatment from a physician who objects to doing so. This absence of consensus is largely because the major judicial opinions in bioethical jurisprudence have addressed only a small part of the larger issue: namely, under what circumstances a patient can refuse to accept treatment that, although life-sustaining, is unable to cure the underlying affliction. These decisions did not face squarely the broader issue of the physician's right to refuse to provide such treatment. In other words, the courts allowed the patient to use ineffectiveness or lack of benefit as a predicate to forego treatment, but they failed to address whether the doctor could use the same argument as a basis for refusing to provide requested interventions.

Although there seems no true consensus as to the responsibilities of the physician in the physician-refusal case, there exists in the medical profession certain ethical standards of behavior—what Justice Cardozo may have.
considered the "consecrated principles"\textsuperscript{105} to which the judiciary must look before formulating official opinions.

\textbf{A. The Tradition of Hippocrates}

Historically, the obligations of the physician can be traced to the Hippocratic tradition. In the treatise entitled \textit{The Art} in the Hippocratic Corpus, medicine is defined as having three roles: (1) "to do away with the sufferings of the sick;" (2) "to lessen the violence of their diseases;" and (3) "to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless."\textsuperscript{106} The Greek physician was "deeply conscious of the religious and ethical imperative to respect the limits of his art. . . . Under the influence of his beliefs about nature, man and his own art, the Greek physician understood that it was his duty to abstain from treating the incurably and mortally ill . . . ."\textsuperscript{107} Clearly, the Hippocratic tradition not only calls physicians to relieve bodily suffering, but it also places on them an affirmative obligation to refuse to provide medical treatment when medicine cannot cure the disease or improve the patient's condition.

This tradition follows two fundamental tenets. First, physicians must act solely for the benefit of their patients. Second, physicians must "guard [their] patients against the evil which they may suffer through themselves."\textsuperscript{108} These central duties are rooted in the thesis of the ancient Pythagoreans that "men by nature are liable to inflict upon themselves injustice and mischief."\textsuperscript{109} Moreover, as everything that is given to the body brings about a "certain disposition of the soul . . . the physician must tend to the soul as well as to the body, and in so doing he must not forget the moral implications of medical actions."\textsuperscript{110} The inherent duty of the physician, then, is not only to make clinical judgments about a proposed course of treatment, but also to evaluate the effect of that treatment upon the patient. If in that evaluation the physician concludes that the proposed treatment will either harm the patient, or will not benefit that patient, he cannot provide it without violating his professional duty.

\textsuperscript{105} \textsc{Cardozo, supra note 1.}


\textsuperscript{107} \textsc{Amundsen, supra note 106, at 25 (quoting P. Lain Enratalgo, Doctor and Patient 48 (F. Partridge trans., 1969)) (emphasis added).}

\textsuperscript{108} \textsc{Richard M. Zaner, Ethics and the Clinical Encounter 208 (1988) (emphasis added).}

\textsuperscript{109} \textsc{Id.}

\textsuperscript{110} \textsc{Id.}
B. The President's Commission

In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research issued its landmark report *Deciding to Forego Life-Sustaining Treatment.* This report begins with the realization that "the drive to sustain life can conflict with another fundamental (and arguably more venerable) objective of medicine—the relief of suffering." Noting the limited role of medicine in the Hippocratic tradition, the report states that "[h]ealth care professionals serve patients best by maintaining a presumption in favor of sustaining life, while recognizing that competent patients are entitled to choose to forego any treatments, including those that sustain life." In its Summary of Conclusions, the President's Commission justifies some constraints on patients' decisions: "Health care professionals or institutions may decline to provide a particular option because that choice would violate their conscience or professional judgment, though in doing so they may not abandon a patient."

The President's Commission takes a firm position in favor of preserving the ethical integrity of the medical profession. Specifically, it declares that "[a]lthough competent patients ... have the legal and ethical authority to forego some or all care, this does not mean that patients may insist on particular treatments. The care available from health care professionals is generally limited to what is consistent with role-related professional standards and conscientiously held personal beliefs."

C. The Medical Associations

The statements of the medical associations are in accord with the President's Commission. While generally accepting the right of the patient to refuse life-sustaining medical treatment, the various membership associations of the medical profession support an ethically active and discerning role for physicians in complying with patient requests. In 1982, the American Medical Association's Judicial Council stated that where the physician's commitment to prolonging life and relieving suffering conflict with one another, "the physician, patient, and/or family of the patient have the discretion to resolve the conflict."

111. President's Comm'n, supra note 59.
112. Id. at 15.
113. Id. at 15 n.2.
114. Id. at 3.
115. Id.
116. Id. at 44 (emphasis added).
The AMA's Council on Ethical and Judicial Affairs reasserted this position in a 1986 statement that reads: "[T]he physician should determine what the possibility is for extending life under humane and comfortable conditions. . . . In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens." More recently, the AMA has defined the physician's obligation to provide requested treatment in terms of only that which is "medically indicated." In doing so, it has provided explicitly for a policy in which patient-transfer is the first option. In a 1990 statement, the Council on Ethical and Judicial Affairs stated this policy as follows:

The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.

In 1991, the AMA's Council on Ethical and Judicial Affairs established guidelines for the appropriate use of do-not-resuscitate orders. In no uncertain terms, the Council declared that a physician "is not ethically obligated to make a specific diagnostic or therapeutic procedure available to a patient, even on specific request, if the use of such a procedure would be futile." Despite the use of the term "futility" in the Council's statement, and in the statements by the Society for Critical Care Medicine and the American Thoracic Society, a thorough discussion of the various interpretations of medical futility is beyond the scope of this Comment and is therefore not attempted herein. As numerous articles have demonstrated, the concept of futility is fraught with numerous interpretations and has triggered an explosion of scholarly debate. See, e.g., Leslie J. Blackhall, Must We Always Use CPR?, 317 NEW ENG. J. MED. 1281, 1281-85 (1987); Daniel Callahan, Medical Futility, Medical Necessity: The Problem Without A Name, HASTINGS CTR. REP., July-Aug. 1991, at 30, 31-35; J. Chris Hackler & F. Charles Hiller, Family Consent to Orders Not to Resuscitate, 264 JAMA 1281, 1282-83 (1990); John D. Lantos et al., The Illusion of Futility in Clinical Practice, 87 AM. J. MED. 81, 82 (1989); Lawrence J. Schneiderman et al., Medical Futility: Its Meaning and Ethical Implications, 112 ANNALS INTERNAL MED. 949, 950-53 (1990); Mildred Solomon, "Futility" as a Criterion in Limiting Treatment, 327 NEW ENG. J. MED. 1239, 1239 (1992); Veatch & Spicer,
The AMA's general position is supported by the Society for Critical Care Medicine, whose December 1990 report stated:

A healthcare professional has no obligation to offer, begin, or maintain a treatment which in his or her best judgment, will be physiologically futile. . . .

Treatments that offer no benefit and serve to prolong the dying process should not be employed. . . .

In light of a hopeless prognosis, the indefinite maintenance of patients reliably diagnosed as being in a persistent vegetative state (PVS) raises serious ethical concerns both for the dignity of the patient and for the diversion of limited medical and nursing resources from alternative applications that could offer medical and nursing benefit to others. . . . The PVS patient should be removed from the ICU unless it is not possible otherwise to meet the patient's nursing care needs.123

The Society for Critical Care Medicine's report flatly declares that the physician is under no obligation to provide therapy that is burdensome or has no chance of achieving benefit.124 While physicians should discuss their objections and suggestions for alternative treatment with the patient, those who object to providing requested treatment on grounds of conscience are not obligated to comply with the request.125 As a solution to this conflict, transfer of the patient to another physician is suggested.126

The following declaration by the American Thoracic Society demonstrates its philosophical agreement with the Society for Critical Care Medicine and the AMA:

[A] life-sustaining intervention may be withheld or withdrawn from a patient without the consent of the patient or surrogate if the intervention is judged to be futile. A life-sustaining intervention is futile if reasoning and experience indicate that the intervention

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125. Consensus Report, supra note 123, at 1436.

126. Id. at 1438.
would be highly unlikely to result in meaningful survival for the patient.
A physician has no ethical obligation to provide a life-sustaining intervention that is judged futile . . . even if the intervention is requested by the patient or surrogate decision maker. Forcing physicians to provide medical interventions that are clearly futile would undermine the ethical integrity of the medical profession.\textsuperscript{127}

To remain faithful to the Hippocratic tradition, physicians cannot administer treatments that would harm their patients,\textsuperscript{128} and they must refuse to provide treatments that cannot help patients "overmastered" by their diseases.\textsuperscript{129} It would be an unprecedented reversal of this ancient tradition for a modern court to order a physician to perform a medical intervention that, in the physician's judgment, is non-beneficial, futile, harmful, or otherwise violative of the physician's ethical obligations. The medical profession has articulated ample standards that provide today's judiciary with strong guidance as to the obligations to which physicians must adhere.\textsuperscript{130} When confronting a physician-refusal case, judges should, as Justice Cardozo exhorts, draw their inspiration from the principles, methods, and standards so firmly established in the profession and so deeply rooted in the philosophical tradition of Hippocrates. To do otherwise would chart an imprudent and hazardous course for the courts, one that would substitute physician judgment with untrained judicial conjecture.

IV. EXISTING JUDICIAL PRECEDENT

A. The State Interest in Preserving the Ethical Integrity of the Medical Profession

The early Jehovah's Witness decisions were among the initial cases in which American courts engaged the issues of medical ethics.\textsuperscript{131} In these cases, controversies arose when physicians sought to administer blood transfusions to patients who were Jehovah's Witnesses.\textsuperscript{132} Although these pa-

\begin{itemize}
  \item \textsuperscript{128} See supra note 97 and infra note 201 and accompanying text.
  \item \textsuperscript{129} See supra note 106 and accompanying text.
  \item \textsuperscript{130} See supra notes 106-27 and accompanying text.
\end{itemize}
patients would likely die without the blood, they and their families refused on religious grounds to authorize the transfusions. The first court to address the issue was the Circuit Court of Appeals for the District of Columbia in In re President and Directors of Georgetown College, Inc. In Georgetown College, a twenty-five-year-old mother had been rushed to Georgetown University Hospital after she lost two-thirds of her blood supply from a ruptured ulcer. The patient and her husband, both Jehovah's Witnesses, refused a transfusion. Fearing civil liability, the hospital's doctors sought court determination of their legal rights and responsibilities before providing or withholding the necessary transfusion. Judge J. Skelly Wright granted permission for the physicians to override the patient's refusal and administer the transfusions.

In the years to come, other courts confronted many such cases involving Jehovah's Witnesses. During this period, the analytical construct of the countervailing state interests developed by Judge Wright in Georgetown College became the foundational framework for bioethical jurisprudence. Judge Wright identified three state interests at issue in these cases: (1) the state interest in preventing suicide; (2) a parens patriae interest in protecting the patient's minor children from abandonment by their parent; and (3) the protection of the medical profession's desire to act affirmatively to save life without fear of civil liability. Using the state interests in Georgetown College as a starting point, the Massachusetts Supreme Judicial Court in Superinten-

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133. Georgetown College, 331 F.2d at 1002; George, 239 F. Supp. at 753; Heston, 279 A.2d at 671; Powell, 267 N.Y.S.2d at 451. The basis of their objection is found in the biblical proscriptions against “eating blood” found in Acts 15:28-29; Deuteronomy 12:23; Genesis 9:3-4; and Leviticus 17:10-14. Paris, supra note 131, at 2 n.7.


135. Georgetown College, 331 F.2d at 1006.

136. Id. at 1002-03.

137. Id. at 1001-02.


140. Georgetown College, 331 F.2d at 1008-09.
dent of Belchertown State School v. Saikewicz\(^\text{141}\) surveyed the decisions involving the right of an individual to refuse medical intervention and distilled from them a modified set of four state interests: "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."\(^\text{142}\)

The seminal case on the refusal of life-sustaining medical treatment is the New Jersey Supreme Court's 1976 landmark opinion in *In re Quinlan*.\(^\text{143}\) In this case, Mr. Quinlan sought to have a respirator disconnected from his twenty-two-year-old daughter, Karen Ann, whom the court described as "profoundly damaged" and "probably irreversibly doomed to no more than a biologically vegetative remnant of life."\(^\text{144}\) Because the medical treatment could not restore Karen to a conscious, functioning existence, the *Quinlan* court reasoned that the state's interest in preserving life weakened "as the degree of bodily invasion increases and the prognosis dims."\(^\text{145}\) Reasoning from a right of privacy standpoint, the court determined that Karen's right to be free from bodily invasion by further treatment was not diminished by her mental incompetency.\(^\text{146}\) To effectuate that right, the court allowed her father to refuse the treatment on her behalf.\(^\text{147}\)

In the wake of *Quinlan*, courts increasingly found themselves confronted with the fact that modern medicine has its curative limits, despite its Baco-nian drive to sustain biological life. Taking a cue from the *Quinlan* court, and in recognition of this medical reality, American courts began to allow patients the right to refuse life-sustaining medical treatment when further treatment could not cure them. For example, in *Superintendent of Belchertown State School v. Saikewicz*,\(^\text{148}\) the court held that it was in the best interest of a sixty-seven-year-old retarded man afflicted with acute myeloblastic monocytic leukemia not to receive chemotherapy treatment when his disease was "invariably fatal," and the chances for remission, which would only have lasted for two to thirteen months in any scenario, were low.\(^\text{149}\) While chemotherapy could delay Joseph Saikewicz's death, it could

\(^{142}\) Id. at 425 (emphasis added).
\(^{144}\) Id. at 662.
\(^{146}\) *Quinlan*, 355 A.2d at 664.
\(^{147}\) Id. at 671-72.
\(^{149}\) Id. at 419-21, 435.
not cure his underlying condition.

In addition to articulating the four state interests mentioned above,\(^{150}\) the Saikewicz decision highlighted the need to maintain the ethical integrity of the medical profession by seeking out and applying the profession’s established standards of medical ethical practice:

Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in Quinlan, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State’s interest in protecting the same.\(^{151}\)

By acknowledging that existing medical mores do not require the continuation of aggressive treatment in all circumstances, the Saikewicz court was able to reconcile the patient’s right to refuse medical treatment with the state’s interest in preserving the medical profession’s ethical integrity. This reconciliation has been indispensable to recognizing patients’ rights while avoiding erosion of the medical profession’s ethical standards.

Nearly a decade later, the Massachusetts Supreme Judicial Court’s decision in Brophy v. New England Sinai Hospital, Inc.\(^{152}\) stands out as a model for respecting both a patient’s right to refuse life-sustaining treatment and the state’s interest in preserving the ethical integrity of the medical profession. In this case, a healthy, robust fireman, Paul Brophy, was stricken by a sudden brain aneurysm.\(^{153}\) Following surgery, he never regained consciousness. He was in a persistent vegetative state, unable to chew or swallow, and maintained by a surgically inserted gastronomy tube (G-Tube), through which he received nutritional fluids and hydration.\(^{154}\) Because of irreversible brain damage that left him unable to respond to his environment, to communicate, to act voluntarily, or to reason, the likelihood of Brophy’s ever regaining cognitive functioning was substantially less than one percent.\(^{155}\) Because Brophy previously had expressed a desire not to be kept alive in such a condition, and because his wife felt that his “life [was] over,”

\(^{150}\) See supra notes 141-42 and accompanying text.

\(^{151}\) Saikewicz, 370 N.E.2d at 426-27.

\(^{152}\) 497 N.E.2d 626 (Mass. 1986).

\(^{153}\) Id. at 628.

\(^{154}\) Id.

\(^{155}\) Id. at 630. This was the testimony of Dr. Ronald Cranford, who had made extensive studies on the condition of the persistent vegetative state. Id.
Brophy’s wife and family requested that his physician remove or clamp the G-Tube.  

The attending physician refused to comply with Mrs. Brophy’s request because of his belief that doing so “would wilfully be causing Brophy’s death.” The nursing and medical staff at the hospital, as well as the hospital’s physician-in-chief, agreed with this position. In setting aside the trial court’s subsequent injunction against removal of the G-Tube, the Supreme Judicial Court of Massachusetts effectuated Brophy’s constitutional right of privacy and his common law right to uninvaded bodily integrity by holding that Mrs. Brophy could exercise her incompetent husband’s judgment and order the measures she deemed necessary. Because the doctors at New England Sinai believed that removal or clamping of the G-Tube was “contrary to their view of their ethical duty toward their patients,” the court did not require them to participate in the termination of treatment. Instead, it ordered the hospital to assist in transferring Brophy to a medical facility at which the physicians would agree to perform the removal. 

In so doing, the court firmly announced the policy that a hospital and its staff “should not be compelled . . . [to act] contrary to [their] moral and ethical principles, when such principles are recognized and accepted within a significant segment of the medical profession and the hospital community.” The court added that neither the doctrine of informed consent nor any other provision of law would require such a result. Taking particular note of the hospital’s willingness to transfer Brophy to another facility at which acquiescence in the Brophy's request would not offend the ethical standards of the physicians, the court concluded that “[a] patient’s right to refuse medical treatment does not warrant such an unnecessary intrusion upon the hospital’s ethical integrity in this case.”

156. Id. at 628, 631-32.  
157. Id. at 632.  
158. Id. The court noted, however, that “[a] significant portion of the medical community disagrees with New England Sinai Hospital and considers it appropriate to withhold hydration and nutrition from individuals like Brophy when that is the wish of the patient and his family.” Id.  
159. Id. at 633, 639-40.  
160. Id. at 639.  
161. Id.  
162. Id.  
163. Id.  
164. Id. Contra Gray v. Romeo, 697 F. Supp. 580, 591 (D.R.I. 1988) (concluding that if patient in persistent vegetative state could not be transferred to another hospital that would respect her wishes to remove her feeding tube, her present hospital would have to accede to her requests despite the ethical objections of its personnel); In re Jobes, 529 A.2d 434, 450 (N.J.
Brophy established important legal precedent by permitting transfer of the patient to the care of a physician whose ethical principles did not conflict with the patient's wishes. This example was followed in the Baby L case, which avoided compromising the ethical and professional standards of the physicians while satisfying the demands of the patient and family. In that case, "[t]he court acknowledged that no physician or institution can be required to provide an intervention contrary to conscience." The state's interest in preserving the ethical integrity of the medical profession has been universally acknowledged as a firmly established principle of American bioethical jurisprudence. Over the years, courts consistently have endeavored to avoid infringing on the consciences and ethical principles of physicians. For example, in a 1991 Jehovah's Witness case, in which a thirty-eight-year-old mother refused a blood transfusion for a hemorrhaging stomach ulcer, the court upheld her right to refuse the transfusion, but strongly underscored its commitment to the ethical integrity of the medical profession as follows:

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166. Paris, supra note 11, at 1013.
167. *Id.* at 1014.
The State has an interest in maintaining the ethical integrity of the medical profession by giving hospitals and their staffs a full opportunity to assist those in their care. So long as we decline to force the hospital to participate ... there is no violation of the integrity of the medical profession. We have recognized that medical ethics do not require that a patient's life be preserved in all circumstances. Last, the ethical integrity of the medical profession is not threatened by allowing competent patients to decide for themselves whether a particular medical treatment is in their best interests.169

In a 1992 case, Guardianship of Doe,170 the Massachusetts Supreme Judicial Court affirmed judgment in favor of terminating the feeding and hydration of an incompetent patient in a persistent vegetative state. Again, this court firmly resisted judicial intrusion upon the ethical integrity of the physicians and medical staff involved. Even though the trial judge found no dispute with the position that termination did not undermine the integrity of the medical profession in this case, the Supreme Judicial Court held that none of the medical personnel or staff members who disagreed with the withdrawal of the feeding and hydration tube would be required to care for the patient.171

The most important principle to be distilled from these cases is the rule articulated in Brophy that preserves the ethical integrity of the medical profession while providing due respect for patient autonomy. That simple but prudent and necessary formulation is the following: When physicians and medical staff hold moral and ethical principles that are recognized and accepted within a significant segment of the medical profession and the hospital community, they should not be compelled to act contrary to those principles.172

As testimony to the prudence of this position is the “Unnecessary Treatment Provision” recently enacted into law in Virginia in the Health Care Decisions Act of 1992, which embraces the Brophy approach:

Section 54.1-2990. Medically unnecessary treatment not required. . . . 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. However, in such a case, if the physician’s determination is contrary to the terms of an advance directive of a qualified patient or the treatment decisions of a person designated to make the decision under this article, the physician shall make a reasonable effort

169. Munoz, 564 N.E.2d at 1023.
171. Id. at 1270 & n.17.
to transfer the patient to another physician.\textsuperscript{173}

As one commentator has noted, this legislation represents an attempt to "accommodate the values of both patients and physicians, and allow room for differences while not compelling physicians to act in violation of their own integrity and professional codes of ethics or practice standards."\textsuperscript{174} Furthermore, it acknowledges "that physicians, like patients and surrogate decision makers, are moral agents . . . .\textsuperscript{175}

B. The Legal Circumscription of Patient Autonomy: A Negative Right to Refuse Treatment

Whether they are interpreted individually or collectively, none of the major health care cases from \textit{Quinlan} to \textit{Brophy} to the one Supreme Court decision on point, \textit{Cruzan v. Director, Missouri Department of Health},\textsuperscript{176} supports the right of a patient to demand a specific intervention from a physician. The \textit{Quinlan} court held that an irreversibly unconscious patient possesses a right to decline life-sustaining treatment.\textsuperscript{177} This ruling was founded not upon a positive right, but upon two negative rights: the patient's right to privacy\textsuperscript{178} and her right to be free from unwanted bodily invasion.\textsuperscript{179} This foundation was echoed by the \textit{Brophy} court, which noted that "[t]he right of a patient to refuse medical treatment arises both from the common law and the unwritten and penumbral constitutional right to privacy."\textsuperscript{180} In \textit{Saikewicz}, the court spoke of the common law's recognition that "a person has a strong interest in being free from nonconsensual invasion of his bodily integrity."\textsuperscript{181} The United States Supreme Court itself recognized that "[a]fter \textit{Quinlan} . . . most courts have based a right to refuse treatment either solely on the common law right to informed consent or on both the common law right and a constitutional privacy right."\textsuperscript{182} Thus,

\begin{footnotesize}
\begin{enumerate}
\item[174.] Id. at 4.
\item[175.] Id.
\item[176.] 110 S. Ct. 2841 (1990).
\item[178.] Id. at 662-64.
\item[179.] Id. at 664.
\item[182.] \textit{Cruzan} v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841, 2847 (1990).
\end{enumerate}
\end{footnotesize}
neither *Quinlan* nor its progeny based the right to refuse treatment upon, nor do they go so far as to support, a positive right of a patient to direct or demand a specific medical intervention. Nor is such a positive right supported by the opinion of the Supreme Court in *Cruzan*. The *Cruzan* Court did accept the existence of a constitutionally protected privacy right of competent patients to refuse unwanted medical treatment; however, it did not recognize an established corollary of this right that would entitle a patient to access to a specific medical intervention from a physician.

No court or medical association has ever recognized such a right. As Margot L. White of the University of Virginia notes:

> [T]he patient's option to refuse treatment has never been presumed to extend to a right to have any treatment whatsoever. Neither the professional codes of ethics of the medical profession nor the courts have ever said that patients can demand antibiotics for treatment of a virus, or that a physician is legally compelled to perform a surgical procedure that the patient wants but for which there is no medical indication. . . . The patient's or surrogate's legal rights to consent to or to refuse treatment have always been presumed to operate within the range of what is appropriate to the patient's condition.

This distinction is great and must be underscored. Taking the same position, Professors Veatch and Spicer write:

> Autonomy gives the patient a right to refuse treatment—that is, to leave the medical relationship. . . . Autonomy is a liberty right. The patient has a right to cancel the patient/physician relationship and at least metaphorically walk away. . . . But that principle cannot imply that autonomy can give the patient or surrogate a right of access to care.

Most recently, Professor Yale Kamisar, one of the nation's preeminent constitutional scholars, has added his voice to the debate. Pointing out Justice Oliver Wendell Holmes' observation that all rights eventually tend to declare themselves absolute, Professor Kamisar agrees with Holmes' caveat that all rights are limited by those principles which surround the right.

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183. *Id.*
184. *Id.* at 2851.
186. *Veatch* & *Spicer*, * supra* note 29, at 23.
187. Professor Kamisar is the Clarence Darrow Distinguished University Professor of Law at the University of Michigan.
188. *Yale Kamisar, A Law to Stay the Cold Hand of “Dr. Death,”* *WASH. LEGAL TIMES*, Mar. 8, 1993, at 32.
189. *Id.* at 33.
On this basis, Kamisar concludes that "the right to die should be confined to the right to declines or terminate life-sustaining treatment."

Under the present state of the law, the concept of patient autonomy does not embrace an affirmative right of access to medical care. Rather, autonomy is limited by the reach of the legal roots that established it: the constitutional right to privacy; the common law doctrine of informed consent; and the common law right to be free from unwanted or nonconsensual bodily invasion. Each is a negative right, from which no entitlement to medical care properly can be inferred. There is no precedent in any of these cases to support a court order directing physicians to provide a given intervention against their medical and ethical judgments. In fact, the holding in *Brophy* was unequivocally conditioned on the avoidance of such a result.

V. ABSOLUTE AUTONOMY: THE DEATH KNELL FOR THE ETHICAL INTEGRITY OF THE MEDICAL PROFESSION

Extending autonomy to embrace the right to receive requested treatment would deprive the physician of a capacity to incorporate ethics and values into the practice of medicine. In everyday practice, the ability to make value

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190. *Id.*

191. *See* cases cited *supra* note 73.

judgments is essential to the physician's fulfilling his duty to protect and benefit his patients. For example, a surgeon cannot be compelled to perform a risky operation on a patient he knows is a poor candidate for surgery. Were the physician denied the use of his professional judgment and legally obliged to accede to patient requests, he would be unable to refuse an angina patient's demand for bypass surgery even though the doctor might believe the patient's health would make the patient more likely to die on the operating table than to have the angina relieved. Inherently, such refusal would involve a value judgment, weighing the value of relieving the angina pain against the risk of death on the operating table. The ability of the physician to make this judgment is absolutely essential to the duty of physicians not to harm to their patients. To deny them this capacity would result in untrained patients speculating as to the most advisable course of treatment and then designing the treatment. Such self-treatment would effectively undermine, rather than further, autonomy by exposing patients to greater risk.

As Tomlinson and Brody write, "Prudent people do not wish to entrust their health to physicians who are powerless to resist irrational or unreasonable demands." "It is for the sake of patient autonomy, then, that physicians must be able to restrict the alternatives made available to patients and must be able to employ value judgments in doing so." Therefore, these authors conclude: "[P]hysicians must be able to employ reasonable, socially validated value judgments to restrict the alternatives offered to patients, for the sake of both physician integrity and patient autonomy."

The proposition is unacceptable that in determining the best treatment for a patient—competent as well as incompetent—we should focus not on the decision itself, but on who is to make the decision. This is not only "nonsense," but offensive to the physician's obligation to provide care that is in the best interest of the patient. Such an emphasis would erode the patient-physician relationship and, because of lack of skilled medical guidance, would diminish rather than enhance the patient's ability to obtain the best treatment possible. An exaggerated emphasis on patient autonomy must not prevent the physician from carrying out his role. As the
bioethicist, Rev. John J. Paris, S.J.,\textsuperscript{201} writes:

It is the physician, not the patient, who must sort out the possibilities, weigh the pros and cons, and recommend a course of action. That responsibility must not be shifted onto the shoulders of the patient in a misguided attempt to respect autonomy. The patient or family can of course accept or reject the physician's recommendation. They are not free, however, to design their own treatment; nor is the physician bound to provide it.\textsuperscript{202}

If physicians were legally obliged in the name of autonomy to comply with patients' treatment designs, the slippery slope toward physician-assisted suicide would steepen to a nearly vertical drop. In light of the actions of Dr. Jack Kevorkian\textsuperscript{203} and of the popularity of the State of Washington's Proposition 119,\textsuperscript{204} it is conceivable that patient requests for physician participation in patient suicide would be numerous. Were physicians unequipped to resist such overtures and permitted only value-neutral medical judgments, the death knell of the Hippocratic tradition would sound. Ostensibly, compliance with such requests would contradict the vow in the Hippocratic Oath that "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."\textsuperscript{205} Such demands—even on legal grounds—have already been realized by the California Court of Appeal in Donaldson v. Van DeKamp.\textsuperscript{206} In this case, a patient suffering from an inoperable brain tumor sought a physician's assistance in bringing about his

\textsuperscript{201} Fr. Paris is the Michael P. Walsh Professor of Bioethics at Boston College, Chestnut Hill, Massachusetts. He served as a member of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research and participated in the Commission's authorship of its landmark report Deciding to Forego Life-Sustaining Medical Treatment, supra note 59. He has written extensively in the area of physician-refusal. See Paris, supra note 8; Paris, supra note 11.

\textsuperscript{202} Paris, supra note 11, at 1013.

\textsuperscript{203} For an assessment of the ethical implications of Dr. Kevorkian's actions in assisting his patients end their lives with his "suicide machines," see Daniel Callahan, Trying to make Peace with Human Mortality: Here's One Vote Against Legalized Euthanasia, BOSTON GLOBE, Dec. 22 1991, at A22. For analysis of the State of Michigan's legal reaction, see Kamisar, supra note 188, at 32-33 (discussing Michigan legislation, signed into law on December 15, 1992 and effective on March 30, 1993, making assisted suicide a felony punishable by up to four years in prison and predicting its constitutionality).


\textsuperscript{205} The Hippocratic Oath, in BIOMEDICAL ETHICS 54 (Thomas A. Mappes & Jane S. Zembaty, eds., 2d ed. 1986).

\textsuperscript{206} 4 Cal. Rptr. 2d 59 (Cal. Ct. App. 1992).
death so that he could be cryogenically suspended until a cure was discovered for his tumor.\textsuperscript{207} The patient claimed to have a right to such assistance from the physician.\textsuperscript{208} Prudently, the court held that the patient had no such right.\textsuperscript{209} Nonetheless, some stridently maintain that “current law gives patients [a right to die with physician assistance] in some cases, and that this right is not categorically different from the right to die by refusing or discontinuing treatment.”\textsuperscript{210} However, proponents of this position also caution that “the right to die with assistance would provide only a right against state interference, not a right to force an unwilling physician to assist in a patient’s suicide.”\textsuperscript{211}

VI. CONCLUSION

Simply stated, the preference for a certain medical treatment does not imply a right to receive that treatment. While a patient’s right to refuse medical treatment is firmly established as a matter of both constitutional and common law, there is no corollary of that precedent that confers an affirmative right of access to medical care. The President’s Commission made this point unequivocally, and it bears repeating here:

> Although competent patients . . . have the legal and ethical authority to forego some or all care, this does not mean that patients may insist on particular treatments. The care available from health care professionals is generally limited to what is consistent with role-related professional standards and conscientiously held beliefs.”\textsuperscript{212}

Since, as a general rule, judges do not possess medical training and have not undertaken the obligations of the Hippocratic tradition, they should not assume the physician’s responsibility for determining which course of treatment is correct for a patient. When presented with a physician-refusal case, courts should refrain from ordering physicians to begin or continue a course of treatment or perform a procedure that in the physician’s professional

\textsuperscript{207} Id. at 60-61.
\textsuperscript{208} Id. at 61.
\textsuperscript{209} Id. at 62-63.
\textsuperscript{212} President’s Comm’n, supra note 59, at 44.
judgment is not medically indicated, effective, or beneficial. Instead, as an initial recourse, courts should employ the transfer approach established in Brophy and adopted in the Virginia Health Care Decisions Act. If it is found that the moral and ethical principles upon which the attending physicians base their objections are recognized and accepted within the medical profession, the court should not order those physicians to provide the medical treatment requested.

In order to maintain the ethical integrity of the medical profession, and to preserve for physicians the moral capacity necessary to fulfill their Hippocratic obligations, priority must be given to the possibility of transferring the patient to "alternative caregivers who might be likeminded with the [patient and or his surrogate]." This was the path chosen by the Brophy court and followed in the Baby L case. Moreover, this approach is supported by the American Medical Association, and it has been endorsed legislatively in the Virginia Health Care Decisions Act. In the rare circumstance that no physician will agree to provide the type of medical treatment

215. See Brophy, 497 N.E.2d at 639. Indeed, the acceptability of the refusal decision to other medical professionals is a wise and proper requirement for enforcement of the decision. One ethicist has proposed that the following minimal safeguards should be observed prior to any decision to refuse life-saving medical treatment: "[A]greement among health care workers, the concurrence of an ethics committee, openness to a second opinion, and a comprehensive note in the patient's chart detailing all the factors considered in the decision." Paris, supra note 11, at 1014.
216. Avery, supra note 87, at 410. See also Alan R. Fleischman, Point-Counterpoint: Physicians, Refusal of Requested Treatment 10 J. PERINATOLOGY 407, 408 (1990) ("If we cannot provide the requested care based on our strongly held personal beliefs, it is our obligation to seek to find another physician who would provide the requested treatment to prolong the child's life ....").
217. See Brophy, 497 N.E.2d at 639-40.
218. See Paris, supra note 11, at 1013-14.
219. "[T]he physician should determine what the possibility is for extending life under humane and comfortable conditions. . . . In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens." COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MEDICAL ASS'N, WITHHOLDING OR WITHDRAWING LIFE PROLONGING MEDICAL TREATMENT 1 (Mar. 15, 1986).

The AMA has also stated:

The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.

sought—that is, there is a consensus that the treatment is either futile or non-beneficial (and therefore contrary to the physician's obligation to benefit the patient)—the patient's request would fall outside the boundaries of societal judgment about what medical goals are reasonable.\textsuperscript{221} If a physician cannot be found who will accept the patient and provide the desired treatment, "then this will [confirm] that the [original] physician's assessment is widely shared and not idiosyncratic."\textsuperscript{222} Under the Virginia Health Care Decisions Act\textsuperscript{223} and under the standard set by the President's Commission,\textsuperscript{224} no physician is obligated to provide such medical care.\textsuperscript{225} Were a court to order a physician or other health care provider to comply with such a wish, that judge would be Cardozo's knight-errant, crusading into the practice of medicine to propose and order the provision of his own vision of proper medical care while overriding a consensus of objection from the attending physicians and disregarding nearly 2,500 years of the Hippocratic tradition to the contrary.

Schooled by that tradition and bound to uphold it, physicians have an "active obligation to [their] patients to ensure that the suffering incurred by the interventions [they] recommend is outweighed by the benefit of an expected recovery from the underlying illness."\textsuperscript{226} To fulfill this obligation, courts must allow physicians the moral and ethical capacity to refuse to provide medical care that would compromise either clinical judgment or medical ethics. As one noted neonatologist writes: "[I]f physicians are to be held responsible for their acts, they must have some freedom of choice, some authority over their own actions. For this reason, parents [of young patients] cannot compel improper medical acts from physicians. Medical interventions must be defensible as good medicine."\textsuperscript{227}

In the end, courts must realize and accept the limits of medical science because, "[a]s the Hippocratic tradition teaches, medicine is properly bound by the potentialities of the object and the powers of the art."\textsuperscript{228} Quite simply, medicine cannot perform miracles. Courts should not force physicians to attempt them.

\textit{James J. Murphy}

\begin{itemize}
\item \textsuperscript{221} See Tomlinson & Brody, \textit{supra} note 88, at 1279.
\item \textsuperscript{222} White, \textit{supra} note 173, at 4.
\item \textsuperscript{223} See VA. CODE ANN. § 54.1-2990 (Michie Supp. 1992).
\item \textsuperscript{224} President's Comm'n, \textit{supra} note 59, at 44.
\item \textsuperscript{225} Paris, \textit{supra} note 11, at 1013.
\item \textsuperscript{226} \textit{Id}.
\item \textsuperscript{227} Avery, \textit{supra} note 87, at 410.
\item \textsuperscript{228} Jecker, \textit{supra} note 65, at 8.
\end{itemize}