Futility and the Principle of Medical Futility: Safeguarding Autonomy and the Prohibition Against Cruel and Unusual Punishment

George P. Smith II
The Catholic University of America, Columbus School of Law

Follow this and additional works at: https://scholarship.law.edu/scholar

Part of the Bioethics and Medical Ethics Commons, and the Medical Jurisprudence Commons

Recommended Citation

This Article is brought to you for free and open access by the Faculty Scholarship at CUA Law Scholarship Repository. It has been accepted for inclusion in Scholarly Articles and Other Contributions by an authorized administrator of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.
ARTICLES

FUTILITY AND THE PRINCIPLE OF MEDICAL FUTILITY: SAFEGUARDING AUTONOMY AND THE PROHIBITION AGAINST CRUEL AND UNUSUAL PUNISHMENT

George P. Smith, II*†

I. INTRODUCTION

When medical treatment is deemed to be "futile," it frees the physician from the moral, medical, and legal duty to provide such treatment.¹

* B.S., J.D., Indiana University; LL.M. Columbia University. Professor of Law, The Catholic University of America, Washington, D.C.

The research for this article began in December 1993 when I was a Visiting Scholar at The Center for The Study of Society and Medicine of The College of Physicians and Surgeons of Columbia University in New York City. I acknowledge the kindness and general support provided by Dr. David J. Rothman, Director of the Center, during my visit.

In July 1994, when I was a Visiting Professor at The University of Otago Faculty of Law and Visiting Fellow at the University Bioethics Center, Dunedin, New Zealand, I completed the research and initial draft of this Article. I thank Dean J. Stuart Anderson and Professor Peter D.G. Skegg of the Law Faculty, and Professor Alastair V. Campbell, Director of the Bioethics Research Center, for their gracious hospitality during my stay. Finally, I acknowledge with pleasure, the research and editorial assistance I received from John E. Durkin, J.D., The Catholic University of America, Class of 1994.

With great professional admiration and respect, and in personal friendship, this article is dedicated to two giants of the law, Dieter Giesen and Harry D. Krause. I take this opportunity also to acknowledge my profound debt of gratitude to Dieter for his monumental treatise, *International Medical Malpractice Law*, a work that has not only enlightened me and countless others professionally, but also has shaped my whole philosophy of law and medicine.

† An overlapping, but much shorter essay, authored by Professor Smith, entitled, "Restructuring the Principle of Medical Futility," appears in 11 J. PALLIATIVE CARE 9 (1995).

¹ Lawrence J. Schneiderman & Nancy Jecker, *Futility in Practice*, 153 ARCH. INTERN. MED. 437, 440 (1993) [hereinafter *Futility in Practice*] (stating that "overwhelming agreement has been reached in the medical community that physicians are not required to provide futile treatment").

A physician has no duty to continue treatment, once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the
While most reasonable persons agree with this proposition, much disagreement exists as to the definition of futile treatment and who decides whether a given treatment is futile. This Article begins with a discussion of various definitions of futility and distinguishes futility from other grounds for denying medical treatment. Next, this Article examines the issue of who decides whether a given treatment is futile and what operational guidelines may be employed to reach this conclusion. A three-tiered decisional structure is then proposed for testing whether a given treatment falls within the scope of these guidelines. Under the first tier, the treating physician would have the primary responsibility of determining whether a particular treatment should be withheld on the grounds of futility. While the physician would be under a duty not to prescribe treatment deemed futile, he would be obliged to inform the patient and his family of this decision—including the reasons for the decision. This would allow, under the second tier, for the patient or his family to appeal the decision to the hospital ethics committee. The third tier recognizes a right of limited appeal to the courts. Thereafter, this Article attempts to counter arguments contending that the doctrine of futility infringes on patient autonomy. Finally, this Article concludes by submitting that a uniform policy compelling the administration of futile medical treatment is equivalent to cruel and unusual punishment and should not, therefore, be recognized as an affirmative duty for physicians to pursue in all cases.


"[I]f a treatment is clearly futile . . . there is no obligation to provide the treatment." Nancy S. Jecker & Lawrence J. Schneiderman, Medical Futility: The Duty Not to Treat, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 151, 156 (hereinafter Medical Futility) (quoting THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 19 (1987)). "CPR may be withheld, even if previously requested by the patient, ‘when efforts to resuscitate a patient are judged by the treating physician to be futile.’" Id. (quoting American Medical Association, Council on Ethical and Judicial Affairs, Guidelines on the Appropriate Use of Do-Not-Resuscitate Orders, 265 JAMA 1868, 1870 (1991)). "Forcing physicians to provide medical interventions that are clearly futile would undermine the ethical integrity of the medical profession." Id. (quoting American Thoracic Society, Bioethics Task Force, Withholding and Withdrawing Life-Sustaining Therapy, 115 ANNALS INTERNAL MED. 478, 478-85 (1991)). "Treatments that offer no benefit and serve to prolong the dying period should not be employed." Id. (quoting Task Force on Ethics of the Society of Critical Care Medicine, Consensus Report on the Ethics of Foregoing Life-Sustaining Treatments in the Critically Ill, 18 CRITICAL CARE MED. 1435, 1435-39 (1990)).
II. THE NEED TO DEFINE FUTILITY

Prior to broaching an analytical discussion of the definition of futility, an initial question must be posited: What value is to be derived from reaching a consensus on the meaning of this word and its application as a medical principle? Even though discussions of futility raise difficult issues and require acknowledgement of the limits of health care and the inevitability of death, an examination of the facts dictate that this highly complex and sensitive issue be explored.

In the United States, approximately 1.6 million persons die in hospitals or long term health care facilities each year. Approximately seventy percent of these persons die as a result of someone’s decision to withdraw or withhold life-sustaining treatment. Physicians often make these decisions without clear guidelines and without informing the patient or family. As a result, extraneous factors such as race, wealth, gender, and age of the patient, as well as judgments on the quality of the patient’s life and concerns with cost containment, may cloud a physician’s determination to withhold or withdraw treatment. A clear working definition of futility is needed to ensure that physicians not only inform patients and their families about the decision to withdraw or withhold treatment, but also to provide the patients, their families, and the courts with objective criteria against which they may judge the medical decision.

4. Id.
5. Id. Dr. David Bihari, Director of the Intensive Care Unit of Guy’s and St. Thomas’ Hospital in London, was rebuked by his hospital for announcing his reliance on a computer program, termed RIP, to assist him in his clinical evaluation of whether to terminate a patient’s life-sustaining treatment. Nigel Hawkes, ‘Doomsday’ Computer Disowned by Hospital, The Times (London), Aug. 25, 1994, at 3. If the program concludes that a patient will die within 90 days, a small black coffin with a white cross appears on the screen. Id. Dr. Bihari confirmed that the program’s predictions were wrong five percent of the time. Id.
6. Futility in Practice, supra note 1, at 438-40.
7. A precise definition of futility would provide the courts with a standard to be employed in civil and criminal proceedings. See generally Symposium on Medical Futility, 25 Seton Hall L. Rev. 873 (1995) (proposing that a “serviceable construction for medical futility be grounded in the definition of ‘standard of care’”).
8. Futility may be used both defensively and offensively. Edward R. Grant, Medical Futility: Legal and Ethical Aspects, 20 L. Med. & Health Care 330, 333 (1992). Futility is defensive when a physician or hospital raises it as a defense to civil charges of malpractice or criminal charges of homicide. Id. Futility is offensive when physicians and hospitals employ it to deny a request for continued treatment by the patient or family. Id.
The issue of futility sparks the most discussion when the patient is in a persistent vegetative state ("PVS") and when the physician commands a do not resuscitate ("DNR") order. A patient diagnosed as being in a PVS has no chance of regaining consciousness or returning to a sapient existence. Similarly, when a patient suffers from severe and irreversible dementia—meaning that he is unable to initiate any purposeful activity and only accepts nourishment and bodily care in a helpless, passive state—his condition could be classified as futile. The definitional scope

9. Robert D. Truog, M.D. et al., Sounding Board: The Problems with Futility, 326 New Eng. J. Med. 1560, 1560 (1992). In a study of 863 internists affiliated with the University of Pennsylvania (of whom 481 responded), it was found that the physicians' choice of which life support mechanisms to withdraw was determinative of the rapidity, painlessness, and dignity of a patient's death. Nicholas A. Christakis & David A. Asch, Biases In How Physicians Choose to Withdraw Life Support, 342 The Lancet 642, 642 (1993). A critically ill patient may be dependent on numerous life-sustaining means at any one time, ranging from blood transfusions, kidney dialysis, intravenous drugs, artificial feeding, antibiotics, and mechanical ventilation. Id. This study found that the type of support most doctors were willing to withdraw was blood transfusion or dialysis, followed by intravenous blood pressure drugs, intravenous feeding, antibiotics, mechanical ventilation, tube feeding, and least preferred of all, intravenous fluids. Id. Internists would prefer to withdraw treatment supporting organs that failed for natural reasons (underlying disease) or recently instituted therapy, as opposed to treatment a patient has been receiving for long periods of time. Id. See generally George P. Smith, II, Final Choices: Autonomy in Health Care Decisions Ch. IV (1989) (discussing "the right to a good death").

10. See Marcia Angell, The Case of Helga Wanglie: A New Kind of "Right to Die" Case, 325 New Eng. J. Med. 511, 512 (1991) (since Helga Wanglie was in a PVS, her doctors concluded that keeping her on a respirator was "non-beneficial" because it would not restore her to consciousness"). A PVS differs from a coma in that persons in a coma have the potential to regain consciousness. Larry Maldonado, Bioethics and the Law: The Case of Helga Wanglie: A Clash at the Bedside: Medically Futile Treatment v. Patient Autonomy, 14 Whittier L. Rev. 129, 130 (1993).

The Multi-Society Task Force on PVS defines persistent vegetative state as a condition that arises one month after an acute traumatic or nontraumatic brain injury, or as a condition lasting at least one month in patients with either degenerative or metabolic disorders or developmental malformations. The Multi-Society Task Force on PVS, Medical Aspects of the Persistent Vegetative State (pt. 1), 330 New Eng. J. Med. 1499, 1499 (1994) [hereinafter Medical Aspects of PVS (pt. 1)]. A patient moves to a state of permanent vegetation when, with a high degree of clinical certainty, a diagnosis is made that there is an exceedingly small chance consciousness will be regained. Id. Therapy aimed at reversing the PVS has not been successful. The Multi-Society Task Force on PVS, Medical Aspects of the Persistent Vegetative State (pt. 2), 330 New Eng. J. Med. 1572, 1572 (1994) [hereinafter Medical Aspects of PVS (pt. 2)].

Futility and the Principle of Medical Futility

of futility could also include treatment for those in a deep, irreversible coma for an extended period of time (i.e., six months to a year), as well as those who are permanently vegetative. The central point to any determination that medical treatment would be futile should be an understanding, if not a realization, that terminal illness should not be the sole and necessary criterion for withholding treatment. For example, many comatose or barely conscious patients are not terminally ill yet are in such an irrevocable state of mental and physical deterioration—with no realistic hope of a qualitative restoration of health—that they should be properly classified as outside the bounds of treatment.

A DNR is ordered when a physician concludes that it is not worth the effort to effect cardiopulmonary resuscitation ("CPR") in the event of cardiac or respiratory arrest. While the law does not prevent a physician from ordering a DNR, problems arise due to the absence of clear guidelines for making the DNR decision and the fact that patients and their families are often unaware whether and why such a decision is

---

12. See Daniel Callahan, Setting Limits: Medical Goals in an Aging Society 181 (1988). When adults or children suffer from posttraumatic PVS for 12 months, recovery of consciousness is unlikely. Medical Aspects of PVS (pt. 2), supra note 10, at 1572. In cases of nontraumatic PVS occurring for three months, it is exceedingly rare for adults and children to recover consciousness. Id. The overall life expectancy for either posttraumatic or nontraumatic PVS range from two to five years. Id. at 1575. Moreover, when artificial nutrition and hydration are withdrawn from PVS patients, they usually die within 10 to 14 days. Id. at 1578.

13. Nancy K. Rhoden, Litigating Life and Death, 102 Harv. L. Rev. 375, 442-43 (1988). Professor Rhoden defines reasonableness as "turning on the question of whether the patient retains any capacity to experience and enjoy life," and would allow a physician a right to challenge a patient or surrogate decisionmaker on the basis of reasonableness. Id. at 432.

14. See Truog, supra note 9, at 1560. The following description of the procedure for cardiopulmonary resuscitation is illustrative of the time and resources it requires:

If a patient goes into cardiac or respiratory arrest, the nurse in attendance causes a notice to be broadcast on the hospital's intercommunications system giving a code word and the room number. The members of the code team converge on the room immediately from other parts of the hospital . . . . [I]f the code is broadcast at night, all doctors then in the hospital for whatever reason are expected to respond to the code. [When a DNR order or] a 'no-code' order [is] entered in a patient's medical record [, it] instructs the nursing staff, as part of the attending physician's ongoing [patient care] instructions . . . not to summon the code team in the event [the patient suffers] cardiac or respiratory arrest.


15. In re Dinnerstein, 380 N.E.2d at 139. The court held that it was permissible for a physician to write a DNR order without the prior consent of the courts. Id. See generally Paul Goulden, Non-treatment Orders, Including Do Not Resuscitate (DNR), in Principles of Health Care Ethics Ch. 62 (Raanon Guillon ed., 1994).
made.  

III. Defining Futility

This section examines many of the definitions presented in the literature and concludes that the definition offered by Lawrence Schneiderman and Nancy Jecker offers the best working definition of medical futility. There are four general clinical uses of the futility doctrine employed in the medical profession: (1) a cure is physiologically impossible; (2) the treatment is nonbeneficial; (3) the treatment is unlikely to produce a desired benefit; and (4) that the treatment is plausible, but not yet validated. These uses of futility serve as a backdrop to the various definitions of futility proposed in the literature.

A. Futility: Physiologically Impossible

Under the “physiologically impossible” definition of futility, a treatment is deemed futile only “when the patient is moribund and will die

16. See Marni J. Bonnin et al., Distinct Criteria for Termination of Resuscitation in the Out-of-Hospital Setting, 270 JAMA 1457, 1457 (1993) (identifying “distinct criteria for appropriate on-scene termination of resuscitation efforts for out-of-hospital cardiac arrest when on-scene interventions fail to restore spontaneous circulation”). The study concluded that resuscitation efforts performed on individuals suffering from cardiac arrest meeting distinct criteria should not be performed outside a patient care facility because such treatment would be futile. Id. The study stated that “[e]xcluding patients with persistent ventricular fibrillation, resuscitative efforts can be terminated at the scene when normothermic adults with unmonitored, out-of-hospital, primary cardiac arrest do not regain spontaneous circulation within 25 minutes following standard advanced cardiac life support.” Id. The study based this conclusion on the fact that there is no benefit to continue resuscitation efforts because, in all likelihood, the patient will not live to be discharged from the hospital. Id. The authors also noted that if recommendations not to give CPR are adhered to on a national level, $500 million per year would be saved. Id. at 1461.

17. See discussion infra Part III.D (discussing Schneiderman and Jecker’s definition).

18. Steven H. Miles, Medical Futility, 20 L. MED. & HEALTH CARE 310, 310 (1992). These uses of futility are not mutually exclusive. Id.

19. Id.

20. Id.; see also Alfred F. Conard, Elder Choice, 19 AM. J.L. & MED. 233, 236-37 (1993) (noting the controversy over who decides the definition of futility); Nancy S. Jecker & Lawrence J. Schneiderman, Is Dying Young Worse Than Dying Old?, 34 THE GERONTOLOGIST 66 (1994) [hereinafter Dying Young] (defining a futile treatment as one in which “the likelihood that it will in fact prolong life is exceedingly low or the quality of life thereby gained [is] exceedingly poor”).

21. Miles, supra note 18, at 310.

22. Id. See generally Tom Tomlinson & Diane Czlonka, Futility and Hospital Policy, HASTINGS CENTER REP., May-June 1995, at 28 (identifying “issues relevant to the development of effective and defensible hospital policies supporting physician judgments not to provide futile resuscitation”).
within hours or days regardless of treatment given." This definition is clearly inadequate because it bars treatment only when all treatment would undoubtedly fail. While it is not difficult to justify a decision to withhold or withdraw treatment on such grounds, this definition of futility does not cover many situations where withholding or withdrawing care on the ground of futility would be justifiable. For instance, this definition is too narrow to permit withholding or withdrawing treatment from a body doomed to existence in a PVS. Accordingly, the "physiologically impossible" definition of futility is inadequate.

B. Futility: Nonbeneficial or Unlikely to Produce a Benefit

The second and third uses of futility in the medical profession—that treatment is futile if it is nonbeneficial or if it is unlikely to produce a desired benefit—distinguish between effect and benefit. The goal of medicine is to benefit the patient, not merely to produce a physiological effect on the patient. For example, nutritional support could have the effect of preserving a host of organ systems in a patient but it would not be considered a benefit because this treatment could not restore the patient to a conscious and sapient state. Another example is when a doctor refuses to honor a patient's demand that he be given a blood transfusion for a simple cold. While the transfusion would certainly produce a physiological effect on the patient's body, it would not cure his cold, and therefore, the blood transfusion would not offer him any benefit. Thus, within this framework, a treatment that does not offer the patient a benefit, regardless of whether it produces an effect on the body, should be withheld on the grounds of futility.

23. See Cotler and Gregory, supra note 2, at 220.
24. Lawrence J. Schneiderman et al., Medical Futility: Its Meaning and Ethical Implications, 112 ANNALS INTERNAL MED. 949, 950 (1990). "Physicians should distinguish between the effect, which is limited to some part of the patient's body, and a benefit, which the patient has the capacity to appreciate and which improves the patient as a whole." Futility in Practice, supra note 1, at 437.
25. See Schneiderman et al., supra note 24, at 950. The authors may, in fact, be discussing futility of life.
26. "[A] treatment that cannot provide a minimum likelihood or quality of benefit should be regarded as futile, and such treatment is not owed to the patient as a matter of moral duty." Futility in Practice, supra note 1, at 438. Comprehensive care becomes futile when, for example, caretakers prolong the use of artificial ventilators to treat intensive care patients over the age of 80. Such care is also not cost effective. Researchers in upstate New York hospitals found that when the sum of a patient's age and the number of days on a respirator reached at least 100, the patient's chance of survival was near zero. Ian L. Cohen et al., Mechanical Ventilation for the Elderly Patient in Intensive Care: Incremental
When using this distinction between effect and benefit, it is important to note that giving comfort and palliative care to patients for whom there is no possibility of recovery is a benefit and should not be withheld as futile unless such treatment does not comfort or alleviate pain. Palliative care does not seek to cure a person's ailment or reverse a terminal prognosis. Rather, palliative care offers the benefit of alleviating or moderating the patient's pain or discomfort and allows the patient to live out his remaining time in dignity.

All uses of futility share the same goal of withholding treatment when there is no benefit. Nonetheless, there are differences worth noting. Withholding nonbeneficial treatment on the grounds of futility is another way of phrasing the physician's duty not to prescribe treatment that would harm the patient. No balancing is involved; there is merely a prohibition against prescribing harmful treatment. When the physician wishes to withhold treatment on the grounds of futility because the treatment is unlikely to produce a desired benefit, however, the physician must balance the possible harm against the possible good. The factors in the balance will not be logical absolutes, but rather statistical probabili-

Changes and Benefits, 269 JAMA 1025, 1025 (1993). Thus, a 90 year-old on a respirator for 10 days and an 85 year-old on a respirator for 15 days would have little chance of survival.

27. See Schneiderman et al., supra note 24, at 950.

28. See generally Cicely Saunders & Mary Baines, Living with Dying: The Management ofTerminal Disease (2d ed. 1989) (providing that the purpose of treating "terminal disease is more than the mere absence of symptoms, it is that the patient and his family should live to the limits of their potential").

29. See generally Balfour M. Mount, Palliative Care of the Dying, in Care for the Dying and the Bereaved 17 (Ian Gentles ed., 1982) (providing that palliative care is different from customary patient care programs in that "there is concern for the family and other loved ones as well as the patient"); Mary Baines, Tackling Total Pain, in Hospice and Palliative Care an Interdisciplinary Approach 26 (Dame C. Saunders OM, DBE, FRCP, ed., 1990) (providing "a plan of treatment for the individual patient who complains of severe pain").

30. Futility in Practice, supra note 1, at 438. The balancing of probabilities is evident in Lance K. Stell's definition of futility:

When any intervention, including those that are life-sustaining, (a) fails to hold a reasonable promise for bringing about the patient's recovery as verified by current medical knowledge and experience, (b) imposes burdens grossly disproportionate to any expectable patient benefit, (c) plays no effective role in mitigating the patient's discomfort, and (d) serves only to artificially postpone the moment of the patient's death by sustaining, supplanting or restoring a vital function, then the intervention is medically futile and there is no obligation to offer to initiate it, or to offer to continue it.

Stell, supra note 3, at 495. Note that the author employs the word "reasonable" in describing the promise for discovery and the word "disproportionate" when comparing the possible burden to the possible benefit.
ties of success or harm derived through experimentation and analysis of
data.31 "Futility refers to an expression of success that is either
predictably or empirically so unlikely that its exact probability is often
incalculable."32 Medicine is a science but not an exact science. Thus, by
limiting futility to instances when it can be stated to a logical certainty
that the treatment will be more harmful than beneficial would unduly
restrict its usefulness.

C. Futility: Plausible But Not Validated Treatment

The last use of futility describes the situation when the treatment has
not been validated as an appropriate treatment for a given diagnosis.
This, however, is not an appropriate ground for withholding treatment.
In fact, such experimentation, where there is a reasonable likelihood of
success, should be encouraged. In prescribing a treatment that has not
yet been validated, however, the physician should inform the patient that
the patient is, in essence, the subject of an experiment and follow the
appropriate procedures of medical experimentation.33 Where there is a
plausible likelihood that the treatment could benefit the patient, experi-
mentation and documentation should be encouraged so the physician
could assess whether the treatment was futile or not.

D. Futility: The Schneiderman and Jecker Proposal

Lawrence Schneiderman and Nancy Jecker have proposed the best
working definition of futility. According to these authors, futility may be

The same type of balancing is evident in J. Chris Hackler and F. Charles Hiller's defini-
tion of futility:
[Physicians should be able] to write . . . do-not-resuscitate order[s] over family
objections when (1) the patient lacks decision-making capacity, (2) the burdens of
treatment clearly outweigh the benefits, (3) the surrogate does not give an appro-
appropriate reason in terms of patient values, preferences, or best interests, and (4) the
physician has made serious efforts to communicate with the family and to mediate
the disagreement.

J. Chris Hackler, PhD & F. Charles Hiller, MD, Family Consent to Orders Not to Resusci-
tate: Reconsidering Hospital Policy, 264 JAMA 1281 (1990). But see Tom Tomlinson, PhD
& Howard Brady, MD, PhD, Futility and the Ethics of Resuscitation, 264 JAMA 1276, 1280
(1990) (advocating a multilevel dialogue which stresses shared powers for enhancing a pa-
tient's understanding of the limits of medical intervention by eliminating the consent pro-
cess for futile acts of CPR).
31. See Miles, supra note 18, at 311.
32. Schneiderman et al., supra note 24, at 950. For example, a miracle does not rid the
act of its futility because by its very nature a miracle is a rare exception that defies the
odds. Id. at 951.
33. See discussion infra part III.F (explaining why experimentation is not futility).
defined both quantitatively and qualitatively. Under their definition, if the treatment is either quantitatively or qualitatively futile, no duty exists for a physician to administer it. The authors' criteria for determining both quantitative and qualitative futility is examined below.

The quantitative definition focuses on the probability that an intervention will effectuate a particular outcome and assesses whether that probability falls below a minimum threshold. A recent study in the New England Journal of Medicine, for example, calls for withholding aggressive resuscitation of infants born at less than twenty-five weeks gestation. Through studying the mortality and morbidity of preterm infants, researchers found that all twenty infants in their study born at twenty-two weeks gestation did not survive to hospital discharge, while thirty-one out of thirty-nine infants born at twenty-five weeks did survive to hospital discharge. While aggressive interventions kept the infants born at twenty-two weeks alive for up to four months, the results show that the doctors were only prolonging imminent death. The authors could find no justification for prolonging the death of these infants beyond a few hours to permit the parents to say goodbye. In essence, the study concluded that treating preterm infants born at twenty-two weeks is futile because there is no chance they will ever be viable.

Until July 1, 1993, the therapeutic treatment of children born with anencephaly (without a brain) would have been universally acknowl-

34. See Schneiderman et al., supra note 24, at 951. There are two central criticisms of this approach. First, what values do physician's use in determining whether to meet a patient's demand to continue or discontinue treatment. Daniel Callahan, Medical Futility, Medical Necessity: The Problem-Without-A-Name, 21 HASTINGS CENTER REP., July-Aug. 1991, at 30, 32. Callahan suggests that the political system should decide which values physicians should consider in this decision. Id. The second criticism is that the authors have no justification for arriving at the arbitrary quantitative number. Id. at 31.

35. Nancy S. Jecker & Robert A. Pearlman, Medical Futility: Who Decides?, 152 ARCHIVES INTERNAL MED. 1140, 1140 (1992). Although the term quantitative implies that a futility decision based on quantitative considerations is value-free, such decisions actually involve value choices. Id. For example, what levels of confidence are to be used in reaching conclusions and what justifies the minimum threshold. Id.


37. Id.

38. Id. at 1599.

39. Id.

40. See id. Other futile conditions for infants include gross paralysis with a neurologic segmental level; gross congenital defects such as cyanotic heart disease (cardiac malformation causing insufficient oxygen to the blood); intracranial birth injury; and gross hydrocephalus. See George P. Smith, II, Quality of Life, Sanctity of Creation: Palliative or Apotheosis, 63 Neb. L. REV. 709, 726, 729 (1984).
edged in the medical community as the "paradigm case of futile treat-
ment" simply because the higher brain is irreplaceable and death occurs
shortly after birth.41 On that date, however, an unsophisticated federal
district court in Virginia42 held, and was later affirmed by the United
States Court of Appeals for the Fourth Circuit,43 that such an infant was
protected by federal law44 and consequently entitled to ventilator resusci-
tation whenever she would suffer episodes of respiratory distress.45 The
controlling medical condition for the court was not anencephaly, but in-
termittent breathing difficulties.

In search of a quantitative definition of futility, Schneiderman and

41. John C. Fletcher, The Baby K Case: Ethical and Legal Considerations of Disputes
1994).
43. In re Baby K, 16 F.3d at 598.
44. The court found that the principle controlling law was The Emergency Medical
Treatment and Active Labor Act ("EMTALA"), which requires hospitals to provide stabili-
zizing treatment to patients who present an emergency medical condition. Id. at 597. Stabili-
zizing Baby K was found to be mandated regardless of the fact that her underlying
condition limited her life expectancy and her quality of life. Id. Furthermore, the court
found that EMTALA requires physicians to provide stabilizing treatment regardless
whether they consider it morally and ethically inappropriate. Id. The court held that EM-
TALA does not create an exemption from treatment for anencephalic infants, comatose
patients, cancer patients, or others similarly afflicted by chronic conditions affecting quan-
tity and quality of life—"all of whom may repeatedly seek emergency stabilizing treatment
for respiratory distress and also possess an underlying medical condition that severely af-
facts their quality of life and ultimately may result in their death." Id. at 598.

The district court concluded that Baby K was a "handicapped" and "disabled" person
The court further stated that anencephaly was also a "disability" within the meaning of the
Americans with Disabilities Act ("ADA"). Id. at 1028. The ADA "prohibits discrimina-
tion against disabled individuals by 'public accommodations.'" Id. (quoting 42 U.S.C.
§ 12182 (Supp. V 1993)). The court found the infant's lack of cerebral function-
ing prevented it from walking and from seeing. Id.

45. On appeal, the United States Court of Appeals for the Fourth Circuit limited itself
solely to whether EMTALA was the dispositive legislation. In re Baby K, 16 F.3d at 592
n.2.

In dissent, Senior Circuit Judge Sprouse observed, with wise clarity, that EMTALA was
designed to correct hospital "dumping" of indigent or uninsured emergency patients and to
extend it to include other hospital patient relationships, as here, would be totally inconsis-
tent with the meaning and spirit of EMTALA. Id. at 598; see also George J. Annas, Asking
the Courts to Set the Standard of Emergency Care—The Case of Baby K, 330 New Eng. J.
Med. 1542 (1994) (criticizing a merger of legal requirements, ethical guidelines, and medi-
cal standards by attending physicians on the case and the primary hospital). See generally
Erik Olson, No Room at the Inn: A Snapshot of an American Emergency Room, 46 Stan.
L. Rev. 449 (1994) (discussing the apparent ineffectiveness of state and federal antidump-
ing laws).
Jecker concluded that if in the last 100 cases a given treatment for a given condition has proved to be useless, it is futile, and therefore, need not be administered. While the authors offer little support for deciding on the number 100, any number would inevitably be arbitrary. The number 100, however, seems reasonable because it is a sufficient quantity to discount any unknown variables. Record keeping in all cases is encouraged so that treatments that offer no relief in over 100 cases may be deemed futile and need no longer be prescribed. Withholding treatment that is plausible, but not yet validated, is rejected implicitly in this construct because a treatment is not to be deemed quantitatively futile until it has been tried at least 100 times and has failed every time.

Schneiderman and Jecker also offer a definition of qualitative futility: "[A]ny treatment that merely preserves permanent unconsciousness or that fails to end total dependence on intensive medical care" is qualitatively futile and should be withheld. For an individual who has no chance of regaining consciousness, any treatment that merely sustains life would be quantitatively futile, and thus, withheld. The scope of the Schneiderman and Jecker definition is appropriately narrow with the primary focus being the person in a PVS. The quality of life of a person in a PVS is minimal, if it exists at all. By virtue of the diagnosis, there is no chance of recovery. Keeping that person from his destiny and depriving him of a right to die with dignity does not in any way further the goals of medicine.

It is impossible to discuss qualitative futility without discussing quality of life. However, extra care should be given to ensure that decisions of qualitative futility do not extend beyond the limited definition offered by the authors.

46. Schneiderman et al., supra note 24, at 951. To require otherwise would demand that physician supply a placebo. Id. at 952. Anecdotal evidence of miracles must be viewed with caution. Id.
47. See id.
48. Id. at 952. The authors do not advocate that all qualitative decisions be made unilaterally by physicians; rather, only those on the far end of the continuum, such as "continued biologic life without conscious autonomy," "conditions requiring constant monitoring, ventilatory support, and intensive care nursing," and "conditions associated with overwhelming suffering for a predictably brief time." Id.

When discussing qualitative futility, the decision that a treatment is futile must not be confused with the decision that a patient's life is futile. Grant, supra note 8, at 331. Nor should futility be used to justify withholding treatment from the aged and severely disabled. Id. A futility decision should "give low order consideration to any assessment of quality of life that is not closely dependent upon the clinical situation." Id. at 334. While common sense dictates that many decisions will inevitably factor in quality of life, the greatest care should be taken to minimize it. Id.
above. For instance, qualitative futility should not be invoked to justify not performing curative eye surgery merely because the patient has Down's syndrome. Such quality of life decisions are inappropriate for the medical profession to make. If it is possible to restore the patient to a sapient state or free the patient from total dependence on medical care, the physician has a duty to offer the treatment because that treatment would benefit the person regardless of the existence of a handicap or other disability.

E. Futility: What Futility Is Not

When discussing medical futility, it is necessary to discuss what medical futility is not. Medical futility is not an act that is impossible to perform.\textsuperscript{50} It may be entirely possible that a physician has both the technology and skill to perform CPR, yet rightly refuses to do so on the ground that such treatment is futile.\textsuperscript{51} A given treatment is also not futile merely because it would subject the patient to extreme pain and a lengthy recovery;\textsuperscript{52} nor is a treatment futile if it leaves the patient with a severe mental or physical handicap\textsuperscript{53} because the patient or his family, rather than the physician, should have the right to balance the possible harm and good of such a course of action. Allowing a physician to withhold treatment if it is possible or even probable that the patient will be mentally or physically handicapped as a result of such treatment empowers the physician to make quality of life determinations that too greatly infringe on the pa-

\textsuperscript{50} Schneiderman et al., supra note 24, at 950.
\textsuperscript{51} In a 1992 study of the practices of internal medicine residents at the University of Washington and the Seattle Veterans Affairs Medical Center, it was found that the medical standards used to determine the cutoff points for quantitative futility and qualitative futility were erratic. J. Randall Curtis et al., \textit{Use of the Medical Futility Rationale in Do-Not-Attempt-Resuscitation Orders}, 273 JAMA 124 (1995). Accordingly, one-third of the physicians in the study wrote DNR orders for patients they thought had a five percent or greater chance of survival. \textit{Id}. Several patients estimated to have a 20\% or better chance were also excluded from any consideration of resuscitation. \textit{Id}. In one-third of the 145 cases in this study, the decision to issue a DNR order was made unilaterally by the physician without consulting the patient or family member. \textit{Id}. In these cases, quality of life was the rationale for the issuance of the DNR order. \textit{Id}. The conclusion of this study was \textit{not} to restrict DNR orders to patients with a one percent or less chance of survival, but rather to have physicians seek greater candor in their relationships with their patients, thereby enabling them to discuss the odds of survival and their predicted quality of life and then seek a mutual agreement on what course of action to follow. \textit{Id}.

\textsuperscript{52} Merely because a treatment may result in “frequent hospitalization, confinement to a nursing home, or severe physical or mental handicaps” does not make that treatment futile. \textit{Medical Futility, supra note 1}, at 156-57.
\textsuperscript{53} \textit{Id}.
tient's autonomy. The quality of life decisions made by the physician should be limited to those where there is no reasonable probability that the patient will regain consciousness or when there is no chance that the therapeutic treatment will enable the patient to be free from total dependence on intensive medical care.

The principle of futility must not be used to mask prejudice, such as a refusal to treat an HIV-positive patient for fear of contracting AIDS.\textsuperscript{54} Futility is not hopelessness. Hopelessness is a subjective determination that the patient will not recover; futility is an objective determination that there is low probability of recovery.\textsuperscript{55} It is logically consistent for a patient to give up hope that a given treatment will be effective when medical data indicates that it will. It is also logical that a patient will still have hope that a given treatment will work despite all medical data indicating otherwise. However, futility should not be rejected in hopes of a miracle\textsuperscript{56}—for to do so would carve an exception out of the futility doctrine capable of engulfing the entire theory.

\textbf{F. Medical Experimentation}

Futility must also be distinguished from medical experimentation. Under normal situations, if a treatment is deemed futile a physician is under a duty not to administer it.\textsuperscript{57} Nonetheless, if the physician wants to administer the treatment for experimental reasons, he must obtain informed consent from the patient “to [administer] therapy of no proven benefit [to the patient] with the hope of possibly benefiting [the patient], while serving to advance knowledge in a systematic way.”\textsuperscript{58} While experimentation should be encouraged to determine which treatments actually benefit patients, a physician must exercise extreme caution when choos-

\textsuperscript{54} Futility in Practice, supra note 1, at 438. A physician should not mask her fear of performing surgery on an HIV-positive patient with the doctrine of futility. The fact that a patient is HIV-positive does not justify withholding treatment because the latent period from infection to full blown AIDS is usually ten years. \textit{Id.} Moreover, the medical profession dictates that physicians have a duty not to discriminate against patients solely on the basis of their HIV status. Medical Futility, supra note 1, at 153.

\textsuperscript{55} Schneiderman et al., supra note 24, at 950.

\textsuperscript{56} See Futility in Practice, supra note 1, at 439-40; Schneiderman et al., supra note 24, at 951.

\textsuperscript{57} See discussion infra part VI (considering the physician's duty not to provide futile treatment).

\textsuperscript{58} Futility in Practice, supra note 1, at 439. The important thing to note here is the role of the patient in the process. The physician has no right to unilaterally decide to conduct an experiment on the patient using futile treatment. Such experimentation cannot be performed without informed consent.
ing this path and should place particular emphasis on the minimal likelihood that such treatment will directly benefit the patient.\textsuperscript{59} To do otherwise would jeopardize the patient’s autonomy.

\textbf{G. Rationing}

Medical futility is often confused with resource allocation or rationing, even though they differ significantly. When a given treatment is deemed to be futile, the implication is that it has no therapeutic benefit.\textsuperscript{60} Futility decisions do not rest on the fact that there are scarce resources.\textsuperscript{61} Rationing, however, implies that the treatment may provide a therapeutic benefit, but concerns of cost and allocation of limited resources dictate that the treatment not be given.\textsuperscript{62}

It is clear that physicians should not make bedside decisions to withhold or withdraw treatment based on the allocation of scarce resources. Given that the United States has no universally accepted system for resource allocation,\textsuperscript{63} there is “no guarantee that any limits a[n] [individual] physician imposes on his or her patients will be equitably shared by other physicians and patients in the same circumstances.”\textsuperscript{64} In other words, there are no guarantees that foregoing treatment on one patient will result in another patient receiving medical services.\textsuperscript{65} Thus, physicians should not make bedside allocation decisions by cloaking them in the veil of futility.

The impropriety of making \textit{bedside} allocation decisions when determining whether or not to withhold or withdraw treatment does not mandate that the futility of a given treatment should not be considered when resource allocation is determined on a macro level away from the bedside.\textsuperscript{66} For instance, there are at least 10,000 people in a PVS in the

\begin{itemize}
\item \textsuperscript{59} See discussion \textit{infra} parts VI.A-B (considering the dangers of offering patients futile treatment).
\item \textsuperscript{60} Schneiderman et al., \textit{supra} note 24, at 952-53.
\item \textsuperscript{61} Jecker & Pearlman, \textit{supra} note 35, at 1143-44; Schneiderman et al., \textit{supra} note 24, at 953.
\item \textsuperscript{62} \textit{Futility in Practice}, \textit{supra} note 1, at 438. This does not imply that futility should not be considered in a health care system where rationing is explicit.\textsuperscript{67}
\item \textsuperscript{63} Schneiderman et al., \textit{supra} note 24, at 953.
\item \textsuperscript{64} \textit{Id.}
\item \textsuperscript{65} \textit{Id.}
\item \textsuperscript{66} Ronald Cranford & Lawrence Gostin, \textit{Futility: A Concept in Search of a Definition}, 20 L. \textit{MED.} \& \textit{HEALTH CARE} 307, 308 (1992). While the harsh reality of reallocating health care resources may very well be a valid reason for society to reconsider its willingness to pay for futile treatments for dying patients, it is not regarded as a valid criteria for a physician to consider in reaching a determination that treatments for a particular dying
\end{itemize}
United States today. Each of these persons cost the federal government anywhere from $80,000 to $150,000 per year to maintain. Accordingly, this country is spending over one billion dollars per year to preserve human beings for whom there is no chance of recovery. Assuming that the United States will eventually turn to explicit resource allocation, undoubtedly this expense would be questioned. It would not be unjustifiable to base resource allocation decisions on the potential success of the treatment, rather than social status, gender, race, or ability to pay. The fears of the "slippery slope" associated with bedside resource allocation

67. Callahan, supra note 34, at 35.
68. Id.
69. Although exact figures are not available regarding the financial savings to be effected from adopting policies that futile treatment be withheld or withdrawn, it is estimated that "tens and probably scores of billions of dollars" would be saved annually. Hospitals Establish Policies to Limit Futile Care, Hosp. Ethcs, Sept.-Oct. 1993, at 10, 10 (quoting JAMA Editor George D. Lundeberg, M.D.). Close to one-third of the annual Medicare budget goes to caring for elderly patients in the last year of their lives. Diane Granat, Judgment Days: Sometimes the Hardest Decisions in a Hospital are When to Give Up and Say Goodbye, WASHINGTONIAN, July 1993, at 54, 71.


70. Although rationing may be a painful decisionmaking process, a consideration of the potential rehabilitative success of treatment is considered by some to be a more ethically acceptable focus than other factors such as social worth or ability to pay. Stuart J. Youngner, Who Defines Futility?, 260 JAMA 2094, 2095 (1988). In a study of 4,301 patients, 115 of whom had an estimated 1% chance of surviving for 2 months, and thus, were subjected to a "prognosis-based futility guideline," it was found that modest economic savings would accrue if 3 types of life-sustaining treatments (ventilation, kidney dialysis, and drug medications to maintain blood pressure) were removed from these patients until they died. Teno et al., supra note 69, at 1204-05. The reason for this was that even after receiving the treatments their physicians prescribed for them, the patients were so ill that 99 of the 115 died within 5 days after entering the hospital. Id. at 1202. In fact, only one survived beyond two months. Id. The study indicated that up to $5 million could be saved if these 3 treatments were not offered to those who had only a 10% chance of surviving for 2 months. Id. at 1204-05.

71. Dismay over the unethical slippery slope becomes manifest when it is realized that high priced life-supports, if allowed, can be withdrawn from patients who will never be sentient. Angell, supra note 10, at 512. The fear expressed in this statement is that physicians would be uncontrolled in their ability to dispense resources and that they might be guided by prejudice. This fear is greatly mitigated, however, when resource allocation decisions are made away from the bedside in a public forum where all members of society can voice their opinions. There is, nonetheless, a concern that futility may be abused as a cost control tool imposed by the government or health care payers. Grant, supra note 8, at 331. While there is always potential for abuse in any system, there would be less abuse when the standards for witholding or withdrawing treatment are arrived at through public debate,
decisions are greatly mitigated when such determinations are made by society on a macro level. Thus, while great care should be taken not to confuse futility with bedside rationing, the futility of a treatment should be considered when and if this country turns to explicit health care rationing. The nation needs a clear working definition of futility that does not confuse futility with impossibility, hopelessness, experimentation, prejudice, or bedside resource allocation. Until such a definition is adopted, the medical profession will be greatly hampered, if not totally frustrated, when confronted with a patient in a futile condition.

IV. WHO DECIDES?

There are two questions within the debate over who decides whether a given treatment is futile: (1) Who decides the objective standard of futility?; and (2) Who then will make the actual bedside decision to withhold treatment based on the objective criteria?

A. Who Determines the Objective Standards?

Objective standards of futility should, ideally, be decided in the public forum. The medical profession, perhaps through the American Medical Association, should initiate the process by proposing guidelines to spark discussion of this important issue. Once the medical profession presents a proposal, society would have an opportunity to voice their opinions through their elected officials. State legislatures and Congress would either accept the guidelines as proposed by the medical profession or with modifications expressed by their constituencies. Either way, the United States would have standards of futility determined through a democratic process that, at least in accepted theory, represents the social values of the nation. The difficult and elusive nature of futility would dictate that these standards be reasonably flexible.

B. Who Makes the “Bedside” Decision?

Once objective criteria for what constitutes futile treatment have been established, a three-tiered decisional and appeal structure should be es-

---

72. A broad consensus among health care professionals and others should be sought in reaching definitions of futility. Jecker & Pearlman, supra note 35, at 1140.
73. Although a definition of futility may be proposed by the medical profession, it is society that ultimately accepts or rejects such a proposal. Futility in Practice, supra note 1, at 437.
tablished. The treating physician would have the primary responsibility for determining when to withhold treatment on the grounds of medical futility. Once that decision is made, the patient, the patient’s family, or both would have the right to a de novo appeal to the hospital ethics committee. If the party is not satisfied with the decision of the ethics committee, a limited appeal could be taken to the judicial system.

The physician would have the primary responsibility for determining whether a given situation calls for withholding or withdrawing care on the ground that it falls within the established guidelines. The physician’s expertise in the field of medicine and his intimate knowledge of the patient favor the physician as the ideal primary decisionmaker.

Some argue that the patient or family should be able to decide when treatment is futile. However, placing the decision with the physician would actually avoid unnecessary suffering for the patient and family. The physician is trained to make such decisions and is further insulated from the emotional burdens of the patient or family which may make such a decision more difficult or impossible.

The fact that a physician is responsible for making the primary futility decision does not free him from his duty to inform the patient. While some authors argue that futility removes both the duty to treat and the duty to inform, preclusion of a duty to inform infringes too greatly on

74. Jecker & Pearlman, supra note 35, at 1140. But see Hawkes, supra note 5, at 3 (regarding Dr. Bihari’s computerization of futility decisions).


76. Physicians would avoid causing unnecessary patient suffering and placing unfair burdens of guilt on surrogate decisionmakers if they, themselves, acted unilaterally. Youngner, supra note 70, at 2094 (citing Donald J. Murphy, Do-Not-Resuscitate Orders: Time for Reappraisal in Long-Term-Care Institutions, 260 JAMA 2098 (1988)). Dr. Murphy decided that, instead of asking the patient or the family whether they would like “everything possible” done to save the patient’s life, he would speak frankly and relate the actual poor prognoses, accurate descriptions of the patient’s medical condition, and the “grisly realities of dying in a critical care unit.” Murphy, supra, at 2099. His results revealed that 23 out of 24 patients opposed resuscitation. Id.

77. To place matters for which a competent physician is trained into the hands of laymen, particularly those issues that carry high emotional burdens, is a serious misordering of priorities. Grant, supra note 8, at 331.

78. Stuart J. Youngner, Futility in Context, 264 JAMA 1295, 1295 (1990). Not all proponents of futility would require physicians to inform the family of a DNR order. For example, one proposal argues that “when resuscitation would clearly provide no medical
patient autonomy.\textsuperscript{79} Informing the patient and his family of the decision not to administer treatment on the grounds of futility helps patients and families cope with the inevitability of death,\textsuperscript{80} and permits them to seek a second opinion or alternative medical care.\textsuperscript{81} Moreover, informing the patient and documenting that decision makes the physician accountable\textsuperscript{82} for futility decisions negligently made and those decisions not carefully documented.\textsuperscript{83} To adequately protect patients' rights, the physician must be under a duty to inform the patient of the decision to withhold or withdraw treatment on the grounds of medical futility.

When a physician charged with the duty of making the primary futility decision informs a patient and family that such treatment will be withheld or withdrawn, he must also inform the patient and family of their right to appeal the decision. In the construct proposed, the physician must inform the patient and family that they have a right to a \textit{de novo} review of the physician's primary decision with the hospital ethics committee. In this proceeding, the physician would present his case and the patient and family would present theirs. The ethics committee would then discuss the issues and provide a written decision stating the grounds for their decision. If the ethics committee decided in favor of the primary physician, the patient and family could then turn to the courts for relief.\textsuperscript{84}

\begin{footnotesize}
\textsuperscript{79} GEORGE P. SMITH, II, BIOETHICS AND THE LAW 88 (1993). "$[T]his veil of silence often robs the patient of his right of self-determination." \textit{Id.} at 88; \textit{see also} Jecker & Pearlman, \textit{supra} note 35, at 1144 (providing that futility standards should "reflect the consent of the various parties who are subject to them").

\textsuperscript{80} Youngner, \textit{supra} note 78, at 1296.

\textsuperscript{81} Stell, \textit{supra} note 3, at 493.

\textsuperscript{82} Youngner, \textit{supra} note 78, at 1295.

\textsuperscript{83} Stell, \textit{supra} note 3, at 493.

\textsuperscript{84} It should be realized, however, that reaching a consensus among ethicists is considered, by some, not to be a realistic goal. Rather, the real "value of an ethics consultation lies as much in its reconciliatory process as in its prescriptive content." Ellen Fox & Carol Stocking, \textit{Ethics Consultants' Recommendations for Life Prolonging Treatment of Patients in a Persistent Vegetative State}, 270 JAMA 2578, 2582 (1993). For example, in evaluating cases of patients in PVSs, it has been found that medical strategies derive "more or less [from] formalized opinions based on bodies of knowledge composed of several overlapping and potentially contradictory sources (eg, peer-reviewed literature, recognized experts, professional organizations, and textbooks)." \textit{Id.} \textit{See generally} Teodoro F. Dagi, \textit{The Ethical Tribunal in Medicine, in 1 Ethical, Legal, and Social Challenges to a Brave New World} 201-10 (George P. Smith, II, ed., 1982) (discussing the ethical problems arising from the availability of advanced medical technology in the context of the limits of medical epistemology); George P. Smith, II, \textit{The Ethics of Ethics Committees, 6 J. Contemp. Health L. & Pol'y} 157 (1990) (providing that the decision to terminate medical care is an ethical decision, rather than a medical decision).
\end{footnotesize}
The parties could only appeal, however, limited issues in the judicial system. The courts, guided by the social policy established by legislatures and administrative agencies, would be restricted to determining whether the decision to withdraw or withhold treatment was reasonable in light of established social policy guidelines such as those offered by Schneiderman and Jecker. If the physician’s determination of futility was reasonable, the treatment would be withheld or withdrawn.

V. Medical Futility v. Patient Autonomy: A True Battle?

The debate over medical futility has increased over the years with the expansion of patient autonomy. Thirty years ago, there was no need for this debate because technology had not given physicians the tools to provide many treatments that are available today and because few patients questioned their doctors’ orders. As the role of the patient increases in choosing care, so does the debate surrounding futile care. It might be

85. At least one court has indicated that it would not limit an appeal to the issues proposed in this Article. Custody of a Minor, 434 N.E.2d 601 (Mass. 1982). The Supreme Judicial Court of Massachusetts affirmed the Juvenile Court’s order continuing a “no code” for an infant in intensive care by making a de novo review of the case. Id. at 611. The child had been abandoned by her parents and had become a ward of the state. Id. at 602. The court appointed a guardian ad litem and counsel for the child. Id. Because of the child’s condition, the hospital sought a “no code” order. Id. Neither counsel nor the guardian would give consent. Id. The Juvenile Court granted the hospital’s petition and ordered the “no code.” Id. at 603. The Supreme Judicial Court requested the appeal on its own motion. Id. In the meantime, all parties came to agree that the “no code” should be issued. Id. at 608. However, the court ruled that “the fact that the parties to the legal proceeding previously initiated come to agreement, while it is to be given some deference, neither defeats the jurisdiction of the court in a case such as this nor binds it to accept their position.” Id. The court noted six factors justifying its order issuing the “no code”: (1) The child is a ward of the State in the custody of the DSS; (2) the child’s mental faculties have not developed to the point where he is competent to make the decision; (3) the parents have failed to exercise their parental responsibilities toward the child; (4) the child’s condition is incurable and the prognosis for successful treatment is negative; (5) medical opinion on diagnosis and prognosis was clear and unanimous as to the child’s condition and future; (6) attempts to resuscitate would be painful and intrusive. Id.

86. Nonetheless, futility is not a new issue for the courts. Over 40 years ago, in Dallas Railway & Terminal Co. v. Guthrie, 206 S.W.2d 638 (Tex. Ct. App. 1947), the court denied plaintiff’s prayer for future medical expenses based on testimony that the medical profession could do nothing for the plaintiff but give him “comfort and strength.” Id. at 645. Arguably, the court thereby accepted the notion of futility by denying recovery for future treatment that would give the patient no benefit.

87. Boozang, supra note 66, at 63-64. Before the relatively modern acceptance of the principle of self-determination and the validity of informed consent, the doctor-patient relationship was one in which the dominant decisionmaker was the physician and the pa-
suggested that futility is the point at which to draw the line on the advancement of patient autonomy. This is not necessary, however, because the goals of patient autonomy and cessation of futile treatment are not inconsistent. Patient autonomy does not convey the right to demand futile treatment. In effect, offering or administering futile treatment undermines patient autonomy by raising false expectations of recovery.

Patient autonomy includes the right to be a fully informed participant in every aspect of the medical decisionmaking process, as well as the right to refuse medically prescribed lifesaving treatment. \(^{88}\) Thus, patient rights of autonomy or self-determination are abridged, not when there is a denial of opportunities to make any medical decision, but rather when there is a denial of an opportunity to make "a rightful medical decision." \(^{89}\) Patient autonomy does not give the patient the right to demand futile treatment because this is not a rightful medical decision. The patient does not have a right to the treatment because it has been determined that the treatment is not warranted for persons in his condition. The patient does not have a right to opt out of the class to which his medical condition relegates him.

Patient autonomy gives rise to a negative right rather than a positive right—for the patient has a right to refuse a given treatment but not a corresponding right to demand a given treatment. \(^{90}\) Once it has been determined what is futile, a patient's autonomy is not invaded or sacrificial was an obedient party. Id. See generally JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984) (discussing the history of informed consent).

Of course, it is realized that, due to man's communal or interdependent nature, he is never totally free to make independent choices and be truly autonomous. Bruce J. Winick, On Autonomy: Legal and Psychological Perspectives, 37 VILL. L. REV. 1705, 1769 (1992). As a component of several social groups (e.g., family, workplace, various associations and interest groups, and the community itself), an individual's choice is constrained by a variety of social, economic, psychological, religious and familial pressures from these groups. Id. at 1768. Thus, acts of self-determination become influenced or even dependent upon the various desires of these groups and to the anticipated impact such individual expressions will have upon them. Id. at 1769. See generally William M. Altman et al., Autonomy, Competence and Informed Consent in Long Term Care: Legal and Psychological Perspectives, 37 VILL. L. REV. 1671 (1992) (discussing the application of psychological perspectives on autonomy and competency to the legal doctrine of informed consent to facilitate autonomous decisionmaking among elderly nursing home residents).

88. Schneiderman et al., supra note 24, at 949.
89. Jecker & Pearlman, supra note 35, at 1142. The author cites as an example that a physician is not obligated to honor a patient's request for a liver when other patients have prior claims to that scarce resource. Id.
90. Stell, supra note 3, at 484. For example, a physician would not be obligated to honor a patient's request for magnetic resonance imaging ("MRI") for complaints of a bump on their head. Id.
ficed if the physician does not honor the request for such treatment because patients are simply not entitled to futile treatment.\footnote{91} The physician, by virtue of his training and expertise, is given the right to determine what treatment alternatives are available to the patient.\footnote{92} “No ethical principle or law has ever required physicians to offer or accede to demands for treatments that are futile.”\footnote{93} Even civil malpractice standards do not require a physician to render useless interventions.\footnote{94} Moreover, a physician does not have a legal duty to act contrary to his conscience.\footnote{95} Therefore, because patient autonomy does not give the patient the right to demand futile treatment, autonomy is not invaded when the physician withholds treatment on these grounds.

On the contrary, withholding or withdrawing futile treatment furthers the goals of the patient autonomy movement because administering futile treatment, in fact, undermines patient autonomy. Offering treatments known medically to be futile\footnote{96} erode, if not destroy, the principle of au-


\footnote{92}{Paris et al., \textit{supra} note 91, at 1013. The physician, not the patient, is entrusted with the professional responsibility to recommend a course of action—this being formulated once all possibilities are sorted out and all pros and cons weighed. \textit{Id}. It would be a misguided attempt to respect or validate autonomy by shifting this responsibility to the patient. \textit{Id}. The ultimate recommendations made by the doctor may be accepted or rejected by the patient or his family. \textit{Id}. They are not free, however, to design treatment or direct the physician to provide it. \textit{Id}.

\footnote{93}{Schneiderman et al., \textit{supra} note 24, at 950. However, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972), dictates that a patient’s assessment of the risks and benefits sets the standard, rather than the prevailing medical criterion, and Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978), dictates that a patient has the right to accept or reject a proposed “treatment the physician judges to be futile or harmful.” Paris et al., \textit{supra} note 91, at 1014. \textit{See generally Smith, supra} note 79, at Ch. 4 (dealing with informal decisionmaking).

\footnote{94}{Grant, \textit{supra} note 8, at 332. The physician’s duty is to use reasonable medical judgment when determining whether or not to prescribe a particular treatment. \textit{Id}.

\footnote{95}{Paris et al., \textit{supra} note 91, at 1014. “[T]here is nothing in the law which would justify compelling medical professionals . . . to take active measures which are contrary to their view of their ethical duty toward their patients.” \textit{Id}. (citing Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 639 (Mass. 1986)).

\footnote{96}{There is no ethical obligation to offer diagnostic or therapeutic procedures if they are determined to be futile. Council on Ethical and Judicial Affairs, American Medical Association, \textit{Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders}, 265 \textit{JAMA} 1868, 1868 (1991). Thus, a decision to discontinue treatment, even though made with full
Futility and the Principle of Medical Futility

Deception of this sort distorts the patient's perspective and deprives him of the opportunity to make informed decisions. Thus, the doctrine of futility and patient autonomy share the same goals of giving the patient reasonable control over his treatment. A patient will have the right to refuse any treatment offered, but that right does not extend so far as to require the physician to yield to demands for treatments that are futile. By withholding futile treatment, the physician is showing respect for the patient by being honest about the chances of recovery and the futility of providing a given treatment.

Some may contend that a patient or his family has a greater right to demand that treatment be continued once the physician has begun such treatment. The mere fact that a physician has begun treatment, however, does not obligate the physician to continue to administer that treatment once it becomes apparent that the treatment is futile. Patients and their families alike cannot successfully argue for the continuation of such treatment.

Even if a patient and his family could justify such a demand on a knowledge and a knowing intent that the patient will most certainly die will not be recognized as an "unlawful failure to perform a legal duty." Barber v. Superior Court, 147 Cal. App. 3d 1006, 1022 (1983). Standards of good medical practice authorize the discontinuance of therapies regarded as useless. Id. at 1018. The Barber court found "the focal point of [such] decision[s] should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of the biological vegetative existence." Id. at 1019 (quoting In re Quinlan, 355 A.2d 647, 669 (N.J.), cert. denied sub nom. Gofger v. New Jersey, 429 U.S. 922 (1976)).

In the case of In re Dinnerstein, 380 N.E.2d 134 (Mass. App. Ct. 1978), the Appeals Court of Massachusetts held that the physicians attending Shirley Dinnerstein had not exceeded their professional authority by writing, unilaterally, a DNR on her chart. Id. at 139. Both the futility of CPR and the appropriateness of the DNR order were appropriate measures for a terminally and irreversible ill patient. Id. Interestingly, the court stated that "[c]ardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected or where prolonged cardiac arrest dictates the futility of resuscitation efforts. Resuscitation in these circumstances may represent a positive violation of an individual's right to die with dignity." Id. at 139 n.10.

97. Stell, supra note 3, at 493.
98. Youngner, supra note 78, at 1295.
99. According to Schneiderman:
   A futile action is one that cannot achieve the goals of the action, no matter how often repeated. The likelihood of failure may be predictable because it is inherent in the nature of the action proposed, and it may become immediately obvious or may become apparent only after many failed attempts.

Schneiderman et al., supra note 24, at 950.
100. Id. at 953.
reliance theory, physicians would simply find other reasons for not administering the treatment in the first place.\textsuperscript{101} This would frustrate, rather than further, the goals of patient autonomy because physicians would be depriving patients of treatment to which they are rightly entitled.

VI. The Duty \textit{Not} to Administer Futile Treatment

Jecker and Schneiderman offer three reasons why physicians should have a duty \textit{not} to provide futile treatment.\textsuperscript{102} The authors first argue that if it were an option, rather than a duty, physicians could use the term "as a subterfuge for rationing, cost containment, or refusals to treat vulnerable patients."\textsuperscript{103} If each physician was given the discretion to provide treatment deemed to be futile, patients with the means—either independent wealth or superior insurance—could bypass the doctrine of futility by merely changing physicians. This would drastically limit its effect by relegating it to a device for depriving treatment for those who cannot afford it.

It is next argued that since the public looks to the medical profession to set medical standards, making \textit{ad hoc} assessments of futility by individual physicians rather than enforcing objective criteria developed by the medical profession would be an abdication of professional responsibility.\textsuperscript{104} A substantial burden must be placed on the medical profession to take action in order to preserve its stature and credibility by mandating uniform treatment for all patients in a given condition.

Lastly, it is maintained that offering futile treatment exploits the public's fear of death and exaggerates the results that medicine and science

\textsuperscript{101} Stell, \textit{supra} note 3, at 487-88. If such reliance was acceptable, it is likely that health care providers would fight to characterize such care as \textit{a priori} futile. \textit{Id.} at 483. "If physicians cannot terminate trial therapy for failure to achieve hoped for effects, they will have a reason to refrain from offering it." \textit{Id.}

\textsuperscript{102} Medical Futility, \textit{supra} note 1, at 155.

\textsuperscript{103} \textit{Id.} Even before reaching a classification of futility, a new study of elderly persons surviving heart attacks shows conclusively that many of these victims do not receive potentially lifesaving treatments such as clot-busting drugs and blood thinners, and some are not even told to stop smoking. Edward F. Ellerbeck et al., \textit{Quality of Care for Medicare Patients with Acute Myocardial Infarction}, 273 JAMA 1509, 1512 (1995). The possible reasons for this policy include the complexity of treating heart disease in the elderly and a lack of oversight in hospitals. Elderly patients tend to have a variety of conditions which often complicate decisionmaking about appropriate therapy—even though there are acceptable standards for heart attack treatment.

\textsuperscript{104} Medical Futility, \textit{supra} note 1, at 155.
can achieve. This leads to false expectations and inevitable disappointment, which in turn, undermines the public's confidence. While these arguments support the proposition that physicians should have an affirmative duty not to administer futile treatment, more compelling arguments can be found. This paper will consider these more compelling arguments in its discussion of the Eighth Amendment to the United States Constitution.

A. Pain Management or Patient Preference

The argument that efforts should always be undertaken to eliminate pain or other symptoms of human suffering, rather than the person exhibiting them, completely ignores the principle of autonomy or self-determination. Pain management, from a communitarian standpoint, may salve the conscience of the health care provider by forestalling, or perhaps, dispelling the need to even consider euthanasia—instead, allowing time to take its course passively. From the competent patient's standpoint, however, pain management ignores his moral and legal right—acting for whatever purposes are clear to him—to end his life with a semblance of dignity.

While patient pain may be managed effectively today, what occurs when this is merely palliative and the disease that gave rise to the pain continues its malignant progression toward terminality? What if, as a
consequence of the reduction in pain, an individual becomes exceedingly debilitated and his overall quality of functional existence becomes low or even worthless because of the consequent restrictions or reductions in lifestyle and the utter dependence upon others for daily life assistance? Are individual patient preferences, recognized as futile by all reasonably objective medical standards, to be subsumed under a contrived medical mandate of sanctified purposefulness? Whose values and preferences should be given priority—the individual patient’s or those of the medical community?

B. Proportionality

The principle of proportionality is closely related to the principle of medical futility. Proportionality recognizes that overuse, as well as underuse, of medical treatment and advanced life extending technologies may create an unreasonable burden where the harm and suffering inflicted by such a modality of treatment may be disproportionate to any realistic benefit to be derived from it. When this happens, it is recognized that there is no obligation to provide specific treatment.

Proportionality is relatively easy to state and visualize as a cost-benefit theory where costs are balanced against benefits. In practice, however, seeking to quantify both factors in the balancing equation is quite difficult. It is generally thought that this principle can be actualized or structured with considerable less difficulty and more precision through the use of advanced medical directives. Sadly, experience has shown popular and widespread use of such directives to be wanting.

---

2. Id.; see also Steven J. Wolhandler, Note, Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy, 69 Cornell L. Rev. 363 (1984) (arguing that the constitutional right to privacy applies to persons who assist mentally competent terminally ill patients commit suicide).
4. Somerville, supra note 107, at 62.
5. Id.
6. Id.
8. Supra note 107, at 62.
VII. An Ethical Construct for Decisionmaking

When does treatment become futile? Stated otherwise, when does the futility of existence become so obvious that sustaining it becomes useless or, indeed, of no socio-legal, philosophical, ethical, or religious "value"?

The concepts of ordinary versus extraordinary lifesaving treatment must be recognized as highly relative or situational—not only as to time and locale, but also in their application to individual cases. Indeed, both of these concepts have the ultimate effect of serving as value judgments which determine whether a given modality of treatment poses an undue hardship on the patient or provides positive hope for a direct and positive benefit. Accordingly, if a particular mode of either medical or surgical intervention imposes either too great a burden on the patient, or offers no reasonable hope of beneficial recovery, such treatment could be classified as extraordinary, and thus, nonobligatory. This determination is essentially a quality of life statement; in reaching it, either knowingly or unknowingly, a substituted judgment is made that if the proxy decisionmaker were in a similar situation to the patient, he would (or would not) wish to survive in such a state of impairment. Alternatively, a best interests standard could be utilized with the central question being: What course of action is in the patient's best interests?

The basic ethical goals of man should be to respect, safeguard, and advance individual autonomy, seek equity and justice in dealing with one another, and undertake beneficent actions which minimize human suffering and seek to actualize the social utility of the purposes of life. From a Judeo-Christian perspective, the meaning of life is tied to two inextricable components of love: love of God and love of thy neighbor—for it is through love of others that God is, in turn, recognized and loved. Under this interpretation, the very meaning of life is to be found in...
human relationships and the qualities of respect, concern, compassion, and justice that support these associations or relationships.\textsuperscript{123}

\textbf{A. Social Justice}

Under the theory of social justice, each individual is recognized as having an equal opportunity to maximize his potential. A point may be reached, however, where maintenance of an individual defies the very concepts of humanitarianism and justice. Accordingly, when an individual’s medical condition reaches a level where it represents a complete negation of those qualities associated with being a human and maintaining a “relational-potential”\textsuperscript{124} with others, the best and most reasonably prudent decision regarding treatment would be that it not be undertaken or that it be withdrawn and only palliative care be administered.\textsuperscript{125} When maintenance of life means the prolongation of pain, with little or no chance of a real or sustainable level of qualitative recovery, there is no opportunity to grasp or seek the overall meaning of life or “relational-potential,” or to seek “growth in love of God and neighbor” through continued human relationships. At this point, such actions should be recognized as being futile and cease.\textsuperscript{126}

In attempting to structure an ethical construct for decisionmaking in critical at-risk cases, a balancing test should be utilized that weighs the gravity of the harm in allowing lifesaving actions versus the utility of the benefits stemming from the actions. Accordingly, the gravity of the harm would be assessed in terms of not only social and economic costs that might induce serious financial hardships to all members of the primary or afflicted interest group (e.g., the family), but the religious, philosophical and ethical “costs” (or compromises) as well. The utility of the benefits would be measured in terms of an evaluation of the positive consequences that flow to the threatened individual and to society.\textsuperscript{127} In truth, then, this balancing test seeks to arrive at a cost-effective decision through a cost-benefit analysis.\textsuperscript{128}

In order to strengthen and add substance to the balancing test, a number of specific factors may be considered or utilized. Indeed, the late

\begin{itemize}
\item \textsuperscript{123} Id.
\item \textsuperscript{124} Id. at 348-49.
\item \textsuperscript{125} See Smith, supra note 9, at 173; see also Schneiderman et al., supra note 24, at 952 (stating that no patient has a right to be sustained in a vegetative state).
\item \textsuperscript{126} McCormick, supra note 122, at 347.
\item \textsuperscript{127} Smith, supra note 40, at 711.
\item \textsuperscript{128} Id. at 734.
\end{itemize}
Dr. Joseph Fletcher posited a number of such factors that he termed, alternatively, as qualities or indicators of humanhood. The central most factor to be considered in any balancing equation is whether the at-risk patient has a functioning cerebral cortex—for without it one is “nonexistent” and an object rather than subject. Minimal intelligence combines with rationality to build self-awareness and self-control, as well as an ability to be emotive and intuitive. Other factors of importance include: time consciousness, a sense of futurity tied to a theological assertion, a sense of the past, the ability to display curiosity instead of indifference, changeability, a capability to relate to others, compassion or an ability to express concern for others, an ability to communicate, the ability to be idiomorphous or distinctive, and the ability to assert control in life-directing situations and not display utter helplessness.

Together, the Fletcher indicators present a test of humanhood which is shaped by the exigencies of each situation. As such, these factors are shaped or even controlled by a situational ethic which flexibly adapts to each individual problem instead of being directed uniformly by a rigid and unyielding a priori ethical standard. Driven by a case-by-case methodology, the boundaries of the situation ethic are incapable of absolute determination. Yet, the basic norm used in decisionmaking will be love, or simply, human compassion. Some of the indicators of humanhood may have greater or lesser significance depending upon the diagnosis and prognosis of each case and the balance sought to be struck. For example, some patients and their families might well make trade-offs, desiring to place greater value and emphasis on self-control over a sense of the past and an ability to be emotive and intuitive. Other patients and families may value an ability to communicate over compassion and the ability to express concern for others. In employing the reasonableness standard as the linchpin in any ultimate medical decision regarding the continuation of medical treatment or the recognition that such would be medically futile, two primary questions under the ethical construct for decisionmaking will be proposed here: (1) Whether the medically at-risk individual possesses a real likelihood of sustaining a “relational-potential” with others?; and (2) Whether the present or proposed course of medical treatment not only minimizes suffering, but also seeks to maximize the potential utility

130. See id. at 1.
131. Id. at 1-3.
132. Smith, supra note 40, at 734-35.
of a life that functions at qualitative levels of cognition?  

VIII. THE EIGHTH AMENDMENT AND CRUEL AND UNUSUAL PUNISHMENT: A MEDICO-LEGAL REVISION  

A. The Historical Development  

The Eighth Amendment to the Constitution prohibits cruel and unusual punishment being administered to prisoners. This prohibition originated in the Magna Carta, was carried through in the English Declaration of Rights of 1688, and was later adopted as part of the Bill of Rights of the United States Constitution. While the Eighth Amendment has been used only in the context of criminal incarceration, it has contemporary and expanded relevance to the issue of determining whether providing medically futile treatment results in cruel and unusual punishment to a patient. Historically, a prisoner did not have rights and was considered a “slave of the state.” This lack of liberty is analogous to the traditional doctor-

---

133. Id. at 740. Interestingly, in a recent Washington case, while a type of “relational potential” could probably have been sustained, the only reasonable way to minimize suffering for three competent adults in the terminal phases of cancer, AIDS, and emphysema was through assisted suicide. Compassion in Dying v. Washington, 850 F. Supp. 1454, 1456-57 (W.D. Wash. 1994), rev’d, 49 F.3d 586 (9th Cir.), reh’g en banc granted, 62 F.3d 299 (9th Cir. 1995). In spite of state legislative prohibition against assisted suicide, a federal district court ruled, in a case of first impression, that such a prohibition was violative of the Fourteenth Amendment’s due process clause because the constitutionally protected liberty interest guaranteed all citizens a right to make profoundly personal decisions which naturally included the right to die. Id. at 1456. Two United States Supreme Court decisions were cited as controlling authority in the district court’s determination: Planned Parenthood v. Casey, 114 S. Ct. 909 (1994) and Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990). Id. at 1459, 1461. On March 9, 1995, the United States Court of Appeals for the Ninth Circuit reversed the district court’s decision and acknowledged that while the right of privacy may encompass freedom from unwanted medical intervention, it does not include a right to have assistance from a second person. Compassion in Dying, 49 F.3d at 597.  

134. “Excessive bail should not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted.” U.S. CONST. amend. VIII.  


136. Ruffin v. Commonwealth, 62 Va. (21 Gratt.) 790, 796 (1871). It is interesting to note that the Thirteenth Amendment of the U.S. Constitution, enacted six years prior to this decision, provides that slavery “as a punishment for crime whereof the party shall have been duly convicted” is an exception to the ban on slavery. U.S. CONST. amend. XIII. See generally Anthony F. Granucci, “Nor Cruel and Unusual Punishments Inflicted.” THE ORIGINAL MEANING, 57 CAL. L. REV. 839 (1969) (comparing the intent of the prohibitions against cruel and unusual punishment found in the English Bill of Rights of 1689 and the Eighth Amendment of the United States Constitution).
patient relationship wherein patients acquiesced to the prescribed treat-
ment and had little recourse if they disagreed with their doctor. Initially, 
the Eighth Amendment served only to bar "torture and other barbarous 
methods of execution." This is similar to the view that the doctrine of 
futility should be used only to prevent treatment that can harm the pa-
tient. The early interpretation of the Eighth Amendment and this limited 
use of futility do not sufficiently protect prisoners and patients.

Over a span of ninety-five years, the Supreme Court expanded protec-
tion for prisoners under the Eighth Amendment. As early as 1890, the 
United States Supreme Court held in the case of In re Kemmler, that 
prisoners could not be subjected to punishment which subjected them to 
"torture or a lingering death." Twenty years later, the Court declared 
that the Eighth Amendment implies protection from "inhuman and 
barbarous, torture and the like," or actions "so cruel as to shock the 
conscience and reason of men." In 1958, Chief Justice Earl Warren, 
writing for the plurality in Trop v. Dulles, presented a contemporary 
interpretive gloss by stating that the relevance of the Eighth Amendment 
"must draw its meaning from the evolving standards of decency that mark


139. 136 U.S. 436 (1890).

140. Id. at 447.


142. Id. at 356 (citations omitted).

the progress of a maturing society." It had been held previously that acts which shock the general conscience or are thought to be intolerable to notions of fairness were violative of the Eight Amendment's guarantees.

Twentieth century court holdings have sought to restrict the length and character of sentences under the Eighth Amendment. With the case of Wilson v. Seiter in 1991, Justice Antonin Scalia, writing for the majority, sought to structure a two-part inquiry for challenges to the Eighth Amendment: (1) there must be an objective inquiry into the "seriousness" of the alleged conduct or omission; and (2) there must be a subjective inquiry into the state of mind of the responsible official charged with violating Eighth Amendment protections. The baseline standard for the objective inquiry is to be the "minimal civilized measure of life's necessities." More specifically, on the issue of the standard of medical care to be provided within a prison, the court has required petitioners to allege and prove that acts or omissions are sufficiently harmful to show a deliberate indifference to serious medical needs—the level of indifference being of such a degree that offends evolving standards of decency.

B. Contemporary Medico Legal Applications

Several factors dictate that administering futile treatment is "cruel and unusual" within society's evolving standards of decency. If a physician treats a patient when the physician knows that such treatment is futile, the physician implies that there is a possibility, if not a likelihood, that such treatment will be effective. In this case, the physician is knowingly deceiving the patient by offering the patient and his family false expectations of recovery. This deception clearly violates the principle of self-determination and autonomy for the patient himself.

The primary obligation of health care providers is: "Do no harm." Thus, physicians must minimize or prevent mental and physical suffering because this is harmful to patients. Physicians must endeavor to demon-

144. Id. at 101.
148. Id. at 296-301.
149. Id. at 298 (quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981)).
150. Friedman, supra note 135, at 929.
151. Paris et al., supra note 91, at 1014.
strate levels of compassion which counter an all too pervasive indifference within the medical profession to allow terminally ill patients to die lingering deaths—a manner which defies the minimally civilized goal of allowing all individuals to die with humaneness and dignity. What real value is there to pain management if death is imminent and the added days of life provided are of inferior quality?  

Administering futile treatment ignores this primary obligation of a health care provider by exposing the patient to additional risks of that treatment. If a physician prescribed a course of treatment knowing that it was futile, he would be needlessly exposing the patient to additional risks associated with the treatment such as infection or adverse reactions. Even if the futile treatment did not adversely affect the patient, the mere exposure to the risk is cruel. Moreover, some interventions, such as CPR, inflict severe physical trauma. Admiring CPR when there is no medically reasonable chance that the patient will recover from the underlying illness amounts to physical torture. Physicians should be under a

152. See generally George P. Smith, II, Reviving the Swan, Extending the Curse of Methuselah or Adhering to the Kevorkian Ethic?, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 49 (1993); George P. Smith, II, Death be Not Proud: Medical, Ethical and Legal Dilemmas in Resource Allocation, 3 J. CONTEMP. HEALTH L. & POL’Y 47 (1987).

153. The physical dangers of CPR are not widely known to the public. “Ribs can be broken, the trachea damaged, and not uncommonly the brain never completely recovers from oxygen deprivation.” Medical Futility, supra note 1, at 154.

According to a study undertaken at 5 hospitals of more than 2,600 patients hospitalized with 1 of 9 various life threatening conditions (e.g., coma,acute respiratory failure, multiple organ system failure with sepsis or malignancy, chronic obstructive lung disease, congestive heart failure, cirrhosis, metastic colon cancer, or nonsmall cell lung cancer) where life expectancy averaged less than 6 months, results showed significant skepticism by physicians toward their patient's CPR wishes. Joan M. Teno et al., Preferences for Cardiopulmonary Resuscitation: Physician-Patient Agreement and Hospital Resource Use, 10 J. GEN. INTERNAL MED. 179 (1995). Specifically, in the nearly one out of three cases, the doctor's perception of the patient's preference not to have CPR was at odds with the doctor's perception. Id. at 182. This misunderstanding not only resulted in the higher use of hospital beds, ventilators, and CPR, but prolonged dying for those patients who preferred not to be given “extraordinary” lifesaving measures. Id. at 183-85. In those cases where the patient preference for not being resuscitated was accepted by the physician, estimated hospital costs were $20,527 per case. Id. at 182. In contrast, where the physician misunderstood or was uncertain about a patient's wish not to commence CPR, costs accelerated to more than $26,500. Id.

154. In 1986, the California Court of Appeal held that a 28 year-old woman, Elizabeth Bouvia, suffering from cerebral palsy, completely bedridden and immobile, in continued pain, and suffering from degenerative arthritis was “imprisoned” lying “physically helpless subject to ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness.” Bouvia v. Superior Court, 255 Cal. Rptr. 297, 305 (1986) (emphasis added). Writing for the majority, Justice Beach concluded, “We cannot conceive it to be the policy of the State to inflict such an ordeal upon anyone.” Id.
duty not to administer futile treatment because, by doing so, they are inflicting "cruel and unusual punishment" on patients and their families.

It is similarly "cruel and unusual punishment" to sustain patients who exist in a PVS. This is equivalent to giving a life sentence to an innocent person. The remedy for persons in a PVS, however, is not an executive pardon, but rather a death sentence (i.e., the withdrawal of treatment that merely maintains the unconscious nonsapient condition). When a person is diagnosed as being in a PVS, there is an agreement among physicians that such a condition is not "living" and that preservation of "life" in that state is not a proper goal for medicine. This is supported by the "traditional and modern view that . . . expert physician[s] should not prescribe therapies which cannot restore health to a dying person," and that all medical decisionmaking should have as its goal the benefit of the human person. Clearly, physicians have no duty to preserve mere biological "existence" per se.

C. Wanton Acts Freakishly Imposed

The Supreme Court has recognized that "death as a punishment is unique in its severity and irrevocability." Thus, in 1976, the Court held in Gregg v. Georgia that "[t]he Eighth and Fourteenth Amendments cannot tolerate the infliction of a sentence of death . . . to be . . . wantonly and . . . freakishly imposed." All too often, as a "benefit" of advances in medical technology, the prolongation of nonsapient "life" becomes truly a kind of unjust punishment which may realistically be viewed as grossly disproportionate to the ideal of a good and dignified death that all persons seek. Sadly, this extension of life is imposed and dictated all too frequently under freakish conditions in a medical hospital, which for all intents and purposes, is but little more than a prison. The futile maintenance of "life" under artificial conditions of this nature, more often

155. For many physicians, preserving "life" in a vegetative state when all possibility of restoring consciousness is extinguished, has never been regarded as a fundamental goal of sound medical practice. Cranford & Gostin, supra note 66, at 308.
156. Miles, supra note 18, at 311.
157. Grant, supra note 8, at 331.
158. Stell, supra note 3, at 489.
161. Id. at 188 (quoting Furman v. Georgia, 408 U.S. 238, 309-310 (1972) (Stewart, J., concurring)).
162. See, e.g., Estelle v. Gamble, 429 U.S. 97 (1976) (holding that failure to provide adequate treatment to a prisoner constitutes cruel and unusual punishment in violation of the Eighth Amendment).
than not, offends human dignity and "transgresses . . . civilized standard[s] [of] humanity [and] decency."\(^\text{163}\)

While technology has given health care professionals vast ability to preserve the existence of life, the ability to preserve and restore cognitive, sapient life pales in comparison.\(^\text{164}\) Ignoring the considerations of the latter would mean that there is "no real difference between medicine and horticulture."\(^\text{165}\) Sustaining persons in a PVS and other terminal conditions is worse than horticulture. It is cruel to the patient because it denies the patient the right to die with dignity and cruel to the family because of the emotional and financial drain.\(^\text{166}\)

**IX. Conclusion**

Dying is, "[b]y and large, a messy business."\(^\text{167}\) It is both "ugly and dirty" in a world that is intolerant of such qualities.\(^\text{168}\) Perhaps the only true dignity found within the occurrence of death is a full appreciation of

---


\(^\text{164}\) Stell, supra note 3, at 489.

\(^\text{165}\) Id.

\(^\text{166}\) If physicians were under a duty to administer futile treatment, the family could intervene and, out of a sense of guilt, demand that "everything be done." Boozang, supra note 66, at 73 n.277 (quoting PAUL RAMSEY, THE PATIENT AS PERSON: EXPLORATIONS IN MEDICAL ETHICS 143 (1970)). "Out of their guilt, members of the family are likely—at long last—to require that everything possible be done for the hopelessly ill and the dying loved one." Id.

In a decision issued by the Supreme Court of Canada on September 30, 1993, it was held that a 42 year-old woman suffering from amyotrophic lateral sclerosis (Lou Gehrig's disease) could not, under Canadian law, have medical assistance to install an intravenous line containing an effective agent that, at the appropriate time, could be activated by the petitioner to end her life. Rodriguez v. Att'y Gen. of Can., 3 S.C.R. 519, 520 (Can. 1993). Among the arguments made to sustain the appeal from the lower court's adverse finding was that Section 12 of the Canadian Charter of Rights and Freedoms accorded all citizens a right not to be subject to any cruel and unusual punishment. Id. at 522. While conceding "treatment" by the state may include acts other than those of a penal or quasi-penal nature, Justice Sopinka, writing for the majority, held that a state prohibition (as here, against assisted suicide) could not constitute "treatment" within the context of Section 12 of the Charter. Id. In order for the state action to constitute "treatment," it must encompass an active state process "involving an exercise of state control over the individual." Id. Simply because a particular state prohibition impacts negatively upon an individual and causes suffering, does not subject such a person to "treatment" by the state. "The starving person who is prohibited by threat of criminal sanction from 'stealing a mouthful of bread' is likewise not subjected to 'treatment' within the meaning of [Section] 12 . . . ." Id. at 611-12.

\(^\text{167}\) SHERWIN B. NULAND, HOW WE DIE: REFLECTIONS ON LIFE'S FINAL CHAPTER 142 (1994).

\(^\text{168}\) Id. at 255.
the life that precedes it.\textsuperscript{169}

The management of death can surely be both more humane and more efficient when the principle of medical utility is harmonized with patient autonomy. By defining medical utility as "the maximization of the welfare of patients in need of treatment,"\textsuperscript{170} it is clear that criteria are essential in determining, in a fair and equitable manner, who will receive and benefit from an initial use or continuation of scarce medical resources, and conversely, who will not. Utilitarianism, then, in choosing which course of action to follow will evaluate those actions which produce the greatest benefit for the greatest number of individuals.\textsuperscript{171} Social utility is used as an integral part of the balancing equation. Herein lies the problem: How can the needs and prognosis of a particular patient be balanced against the needs of society? Stated otherwise, how can physicians serve two masters, society and patients, in determining the type and amount of medical care?\textsuperscript{172}

The principle of medical futility, delineated and tested in the manner proposed in this Article, can serve as a catalyst for public action, acceptance, or both.\textsuperscript{173} Furthermore, medical futility can serve as the dominant vector of force in validating the very essence of utility, and thus, resolve the inherent conflict between patient needs and greater societal goals. The fact that there is a pressing national need for a clear, objective, and practical definition of futility is without doubt. Yet, the reality of the situation dictates that regardless of the definition settled upon, a debate between and among the medical professionals and social policy makers will inevitably arise. The public, because of its inherent lack of sophistication in this area, will depend upon both groups to educate them and win their acceptance. To fail in this mission means, simply, an increase in suits for medical malpractice by uninformed patients and their families or proxy decisionmakers.

Once defined criteria for medical futility are accepted by health care

---

\textsuperscript{169} Id. at 242.


\textsuperscript{171} Id.; see also Beauchamp & Childress, supra note 114, at 33 (providing an example of a utilitarian act).

\textsuperscript{172} See generally Haddad, supra note 170, at 11 (exploring "ethical implications of rationing for nursing"); Tomlinson & Czlonka, supra note 22, at 33-35 (providing a model futility policy).

\textsuperscript{173} See Terese Hudson, \textit{Are Futile-Care Policies the Answer?}, Hosps. & Health Networks, Feb. 24, 1994, at 26, 32.
providers and the public which they serve, this restructured principle affords the ideal construct for determining the utilitarian balance between patient and majoritarian preferences, wants, or needs. It achieves this by institutionalizing a balancing point that distinguishes the medical actions agreed upon as useful, reasonable, or promotive of restorative quality under particular circumstances with various patient profiles, and those actions not beneficial to patients or economically feasible for society to undertake. In a real way, then, these criteria act as a socio-legal-ethical-medico-economic triage, providing various medical and surgical interventions not regarded as reasonable for use by certain patients with profiles which show that there is no assurance of a sustained level of qualitative rehabilitation or salvageability.¹⁷⁴

Upon the acceptance or adoption of guidelines for determining futility, ideally along the lines of those proposed by Schneiderman and Jecker, a three-tiered decisional structure has been proposed as a mechanism for determining whether a given treatment for a given patient falls within the scope of these guidelines. Accordingly, the treating physician would be given the primary responsibility for making the decision to withdraw or withhold treatment on the grounds of futility. Although he would be under a duty not to prescribe treatment deemed futile by him, he would be obliged to inform the patient, and if necessary, the family of this decision and its rationale. This would provide the patient and family a basis for an “appeal” to the hospital ethics committee, if such course were elected.¹⁷⁵ Any further appeal from an adverse finding by the committee would be to the courts, where a limited review of the reasonableness of the decision to withdraw or withhold treatment would be undertaken.

Absent both a redefinition of death¹⁷⁶ to include a PVS and

¹⁷⁴ The definition of “reasonableness should turn on the question whether the patient retains any capacity to experience and enjoy life. The treatment should provide a benefit to the patient as a responsive, or minimally interactive human being, not as a constellation of bodily systems kept running by mechanical means.” Rhoden, supra note 13, at 437. See generally George P. Smith, II, Triage: Endgame Realities, 1 J. CONTEMP. HEALTH L. & POL’Y 143 (1985) (discussing health allocation problems and schemes).

¹⁷⁵ See, e.g., Smith, supra note 109, at 415 (providing an illustration of whether a patient could seek assistance from the courts to assert a right to self-determination).

¹⁷⁶ See generally Ad Hoc Committee of the Harvard Medical School, A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, 205 JAMA 337 (1968) (defining “irreversible coma as a new criterion for death”); David R. Smith, Legal Recognition of Neocortical Death, 71 CORNELL L. REV. 850 (1986) (examining “the law’s approach to death by inquiring into the legal issues raised by cardiopulmonary, whole brain, and neocortical definitions of death”).

In 1991, New Jersey became the first state to enact a statute recognizing a personal
anencephaly and a failure to achieve a broad consensus to establish criteria for treatment based upon the extent and duration of neurologic damage, perhaps a less contentious approach to the effort of redefining the principle of medical futility would be the acceptance of a presumption that those permanently existing in a vegetative state would not want to be kept alive for an indefinite period of time. Accepting this presumption would, in turn, allow a standard of care to be established that would routinely include a cessation of treatment after a reasonable time. Although the standard of reasonableness would vary with medical circumstances or situations, it would be tied with sufficient clarity to a recognition of irreversibility. Consistent with this new medico-legal presumption would be a shift in the burden to those wishing maintenance of a vegetative state to show that they are acting in accordance with what they know from clear and convincing evidence to be the wishes of the patient himself.\textsuperscript{177}

Since administering futile medical treatment is tantamount to inflicting cruel and unusual punishment on the patient and an abridgement of his rights of self-determination, it is incumbent upon physicians to recognize that they should accept the imposition of an affirmative legal, professional, moral, and ethical duty not to prescribe a modality of treatment that falls clearly within the scope of being considered futile, freakish, and tortious. The utilitarian value of a revalidated and operative principle of futility is all too apparent. Let it be used in a reasonable and compassionate manner to end the cruel punishment of terminal and hopeless cases of "human" existence and, at the same time, hopefully, give rise to an ethic

\textsuperscript{177} This was the argument made by Helga Wanglie's husband even though her continued treatment was futile. Marcia Angell, \textit{After Quinlan: The Dilemma of the Persistent Vegetative State}, 330 \textit{New Eng. J. Med.} 1534, 1535 (1994); Angell, supra note 10, at 511; \textit{see also} Maldonado, supra note 10, at 131 (discussing the medical and bioethical issues involved in the case of \textit{In re the Conservatorship of Helga M. Wanglie}).
of palliative care and less to a relentless pursuit of technologies that extend futility to the point of indecency and inhumaness.\footnote{Dying Young, \textit{supra} note 20, at 71. A disturbing 5 year study of more than 9,000 acutely ill patients in hospitals with an average life expectancy of 6 months (having 1 or more illnesses such as coma, colon cancer, congestive heart failure, or respiratory failure) and the severe processes by which they die, found death for one-third of them was prolonged and painful, with heroic treatments such as mechanical ventilation or CPR being administered routinely even when patients directed these procedures be withheld. The SUPPORT Principal Investigators, \textit{A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT),} 274 JAMA 1591 (1995); Bernard Lo, MD, \textit{Improving Care Near the End of Life: Why Is it So Hard?}, 274 JAMA 1634 (1995).}