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Thaddeus Mason Pope
University of Memphis Cecil C. Humphreys School of Law

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INVOLUNTARY PASSIVE EUTHANASIA IN U.S. COURTS: REASSESSING THE JUDICIAL TREATMENT OF MEDICAL FUTILITY CASES

Thaddeus Mason Pope*

INTRODUCTION

End-of-life care issues are marked with significant conflict.¹ A particularly common type of conflict is the medical futility dispute, in which a patient's surrogate decision-maker demands life-sustaining medical treatment ("LSMT") that the patient's health care provider ("provider") deems medically inappropriate. A leading treatise predicts that medical futility disputes are "likely to occupy as much, if not more [time and] judicial effort in the coming years as conventional end-of-life

* Thaddeus Mason Pope serves as Assistant Professor of Law at the University of Memphis Cecil C. Humphreys School of Law, and is serving as Visiting Assistant Professor at the Widener University School of Law (2007-08). This paper was developed from a presentation for NAELA's November 2006 Advanced Elder Law Institute and was supported by a summer research grant from the University of Memphis. Thanks to Sandra Johnson and Kathy Cerminara for thoughtful comments on an earlier draft.

1. See generally Catherine M. Breen et al., *Conflict Associated with Decisions to Limit Life-Sustaining Treatment in Intensive Care Units*, 16 J. GEN. INTERNAL MED. 283, 285 (2001) (finding that conflict occurred in 78% of cases concerning the limitation of life-sustaining medical treatment); John M. Luce & Douglas B. White, *The Pressure to Withhold or Withdraw Life-sustaining Therapy from Critically Ill Patients in the United States*, 175 AM. J. RESPIRATORY & CRITICAL CARE MED. 1104, 1108 (2007) (arguing that "disagreements between families and clinicians on end-of-life care are commonplace in the United States."); Hasan Shanawani et al, *Meeting Physicians' Responsibilities in Providing End-of-Life Care*, 133 CHEST 755, 780 (2008); Keith M. Swetz et al., *Report of 255 Clinical Ethics Consultations and Review of the Literature*, 82 MAYO CLINIC PROC. 686, 689-90 (2007) (finding that futility disputes are one of the primary reasons for hospital ethics consultations).

cases have in the last three decades."²

While most futility disputes are resolved informally, informal resolution is deeply informed and shaped by the "shadow of the law."³ The perception of legal liability has a considerable impact on physicians' life support decisions.⁴ In one recent survey, providers were asked why they followed the instructions of surrogates instead of doing what they felt was appropriate. Almost all the responding providers cited a "lack of legal support."⁵

But that "shadow of the law" is misperceived. In assessing the judicial treatment of futility cases, it appears that most of the medical, legal, and bioethical literature concludes that courts have generally disfavored providers. Some treatises observe that "the courts have not given the elder law practitioner much guidance in the area of medical futility."⁶ However, these assessments are based on limited and outdated sets of cases.

This article provides a comprehensive review of futility cases over the twenty-five year period from 1983 to 2008. Based on this review, I argue that courts have generally neither prohibited nor punished the unilateral refusal of LSMT. Providers have regularly obtained both ex ante permission and ex post forgiveness for stopping LSMT without consent.⁷

2. ALAN MEISEL & KATHY CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 13.01[D] (3d ed. 2005 & Supp. 2007) [hereinafter *THE RIGHT TO DIE*]. See Pam Belluck, *Even as Doctors Say Enough, Families Fight to Prolong Life*, N.Y. TIMES, Mar. 27, 2005, at 1.1 ("The most common case that comes before the ethics committees . . . are families now insisting on treatment that the doctors believe is unwarranted." (quoting Dr. John J. Paris)).

3. Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 968 (1979).

4. See Henry S. Perkins et al., *Impact of Legal Liability, Family Wishes, and Other 'External Factors' on Physicians' Life-Support Decisions*, 89 AM. J. MED. 185 (1990); S. Van McCrary et al., *Treatment Decisions for Terminally Ill Patients: Physicians' Legal Defensiveness and Knowledge of Medical Law*, 20 L. MED. & HEALTH CARE 364 (1992). See also Thaddeus M. Pope & Ellen A. Waldman, *Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure*, 22 OHIO ST. J. ON DISP. RESOL. 143, 170-85 (2007).

5. Robert Sibbald et al., *Perceptions of "Futile Care" among Caregivers in Intensive Care Units*, 177 CANADIAN MED. ASS'N J. 1201, 1203 (2007).

6. EDWIN KASSER, *ELDER LAW AND GUARDIANSHIP IN NEW YORK* § 4:97 (2008).

7. This article is not an analysis of the legal risks entailed in unilateral withdrawal of LSMT, given the unavoidable material jurisdictional and factual

In Section One, I describe a futility dispute and the informal manner in which such a dispute is usually resolved. I also discuss the current popular perception that the judicial treatment of such disputes generally disfavors health care providers. While few cases are litigated, the perception of the judicial treatment of futility disputes has an enormous impact on the informal resolution of tens of thousands of disputes in the hospital context. Furthermore, I examine the complete available universe of litigated futility cases.⁸ These cases can arise either before LSMT is withdrawn (ex ante cases) or after LSMT is withdrawn (ex post cases).

In Section Two, I differentiate three types of ex ante cases. First, providers have had increasing success securing judicial permission to replace the authorized surrogate decision-maker with another who will agree with the provider's recommendation. Second, providers have had increasing success obtaining declaratory relief allowing the refusal itself. Third, surrogates have typically been able to only temporarily enjoin the withdrawal of LSMT.

In Section Three, I examine cases brought by surrogates after LSMT is withdrawn. These ex post cases are typically adjudicated in favor of providers. Surrogates either cannot establish that the standard of care requires continued LSMT, or they cannot establish causation and damages. Surrogates'

variations. Rather, it is a broad examination of those futility disputes that have been litigated.

8. The leading treatise focuses primarily on reported cases. *THE RIGHT TO DIE*, *supra* note 2, § 13.10 at 13-44 to 13-46 (Supp. 2007). Since the universe of reported cases is rather limited, this article includes a discussion of unreported cases. Of course, since there is no systematic way to locate unreported cases, these are limited to cases discussed in the secondary literature. Cf. Edward K. Cheng & Albert H. Yoon, *Does Frye or Daubert Matter? A Study of Scientific Admissibility Standards*, 91 VA. L. REV. 471, 480 (2005) (observing that "[M]ost state court opinions, particularly at the trial court level, are unpublished or available on Westlaw or Lexis.") (citing David E. Bernstein, *Frye, Frye Again: The Past, Present, and Future of the General Acceptance Test*, 41 JURIMETRICS J. 385, 389 (2001)). Moreover, even some of these cases have been excluded because they are still in litigation. See, e.g., *Allen v. Stanford Univ. Med. Ctr.*, No. 1-06-CV-070514 (Santa Clara Sup. Ct. Mar. 4, 2008) (defendant's motion for summary judgment taken under submission).

actions for damages typically succeed only where the provider's conduct is outrageous, when LSMT is withdrawn in an egregiously insensitive manner.

I conclude by noting some practical implications of my reassessment of the judicial treatment of futility cases. Elder law treatises observe that "a doctor usually will accede to the wishes of a family that insists that care be continued, even if the doctor believes that no benefit is being conferred."⁹ But while this may have been true in the early 1990s, it may be far less true today. Elder law attorneys should counsel their clients to have realistic expectations of what medicine can and will offer.

THE MISPERCEPTION THAT FUTILITY CASES DISFAVOR PROVIDERS

Before embarking on an analysis of the judicial treatment of futility cases, the distinctive features of a futility case must be clarified, and the judicial treatment of such cases must be placed in the appropriate context. Specifically, while most futility disputes are resolved informally, resolution is deeply influenced by the shadow of the law created by the much smaller universe of court cases.

WHAT IS A FUTILITY DISPUTE?

A medical futility dispute arises when a provider seeks to stop treatment that the patient or surrogate wants continued. The provider judges LSMT to be of no benefit and wants to "stop the train" when the patient or surrogate says "keep going."¹⁰ The provider wants to stop LSMT even without consent of the patient or surrogate.¹¹ Accordingly, a medical

9. JOAN M. KRAUSKOPF ET AL., *ELDERLAW: ADVOCACY FOR THE AGING* 13:26 (2d ed. 1993). See ALISON BARNES ET AL., *COUNSELING OLDER CLIENTS* 317 (2d ed. 2005).

10. K. Francis Lee, *Postoperative Futile Care: Stopping the Train When the Family Says "Keep Going,"* 15 *THORACIC SURGERY CLINICS* 481, 481 (2005).

11. Some writers identify *Lebreton v. Rabito*, 650 So.2d 1245 (La. App. 1995), as a futility case. But while the daughter brought a malpractice action for the

futility dispute is sometimes referred to as a “reverse end-of-life,”¹² a “right to life,”¹³ a “duty to die,”¹⁴ or even an “involuntary euthanasia”¹⁵ situation.

The provider and surrogate disagree about the need for LSMT because they each have different goals.¹⁶ The surrogate’s goals may include cure, amelioration of disability, palliation of symptoms, reversal of disease process, or prolongation of life. The provider, on the other hand, may, under the circumstances, judge these goals to be impossible, virtually impossible, or otherwise inappropriate.¹⁷

It was just this sort of disagreement underlying the recent high-profile case of “Baby Emilio.” On November 3, 2005, Emilio Lee Gonzales was born generally healthy; however, within a few weeks, he started exhibiting neurological abnormalities.¹⁸ By November 2006, Baby Emilio showed “global developmental delay and decreased muscle tone and reflexes,” and he was soon diagnosed with Leigh’s disease, a progressive neuron-metabolic disorder affecting the nervous

withdrawal of LSMT by her father, her mother was the authorized decision-maker who had consented to the withdrawal. *Id.* at 1246-47. This was an intra-family dispute, not a futility dispute between a patient or surrogate and a provider. See also Anthony Colarossi, *Man at Center of Living Will Battle Dies*, S. FLA. SUN-SENTINEL, Dec. 11, 2004, at 6B.

12. See, e.g., Thomas Wm. Mayo, *Living and Dying in a Post-Schiavo World*, 38 J. HEALTH L. 587, 602 n.68 (2006); THE RIGHT TO DIE, *supra* note 2, § 13.01[B] at 13-4.

13. See, e.g., Leigh Middleditch, Jr. & Joel Trotter, *The Right to Live*, 5 ELDER L.J. 395 (1997) [hereinafter *The Right to Live*]; Nancy Neveloff Dubler, *Conflict and Consensus at the End of Life*, HASTINGS CENTER. REP. S19, S19 (Nov.-Dec. 2005); Wesley J. Smith, *Suing for the Right to Live*, DAILY STANDARD, Mar. 9, 2004.

14. See, e.g., *The Right to Live*, *supra* note 13.

15. See Mary Ann Roser, *Debate Heats Up on 10-day Medical Law*, AUSTIN AM.-STATESMAN, Aug. 10, 2006, at B1.

16. See Thomas W. Mayo, *Health Care Law*, 53 SMU L. REV. 1101, 1110 n.78 (2000) (“[T]he core dispute is. . . over what constitutes a ‘benefit’ to the patient . . .”); Griffin Trotter, *Editorial Introduction: Futility in the 21st Century*, 19 HEC FORUM 1, 1 (2007).

17. See Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 27-42 (2007) (reviewing physiological futility, quantitative futility, and four versions of qualitative futility).

18. Verified Complaint Ex. B to Ex. 1, *Gonzales v. Seton Family of Hospitals*, No. A07CA267 (W.D. Tex. Apr. 4, 2007).

system.¹⁹ In December 2006, Baby Emilio was admitted to the PICU at Children's Hospital of Austin, where his neurological status worsened as his brain atrophied.²⁰ He depended on a mechanical ventilator for breathing and a nasojunal tube for eating.²¹ Baby Emilio was semi-comatose, unable to move his arms or legs, rarely opened his eyes, and could not empty his bladder.²² He also had frequent seizures, and the providers had "great difficulty keeping his lungs inflated."²³

Baby Emilio's providers determined that his condition was irreversible, and they believed that to continue treatment would only "serve to prolong his suffering without the possibility of cure."²⁴ His providers felt that "the burdens associated with his current care plan outweigh[ed] any benefit Emilio [might have been] receiving"²⁵ and that his "aggressive treatment plan amount[ed] to a nearly constant assault on Emilio's fundamental human dignity."²⁶

However, Baby Emilio's mother, Catarina, demanded that the providers continue the aggressive treatment plan. She refused to consent to the withdrawal of Baby Emilio's life-sustaining treatment,²⁷ insisting that the providers maintain him until "Jesus takes him."²⁸ Catarina would not agree to the providers' recommendations because "every moment of life he has to spend with her is of inestimable value."²⁹ During the winter of 2007, Catarina had multiple conferences with Baby Emilio's providers to discuss his condition and treatment plan,³⁰ but they could not reach a consensus. In February and March of

19. *Id.* at ¶ 17.

20. *Id.* at Ex. B to Ex. 1.

21. *Id.*

22. *Id.*

23. *Id.* at Ex. D to Ex. 1, at 3.

24. *Id.* at Ex. A to Ex. 1.

25. *Id.* at Ex. D to Ex. 1, at 4.

26. *Id.*

27. *Id.* at ¶ 19.

28. *Id.* at Ex. B to Ex. 1, at 3.

29. *Id.* at ¶ 27.

30. *Id.* at Ex. B to Ex. 1, at 2.

2007, Catarina met not only with the providers, but also with the hospital's entire Neonatal/Pediatric Ethics Committee.³¹ Again, no consensus was reached.³² Soon thereafter, Catarina filed two separate lawsuits against both the Children's Hospital and the individual providers.³³

WHILE FUTILITY DISPUTES ARE RARELY RESOLVED IN COURT, JUDICIAL TREATMENT CASTS A LONG, DARK SHADOW OVER THEIR INFORMAL RESOLUTION

While the *Gonzales* case ended up in court, most futility disputes are resolved internally and informally by the medical team. Presumably after a medical team discusses a patient's treatment goals, the nature of a patient's condition, and the range of options, the team comes up with a treatment recommendation, with which most surrogates agree. For example, in a multi-center study by Prendergast and colleagues, fifty-seven percent of surrogates agreed immediately with a provider-recommended care-plan, and ninety percent moved toward agreement within five days.³⁴ In a more recent study, consensus was reached in fifty-one percent of cases after the first meeting, in sixty-nine percent of cases after a second meeting, and in ninety-seven percent of cases after a third meeting.³⁵

Even if the provider and surrogate do not agree on a treatment, it is sometimes possible to transfer a patient to

31. *Id.*

32. *Id.* at Ex. D to Ex. 1.

33. *Gonzales v. Seton Family of Hospitals*, No. 86427 (Travis Cty. Probate Ct, Tex. filed Mar. 20, 2007); *Gonzales v. Seton Family of Hospitals*, No. A07CA267 (W.D. Tex. filed Apr. 4, 2007).

34. Thomas J. Prendergast, *Resolving Conflicts Surrounding End-of-Life Care*, 5 NEW HORIZONS 62, 62 (1997).

35. Daniel Garros et al., *Circumstances Surrounding End of Life in a Pediatric Intensive Care Unit*, 112 PEDIATRICS e371, e373 (2003). See Laurence J. Schneiderman et al., *Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial*, 290 JAMA 1166, 1166 (2003) (concluding that ethics consults "were useful in resolving conflicts that may have inappropriately prolonged nonbeneficial . . . treatments.").

another institution that is willing to comply with the surrogate's treatment requests.³⁶ While this is rarely successful,³⁷ it does sometimes resolve additional disputes.³⁸

When stopping LMST is against the wishes of a patient or surrogate, providers should take unilateral action to stop LSMT only after diligently making all the foregoing attempts to resolve the conflict.³⁹ While most cases will never reach this stage,⁴⁰ a significant percentage will.⁴¹ A recent five-year study of sixteen

36. The model futility policies of most institutional and professional associations provide for transfer. See, e.g., AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS §§ 2.035, 2.037, at 13-15 (2006-07); AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, MEDICAL FUTILITY IN END-OF-LIFE CARE, 281 JAMA 937, 940 (1999). This is consistent with the law of tortuous abandonment, which requires physicians to assist their patients in finding a new provider before terminating a treatment relationship. See *Payton v. Weaver*, 182 Cal. Rptr. 225, 229 (Cal. App. 1982); Stella L. Smetanka, *Who Will Protect the 'Disruptive' Dialysis Patient?*, 32 AM. J. L. & MED. 53, 71-79 (2006). Exploring the possibility of transfer is also required by many state health care decision-making statutes. See generally Pope, *Futility Statutes*, *supra* note 17.

37. See Pope, *Futility Statutes*, *supra* note 17, at 60 n. 343 (collecting cites).

38. See, e.g., Todd Ackerman, *Hospital to End Life Support: Houston Woman Faces Second Fight in 2 Months Over Husband's Care*, HOUSTON CHRON., Apr. 28, 2005, at 5 (discussing how St. Luke's in Houston noted that "more than 30 facilities had rejected Nikolouzos before Avalon Place surprised them and agreed to take [him]."); Joan Beck, *Use Medical Treatment to Save Every Damaged Baby?*, ORLANDO SENTINEL, May 18, 1990, at A13 (The GAL for Baby L "found a pediatric neurologist who was willing to do everything the mother wanted."); Alexander M. Capron, *Baby Ryan and Virtual Futility*, HASTINGS CENTER REP. 20, 20 (Mar.-Apr. 1995) (noting that the parents of Ryan Nguyen found a facility willing to provide the requested treatment.); John J. Paris et al., *Physicians' Refusal of Requested Treatment: The Case of Baby L*, 322 NEW ENG. J. MED. 1012, 1013 (1990) (parents transferred Baby L's care to a consultant pediatric neurologist).

39. See MICHAEL D. CANTOR ET AL., DO-NOT-RESUSCITATE ORDERS AND MEDICAL FUTILITY: A REPORT BY THE NATIONAL ETHICS COMMITTEE OF THE VETERANS HEALTH ADMINISTRATION 1 (Dec. 2000) (arguing that unilateral decisions "should be reserved for exceptionally rare and extreme circumstances after thorough attempts to resolve disagreements have failed"); THE RIGHT TO DIE, *supra* note 2, § 13.04, at 13-22 (noting that "sometimes only litigation can break the impasse between demanding families and resistant health care professionals."); Timothy Bowen & Andrew Saxton, *New Developments in the Law - Withholding and Withdrawal of Medical Treatment*, 14(5) AUSTRALIAN HEALTH L. BULL. 57, 60 (2006).

40. See Troyen A. Brennan, *Ethics Committees and Decisions to Limit Care*, 260 JAMA 803, 807 (1988) ("In all cases [where unilateral DNR orders were entered], the families either ultimately accepted this reasoning or ceased insisting that invasive procedures be used.").

41. See Pope & Waldman, *supra* note 4, at 158-61. See also Robert L. Fine, *The Texas Advance Directives Act of 1999: Politics and Reality*, 13 HEC FORUM 59, 81 (2001) (five of 29 cases went through the whole process, though two died and three agreed

hospitals found that each hospital averaged one case per year in which it decided to unilaterally stop LSMT.⁴² Another study of nine hospitals found that the hospitals decided to unilaterally stop LSMT in two-percent of 2,842 cases.⁴³ Moreover, there are strong reasons to suspect that the rate of intractability will rise.⁴⁴

While few futility cases go to court, those that do exert a strong influence on the resolution of the other cases.⁴⁵ “[W]hile legal power is relevant only in the few disputes that enter the system . . . [b]argaining endowments are . . . relevant to many futility cases.”⁴⁶ Mediation occurs in the “shadow of the law,”⁴⁷ in that both parties consider the likely range of results if the dispute were litigated.⁴⁸ After all, “if agreement cannot be reached in the mediation session, a series of default rules . . . comes into play.”⁴⁹

“[T]he outcome that the law will impose if no agreement is reached gives each [party] certain bargaining chips - an

before treatment was actually stopped); Pendergast, *supra* note 34 at 67 (finding 4% of disputes were intractable).

42. Emily Ramshaw, *Children Fight to Save Mom*, DALLAS MORNING NEWS, Aug. 18, 2006. About half these patients died or were transferred to other facilities before treatment was actually stopped. *Id.*

43. Testimony before the Tex. H. Comm. on Public Health (2005), in INTERIM REPORT 2006, at 36 (citing a written statement of Greg Hooser).

44. The reasons for surrogate insistence are becoming more prevalent. See Pope & Waldman, *supra* note 4, at 158-61. At the same time, provider resistance may increase with changes in reimbursement and an increased focus on palliative care. *Id.*

45. Cf. Roberts v. Stevens Clinic, 345 S.E.2d 791, 801 (W. Va. 1986) (“[B]ecause less than six percent of all serious lawsuits are tried, the most important thing that courts do is to cast a shadow of legal rules within which litigants can craft their own custom-made settlements.”); RANDALL R. BOVBERG & BRIAN RAYMOND, PATIENT SAFETY, JUST COMPENSATION AND MEDICAL LIABILITY REFORM 11 (2003), available at http://www.kpihp.org/publications/docs/patient_safety.pdf (explaining how providers engage in “defensive medicine”) (last visited Feb. 2, 2008).

46. Bethany Spielman, *Bargaining about Futility*, 23 J. L. MED. & ETHICS 136, 137 (1995).

47. Mnookin & Kornhauser, *supra* note 3, at 968.

48. Jeffrey W. Stempel, *Forgetfulness, Fuzziness, Functionality, Fairness, and Freedom in Dispute Resolution: Serving Dispute Resolution Through Adjudication*, 3 NEV. L.J. 305, 308 n.14 (2003).

49. NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS 25 (2004).

endowment of sorts.”⁵⁰ Since a party typically will not agree to settle for an amount less than it would be awarded in litigation, such entitlements typically determine the minimum amount a party will accept in bargaining.⁵¹ Therefore, it appears that the party who can achieve a better litigation outcome will have a higher minimum settlement amount and greater bargaining power.

PROVIDERS GENERALLY PERCEIVE THAT FUTILITY CASES DISFAVOR THE UNILATERAL REFUSAL OF LSMT

It is widely believed that surrogates can achieve the better litigation outcome. “Numerous articles have warned physicians of the serious legal risk in unilaterally writing a DNR order. . .”⁵² Specifically, based on the outcomes of several well-publicized court cases, commentators consistently conclude that courts usually side with families and against hospitals.⁵³

Commentators conclude that “courts have not upheld the right of physicians to make unilateral judgments”⁵⁴ and find that “courts are overriding ostensibly sound physician assessments . . . [and] dictating medical maintenance of . . . gravely debilitated patients.”⁵⁵ This assessment is widely

50. Mnookin & Kornhauser, *supra* note 3, at 968.

51. See Jonathan M. Hyman & Lela P. Love, *If Portia Were a Mediator: An Inquiry into Justice in Mediation*, 9 CLINICAL L. REV. 157, 162 (2003) (noting that “public law provides the norms that guide private dispute resolution. Parties often settle . . . by keeping in mind and balancing the entitlements the litigation system promises.”); Stephen N. Subrin, *A Traditionalist Looks at Mediation: It’s Here to Stay and Much Better than I Thought*, 3 NEV. L.J. 196, 227 (2003) (“[t]he results of mediation are frequently - I actually believe usually - dependent upon the range of potential results that would come from formal adjudication.”).

52. Edward F. McArdle, *New York’s DNR Law: Groundbreaking Protection of Patient Autonomy or a Physician’s Right to Make Medical Futility Determinations*, 6 DEPAUL J. HEALTH CARE L. 55, 71 (2002).

53. Jack K. Kilcullen et al., *A Multilevel Examination of a Critically Ill Patient, in THREE PATIENTS: INTERNATIONAL PERSPECTIVES ON INTENSIVE CARE AT THE END OF LIFE* 123 (2002).

54. Paul R. Helft et al., *The Rise and Fall of the Futility Movement*, 343 NEW ENG. J. MED. 293, 295 (2000).

55. Norman L. Cantor, *Can Healthcare Providers Obtain Judicial Intervention against Surrogates Who Demand ‘Medically Inappropriate’ Life Support for Incompetent Patients?*, 24 CRITICAL CARE MED. 883, 884 (1996).

reprinted in medical journals,⁵⁶ bioethics journals,⁵⁷ and even in many law reviews.⁵⁸

While some authors have made more careful and qualified case assessments, they emphasize the uncertainty and risk.⁵⁹

56. See, e.g., Am. Coll. of Obstetricians and Gynecologists, *Committee Opinion No. 362: Medical Futility*, 109 OBSTETRICS & GYNECOLOGY 791, 792 (2007) (noting that "litigation . . . has generally resulted in courts supporting the views of patient or family . . ."); Robert A. Burt, *The Medical Futility Debate: Patient Choice, Physician Obligation, and End-of-Life Care*, 5 J. PALLIATIVE MED. 249, 250 (2002) ("[C]ourts have rejected physician claims to use futility . . ."); Robert S. Chabon et al., *The Case of Baby K*, 331 NEW ENG. J. MED. 1383, 1383 (1994) ("In no reported case has a court ruled that a physician may . . . override a parent's wish to continue life support for his or her dying child."); Lewis L. Low & Larry J. Kaufman, *Medical Futility and the Critically Ill Patient*, 58 HAWAII MED. J. 58, 62 (1999) ("To date, the U.S. courts have refused to grant physicians and hospitals the power to override the opinions of family members on matters of futility."); Stanley A. Nasraway, *Unilateral Withdrawal of Life-Sustaining Treatment: Is It Time? Are We Ready?*, 29 CRITICAL CARE MED. 215, 217 (2001); James E. Szalados, *Discontinuation of Mechanical Ventilation at End-of-Life: The Ethical and Legal Boundaries of Physician Conduct in Termination of Life Support*, 23 CRITICAL CARE CLINICS 317, 325 (2007).

57. See, e.g., Peter A. Clark, *Medical Futility in Pediatrics: Is It Time for a Public Policy?*, 23 J. PUB. HEALTH POL'Y 66, 66-67 (2002); Robert A. Gatter, Jr. & John C. Moskop, *From Futility to Triage*, 20 J. MED. & PHIL. 191, 194 (1995).

58. See, e.g., Peter N. Cultice, *Medical Futility: When Is Enough, Enough*, 27 J. HEALTH & HOSP. L. 225 (1994); Judith Daar, *Medical Futility and Implications for Physician Autonomy*, 21 AM. J. L. & MED. 221, 223 (1995); Sandra H. Johnson et al., *Legal and Institutional Policy Responses to Medical Futility*, 30 HEALTH L.J. 21 (1997) ("[T]he courts have almost uniformly ordered continued treatment."); Patrick Moore, *An End-of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment that Physicians Are Unwilling to Provide*, 48 B.C. L. REV. 433, 439 (2007).

59. See, e.g., NAT'L CTR. FOR STATE COURTS, *GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE SUSTAINING MEDICAL TREATMENT CASES* 147 (2d ed. 1993) (finding that there is "as yet no consensus . . . on the legal ramifications associated with [futility]. . ."); Gordon B. Avery, *Futility Considerations in the Neonatal ICU*, 22 SEMINARS PERINATOLOGY 216, 219-20 (1998); Jesse A. Goldner et al., *Responses to Medical Futility Claims*, in HEALTH LAW HANDBOOK 401, 401 (1997) (noting that the current legal status of claims of medical futility is confusing); Sandra H. Johnson et al., *Legal and Institutional Policy Responses to Medical Futility*, 30 HEALTH L.J. 21 (1997); Alan Meisel, *Ethics and Law: Physician-Assisted Dying*, 8 J. PALLIATIVE MED. 609, 615 (2005); E. Haavi Morreim, *Profoundly Diminished Life*, 24 HASTINGS CENTER REP. 33, 36 (Jan.-Feb. 1994) (noting that "[c]ourts have yet to offer guidance . . ."); John M. Luce & Douglas B. White, *The Pressure to Withhold or Withdraw Life-sustaining Therapy from Critically Ill Patients in the United States*, 175 AM. J. RESPIRATORY & CRITICAL CARE MED. 1104, 1106 (2007) (correctly noting that the *Baby K* and *Wanglie* cases did not "fac[e] the futility issue head on"); Nasraway, *supra* note 56, at 217 ("Unilateral withdrawal . . . is still uncharted territory."); Sibbald, *supra* note 5, at 1206 (noting there is little case law to guide decision-making in the face of patient or surrogate opposition); Karen Trotochaud, *'Medically Futile' Treatments Require More than Going to Court*, CASE MANAGER, May-June 2006, at 60, 63 ("[L]egal cases have provided limited and confusing guidance . . .").

Moreover, much of what providers have learned about litigated cases is distorted. "[A]s the information gets passed along, it gets simplified, and sometimes oversimplified, and sometimes distorted, as in a children's game of 'telephone.'"⁶⁰ After all, "[e]ven experts can succumb to reductionist tendencies and lose sight of the subtleties."⁶¹ In short, actual risks are likely overestimated by providers.⁶²

Both providers and surrogates seem to believe that substantive end-of-life medical decision-making law favors surrogates. Both understand that surrogates have an effective "veto authority" over physician judgment.⁶³ It appears that both expect the surrogates to likely win a litigated case if an agreement is not reached in LSMT negotiations and mediation. It is this understanding that ultimately casts a shadow on negotiations, rather than actual law.⁶⁴ "The most efficacious social facts in the actual hospital situation are [provider] perceptions themselves, not the objective risks"⁶⁵

But this pejorative assessment of providers' non-settlement alternatives appears off-base. Not only have providers

60. Alan Meisel, *The Role of Litigation in End of Life Care: A Reappraisal*, HASTINGS CENTER REP. S47, S48 (Nov.-Dec. 2005).

61. *Id.*

62. Cf. Regina Ohkyusen-Cawley et al., *Institutional Policies on Determination of Medically Inappropriate Interventions: Use in Five Pediatric Patients*, 8 PEDIATRIC CRITICAL CARE MED. 225, 225 (2007) ("[C]ourts have endorsed patient or surrogate insistence on continued intervention, possibly fostering the reluctance of medical professionals to limit nonbeneficial interventions."). Marshall Kapp argues that the legal risks in the early 1990s were not serious and concedes that physicians had "overblown anxiety." Marshall Kapp, *Futile Medical Treatment: A Review of the Ethical Arguments and Legal Holdings*, 9 J. GEN. INTERNAL MED. 170, 175 (1994).

63. Cf. Jacquelyn Slomka, *Clinical Ethics and the Culture of Conflict*, HASTINGS CENTER REP. 45, 46 (Mar.-Apr. 2005) (noting that "[a]n increasingly litigious society as well as bioethical emphasis on patient and family autonomy. . . have led to physicians' disempowerment . . .").

64. See Pope & Waldman, *supra* note 4. Cf. Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 L. & CONTEMP. PROBLEMS 119, 119 (1991) ("[T]o the extent that a crisis is in fact widely perceived, it has the quality of a self-fulfilling prophecy"); Spielman, *supra* note 46, at 137 ("[I]n the clinical setting . . . myths about the law often overshadow reality.").

65. Stephen Toulmin, *Institutions and their Moral Constraints*, in INTEGRITY IN HEALTH CARE INSTITUTIONS: HUMANE ENVIRONMENTS FOR TEACHING, INQUIRY, AND HEALING 21, 26 (Ruth E. Bulger & Stanley J. Reiser eds., 1990).

frequently prevailed in futility cases, but they also have more legislative protection than ever before.⁶⁶ Some surrogates have successfully litigated cases against providers. But those cases are legally and factually unique, so they simply cannot support a sweeping statement that the surrogates are favored judicially in all futility cases.

EX ANTE ACTIONS: GOING TO COURT BEFORE LSMT IS WITHDRAWN

There are seven basic ways to resolve a futility dispute: (1) the patient dies; (2) the surrogate accedes to the provider's recommendation; (3) the surrogate replaces the provider with another provider willing to provide the requested treatment; (4) the provider accedes to the surrogate's request; (5) the provider replaces the surrogate; (6) the provider overrides the surrogate; or (7) the surrogate overrides the provider. It appears that a dispute typically goes to court only when parties take one of the last three approaches.

Court actions are brought forth by way of four basic procedural vehicles, which can be categorized as either *ex ante* or *ex post* cases. If the provider withdraws treatment without consent or judicial permission, the surrogate may sue for damages. These *ex post* cases are discussed in Section III. The other three procedural vehicles, which are categorized as *ex ante* cases, are discussed here in this section.

The *ex ante* cases involve going to court before treatment is withdrawn. First, if the provider plans to replace the surrogate, he or she will do that before withdrawing LSMT. The goal of surrogate replacement is to secure the consent of a newly-authorized decision-maker. Second, where a provider plans to override the surrogate and withdraw LSMT without consent, a provider can first seek declaratory relief or permission to stop

66. See Pope, *Futility Statutes*, *supra* note 17 (surveying state statutes that grant providers civil, criminal, and disciplinary immunity for refusing to comply with inappropriate treatment requests).

treatment. Third, a surrogate can seek an injunction to continue the treatment.

PROVIDER ACTIONS TO REPLACE THE SURROGATE OFTEN SUCCEED

Sometimes providers ask courts to adjudicate the fitness of the current surrogate decision-maker rather than the underlying appropriateness of the LSMT.⁶⁷ Some have even suggested that this should be the preferred method of resolving futility disputes,⁶⁸ given the body of jurisprudence concerning how to select surrogates for patients without capacity.⁶⁹

In early cases, courts were generally unwilling to negate a surrogate's right to make health care decisions on behalf of a patient.⁷⁰ However, in more recent cases, providers have successfully replaced surrogates who demanded LSMT that providers deemed inappropriate.

67. Sometimes no surrogate is reasonably available. Such a case is not really a futility dispute because not only does no one challenge the provider, but also the provider is the authorized decision-maker in many jurisdictions. See, e.g., TENN. CODE. ANN. § 68-11-1806(c)(5) (2006). Cf. Sumeeta Varma & David Wendler, *Medical Decision Making for Patients without Surrogates*, 167 ARCHIVES INTERNAL MED. 1711, 1712 (2007); Douglas B. White et al., *Life Support for Patients without a Surrogate Decision Maker: Who Decides?*, 147 ANNALS INTERNAL MED. 34 (2007).

68. See Jeffrey P. Burns & Robert D. Truog, *Futility: A Concept in Evolution*, 132 CHEST 1987, 1991-92 (2007); Robert D. Truog, *Tackling Futility in Texas*, 357 NEW ENG. J. MED. 1558, 1559 (2007) (endorsing "existing pathways to challenge the legitimacy of the surrogate to make these decisions and to seek appointment of another decision maker"). See also Rasa Gustatis, *Right to Refuse Life-Sustaining Treatment*, 81 PEDIATRICS 317, 319 (1988) (suggesting the use of child abuse laws to override parental requests for inappropriate treatment). But cf. Robert Schwartz, *Autonomy, Futility, and the Limits of Medicine*, 1 CAMBRIDGE Q. HEALTHCARE ETHICS 159, 161 (1992) (arguing that the question whether Mr. Wanglie was his wife's best substitute decision-maker was the "wrong question," and "[t]he real question [should have been] . . . whether the continuation of ventilator support and gastrostomy feeding were among the reasonable medical alternatives that should have been available to Mrs. Wanglie or her surrogate decision-maker, whoever that might be.").

69. See generally THE RIGHT TO DIE, *supra* note 2, at §§ 8.01-8.11 (outlining the jurisprudence of selecting surrogate decision makers); CLAIRE C. OBADE, PATIENT CARE DECISION MAKING: A LEGAL GUIDE FOR PROVIDERS ch.11 (1991 & Supp. 2007) (explaining various methods for surrogate decision-making).

70. See Lee, *supra* note 10, at 487.

In re Wanglie is one of the earliest and most widely-discussed cases.⁷¹ Helga Wanglie was an eighty-six year old woman who was in a persistent vegetative state and dependent on a ventilator as a result of cardiorespiratory arrest.⁷² Her providers determined that she could never appreciate any benefit from continued LSMT, so they advised her husband Oliver to remove the ventilator.⁷³ However, Oliver would not consent to stopping LSMT.⁷⁴

The providers petitioned the local probate court to appoint a professional conservator to make health care decisions for Helga.⁷⁵ The hospital-nominated conservator presumably would accede to the providers' recommendation to stop LSMT, unlike Oliver. Despite the provider's efforts, the probate court denied the petition and instead appointed Oliver as conservator.⁷⁶ The court noted that Oliver was Helga's husband of fifty-three years.⁷⁷ Moreover, his decision to continue LSMT did not constitute grounds to remove his decision-making authority. The court could not conclude that Oliver's decision to continue LSMT was inconsistent with Helga's preferences or best interests.⁷⁸

While *Wanglie* is certainly the most famous case from the early 1990s in which a court rejected a provider's attempt at "surrogate shopping," it is not the only case.⁷⁹ In *Nguyen v.*

71. *In re Wanglie*, No. PX-91-283 (Minn. Prob. Ct. Hennepin County June 28, 1991), reprinted in 7 ISSUES L. & MED. 369 (1991).

72. *Id.* at 374.

73. *Id.* at 371.

74. *Id.*

75. *Id.* at 371, 376.

76. *Id.* at 372, 377.

77. *Id.* at 376.

78. *Id.*

79. See, e.g., *In re Baby K*, 832 F. Supp. 1022, 1031 (E.D. Va. 1993) (ruling that the mother's decision to continue treatment was not "so unreasonably harmful as to constitute child abuse or neglect"); *Belcher v. Charleston Area Med. Center*, 422 S.E.2d 827, 838 (W. Va. 1992) (while providers received consent to a DNR order from a 17-year-old's parents, the court held that consent was valid only if the boy lacked capacity to decide for himself); *In re Doe*, Civ. No. D-93064 (Ga. Super. Ct. Oct. 17, 1991) (mem.), *aff'd*, 418 S.E.2d 3, 7 (Ga. 1992) (holding that providers could not withdraw LSMT from a child with only the mother's consent where the child's

Sacred Heart Medical Center, a Washington court rejected a provider's argument that a child's parents serving as surrogate decision-makers should be replaced because their decision to continue LSMT constituted child abuse.⁸⁰ Similarly, a District of Columbia court refused to replace a mother as surrogate decision-maker for her two-month-old baby simply because she requested continued LSMT.⁸¹

Some commenters cite *Wanglie* and other cases from the early 1990s to conclude that the strategy of having an alternative decision maker appointed by the court is "rarely successful."⁸² But it appears that these early decisions have little relevance today. First, these decisions were narrow in focus, in that they foreclosed only one legal avenue for providers to override surrogate requests. While the answers to the legal questions asked in *Wanglie* and *Nguyen* disfavored providers, these are not the only questions relevant in medical futility cases.⁸³ Providers can also seek *ex ante* permission or *ex post* forgiveness for unilaterally refusing a surrogate's request.⁸⁴

Second, emboldened by empirical evidence attacking the accuracy of surrogate decisions,⁸⁵ providers have been

father was available). Professor Annas suggests *Doe* is not a futility case, but instead a dispute about who is the authorized decision-maker. George J. Annas, *The Case of Baby K*, 331 NEW ENG. J. MED. 1385 (1994). This is belied by the course of the litigation, which demonstrated that the hospital was hardly agnostic as to which parent had authority. It argued that "continued aggressive treatment . . . constituted medical abuse." In re *Doe*, 418 S.E.2d at 4.

80. *Nguyen v. Sacred Heart Medical Center*, 987 P.2d 636, 638 (Wash. Ct. App. 1999); John Altomare & Mark Bolde, *Nguyen v. Sacred Heart Medical Center*, 11 ISSUES L. & MED. 199, 200 (1995) (noting that while the hospital attempted to characterize continued treatment as "cruel and inhumane," the court held that the argument had no merit).

81. Benjamin Weiser, *A Question of Letting Go: Child's Trauma Drives Doctors to Reexamine Ethical Role: The Case of Baby Rena*, WASH. POST, July 14, 1991, at A1.

82. Burns & Truog, *supra* note 68, at 1989.

83. Cf. THE RIGHT TO DIE, *supra* note 2, § 13.03[A], at 13-13.

84. Providers can also seek declaratory relief. See *infra* "Provider Actions For Declaratory Relief Often Succeed" notes 103-21 and accompanying text. Or providers can proceed to withdraw LSMT and defend any subsequent damages case. See *infra* "Ex Post Actions: Going to Court After LSMT Is Withdrawn" notes 142-214 and accompanying text.

85. Lauren G. Collins et al., *The State of Advance Care Planning: One Decade after SUPPORT*, 23 AM. J. HOSPICE & PALLIATIVE MED. 378, 379-80 (2006).

increasingly able to establish that surrogates refusing to follow recommendations to stop LSMT are not acting in patients' best interests.⁸⁶ "A patient's preservable existence might be so tortuous, painful, or filled with suffering that it would be deemed inhumane for a surrogate to dictate continued medical intervention."⁸⁷ Even permanent unconsciousness is increasingly broadly recognized as a status in which a patient can derive zero benefit from continued LSMT.⁸⁸

By the mid-1990s, judicial hostility to surrogate shopping began to wane.⁸⁹ Courts began replacing surrogates in situations where the only ground for disqualification was the fact that the surrogate demanded LSMT for the patient contrary to provider recommendations. Courts are prepared to override

86. Courts seemed always prepared to allow surrogate shopping when a parent is decision-maker and a parent's own physical abuse caused a child's dependence on LSMT. For instance, one Pennsylvania case involved a mother who abused her two-year-old baby. Providers recommended stopping LSMT, but the baby's father refused because he was concerned about his wife's criminal liability. The hospital prepared to ask a court to appoint a guardian because the father was looking out for his wife's interests, not the interests of the child. Steve Twedt, *Should Comatose Baby Live? Hospital, Dad Differ*, PITT. POST-GAZETTE, June 3, 1990, at A1. The father then acceded to the hospital's recommendation to withdraw LSMT. *Father Ends Life Support*, PITT. POST-GAZETTE, June 24, 1990, at A3; Mary Pat Flaherty, *Right to Die Decision Has Little Impact Here*, PITT. POST-GAZETTE, June 27, 1990, at A1. Cf. J.N. v. Sup. Ct., 67 Cal. App. 3d 384, 391 (Cal. Ct. App. 2007) (holding that guardian of minor has the burden of bringing expert testimony to prove that the LSMT is in the minor's best interest); D.K. v. Commonwealth, 221 S.W.3d 382, 384 (Ky. Ct. App. 2007) (permitting a guardian to remove LSMT once parental rights were permanently terminated); *In re Matthew W.*, 903 A.2d 333, 335 (Me. 2006) (holding that a pre-termination protection order allowing DNR for minor without parental consent violated the parents' right to due process); *In re Smith*, 133 P.3d 924, 929-30 (Or. Ct. App. 2006) (holding that a mother was not in a position to make decisions for her minor child where she chose not to be involved in the child's health care decisions on a regular basis); *In re Stein*, 821 N.E.2d 1008 (Ohio 2004) (finding that a limited guardian did not have the authority to withdraw LSMT when parental rights had not yet been permanently terminated); *In re Tabatha R.*, 564 N.W.2d 598, 605 (Neb. 1997) (discussing due process rights of parents during termination of parental rights determination).

87. Cantor, *supra* note 55, at 884.

88. *Id.* at 884-85.

89. Cf. *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072, 1076 (La. Ct. App. 1998) (noting that if a surrogate insists on inappropriate treatment, "the usual procedure . . . is to transfer the patient or go to court to replace the surrogate or override his decision." One argument is that the surrogate is not fulfilling his or her statutorily-provided role. Another argument is "that the guardian or surrogate is guilty of abuse by insisting on care which is inhumane.").

even well-intentioned surrogates whose demands for continued LSMT cause a patient unwarranted extreme suffering.⁹⁰

For example, in the case *In re Mason*, the Massachusetts General Hospital successfully moved the local probate court to "override" a health care agent's refusal to consent to a do not resuscitate ("DNR") order.⁹¹ In granting the hospital's petition, the court explained that since the agent was "in denial" about his mother's deterioration and distrustful of her providers, he had not given "full consideration of acceptable medical alternatives."⁹²

Similarly, in a case referred to as *Baby Terry*, the court replaced the parents of two-month-old Terry Achtabowski Jr. with a guardian.⁹³ Baby Terry was born premature at twenty-three weeks gestation, was dependent on a ventilator, and had a host of serious medical problems that made his prognosis very bleak.⁹⁴ Since continued treatment was painful and offered virtually no prospect for recovery, the Genesee County Department of Social Services alleged that Baby Terry's parents were neglectful in requesting continued treatment.⁹⁵ The Michigan Probate Court did not find the parents neglectful, but it did determine that they were "incompetent" to decide what was best for their son. The court reasoned that the parents lacked the requisite capacity to make medical decisions for their son because their demands for continued LSMT evidenced that they were emotionally unable to appreciate the circumstances.⁹⁶

Most recently, in *In re Howe*, the Massachusetts Probate

90. Cf. *In re Guardianship of Myers*, 610 N.E.2d 663, 671 (Ohio Misc. 1993) (appointing guardian other than parents of permanently comatose minor where one parent refused to consent to stopping LSMT).

91. *In re Mason*, 669 N.E.2d 1081, 1085 (Mass. App. Ct. 1996).

92. *Id.*

93. James Bopp, Jr. & Richard E. Coleson, *Child Abuse by Whom? Parental Rights and Judicial Competency Determinations: The Baby K and Baby Terry Cases*, 20 OHIO N.U.L. REV. 821, 825-826 (1994) (citing *In re Achtabowski*, No. G93142173GD (Mich. Probate Ct. July 30, 1993)); *Baby Dies, Was Focus of Battle*, ORLANDO SENTINEL, Aug. 13, 1993, at A10.

94. Bopp & Coleson, *supra* note 93, at 825.

95. *Id.* at 834.

96. *Id.* at 826, 832.

Court initially seemed to return to the earlier hostile approach to surrogate shopping. The court ruled that where a surrogate decision-maker insisted on continued LSMT for her mother, “the evidence is insufficient to warrant court usurpation of [a daughter’s] role as her mother’s health care agent.”⁹⁷ But as the patient’s condition deteriorated, the daughter’s decision to continue LSMT increasingly diverged from the hospital’s assessment of the patient’s preferences and best interests. Several months later, the court suggested that the agent’s own personal issues were “impacting her decisions” and urged the daughter to “refocus her assessment.”⁹⁸ A year later, the hospital again planned to remove LSMT, and the court denied the daughter’s request for a temporary restraining order (TRO).⁹⁹ The daughter soon agreed to withdraw LSMT “because she believed the court was prepared to rule against her.”¹⁰⁰

Surrogates are generally obligated to make health care decisions in accordance with the patient’s preferences and best interests.¹⁰¹ Particularly for a conscious or semi-conscious patient, continuing LSMT contrary to provider recommendations often contravenes patient preferences and best interests.¹⁰² Consequently, surrogates who make such requests are often acting outside the scope of their authority and should be replaced with other decision makers.

97. *In re Howe*, No. 03-O-1255, 2004 WL 1446057, at *21 (Mass. Prob. & Fam. Ct. Mar. 22, 2004).

98. *Id.* at *20-21.

99. See Liz Kowalczyk, *Plan to Take Woman off Life Support is Halted*, BOSTON GLOBE, Feb. 23, 2005, at B1.

100. *Daughter Explains Agreement to End Care*, BOSTON GLOBE, Mar. 23, 2005, at B2.

101. See generally THE RIGHT TO DIE, *supra* note 2, at §§ 4.01-4.10 (discussing incompetent patients and surrogacy).

102. Cf. Nina A. Kohn & Jeremy A. Blumenthal, *Designating Health Care Decision Makers for Patients Without Advance Directives: A Psychological Critique* (forthcoming 2008); David I. Shalowitz et al., *The Accuracy of Surrogate Decision Makers*, 166 ARCHIVES INTERNAL MED. 493 (2006) (finding that surrogates incorrectly predicted patient preferences in one-third of cases).

PROVIDER ACTIONS FOR DECLARATORY RELIEF OFTEN SUCCEED

While the foregoing cases address the question of who is the appropriate decision-maker for the patient, other cases more directly address the appropriateness of the treatment itself. In these cases, providers ask the court to declare that the providers would not violate the law by refusing the requested LSMT.

It appears that the generally accepted view is that it is easier for providers to ask for forgiveness than to ask for permission. Schneiderman and Capron warn that “[p]hysicians should not expect the courts to give them prior permission to forgo futile treatment.”¹⁰³ Since judges do not want to make decisions that may lead to a patient’s death, it is thought that courts typically deny provider requests for declaratory relief.¹⁰⁴

In perhaps the most famous futility case, *In re Baby K*, the court denied declaratory relief.¹⁰⁵ Baby K was born with anencephaly, a birth defect in which part of the skull and the higher brain are missing.¹⁰⁶ While Baby K was later moved to a nursing home, she was periodically transferred to Fairfax hospital due to breathing difficulties.¹⁰⁷ “Because aggressive treatment would serve no therapeutic or palliative purpose [Baby K’s providers] recommended that [she] only be provided

103. Lawrence J. Schneiderman & Alexander M. Capron, *How Can Hospital Futility Policies Contribute to Establishing Standards of Practice?*, 9 CAMBRIDGE Q. HEALTHCARE ETHICS 524, 530 (2000).

104. See, e.g., Goldner et al., *supra* note 59, at 407 (“[W]hen the issue has been presented in the context of a dispute . . . concerning prospective treatment . . . courts have almost consistently sided against the health care professionals . . .”); Diane E. Hoffman & Jack Schwartz, *Who Decides Whether a Patient Lives or Dies?*, TRIAL, Oct. 2006, at 30, 37; John M. Luce & Ann Alpers, *End-of-Life Care: What Do the American Courts Say*, 29 CRITICAL CARE MED. N40, N41-41 (2001); William Meadow et al., *Current Opinion in Pediatrics and Law 2001*, 14 CURRENT OPINION IN PEDIATRICS 170, 171 (2002); John J. Paris et al., *Howe v. MGH and Hudson v. Texas Children’s Hospital: Two Approaches to Resolving Family-Physician Disputes in End-of-Life Care*, 26 J. PERINATOLOGY 726, 726 (2006); William Prip & Anna Moretti, *Medical Futility: A Legal Perspective*, in MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS 136, 152 (Marjorie B. Zucker & Howard D. Zucker eds., 1997).

105. *In re Baby K*, 832 F. Supp. 1022 (E.D. Va. 1993), *aff’d*, 16 F.3d 590 (4th Cir. 1994).

106. *In re Baby K*, 16 F.3d at 592.

107. *Id.* at 593.

with supportive care.”¹⁰⁸ Baby K’s mother would not consent, insisting that Baby K be provided with a ventilator.¹⁰⁹

Baby K’s providers asked the local federal district court if they were obligated to provide the requested LSMT.¹¹⁰ However, the providers framed their claim under the Emergency Medical Treatment and Active Labor Act (EMTALA).¹¹¹ While the court ruled that the providers were so obligated, that holding is limited to the peculiar facts of the case and the coincidental application of the federal statute.¹¹² Only because Baby K newly arrived at the hospital in an “emergency medical condition,” was the hospital obligated to stabilize her condition.¹¹³ EMTALA’s scope is limited and it “cannot be invoked to require treatment in the vast majority of futility cases.”¹¹⁴

Under current EMTALA law, Fairfax Hospital arguably would not have had any obligation to treat Baby K because both

108. *Id.* at 592.

109. *Id.* at 593.

110. *Id.* at 592.

111. 42 U.S.C.A. § 1395dd (Westlaw current through Feb. 2, 2008).

112. The Fourth Circuit affirmed on only the EMTALA claim, but the district court also based its ruling both on Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a), and on the Americans with Disabilities Act (ADA), 42 U.S.C. § 12182(a). *See In re Baby K*, 832 F. Supp. at 1027-29. However, typically such claims cannot succeed in the futility context because the patient’s need for LSMT is directly related to his or her disability. *See generally* Schiavo v. Schiavo, 403 F.3d 1289, 1294 (11th Cir. 2005) (noting that “[t]he Rehabilitation Act, like the ADA, was never intended to apply to decisions involving the termination of life support or medical treatment.”); *Grzan v. Charter Hosp.*, 104 F.3d 116, 120-21 (7th Cir. 1997) (reviewing cases and legislative history); *Rideout v. Hershey Med. Ctr.*, 30 Pa. D. & C.4th at ¶ 95 (1995) (quoting *Anderson v. Univ. of Wis.*, 841 F.2d 737, 740 (7th Cir. 1988) that “the Rehabilitation Act forbids discrimination based upon stereotypes about a handicap, but it does not forbid decisions based on the actual attributes of the handicap.”); *Johnson v. Thompson*, 971 F.2d 1487, 1492-94 (10th Cir. 1992) (discussing discrimination based on the degree of a handicap and Section 504). On the other hand, while there is no positive constitutional right to medical care, later courts have agreed with the district court that decided the *Baby K* case and have held that unilateral refusals may conflict with the free exercise clause and constitutional parental rights. *See Rideout*, 30 Pa. D. & C.4th at ¶ 84; *In re Baby K*, 832 F. Supp. at 1030.

113. *In re Baby K*, 16 F.3d at 594-96.

114. THE RIGHT TO DIE, *supra* note 2, at § 13.06[C] (explaining that EMTALA does not apply to in-patients).

she and her mother were inpatients.¹¹⁵ The *In re Baby K* court itself later clarified that EMTALA applies “only in the immediate aftermath of admitting [a patient] for emergency treatment,” and that there can be no EMTALA violation for entry of an “anti-resuscitation order” after a good faith admission.¹¹⁶ That interpretation has been confirmed in regulations and appellate opinions.¹¹⁷ In most subsequent unilateral withdrawal cases courts have explicitly noted that since the patient was already admitted, EMTALA did not apply.¹¹⁸ In short, the *Baby K* holding is far more limited than generally understood.

Furthermore, providers have frequently succeeded in obtaining declaratory relief to stop LSMT. Most of the reported cases involve providers securing judicial permission to stop LSMT for patients declared brain dead.¹¹⁹ The notoriety of the *Baby K* decision effectively chilled providers from seeking ex ante judicial permission to stop LSMT.¹²⁰ But at least one court

115. See Thaddeus M. Pope, *EMTALA: Its Application to Newborn Infants*, 4 ABA HEALTH SOURCE No. 7 (Mar. 2008).

116. *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 352-53 (4th Cir. 1996).

117. See *Preston v. Meriter Hosp. Inc.*, 700 N.W.2d 158, 174-78 (Wis. 2005) (Roggensack, J., dissenting); 42 C.F.R. § 489.24(a)(1)(ii) (2003) (“If the hospital admits the individual as an inpatient . . . the hospital’s obligation under [EMTALA] ends”); 42 C.F.R. § 489.24(d)(2) (2007) (providing that “[i]f a hospital . . . admits that individual as an inpatient . . . the hospital has satisfied its special responsibilities under [EMTALA].”).

118. See, e.g., *In re AMB*, 640 N.W.2d 262, 289 (Mich. Ct. App. 2001) (holding that there was no EMTALA violation “when the staff made the decision to discontinue the medical interventions” after the baby had been admitted for more than one week); *Causey*, 719 So. 2d at 1075 (noting that “EMTALA provisions are not applicable to the present case [where the patient had already been admitted.]”); *Rideout*, 30 Pa. D. & C. 4th at 87-91. See also *Gonzales*, No. 86427 (Travis Cty. Probate Ct, Tex. filed Mar. 20, 2007) (Guardian Ad Litem’s Trial Brief on Legal Issues).

119. See, e.g., *In re Long Island Jewish Med. Ctr.*, 641 N.Y.S.2d 989 (Sup. Ct. 1996) (granting hospital authorization to withdraw LSMT from brain dead infant); *In re Haymer*, 450 N.E.2d 940, 940-41 (Ill. App. Ct. 1983); Frank Bruni, *Medical Certainty, Legal Limbo*, N.Y. TIMES, Feb. 28, 1996, at B1 (reporting that a trial court granted relief to a hospital). Cf. *Dority v. Sup. Ct.*, 193 Cal. Rptr. 288 (1983) (noting that “[t]he medical profession need not go into court every time it declares brain death . . .”).

120. Kathy L. Cerminara, *Critical Essay: Musings on the Need to Convince Some People with Disabilities that End-of-Life Decision-Making Advocates Are Not Out to Get Them*, 37 LOY. U. CHI. L.J. 343, 379-81 (2006).

has granted declaratory relief permitting providers to unilaterally withdraw LSMT from a living patient.¹²¹

SURROGATE ACTIONS FOR INJUNCTIVE RELIEF SUCCEED ONLY TEMPORARILY

Just as providers may ask the court for a green light, surrogates may ask the court for a red light. In these cases surrogates ask the court to issue an injunction prohibiting the providers from stopping LSMT.

For the same reason that providers are thought to be unlikely to obtain declaratory relief, surrogates are thought likely to be successful in obtaining injunctive relief. Two distinguished commentators recently observed that the “Courts may be more willing to order the provision of care consistent with a patient’s wishes when he or she is still alive”¹²²

Indeed, courts appear to regularly issue surrogate-sought injunctions, but the injunctions are only temporary in nature. Given the imminent irreparable injury *viz.* the patient’s death, it is not surprising that courts grant immediate relief as an emergency procedure.¹²³ As the estimable Judge J. Skelly Wright explained, “the compelling reason for granting the writ was that a life hung in the balance. There was no time for research or reflection.”¹²⁴ A temporary injunction preserves the status quo,

121. *See, e.g.,* Child & Family Serv. of Cent. Manitoba v. R.L. and S.L.H., 154 D.L.R.4th 409, ¶¶ 13-14 (1997) (noting that “[t]here is no need for a consent from anyone for a doctor to refrain from . . . heroic measures to maintain the life of a patient in an irreversible vegetative state.”).

122. Hoffman & Schwartz, *supra* note 104, at 37. *See* Goldner et al., *supra* note 59, at 407 (“[W]hen the issue has been presented in the context of a dispute . . . concerning prospective treatment . . . courts have almost consistently sided against the health care professionals”); Schneiderman & Capron, *supra* note 103, at 530 (“Physicians should not expect the courts to give them prior permission to forgo futile treatment . . .”).

123. *Cf.* Wright & Miller, 11A FED. PRACTICE & PROC. § 2951 (2d ed. 2007).

124. *In re* President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1009 (D.C. Cir. 1964). *See also* Cruzan v. Director, Missouri Dep’t Health, 491 U.S. 261 283 (1990) (“An erroneous decision not to terminate results in a maintenance of the status quo An erroneous decision to withdraw life-sustaining treatment,

pending a hearing.¹²⁵ For example, in cases where the patient is brain dead, courts may grant injunctions to either give the surrogate "accommodation" time or permit a confirmation of the diagnosis.¹²⁶

The injunctions obtained by surrogates are only interim measures. Courts seem to do not generally order indefinite LSMT. For example, many surrogates have sought injunctions prohibiting providers from removing LSMT from corpses.¹²⁷ While courts may grant temporary relief, they ultimately deny such motions. For example, in *Fennell v. Emory Eastside Medical Center*, the judge granted an injunction ordering the hospital to continue LSMT for Donald Fennell, a man who had been declared brain dead.¹²⁸ Less than forty-eight hours later, the

however, is not susceptible of correction.").

125. See, e.g., *Rotaru v. Vancouver Gen. Hosp. Intensive Care unit*, 2008 BCSC 318 ¶¶ 18-20 (denying injunction ordering continued LSMT, but not dismissing the petition and allowing petitioner to gather more evidence); *Golubchuk v. Salvation Army Grace Gen. Hosp.*, 2008 MBQB 49 ¶¶ 25-26 (granting interim injunction pending a trial of disputed issues of fact and law); *Jin v. Calgary Health Region*, 2007 ABQB 593 ¶ 40 ("I am mindful that the injunction is for a brief period and on balance I prefer to rescind the DNR order and preserve the status quo until there is either consensus or a legal determination on full evidence.").

126. See, e.g., *THE RIGHT TO DIE*, *supra* note 2, 13.08[A], at 13-40; *Dority v. Sup. Ct.*, 193 Cal. Rptr. at 288 (describing a hospital's policy of keeping brain dead children on life support "until the parents were emotionally able to realize what the medical opinion was" and suggesting that hospitals encourage parent consultation and participation).

127. See, e.g., *Cole v. Univ. of Kansas Med. Center*, No. 06-CV-830 (Wyandotte County Dist. Ct. Kan. 2006) (granting a TRO but dissolving it after the diagnosis was independently confirmed); *Alvarado v. N.Y. City Health & Hosp. Corp.*, 547 N.Y.S.2d 190 (Sup. Ct. 1989), *vacated and dismissed*, 550 N.Y.S.2d 353 (App. Div. 1990) (where patient was later determined not brain dead); *Dority v. Sup. Ct.*, 193 Cal. Rptr. at 288 (denying parents' petition for writ of prohibition against removing LSMT from brain dead child). Cf. *Megan Tench, End-of-Life Lawsuit Outliving Its Subject*, BOSTON GLOBE, Dec. 6, 2006, at B3 (reporting denial of relief for Cho Fook Cheng). But cf. *Shively v. Wesley Med. Center*, No. 06-CV-640 (Sedgwick County Dist. Ct. Kan. Feb. 10, 2006) (granting TRO forbidding providers from performing the tests necessary to diagnose brain death); *Brain Dead Girl Will Be Sent Home on Life Support*, N.Y. TIMES, Feb. 19, 1994, at 9 (hospital agreed to cover expenses of home LSMT for Theresa Hamilton, who had been declared brain dead); *Lois M. Collins & Linda Thomson, Jesse Loses His Battle with Brain Tumor*, DESERET MORNING NEWS, Nov. 20, 2004, at B.01 (reporting that the Utah Third District Court granted a TRO, which prevented a hospital from removing LSMT from brain dead Jesse Koochin).

128. *Andria Simmons, Death Not Just a Family Matter*, ATLANTA J.-CONST., Dec. 14, 2007, at A1.

judge authorized the hospital to stop LSMT.¹²⁹ It is well-settled that once a patient is determined brain dead, further treatment is not required.¹³⁰

Similarly, no court has ever granted a permanent injunction ordering continued LSMT for living patients. In *Nguyen v. Sacred Heart Medical Center* for example, the hospital refused to place Baby Ryan on dialysis, despite his parents' request.¹³¹ The court issued a TRO ordering the hospital to resume dialysis.¹³² However, the family was soon able to transfer Baby Ryan to another facility, mooting the dispute.¹³³ The court never ruled on the parents' petition for permanent injunction.¹³⁴ And in *Baby L*, the probate judge appeared willing to approve the mother's petition for injunctive relief, but the issue was rendered moot when the mother of the patient was able to transfer his care to another provider.¹³⁵

Finally, a number of surrogates in Texas have successfully enjoined the unilateral termination of LSMT.¹³⁶ Such cases were widely reported in the press.¹³⁷ But again, these injunctions

129. *Id.*

130. *See, e.g., Cavagnaro v. Hanover Ins. Co.*, 565 A.2d 728, 729 (N.J. Super. Ct. App. Div. 1989) (holding that treatment for a brain dead patient was not medically necessary, so insurer had no obligation to pay for it). Since provider obligations with respect to brain dead patients are comparatively more settled, they may not provide material guidance for other types of futility cases.

131. *Altomare & Bolde*, *supra* note 80, at 200.

132. *Id.* (citing *Nguyen*, No. 94-206074-5 (TRO)).

133. *Id.* at 201.

134. *Id.* (holding that the TRO was dissolved and the petition for permanent injunction dismissed).

135. *See Paris et al.*, *supra* note 38, at 1013.

136. *See, e.g., Gonzales*, No. 86427 (Travis Cty. Probate Ct, Tex. filed Mar. 20, 2007); *Hudson v. Texas Children's Hosp.*, 177 S.W.3d 232 (Tex. App. 2005); *In re Nikolouzos*, 179 S.W.3d 581 (Tex. App. 2005) (granting an injunction until an appeal could be assigned); *Ramshaw*, *supra* note 42 (TRO granted for Ruthie Webster). In other cases, hospitals agreed to an extension just before a pending hearing. *See, e.g., Todd Ackerman, Transfer Resolves Latest Futile Care Case*, HOUS. CHRON., July 31, 2006.

137. *See, e.g., Kristina Herrndobler, Court Keeps Woman on Life Support*, BEAUMONT ENTERPRISE, Aug. 11, 2006, at A.1 (reporting a TRO in the case of Daisy Conner); *Bill Murphy, Comatose Surgeon Would Prefer Death*, HOUS. CHRON., Mar. 21, 2001, at 26 (reporting a TRO in the case of Joseph Ndiyob); *Ramshaw*, *supra* note 42 (reporting a TRO in the case of Ruthie Webster).

were temporary in nature and granted pursuant to the unique Texas Advance Directives Act for a limited time and purpose. The Act allows a provider to unilaterally refuse LSMT after giving a surrogate ten days to find an alternate provider that will provide the requested LSMT.¹³⁸ Texas courts have the power to extend the ten-day period if a surrogate shows that "there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted."¹³⁹ Courts have no other authority or jurisdiction.¹⁴⁰

While surrogates often obtain injunctions prohibiting the removal of LSMT, these injunctions typically operate like TROs. They are short-term stop-gap orders, pending a hearing several days later.¹⁴¹ Courts normally dissolve the temporary injunction and permit providers to stop LSMT. Providers are similarly successful when they initiate an *ex ante* action. Specifically, providers are increasingly successful in actions to replace a surrogate who demands non-recommended LSMT. Also, while seeking declaratory judgment remains an unpopular procedural vehicle, available precedent fails to indicate that such petitions would be unsuccessful.

138. TEX. HEALTH & SAFETY CODE ANN. § 166.046(e) (Vernon 2006). *See, e.g.,* Lance Lightfoot, *Incompetent Decisionmakers and Withdrawal of Life-Sustaining Treatment: A Case Study*, 33 J. L. MED. & ETHICS 851, 854 (2005) (citing Final Order Denying Plaintiff's Request for an Extension of Time Under the Health & Safety Code Section 166.046(f), *Hudson v. Texas Children's Hosp.*, No. 352,526 (Probate Ct., Harris County, Tex. Mar. 14, 2005)). *Nikolouzos v. St. Luke's Hosp.*, 162 S.W.3d 678, 679-80 (Tex. App. 2005) (affirming the denial of TRO because petitioner did not show a probable transfer).

139. TEX. HEALTH & SAFETY CODE ANN. § 166.046(g) (Vernon 2006).

140. *See* Lightfoot, *supra* note 138, at 852. *See also* *Nikolouzos*, 162 S.W.3d at 683 (finding medical evidence "irrelevant" since the "hospital's ethics committee has determined the care is inappropriate."); H. Comm. Pub. Health, Tex. H.R., *Interim Report 2006*, at 35 ("The court considers whether another provider who will honor the patient's directive is likely to be found; it does not address the issue of whether the decision to withdraw life support is valid.").

141. Sometimes, the patient dies during the temporary injunction period, such that the injunction has a practically dispositive impact.

EX POST ACTIONS: GOING TO COURT AFTER LSMT IS WITHDRAWN

While providers are often successful in ex ante actions, they are almost uniformly successful in ex post actions. Providers usually prevail when a surrogate brings a lawsuit after the unilateral termination of LSMT.¹⁴² Indeed, usually a surrogate succeeds only if he or she shows that the provider's nonconsensual refusal of LSMT was so egregious as to constitute the tort of outrage.

A surrogate bringing a damages action on another legal theory rarely succeeds because the surrogate: (1) cannot establish that the standard of care required continued LSMT, (2) cannot establish causation and damages, or (3) cannot rebut the provider's statutory right to refuse LSMT.

SURROGATE ACTIONS FOR DAMAGES TYPICALLY SUCCEED ONLY WHEN PROVIDER CONDUCT IS OUTRAGEOUS

Hoffman and Schwartz note that “[p]laintiffs who seek damages for the withholding or withdrawal of requested life-saving treatment may fare better, especially when the facts indicate egregious conduct by hospital personnel.”¹⁴³ In fact, a comprehensive review of litigated futility cases appears to support an even stronger statement that surrogate actions for damages typically succeed *only* when provider conduct is

142. See Ann Alpers, *Respect for Patients Should Dominate Health Care Decisions*, 170 W. J. MED. 291, 292 (1999) (“Physicians are likely to get better legal results when they refuse to provide non-beneficial treatment and then defend their decisions as consistent with professional standards than when they seek advance permission to withhold care.”); Goldner, *supra* note 59, at 407 (finding that in cases “in which physicians have been sued . . . based upon their termination of life-sustaining treatment, the courts almost uniformly have displayed great deference to medical judgments”); Johnson et al., *supra* note 59, at 23 (observing that in “malpractice and related litigation . . . the outcomes seem to be more deferential to professional standards of practice”); Lee, *supra* note 10, at 485 (“[W]hen legal action is brought by the surrogates following the death of the patient, some legal precedents seem to validate the physician’s right to unilaterally withdraw life-sustaining treatments.”); Luce & Alpers, *supra* note 104, at N42.

143. Hoffman & Schwartz, *supra* note 104, at 37.

outrageous. Furthermore, surrogates cannot establish outrageous conduct by pointing to the unilateral withdrawal of LSMT itself, but only by demonstrating that the manner in which it was withdrawn was outrageous.

OUTRAGEOUS PROVIDER CONDUCT

In *Rideout v. Hershey Medical Center*, the parents of three-year-old Brianna Rideout favored aggressive treatment for her brain cancer.¹⁴⁴ As Brianna's condition deteriorated, her parents remained adamant, and providers planned to remove her ventilator without her parents' consent.¹⁴⁵ However, the providers did far more than withdraw LSMT. They assured Brianna's parents that they would remove her ventilator only when the parents were at Brianna's bedside.¹⁴⁶ Nevertheless, the providers removed the ventilator outside the parents' presence, as the parents were in the hospital patient advocate's office trying to obtain legal assistance.¹⁴⁷ Brianna's parents learned of the surprise disconnection when the hospital chaplain, who was in Brianna's room, announced it over the hospital's intercom system.¹⁴⁸

The Pennsylvania Common Pleas Court held in favor of the parents' claims for negligent and intentional infliction of emotional distress,¹⁴⁹ as the providers withdrew the ventilator in a secretive, insensitive, and disrespectful manner. Moreover, the providers specifically anticipated that the parents would have a strong emotional reaction because the providers had requested that city police officers be present.¹⁵⁰

Similarly, in *Manning v. Twin Falls Clinic & Hospital*, the patient had chronic obstructive pulmonary disease (COPD)

144. *Rideout*, 30 Pa. D. & C. 4th at 59-61.

145. *Id.* at 69-70.

146. *Id.* at 63.

147. *Id.* at 63, 69.

148. *Id.* at 63.

149. *Id.* at 70.

150. *Id.* at 70.

resulting in decreased ability to transfer oxygen to his bloodstream.¹⁵¹ The patient's condition was rapidly deteriorating, but contrary to his family's objections, the providers moved him to another room without the aid of a portable oxygen unit.¹⁵² This patient experienced respiratory distress and died.¹⁵³ The court affirmed a punitive damages verdict for infliction of emotional distress.¹⁵⁴

Intentional infliction of emotional distress was also the cause of action in *Estate of Bland v. Cigna Health Plan of Texas*.¹⁵⁵ Bland, a terminally ill AIDS patient, was dependent upon a ventilator.¹⁵⁶ Both Bland and his family insisted that he remain on the ventilator.¹⁵⁷ However, the chair of the ethics committee ordered the ventilator removed, apparently at the direction of the Cigna medical director. This was done without consulting Bland, his family, or Bland's primary care physician.¹⁵⁸ The ventilator removal seemed both secretive and financially motivated.

The intentional infliction of emotional distress is not a favored tort in the law.¹⁵⁹ It is particularly difficult to show that a provider's conduct was extreme and outrageous when the provider reasonably believed that her objective was not only legitimate but even professionally and ethically necessary and appropriate.¹⁶⁰ Consequently, in the several futility cases in which recovery was allowed, it is no surprise that liability was premised not on the fact that providers unilaterally withdrew

151. *Manning v. Twin Falls Clinic & Hosp., Inc.*, 830 P.2d 1185, 1187 (Idaho 1992).

152. *Id.* at 1187-88.

153. *Id.* at 1188.

154. *Id.* at 1191, 1195.

155. *Bland v. Cigna Healthplan of Texas, Inc.*, No. 93-52630-A (Harris County Tex. Dist. Ct., Apr. 25, 1995) (First Amended Petition § III).

156. *Id.* at § I.

157. *Id.*

158. JOHN FLETCHER ET AL., *INTRODUCTION TO CLINICAL ETHICS* 272, 273 (2d ed. 2000); Mimi Swartz, *Not What the Doctor Ordered*, *TEX. MONTHLY*, Mar. 1995, at 86.

159. See J.D. LEE & BARRY LINDAHL, *3 MODERN TORT LAW: LIABILITY AND LITIGATION* § 32:3, 32-8 (Thomson/West 2006).

160. See *id.* at § 32-11.

LSMT, but rather, on how they did it.¹⁶¹

THE UNILATERAL REFUSAL OF LSMT IS NOT PER SE OUTRAGEOUS

In some cases, surrogates have alleged that the unilateral withdrawal of LSMT is itself outrageous conduct because it is done without consent and against patient or surrogate wishes. However, courts have consistently rejected this proposition. For example, in *Gallups v. Cotter*, Pamela Gallups, a minor, was rendered brain dead after a car accident.¹⁶² Providers made at least eight confirmations of the brain death diagnosis. And they had six discussions with the family between June 28 and July 8, whereby they recommended removing LSMT.¹⁶³ While there was a dispute over whether consensus was reached, providers allegedly removed Pamela from life support against her parents' wishes.¹⁶⁴ Nevertheless, the court found no evidence of "recklessness."¹⁶⁵

Courts have similarly denied claims for outrage or intentional infliction of emotional distress based solely on the fact that providers unilaterally withdrew LSMT from a living

161. Not only liability but even a lawsuit itself may be averted through considerate handling. See generally NANCY BERLINGER, AFTER HARM: MEDICAL ERROR AND THE ETHICS OF FORGIVENESS 51-62 (2005) (discussing "The 'I'm Sorry' Laws"); Pam Baggett, *I'm Sorry: Apologizing for a Mistake Might Prevent a Lawsuit*, TEX. MED., Jan. 2005, at 56; Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 463 (2003) (arguing that apologies go a long way in reaching settlements); Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1612 (1994) (explaining how patients' families often feel that there is a lack of information and apologies). For example, in *Bryan v. UVA*, the University of Virginia risk management department believed that the primary cause for the state and federal actions was a dispute over billing; when the hospital turned the account over to a collection agency, the family gave the demand letters to an attorney to review, who coincidentally noticed grounds for a lawsuit in a subsequent review of the medical records. FLETCHER ET AL., *supra* note 158, at 272.

162. *Gallups v. Cotter*, 534 So. 2d 585, 586 (Ala. 1988).

163. *Id.* at 586-87.

164. *Id.* at 587.

165. *Id.* at 589 (holding that acting without consent is "insufficient . . . to show defendants acted intentionally or recklessly"). The court had already disposed of claims for wrongful death, breach of contract, and fraud. *Id.* at 587.

patient.¹⁶⁶ For example, in *Gilgunn v. Massachusetts General Hospital*, the attending physician wrote a do not resuscitate order, despite the surrogate's demands for aggressive treatment.¹⁶⁷ The claim for negligent infliction of emotional distress proceeded to a jury.¹⁶⁸ The jury returned a verdict for the providers.¹⁶⁹

OTHER SURROGATE ACTIONS FOR DAMAGES TYPICALLY DO NOT SUCCEED¹⁷⁰

Hoffman and Schwartz observe that plaintiffs "face uncertainty when health care providers defend their action on futility grounds."¹⁷¹ In fact, once we account for the outrage cases, plaintiffs face not uncertainty, but instead, probable failure. "[C]ourts are hesitant to penalize physicians who reasonably rely on what they perceive to be professional standards concerning effectiveness of treatment measures."¹⁷²

166. See, e.g., *Morgan v. Olds*, 417 N.W.2d 232 (Iowa. App. 1987); *Nguyen v. Sacred Heart Medical Center*, 987 P.2d 634, 636 (Wash. App. 1999) (refusing to allow plaintiffs to pursue claim for outrage). Cf. *Hartsell v. Fort Sanders Reg'l Med. Center*, 905 S.W.2d 944 (Tenn. Ct. App. 1995) (trial court dismissed the claim for outrage); *Litz v. Robinson*, 955 P.2d 113, 113-14 (Idaho Ct. App. 1997) (involving a unilateral DNR); *Strickland v. Deaconess Hosp.*, 735 P.2d 74 (Wash. Ct. App. 1987) (involving unilateral removal of a respirator).

167. John J. Paris et al., *Use of a DNR Order Over Family Objections: The Case of Gilgunn v. MGH*, 14 J. INTENSIVE MED. 41, 41-42 (1999).

168. *Id.* at 44.

169. *Id.* at 45.

170. Actions fail for a variety of fact-specific reasons. For example, in *Kranson v. Valley Crest Nursing Home*, 755 F.2d 46 (3d Cir. 1985), the court found in favor of a nursing home that failed to provide CPR to a resident because the plaintiffs could not establish municipal liability. In *Strickland*, 735 P.2d at 78, plaintiffs lacked standing to bring claims for negligence and informed consent. See also *Judge Dismisses Suit over Death*, ST. LOUIS POST DISPATCH, June 28, 1996, at 3B (a court dismissed a wrongful death case because patient Philip Taylor's agent lacked standing to challenge unilateral DNR). Criminal actions have also been unsuccessful. See, e.g., *Grotti v. Texas*, 209 S.W.3d 747 (Tex. App. 2006) (reversing physician's homicide conviction for occluding a patient's endotracheal tube because there was insufficient evidence that the patient was alive at the time); *State v. Naramore*, 965 P.2d 211, 216, 223 (Kan. Ct. App. 1998) (reversing physician's murder conviction for stopping LSMT he considered futile). In this section of this article, I discuss only the more common causes of action.

171. Hoffman & Schwartz, *supra* note 104, at 37.

172. Goldner et al., *supra* note 59, at 409; Prip & Moretti, *supra* note 104, at 152;

Specifically, surrogates have difficulty establishing the prima facie elements of their tort-based theories. First, they can find it difficult to establish that the standard of care required continued LSMT. Second, given the patient's extreme fragility and illness, they cannot establish causation and damages. Third, they cannot rebut provider's statutory presumptive right to refuse LSMT.

SURROGATES CANNOT ESTABLISH THAT THE STANDARD OF CARE REQUIRES CONTINUED LSMT

In medical malpractice actions, plaintiffs must establish a breach of the applicable standard of care by the provider.¹⁷³ Therefore, unless plaintiffs have a federal or constitutional cause of action, a threshold requirement is showing that the unilateral refusal does not comply with the standard of care.¹⁷⁴

Plaintiffs have never been able to show that the standard of care requires continued LSMT for brain dead patients.¹⁷⁵ Similarly, in most of the reported cases, plaintiffs have been unable to establish that the standard of care requires continued LSMT for living patients.¹⁷⁶ As a consequence, courts ordinarily

see Schneiderman & Capron, *supra* note 103, at 530.

173. BARRY R. FURROW ET AL., HEALTH LAW 264-70 (2d ed. 2000); STEVEN E. PEGALIS, AMERICAN LAW OF MEDICAL MALPRACTICE §§ 3.1-3.3 (3d ed. 2007).

174. In *DeKalb Med. Center v. Hawkins*, the plaintiff successfully resisted providers' attempt to characterize his claim for "tortious termination of life support" as a medical malpractice action. 2007 Ga. App. LEXIS 1269 (Nov. 29, 2007). Since the court allowed plaintiff to proceed on an intentional tort/wrongful death theory, he presumably will not need to establish standard of care. In contrast, the court in *Ussery v. Children's Healthcare of Atlanta, Inc.* rejected plaintiff's intentional tort allegations, allowing them to pursue only their negligence claims. 656 S.E.2d 882 (Ga. App. 2008).

175. See, e.g., *Gallups v. Cotter*, 534 So. 2d 585 (Ala. 1988).

176. See, e.g., *Berkeley v. Dowds*, 61 Cal.Rptr.3d 304, 311 (Cal. Ct. App. 2007) (affirming demurrer where plaintiff's counsel conceded that defendant's conduct "was within the standard of care"); *Gamble v. Perra*, No. 1-575-05 (Tenn. Ct. App. Feb. 22, 2007) (affirming the dismissal of tort claims because the wife showed that neither the prescription of pain medication nor the failure to attempt CPR was outside the standard of care); *Litz*, 955 P.2d at 113 (affirming summary judgment in favor of providers who placed unilateral DNR order); *Nguyen*, 987 P.2d at 636 (affirming dismissal of malpractice action in case involving unilateral removal from dialysis); *Preston*, 700 N.W.2d at 163 (affirming the dismissal of causes of action for malpractice and informed consent); John J. Paris et al., *Resuscitation of a*

grant summary judgment in favor of providers because plaintiffs fail to introduce evidence showing that the standard of care required continued LSMT.

For example, in *Duensing v. Southwest Texas Methodist Hospital*, providers stopped a patient's dialysis without the consent of the patient's surrogate.¹⁷⁷ The surrogate sued for medical malpractice, but presented no evidence showing that withdrawing dialysis was inconsistent with the standard of care.¹⁷⁸ The plaintiff "failed to establish expert testimony that terminating the dialysis of a terminally ill and mentally incapacitated patient even without the consent of the patient's family was necessarily a breach of medical standards."¹⁷⁹ Moreover, the plaintiff's own experts conceded that the providers complied with the standard of care.¹⁸⁰ Therefore, the court granted summary judgment in favor of the providers, and the U.S. Court of Appeals for the Fifth Circuit affirmed.¹⁸¹

Similarly, in *Kelly v. St. Peter's Hospice*, a surrogate sued a New York hospice for medical malpractice involving his wife's treatment because, among other things, the hospice (1) did not provide sufficiently aggressive care, (2) used an excessive amount of morphine, and (3) failed to insert an IV line for nutrition and hydration.¹⁸² The New York appellate court

Micropreemie: The Case of MacDonald v. Milleville, 18 J. PERINATOLOGY 302 (1998) (holding physician had no obligation to seek authorization to cease resuscitation of 23-week gestation baby after ten minutes); Defendant-Respondent Brief in *Baby K*, 2003 WL 24028986, at *24-25 & *28 (plaintiff's expert did not establish the standard of care required resuscitation of anencephalic infant). Tellingly, attorney Mark Geragos never filed a promised lawsuit on behalf of Nataline Sarkisyan after Cigna determined that a liver transplant was not covered under Sarkisyan's medical plan. Alicia Chang, *Cigna Faces Lawsuit in Death after Policy Fight*, CHI. TRIB., Dec. 23, 2007, at 3.

177. *Duensing v. Southwest Tex. Medical Hosp.*, No. SA-87-CA1119 (W.D. Tex. 1988), *aff'd sub nom. Duensing v. Ruff*, No. 89-5517 (5th Cir. Feb 3, 1990).

178. *Id.*

179. *Duensing v. Ruff*, No. 89-5517 at 3-4.

180. *Id.* at 4-5. Furthermore, the defendants' position was supported at least by a school of thought. See FURROW ET AL., *supra* note 173, at 288-90; *Jones v. Chidester*, 610 A.2d 964, 966 (Pa. 1992).

181. *Duensing v. Southwest Tex. Medical Hosp.*, No. SA-87-CA1119.

182. *Kelly v. St. Peter's Hospice*, 553 N.Y.S.2d 906, 907 (N.Y. App. Div. 1990) (noting that the husband was unaware that his wife had checked into hospice,

affirmed summary judgment in favor of the hospice because the plaintiff-surrogate failed to present evidence that the provider's treatment departed from acceptable medical practice.¹⁸³

In other cases, plaintiffs have introduced competent expert evidence regarding the standard of care, but juries have still largely held that the providers did not breach the standard. For example, in *Gilgunn*, the jury determined that the patient would have wanted LSMT, which her providers unilaterally withdrew.¹⁸⁴ However, the jury concluded that none of the defendants were negligent because "the actions of the physicians and of the [hospital] were within the standard of care."¹⁸⁵

Similarly, in *LaSalle Nat'l Trust v. Swedish Covenant Hospital*, the court affirmed a verdict in favor of providers who adhered to a "compassionate care" policy and refused to provide aggressive treatment to an extremely premature infant.¹⁸⁶ The jury concluded that unilaterally refusing LSMT did not breach the standard of care.¹⁸⁷ While the jury verdict lacks the force of law as a legal precedent, it is a powerful statement that the standard of care does not require all that the patient would have wanted.

In other cases, plaintiffs have voluntarily dismissed their lawsuits upon realizing the weakness of their claims. For example, in *Burks v. St. Joseph's Hospital*, the plaintiffs voluntarily dismissed their claims for medical malpractice.¹⁸⁸ Soon after arriving at a Milwaukee emergency room, Shemika Burks gave birth to a severely premature baby who weighed only seven ounces.¹⁸⁹ The hospital did not attempt to resuscitate the baby,

which is typically for palliative treatment, not curative treatment).

183. *Id.* at 908.

184. Paris et al., *supra* note 167, at 45.

185. *Id.*

186. *LaSalle Nat'l Trust v. Swedish Covenant Hosp.*, 652 N.E.2d 1089, 1090-91 (Ill. App. Ct. 1995).

187. *Id.* at 1095.

188. *Burks v. St. Joseph's Hosp.*, No. 95-CV-002639, at 17:4-6 (Milwaukee County Cir. Ct., Wis. Apr. 29, 1996) (hearing on motion for summary judgment); *Burks v. St. Joseph's Hosp.*, 596 N.W.2d 391, 393 (Wis. 1999).

189. *Burks*, 596 N.W.2d at 392.

and the baby died three hours later.¹⁹⁰ The plaintiffs dismissed the malpractice suit, apparently upon realizing that they could not establish whether it was within the standard of care to resuscitate a 22-week-old fetus.¹⁹¹

SURROGATES TYPICALLY CANNOT ESTABLISH CAUSATION AND DAMAGES

Even when plaintiffs can establish a breach of the standard of care, they still can have difficulty establishing proof of causation or damages, particularly because the patients from whom LSMT is withdrawn are catastrophically ill.¹⁹² In *King v. Crowell Memorial Home*, a son sued the nursing home for treating his mother as DNR, even though his instructions were to use “any and all medical measures.”¹⁹³ While the case went to trial, the court granted the home a directed verdict because the son failed to present sufficient evidence that (1) his mother was DNR at the time of her death, (2) his instructions were not followed, or (3) resuscitative measures would have been successful.¹⁹⁴

In some jurisdictions the causation hurdle is lower, and plaintiffs need only show loss of a chance rather than “but-for causation.”¹⁹⁵ For example, in *Wendland v. Sparks*, a patient’s physician unilaterally decided not to attempt CPR when the

190. *Id.*

191. Brief in Support of Defendant’s Motion to Dismiss EMTALA Claim, at 14-16 (Nov. 9, 1995); Reply Brief in Support of Defendant’s Motion to Dismiss EMTALA Claim, at 4 (Apr. 22, 1996); Email from Mary Wolverton to Thad Pope (Aug. 6, 2007) (on file with author).

192. See, e.g., *Berkeley*, 61 Cal Rptr. 3d at 308, 312 (finding no causal connection where the plaintiff alleged that the providers prematurely removed patient from ICU and denied him medically necessary services); *Gray v. Woodville Health Center*, 225 S.W.3d 613, 619 (Tex. App. 2006); *Kranson*, 755 F.2d at 46 (affirming the dismissal of a claim against municipal nursing home that failed to perform CPR on resident because of the lack of a causal nexus between the home’s CPR policy and the resident’s death).

193. *King v. Crowell Memorial Home*, 622 N.W.2d 588, 592 (Neb. 2001).

194. *Id.* at 594.

195. See LEE & LINDAHL, *supra* note 159, at 25:88-91.

patient suffered cardiorespiratory arrest.¹⁹⁶ While the patient had only a ten percent chance of leaving the hospital following CPR, the court held that “even a small chance of survival is worth something,”¹⁹⁷ and the court allowed the plaintiffs to pursue their malpractice action on a loss of chance theory.¹⁹⁸

But the loss of chance theory alters not only the element of causation, but also the nature of the injury. Under this theory, the injury is not a patient's death, but the loss of chance itself. This may substantially lower available damages.¹⁹⁹ Furthermore, plaintiffs are unlikely to bring low damages cases in the first place.²⁰⁰ Even if the cases are brought, such cases are hard for surrogates to win.

For example, in *Velez v. Bethune*, providers unilaterally withdrew LSMT from a premature infant, and a Georgia appellate court held that plaintiffs' claim for wrongful death was valid.²⁰¹ “Dr. Velez had no right to decide, unilaterally, to discontinue medical treatment even if . . . the child was . . . in the process of dying.”²⁰² But, the court noted that the amount of damages would be very low.²⁰³ The case ultimately settled, and

196. *Wendland v. Sparks*, 574 N.W.2d 327, 328 (Iowa 1998).

197. *Id.* at 332.

198. *Id.* at 333. The case later settled for an undisclosed amount. Email from Julie Davis to Thaddeus Pope (May 2, 2007) (on file with author).

199. It must be noted that even low damages entails a report to the National Practitioner Data Bank, psychological distress, and other repercussions for the provider. BOVBERG & RAYMOND, *supra* note 45, at 6; Subrin, *supra* note 51, at 206 (“The entire litigation process is anxiety-provoking and privacy-invading.”); Mitchell S. Cappell, *A Baseless Malpractice Suit Still Cost Me*, MED. ECON., Feb. 1, 2008.

200. Low damages cases are unlikely to be brought. See LaRae Huycke & Mark M. Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 ANNALS INTERNAL MED. 792, 785 (1994); Daniel Costello, *Lacking Lawyers, Justice is Denied*, L.A. TIMES, Dec. 29, 2007 (reporting the difficulty of obtaining a lawyer in cases with limited damages). *But cf.* Kathy L. Cerminara, *Tracking the Storm: the Far-Reaching Power of the Forces Propelling the Schiavo Cases*, 35 STETSON L. REV. 147, 154-55 (2005) (reviewing the involvement of special-interest groups); Jon B. Eisenberg, *The Terri Schiavo Case: Following the Money*, RECORDER, Mar. 4, 2005, at 4 (reporting how much of the *Schiavo* litigation was funded by conservative organizations like the Philanthropy Roundtable and Life Legal Defense Foundation).

201. *Velez v. Bethune*, 466 S.E.2d 627 (Ga. Ct. App. 1995) (affirming the denial of provider's motion for summary judgment).

202. *Id.* at 629.

203. *Id.*

the providers did not have to pay anything to the plaintiffs.²⁰⁴

SURROGATES CANNOT REBUT PROVIDERS' STATUTORY RIGHT TO REFUSE LSMT

Surrogates have encountered an additional hurdle, in addition to hurdles in establishing the prima facie elements of tort-based causes of action. In many states, health care decisions statutes grant providers the right to refuse LSMT if they deem it medically or ethically inappropriate.²⁰⁵ For instance, the Virginia Health Care Decisions Act (HCDA) provides that “[n]othing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate.”²⁰⁶ A provider may unilaterally stop LSMT after giving a surrogate fourteen days to attempt transfer to another facility willing to provide the requested treatment.²⁰⁷

This Virginia statute had an apparently dispositive impact in at least one case. After the University of Virginia Hospital issued a unilateral DNR order for Shirley Robertson, her surrogate brought an EMTALA action in federal court.²⁰⁸ In *Bryan v. Rectors & Visitors of UVA*, the Fourth Circuit affirmed the dismissal of the EMTALA claim and suggested that the plaintiff proceed in state court, noting that “[s]uch reprehensible disregard for one’s patient” would constitute the “tort of abandonment.”²⁰⁹ Subsequently, the plaintiff proceeded in state court,²¹⁰ but later voluntarily dismissed that action because of

204. Email from Robin C. Correll to Thaddeus Pope (May 11, 2007) (on file with author).

205. See Pope, *Futility Statutes*, *supra* note 17 (arguing that only Texas’ safe harbor is effective). *But cf.* Maureen Kwiecinski, *To Be Or Not to Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies*, 7 ELDER’S ADVISOR 313, 341-342 (2006) (questioning the constitutionality of unilateral decision statutes).

206. VA. CODE ANN. § 54.1-2990(A) (West 2007).

207. *Id.*

208. *Bryan*, 95 F.3d at 349.

209. *Id.* at 352.

210. *Id.*

the Virginia HCDA.²¹¹

Similarly, the Louisiana Health Care Decisions Act provides that the act should not be "construed to require the application of medically inappropriate treatment . . . or to interfere with medical judgment with respect to the application of medical treatment or life-sustaining procedures."²¹² In *Causey v. St. Francis Medical Center*, providers unilaterally withdrew a ventilator and dialysis from a comatose patient with end-stage renal disease.²¹³ The appellate court affirmed the dismissal of the family's intentional battery tort action, observing that Louisiana providers are entitled to unilaterally withdraw LSMT so long as they comply with the standard of care.²¹⁴

Apart from unique outrage cases, actions against unilateral termination of LSMT have been unsuccessful. Surrogates have had enormous difficulty overcoming statutory authorization to refuse LSMT, establishing breach of the standard of care, and establishing causation and damages. The low success rate means not only that the risk of liability is lower than believed, but also that fewer cases will even be brought against providers.²¹⁵

CONCLUSION

While the litigated futility cases do not articulate a clear and unequivocal right of providers to refuse LSMT that they deem inappropriate, these cases also do not support the supposed

211. *Bryan v. Rectors & Visitors of the Univ. of Virginia*, No. CL-95-060 (Fauquier County, Va. Cir. Ct. Nov. 27, 1995) (Order of Nonsuit). It is also hard to establish tortious abandonment because while providers may cease aggressive treatment, they continue comfort care. See *Hartsell*, 905 S.W.2d at 944.

212. LA. REV. STAT. ANN. § 40:1299.58.1(A)(4) (2006).

213. *Causey*, 719 So. 2d at 1073-74.

214. *Id.* at 1075 (citing § 40:1299.58.1(A)(4)). The appellate court did remand the medical malpractice claim to a "medical review panel" to determine whether the providers met the standard of care. See Message from Jeffrey D. Gurriero to Thad Pope (on file with author).

215. See John A. Day, *Should You Risk Taking the Case?* TRIAL, Jan. 2008, at 20; Gary B. Pillersdorf, *Criteria for Case Selection*, in ATLA'S LITIGATING TORT CASES §§ 2.3-2.20 (2007).

right of surrogates to demand such care. Surrogates do not have nearly the amount of bargaining power that they are perceived to possess. Therefore, the fear of legal liability should not have the impact on provider decision-making that it has had.

A reassessment of the judicial treatment of futility cases leads to an obvious implication for health care providers. Physicians make decisions regarding LSMT based largely on perceived constraints from the legal system.²¹⁶ The misperception of those constraints has led to the overtreatment of patients, causing unnecessary suffering and inappropriate use of scarce medical resources.²¹⁷ But firmer, more accurate shadows should produce better results.²¹⁸ With sufficient legal education, providers may be more willing to treat patients in a way they deem medically appropriate.²¹⁹

A reassessment of the judicial treatment of futility cases also leads to two practical implications for elder law attorneys. First, attorneys must educate their clients. It is a long-recognized role of the elder law attorney to advise her clients about advance directives.²²⁰ As elders may have misconceptions about their future care,²²¹ counseling should be directive. It should entail more than the passive documentation of a client's articulated treatment preferences.²²² Attorneys should educate clients so

216. McCrary, *supra* note 4, at 373; Pope & Waldman, *supra* note 4, at 170-85.

217. Pope & Waldman, *supra* note 4, at 186-90. Cf. Alan Bavley & Julius A. Karash, *As Life Ebbs, Bills Can Mount: Millions of Elderly Get Needless and Costly Medical Care as They Near Death*, KANSAS CITY STAR, Jan. 1, 2007 (discussing the Dartmouth Atlas of Health Care).

218. Ruth D. Raisfeld, *Mediators Can Best Help Those Who Help Themselves*, N.Y.L.J., Dec. 1, 2003 (arguing that mediation is more successful with "objective criteria" such as an accurate understanding of "prevailing case law").

219. McCrary, *supra* note 4, at 372. See also Perkins et al., *supra* note 4, at 192 (criticizing the impact of "external factors" on physician decision-making).

220. Nat'l Acad. of Elder Law Attorneys, *Preparing for End of Life*, EYE ON ELDER ISSUES, Aug. 2004, available at http://www.naela.org/pdffiles/eye_on_elder_issues_Aug04.pdf (last visited Feb. 2, 2008).

221. See, e.g., Catherine A. Marco & Roques M. Schears, *ER Decisions to Withdraw CPR*, 9 AMA VIRTUAL MENTOR 174 (2007).

222. See Ed de St. Aubin et al., *Elders and End-of-Life Medical Decisions: Legal Context, Psychological Issues, and Recommendations to Attorneys Serving Seniors*, 7 ELDER'S ADVISOR 259, 287-91 (2006).

that they have realistic expectations of what medicine can offer.²²³

Second, attorneys should empower their clients. Elder law attorneys should be "articulate and forceful advocates so that their client's [treatment] preferences . . . are honored and understood."²²⁴ Sometimes after a careful, thorough discussion of treatment options, attorneys may discover that their client has a religious or cultural reason for wanting to continue LSMT, no matter how dire the circumstances. If so, they should advise their client that an advance directive can be used not only to decline treatment but also to "request that all reasonable measures . . . be taken to sustain life."²²⁵ To be sure, even advance directives can be overridden in futility disputes. However, having clear written documentation of treatment preferences maximizes the chance that such preferences will be honored.²²⁶

223. *Id.*

224. A. KIMBERLY DAYTON ET AL., ADVISING THE ELDERLY CLIENT § 33.7 (2007); Barbara Weinschenk, *End of Life Issues*, ELDER LAW UPDATE 146, 169-70 (Nat'l Bus. Inst. 2007).

225. DAYTON ET AL., *supra* note 224, at § 33.39.

226. Cf. Eric R. Oalican, *Older Clients and Long Term Care*, DRAFTING ESTATE PLANS § 4.8.2 (Mass. CLE, Inc. 2007) (offering the following sample medical directive language: "I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recover, or the cost of the procedures.").