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Seeking a Definition of Medical Futility with Reference to the Louisiana Natural Death Act[†]

Frederick R. Parker, Jr.*

INTRODUCTION

The general question concerning the existence of a patient's right in the United States either to accept or refuse care at the end of life has largely been resolved through a fairly consistent body of jurisprudence, statutory schemes, and pronouncements of professional ethics.¹ The principal statutory expression of this right in Louisiana is found in the Natural Death Act (the "Act"), in which the legislature recognized the right of patients under certain conditions either to withhold treatment at the outset of care or to withdraw treatment that had already been initiated.² However, the legislature left open the ultimate scope of this right, which remains the

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[†] Part of the discussion in this Article is derived from the author's prior analysis in *Law, Bioethics, and Medical Futility: Defining Patient Rights at the End of Life*, 37 U. ARK. LITTLE ROCK L. REV. 185 (2015). That work addressed the issue of medical futility in the specific context of the Uniform Health Care Decisions Act ("UHCDA") and the Uniform Rights of the Terminally Ill Act ("URITIA") with respect to both the refusal of life-sustaining treatment and the active administration of extreme palliative interventions. *Id.* This Article addresses only the first of those issues, with a specific focus on the Louisiana Natural Death Act. A portion of the broader analysis in *Law, Bioethics, and Medical Futility: Defining Patient Rights at the End of Life* that is equally relevant to this discussion in the narrow context of the Louisiana Act is presented here with the permission of the UALR Law Review.

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1. See generally ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE* 2-3-2-41, 7-7-7-50 (3d ed. 2004). These issues initially arose when surrogates for permanently unconscious patients who did not satisfy the legal criteria for whole "brain death" began to refuse treatment that offered no reasonable hope of either restoring the patient's capacity or reversing the dying process. See *id.* at 2-3. Perhaps the most widely cited United States Supreme Court case in this regard is *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). See also TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 170-81 (4th ed. 1994) (describing and integrating surrogate judgment making standards arising out of jurisprudence).

2. LA. REV. STAT. § 40:1151 (2016).

subject of debate both in the courts and among physicians, bioethicists, and moral philosophers. One of the most significant and problematic of these unresolved questions involves the relationship between the Act and the elusive concept of “medical futility.”

Although the Act unambiguously reflects the traditional view of the patient’s right of self-determination as a negative one, the contemporary variant of the question asks whether a patient’s right to *refuse* recommended treatment necessarily encompasses the right to *receive* interventions that have not been offered, and, if so, what constraints might limit the scope of that positive right. Framed from the opposite perspective, the question would ask whether, and to what extent, the Act would recognize a physician’s authority to withhold or withdraw life-sustaining treatment that a patient has expressly requested—whether directly or through a surrogate.³

Although other states have enacted similar statutory schemes as a means of ensuring the patient’s right to refuse life-sustaining treatment,⁴ some commentators have argued that the statutes also were intended to recognize a physician’s authority to unilaterally withhold or withdraw life-sustaining procedures on the grounds of medical futility.⁵ This issue is perhaps most problematic when a surrogate for a permanently unconscious or otherwise irreversibly incapacitated patient seeks treatment that would be beneficial in the sense of postponing the moment of death, but which

3. Cf. MEISEL & CERMINARA, *supra* note 1, at 13-24–13-27.

4. BEAUCHAMP & CHILDRESS, *supra* note 1, at 170–81. See, e.g., UNIF. RIGHTS OF THE TERMINALLY ILL ACT (UNIF. LAW COMM’N 1989); UNIF. HEALTH-CARE DECISIONS ACT (UNIF. LAW COMM’N 1993). According to Meisel, “several” states have adopted the URTIA in either its 1985 or 1989 version. See MEISEL & CERMINARA, *supra* note 1, at 7-54–7-58. According to the Uniform Law Commission’s Legislative Fact Sheet, the UHCDA had been adopted by Alaska, Delaware, Hawaii, Maine, Mississippi, New Mexico, and Wyoming as of 2014, although the advance directive statutes of some states appear to be modified forms of the UHCDA. *Legislative Fact Sheet—Health-Care Decisions Act*, UNIFORM L. COMMISSION, <http://www.uniformlaws.org/LegislativeFactSheet.aspx?title=Health-Care%20Decisions%20Act> [<https://perma.cc/RT3X-YG4X>] (last visited Jan. 10, 2016). See generally MEISEL & CERMINARA, *supra* note 1, at 7-55, 7-79–7-89 (summarizing the law in this regard in other jurisdictions). Notwithstanding the narrow scope of this right as expressed in statutory schemes, however, the various advance directive statutes are cumulative with existing law. According to Meisel, “they are intended to preserve and supplement existing common law and constitutional rights and not to supersede or limit them.” See *id.* at 7-33–7-35.

5. See, e.g., Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 3–4 (2007).

the attending physician has denied because it offers no reasonable hope as a curative measure.

This Article addresses the specific issue of how the Louisiana Act might inform the question of whether, or in what circumstances, treatment can be so futile that a patient has no positive right to receive it. As this issue most commonly arises in the context of permanently incapacitated patients whose surrogates speak on their behalf, it would be appropriate to first consider the relevance of a patient's decisional capacity to the question. As a preliminary matter, this Article begins by discussing the concept of personhood and the relevance of capacity to the right of a severely incapacitated patient to accept or refuse treatment.

I. PERSONHOOD, DECISIONAL CAPACITY, AND THE PROBLEMATIC CONCEPT OF MEDICAL FUTILITY

The courts, practicing physicians, and bioethicists have long struggled in their efforts to define medical futility in a meaningful way, yet they remain confounded in the search for a universal meaning of the term that fairly accommodates the convergence of law, medicine, and bioethics.⁶ The elusive nature of a workable definition stems from the problematic relationship between the ambiguity inherent in the concept of futility, the subtle uncertainties that inevitably attend the exercise of clinical judgment, and the fluid boundaries that define the parameters of professional discretion.⁷

6. In general, it has been said that futility is not “a discrete and definable entity . . . [but] merely the end of the spectrum of therapies with very low efficacy.” MEISEL & CERMINARA, *supra* note 1, at 13-14 (quoting John D. Lantos et al., *The Illusion of Futility in Clinical Practice*, 87 AM. J. MED. 81, 81 (1989)). In the narrow sense, treatment would be considered “futile” if it lacks efficacy in terms of accomplishing the specific physiological objective for which it is sought. *Id.* at 13-15. Physicians are generally regarded as having the professional prerogative to unilaterally withhold or withdraw such objectively futile clinical interventions, and to do so without the patient's consent. *Id.* In a broader sense, futility has been described as the “inability to prolong life for a time,” or the “inability to maintain an acceptable quality of life.” *Id.* at 13-13 (quoting Stuart J. Younger, *Who Defines Futility?*, 260 J. AM. MED. ASS'N 2094, 2095 (1988)). The American Medical Association considers decisions about interventions that are not futile in an objective physiologic sense to be sufficiently value laden as to make them a matter of the patient's prerogative. *See, e.g.*, AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 18-19 (2014).

7. This lack of consensus presumably becomes increasingly problematic as our population ages and as financial considerations increasingly constrain the provision of health care, making the issue likely to be both more common and

At its most fundamental level, the concept of “medical futility” relates to the ultimate scope of a physician’s obligation as a matter of law and bioethics to avail patients of specific clinical interventions.⁸ In the most narrow, purely objective sense, a treatment regimen would be considered “futile” only if it lacks efficacy in terms of being able to accomplish the specific physiological objective for which it is employed.⁹ Thus, an intervention that has been scientifically proven to have no physiological effect on a patient’s condition would not fall within the standard of care, and a physician’s decision not to provide it on the basis of physiological futility would stir no controversy.¹⁰ At the opposite end of the spectrum, and viewed more broadly as a subjective concept, medical futility has been described as reflecting the “inability to prolong life for a time,” or the “inability to maintain an acceptable quality of life.”¹¹

As a practical matter, questions about futility tend to arise in circumstances that fall between the two extremes of purely objective and purely subjective measures, where decisions about the appropriate clinical response to a patient’s condition are grounded primarily in objective,

more significant over time. According to Professor Meisel, the futility debate might be difficult to resolve because it “revolves around fundamentally irresolvable moral conflicts concerning our most deeply held beliefs about the value of life.” MEISEL & CERMINARA, *supra* note 1, at 13-13 (quoting E. Haavi Morreim, *Profoundly Diminished Life: The Casualties of Coercion*, 24 HASTINGS CTR. REP., Jan.–Feb. 1994, at 33, 33.) It also has been suggested that the debate about medical futility will arise with increasing frequency as the scope of advance directives expands beyond their traditional purpose of expressing the patient’s wishes concerning the withholding or withdrawal of life-sustaining treatment to directing the administration of treatment that physicians might consider to be futile. *Id.* at 7-9–7-10, 13-43–13-44. *See also* Pope, *supra* note 5, at 3–4.

8. *See* MEISEL & CERMINARA, *supra* note 1, at 13-14.

9. *Id.* at 13-14–13-15.

10. In its traditional expression, the concept of medical futility most commonly relates to a physician’s determination that a treatment regimen offers no meaningful benefit to the patient in a physiological sense. Physicians generally are regarded as having the professional prerogative to unilaterally withhold or withdraw such objectively futile clinical interventions, and to do so without the patient’s consent. *Id.* at 13-14. *See also* ALBERT R. JONSEN, MARK SIEGLER, & WILLIAM J. WINSLADE, *CLINICAL ETHICS: A PRACTICAL APPROACH TO ETHICAL DECISIONS IN CLINICAL MEDICINE* 20 (McGraw Hill Educ., 8th ed. 2015) [hereinafter *CLINICAL ETHICS*]. Moreover, all interventions would be considered physiologically futile if there is “an utter impossibility” that any of the interventions could produce the desired physiological response to the patient’s condition. *Id.* at 27.

11. MEISEL & CERMINARA, *supra* note 1, at 13-13 (quoting Stuart J. Younger, *Who Defines Futility?*, 260 AM. J. MED. ASS’N 2094, 2095 (1988)).

scientific criteria, though inevitably tempered by the physician's subjective judgment concerning the overall efficacy of the proposed intervention.¹² This apparent dichotomy reflects the full range of factors that bear upon the exercise of clinical judgment, although it inevitably blurs the line between interventions that are medically indicated and those that would be futile to provide under the circumstances.¹³

12. CLINICAL ETHICS, *supra* note 10, at 21. Interventions in these cases are sometimes referred to as “not medically indicated.” *Id.* at 34. In general, interventions are “medically indicated” when “the patient’s impaired physical or mental condition may be improved by their application.” *Id.* at 21. The contemporary version of the futility debate delves into the scope of the term “medically indicated” by asking under what circumstances a physician may override a patient’s request for treatment—whether expressed directly or through a surrogate—that is non-curative, but nevertheless offers an identifiable, though temporary, physiological benefit. *See generally id.* at 30. In general, the underlying principle that governs the physician’s ethical and professional responsibilities “are closely tied to their ability to fulfill the goals of medicine in conjunction with their respect for patients’ preferences about the goals of their lives.” *Id.* at 14. The various facets of this question can be analyzed in relation either to the goals of treatment—to cure the patient’s condition, to mitigate the suffering that might be associated with it, or to provide comfort care—or to the status of the patient as “dying,” “terminal,” or “incurable.” *See generally id.* at 20–26. Any question concerning a physician’s judgment about the clinical viability of an intervention would implicate the law of medical malpractice when a patient contends that a physician mistakenly concluded that it would have been physiologically futile to employ a treatment regimen that, in fact, was a viable clinical option. As a matter of law, such presentations of the futility question are relatively straightforward in the sense that their resolution turns upon reconciling the physician’s conduct with the professional standard of care, which would be established with reference to expert testimony. This Article does not focus on mistakes in determining whether an intervention is futile in an objectively clinical sense, but instead on how the law should define futility in the abstract. *See, e.g., id.* at 44.

13. As noted by Professors Jonsen, Siegler, and Winslade,

Given the nature of medical science and the particularities of each patient, clinical judgment is never absolutely certain. Clinical medicine was described by Dr. William Osler as “a science of uncertainty and an art of probability.” The central task of clinicians is to reduce uncertainty to the extent possible by using clinical data, medical science, and reasoning to reach a diagnosis and propose a plan of care. The process by which a clinician attempts to make consistently good decisions in the face of uncertainty is called *clinical judgment*.

Id. at 26. In light of this “uncertain science” and the “art of probability” that shape the exercise of clinical judgment, it has been suggested that physicians tend to reach widely divergent conclusions about the effectiveness of clinical interventions. *Id.* at

The appropriate placement of that line becomes most uncertain when a physician's clinical judgment incorporates a purely subjective assessment concerning patient characteristics that are unrelated to the physiological efficacy of an intervention. Such cases, which reflect the contemporary focus of the futility question, go beyond the purely objective measure of absolute physiological futility to ask under what circumstances a physician may override a patient's request for treatment that is non-curative but nevertheless offers an identifiable, though merely temporary, physiological benefit.¹⁴ For example, physicians occasionally withdraw nutrition and hydration from permanently unconscious patients after concluding that the continuation of treatment would merely and indefinitely prolong the patient's physical existence, but would do so without offering any hope for his return to a sapient state.¹⁵ In some of

28. These diverse results also have been attributed to the varied levels of clinical experience among physicians and the relative scarcity of studies that demonstrate meaningful probabilities. *Id.* Altogether, the resulting vagueness has led some clinicians and ethicists to deny futility as a meaningful concept, although others consider it useful with respect to interventions that have a low likelihood of success. *Id.* In any event, the contemporary debate about clinical futility focuses on the level of statistical evidence that would support a determination of futility, whether the patient or the physician should decide that an intervention is futile, and what process should be employed to resolve disagreements between patients and their physicians concerning those determinations. *Id.*

14. Pope, *supra* note 5, at 3–4.

15. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). These cases might include patients who are in a persistent vegetative state, a state of permanent unconsciousness, or another such state of severe incapacity that is believed to be irreversible. Patients in a persistent vegetative state generally maintain sufficient brain stem function to enable them to "breathe air, digest food, and produce urine without assistance." MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *HEALTH CARE LAW AND ETHICS* 530 (7th ed. 2007). These patients tend to experience cycles of sleep in which their eyes are closed, and cycles of awakening in which their eyes are open. *Id.* They might smile, utter unintelligible sounds, move their eyes and limbs, though sporadically, and exhibit reflexive responses to physical stimuli by grimacing, coughing, or gagging, all of which give the appearance of consciousness when there is none. *Id.* In contrast, persons in a coma are in a sleep-like state and exhibit no indications of consciousness. See, e.g., *id.* at 530–31. Many of such patients would be considered terminally ill under the customary natural death act, even if their biological life could be sustained indefinitely by application of artificial nutrition and hydration, and by mechanical ventilation.

these cases, physicians have withheld treatment unilaterally, openly disregarding an authorized surrogate's order to the contrary.¹⁶

Some physicians would justify such unilateral decisions to withhold treatment as the legitimate exercise of medical judgment, and at least one court has addressed the issue from that perspective.¹⁷ However, it would be incoherent to resolve these cases with reference to professional judgment unless the physician would also have withheld treatment from otherwise similarly situated patients who had a reasonable prospect of regaining consciousness.¹⁸ Under this view, a custom of unilaterally withholding treatment from only permanently unconscious patients would not reflect the exercise of professional discretion concerning the efficacy of a procedure that a physician reasonably expects to prolong life. Rather, such a custom would appear to reflect only the physician's value judgment concerning the right of a severely incapacitated patient to receive treatment.¹⁹

This perspective compels consideration of whether there is something different about a patient with a severe cognitive impairment that would qualify his right to have a surrogate speak on his behalf after losing capacity. Much of the tension in the present debate about medical futility arises more out of a conflict of visions concerning that fundamental issue than the respect to be accorded the physician's exercise of medical judgment.²⁰

Many of the participants in this debate would resolve the futility question by relying on the traditional legal and ethical principles that have come to define the scope and durability of one's general right to accept or refuse medical treatment at the end of life.²¹ However, one might question the relevance of those principles in the context of a patient who has no reasonable prospect of returning to a sapient existence, particularly when a continuation of treatment would lead to an extended physical life that may span years rather than mere hours or days. With respect to patients in a persistent vegetative state, for example, Peter Singer has said:

16. See, e.g., *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072, 1075–76 (La. Ct. App. 1998).

17. *Id.* at 1076.

18. See, e.g., *id.* at 1075–76.

19. *Id.*

20. According to Professor Meisel, the futility debate might be difficult to resolve because it “revolves around fundamentally irresolvable moral conflicts concerning our most deeply held beliefs about the value of life.” MEISEL & CERMENARA, *supra* note 1, at 13-13 (quoting E. Haavi Morreim, *Profoundly Diminished Life: The Casualties of Coercion*, HASTINGS CTR. REP., Jan.-Feb. 1994, at 33).

21. See generally BEAUCHAMP & CHILDRESS, *supra* note 1, at 170.

They are not self-conscious, rational, or autonomous, and so considerations of a right to life or of respecting autonomy do not apply. If they have no experiences at all, and can never have any again, their lives have no intrinsic value. Their life's journey has come to an end. They are biologically alive, but not biographically.²²

Adherents to this view would disregard the relevance of principles concerning one's fundamental right to self-determination simply by denying that it should be ascribed to permanently unconscious patients.²³

In opposition, there is the idea that any human being is the subject of rights and intrinsic value by virtue of what he is by nature, rather than with reference to any actual capacities he might possess at any point in time during life.²⁴ Those who advocate this view would find it both illogical and unjust to define one's rights with reference to his state of consciousness:

To base the intrinsic value of a being on an accidental attribute—such as consciousness or the immediately exercisable capacity for consciousness—is to base a radical moral difference on a mere quantitative ontological difference. We treat beings who are subjects of rights radically differently from the way we treat other beings. The basis for that radical difference in treatment must be some radical difference in the different types of beings treated differently. Between any human being and a corpse or an aggregate of tissues and organs there is a radical difference. But the difference between a healthy, self-conscious human being and

22. PATRICK LEE & ROBERT P. GEORGE, BODY-SELF DUALISM IN CONTEMPORARY ETHICS AND POLITICS 152 (2008) (quoting PETER SINGER, PRACTICAL ETHICS (3rd. ed. 1993)). Although Singer acknowledges that these persons are “biologically alive,” he nevertheless suggests that, for all practical purposes, they are not. *Id.* From a legal perspective, however, Singer's argument is negated by the definition of death. *See, e.g.*, LA. REV. STAT. § 9:111(A) (2016), which defines a person's “death” in these terms:

A person will be considered dead if in the announced opinion of a physician, duly licensed in the state of Louisiana based on ordinary standards of approved medical practice, the person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, duly licensed in the state of Louisiana based upon ordinary standards of approved medical practice, the person has experienced an irreversible total cessation of brain function.

23. *See supra* note 22 and accompanying text.

24. LEE & GEORGE, *supra* note 22, at 154–55.

a human being incapacitated, even severely incapacitated, is only a difference in degree. It is unjust, then, to pick out such an accidental attribute as self-consciousness or the immediately exercisable capacity for self-consciousness and make that the criterion for whether someone should be treated as a subject of rights or not. Thus, a human being is valuable as a subject of rights in virtue of what he or she is (a person, a subject with the basic nature capacity for conceptual thought and free choice even if he or she cannot right now actualize that basic capacity). And so a human being remains a subject of rights, someone who has a right not to be intentionally killed, for as long as he or she exists.²⁵

The central premise of this Article is that established principles of both law and bioethics that relate to the right of a patient either to accept or refuse medical treatment implicitly reflect and rest upon this perspective.²⁶ Accordingly, the arguments presented here are grounded in the following

25. LEE & GEORGE, *supra* note 22, at 155. The implications of this “singular” view of the human person are profound. Those who see personhood from this perspective would have it that the human body is not a mere external tool to be used, consumed, or subjected to experimentation for the benefit of others without consent. *Id.* at 82. Rather, they would argue that the human organism, in and of itself, has a full moral worth and, as such, is the subject of rights. *Id.* This view would be consistent with that of John Locke, who argued that our lives are inalienable because we hold them in trust for God, who truly owns both our lives and our liberties. According to Locke,

[A] man, not having the power of his own life, cannot, by compact, or his own consent . . . put himself under the absolute, arbitrary power of another, to take away his life, when he pleases. [H]e that cannot take away his own life, cannot give another power over it. . . . [T]he fundamental law of nature being the preservation of mankind, no human sanction can be good, or valid against it.

JOHN LOCKE, TWO TREATISES OF GOVERNMENT 284, 358 (Peter Laslett ed., Cambridge Univ. Press 1988) (1690). The state’s interest in preserving life reflects this premise, by implication if not by design. At the same time, however, the principle of autonomy reflects the law’s recognition that liberty necessarily entails one’s freedom to make choices that are unique to his or her perspective about how to honor that trust.

26. Advance directive statutes, by definition, rest on this premise. *See generally* BEAUCHAMP & CHILDRESS, *supra* note 1, at 170–81 (discussing surrogate decision-making, which rests on the fundamental rule of law that the right either to give or refuse consent to treatment survives incapacity, thus leaving for resolution only one’s preference under the circumstances).

specific assumptions.²⁷ First, because biological life is essential and intrinsic to human personhood, a person comes into being not later than the time of his birth, by which time the human organism itself has been identified as a discrete biological entity that is “a whole . . . member of the species homo sapiens.”²⁸ Second, a person ceases to exist only when the

27. These premises also serve as the foundation for the arguments raised by the author in a broader work concerning medical futility. See Frederick R. Parker, Jr., *Law, Bioethics, and Medical Futility: Defining Patient Rights at the End of Life*, 37 U. ARK. LITTLE ROCK L. REV. 185, 190–91 (2015).

28. LEE & GEORGE, *supra* note 22, at 122. Professors Lee and George ground this reasoning in the science of embryology, from which they conclude “the life of an individual human being begins with the joining of sperm and ovum, which yields a genetically and functionally distinct organism, possessing the resources and active disposition for internally directed development toward human maturity.” *Id.* at 118–19 (citing WILLIAM J. LARSEN, *HUMAN EMBRYOLOGY* (3rd ed. 2001); KEITH L. MOORE & T.V.N. PERSAUD, *THE DEVELOPING HUMAN: CLINICALLY ORIENTED EMBRYOLOGY* (7th ed. 2003); RONAN R. O’RAHILLY & FABIOLA MULLER, *HUMAN EMBRYOLOGY AND TERATOLOGY* (3rd ed. 2001); SCOTT F. GILBERT, *DEVELOPMENTAL BIOLOGY* (7th ed. 2003)). More specifically, they announce “three important points.” *Id.* at 120. First, they announce that the embryo, from its inception, is distinct from any cell of either the father or the mother, as reflected in the fact that “[i]ts growth is internally directed to its own survival and maturation, a distinct end from the survival and flourishing of the mother in whose body this distinct organism resides.” *Id.* Second, they announce that the embryo possesses the genetic composition of a human being. *Id.* Third, they announce that the embryo “is a whole, though obviously immature, human being.” *Id.* Professors Lee and George distinguished the embryo as a separately identifiable organism from the gametes whose union brought it into existence by noting,

They are not only genetically but also functionally identifiable as parts of the male or female potential parents. Each has only half the genetic material needed to guide the development of an immature human toward full maturity, and none of these cells will survive long. They clearly are destined either to combine with an ovum or sperm or to degenerate. Even when they succeed in causing fertilization, they do not survive; rather, their genetic (and cytoplasmic) material enters into the composition of a distinct, new organism.

Id. at 120–21. In contrast with the gametes, they state:

The human embryo, from beginning of fertilization onward, is fully programmed actively to develop himself or herself to the mature stage of a human being. And unless deprived of a suitable environment or prevented by accident or disease, this embryo will actively develop itself in its own distinct direction, toward its own survival and maturity. The direction of its growth is not extrinsically determined, but is in accord with the genetic information and cytoplasmic factors within it. The

biological function of the human body is extinguished by death.²⁹ Third, every human person is, by definition, indistinguishable from his or her body, both the person and the bodily organism constituting but one and the same entity.³⁰ Accordingly, a human person is a particular form of physical organism that integrates into one uniquely identifiable being both biological life and the kinds of things that persons, by nature, have the capacity to do.³¹ The person is an “embodied mind” or a “living bodily entity” rather than a consciousness that possesses or inhabits a body, or a series of conscious experiences.³² In short, one’s self, or person, is so inextricably identified with the human physical organism that we are essentially bodily beings.³³ Finally, every human being is intrinsically valuable as a bearer of rights by virtue of what he or she is.³⁴ Just as no human being can come to be and later acquire intrinsic

human embryo is, then, a whole (though immature) and distinct human organism—a human being.

Id. at 121.

29. The opposing perspective is radically different. LEE & GEORGE, *supra* note 22, at 130–32. If a biological aspect of human life, such as consciousness, is considered to be a merely extrinsic characteristic we ascribe to the human person, it might be said that a person does not come into existence until the organism begins to manifest those characteristics. *Id.* Further, this “dualism” view would consider the human “person” and the human “organism” as distinct entities such that the human person ceases to exist when the organism no longer manifests the characteristics that are uniquely identified with personhood, even if the biological organism itself is not yet dead. *Id.* This perspective, therefore, would assume that a “person” is in some manner distinct from the bodily organism with which he or she is identified. Many who advocate for a right to euthanasia would consider an individual who is permanently unconscious as having ceased to exist as a human person even though the same biological organism with which they “previously were associated” continues to exist. *Id.* at 151–52. Thus, while they would agree that it is wrong to kill a person, they claim that it is not necessarily wrong to kill a human being who is not a person. *Id.*

30. LEE & GEORGE, *supra* note 22, at 130–32.

31. *Id.*

32. *Id.*

33. *Id.* at 132.

34. Professor Budziszewski relates the logic of attributing intrinsic value to all human beings:

To be a person is to be a proper subject of absolute regard—a “neighbor” in the sense of the Commandments—a being of the sort whom the Commandments are about. It is persons whom I am not to kill, persons whom I am to love as I love myself. But what is a person? If we accept the biblical revelation that man is the *imago Dei*, the image of God, then every human being is a person—a person by nature, a kind of thing different from any other kind, a being whose very existence is a kind of

sacrament, a sign of God's grace. Trying to understand man without recognizing him as the *imago Dei* is like trying to understand a bas-relief without recognizing it as a carving. . . . In contemporary secular ethics, the ruling tendency is to concede that there are such things as persons, but to define them in terms of their functions or capacities—not by what they are, . . . but by what they can do. . . . To give but a single well-known illustration, philosopher Mary Ann Warren defines “personhood” in terms of consciousness, reasoning, self-motivated activity, the capacity to communicate about indefinitely many topics, and conceptual self-awareness. If you can do all those things, you're a person; if you can't, you're not. The functional approach to personhood seems plausible at first, just because—at a certain stage of development, and barring misfortune—most persons do have those functions. But Warren thinks persons are their functions [U]nborn babies are not capable of reasoning, complex communication, and so on. . . . If unborn babies may be killed because they lack these functions, then a great many other individuals may also be killed for the same reasons—for example the asleep, unconscious, demented, addicted, and very young, not to mention sundry other cases such as deaf-mutes who have not been taught sign language. . . . [We need] to stop confusing what persons are with what they can typically do. . . . [A functional definition is] appropriate for things that have no inherent nature, whose identity is dependent on our purposes and interests—things which do not intrinsically deserve to be regarded in a certain way, but which may be regarded in any way which is convenient. For example, suppose I am building an automobile and I need to keep two moving parts from touching each other. . . . Anything can be a spacer which fills the space The particular lump of matter I use to accomplish this purpose is not intrinsically a proper subject of absolute regard; my regard for it—even its very identity as a spacer—is relative to how I want to use it, or to what I find interesting about it. By contrast, if I am a person, then I am by nature a rights-bearer, by nature a proper subject of absolute regard—not because of what I can do, but because of what I am. Of course this presupposes that I have a nature, a “what-I-am”, which is distinct from the present condition or stage of development of what I am, distinct from my abilities in that condition or stage of development, and, in particular, distinct from how this condition, stage of development, or set of abilities might happen to be valued by other people. In short, a person is by nature someone whom it is wrong to view merely functionally—wrong to value merely as a means to the ends or the interests of others. If you regard me as a person only because I am able to exercise certain capacities that interest you, then you are saying that I am an object of your regard not in absolute but only in a relative sense. . . . And so the functional definition of personhood does not even rise to the dignity of being wrong.

J. BUDZISZEWSKI, *WHAT WE CAN'T NOT KNOW* 70–72 (2003).

value, no human being can continue to be, but lose the intrinsic value imputed to him or her as a subject of rights.³⁵

These premises are consistent with the longstanding recognition in American law that a patient's right to express either an informed consent or a knowing refusal of treatment is not conditioned upon a finding of decisional capacity—to the contrary, that right both arises and is extinguished with the patient's life.³⁶

II. DEFINING MEDICAL FUTILITY WITH REFERENCE TO THE ACT

The law concerning end-of-life decisions in the United States arose over the past four decades as advances in medical technology enabled physicians to sustain metabolic life well beyond the customary barriers of time and physics by providing artificial means of respiration, circulation, nutrition, and hydration.³⁷ These interventions soon became problematic for physicians and hospitals when surrogates for patients who were believed to be permanently unconscious began to refuse treatment that offered an opportunity to extend biological life indefinitely, though without any expectation that the patient would return to a sapient state.³⁸

When physicians expressed their hesitance to withhold or withdraw treatment from such patients because of concerns about potentially adverse legal and professional consequences, patient surrogates initiated legal proceedings in which they sought judicial sanction.³⁹ Out of these cases arose

35. *Id.*

36. *See In re Conroy*, 486 A.2d 1209, 1229 (N.J. 1985) (“The right of an adult who, like Claire Conroy, was once competent, to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectuation.”); *see generally* BEAUCHAMP & CHILDRESS, *supra* note 1, at 170.

37. *See, e.g., Cruzan v. Dir., Mo. Dep't Health*, 497 U.S. 261, 270, 270 n.3 (1990). According to Justice Brennan's dissent in *Cruzan*:

Medical technology . . . is often capable of resuscitating people after they have stopped breathing or their hearts have stopped beating. Some of those people are brought fully back to life. Two decades ago, those who were not and could not swallow and digest food, died. Intravenous solutions could not provide sufficient calories to maintain people for more than a short time. Today, various forms of artificial feeding have been developed that are able to keep people metabolically alive for years, even decades.

Id. at 328 (Brennan, J., dissenting).

38. *See, e.g., In re Quinlan*, 355 A.2d 647 (N.J. 1976); *Conroy*, 486 A.2d 1209; *Cruzan*, 497 U.S. 261.

39. *See, e.g., Quinlan*, 355 A.2d 647; *Conroy*, 486 A.2d 1209; *Cruzan*, 497 U.S. 261.

a fairly consistent body of jurisprudence that recognized one's general right to forego life-sustaining treatment.⁴⁰ This right traditionally has been understood as the natural corollary to the doctrine of informed consent: if a physician is obligated to obtain a patient's consent prior to providing treatment, the clear inference is that the patient has a corresponding right to refuse treatment.⁴¹

The jurisprudence⁴² eventually culminated in legislative responses in the various states along the lines of the Act.⁴³ Although these statutory schemes vary somewhat from one state to another,⁴⁴ they tend to embody two key elements: first, they expressly recognize one's right to refuse life-sustaining treatment in certain narrowly defined circumstances; and second, they provide immunity from liability for physicians who act in accordance with their patients' decisions to withhold or withdraw such measures.⁴⁵

As a natural implication of the doctrine of informed consent, the recognition of such a right is well-grounded in American law, and one's refusal of treatment generally is not controversial. It becomes problematic from a legal perspective, however, when the refusal relates to treatment that would either prevent the patient's death or, if death is inevitable, extend his life. This is so because a refusal of treatment in either of those cases would bring the patient's interest in self-determination into conflict with the state's

40. See, e.g., *Cruzan*, 497 U.S. 261.

41. See, e.g., *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960) ("Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.").

42. See generally MEISEL & CERMINARA, *supra* note 1, at 2-3. Although many of the early cases arose in the context of competent persons who objected to treatment either on religious grounds or simply as a matter of personal preference, the rapid emergence of advanced medical technology since the 1970s provided the main impetus for the modern so-called "right-to-die" cases. *Cruzan*, 497 U.S. at 270. Such technology has enabled biological life to be sustained almost indefinitely by a combination of devices for artificial respiration, circulation, feeding, and hydration. See *id.* at 328 (Brennan, J., dissenting).

43. LA. REV. STAT. § 40:1151.1 (2016).

44. See generally UNIF. HEALTH-CARE DECISIONS ACT (UNIF. LAW COMM'N 1993); UNIF. RIGHTS OF THE TERMINALLY ILL ACT (UNIF. LAW COMM'N 1989).

45. See MEISEL & CERMINARA, *supra* note 1, at 7-16-7-20.

broader interests in preserving life,⁴⁶ preventing suicide,⁴⁷ preserving the ethical integrity of the medical profession,⁴⁸ and protecting members of vulnerable groups.⁴⁹

46. See, e.g., *In re Conroy*, 486 A.2d 1209, 1239 (N.J. 1985). Some commentators have observed that the predominant jurisprudential trend is to view the state's specific interest in preserving the life of a particular individual as dependent on that individual's interest in preserving his own life, and that most courts seem to have abandoned any effort to balance the individual's right to refuse treatment with the state's interest in preserving life. See, e.g., HALLET AL., *supra* note 15, at 531. The United States Supreme Court noted in *Washington v. Glucksberg*, however, in the context of terminally ill patients who sought the active assistance of a physician in bringing about their death that the states "may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy," and "[t]his remains true, as *Cruzan* makes clear, even for those who are near death." 521 U.S. 702, 729–30 (1997) (citing *Cruzan*, 497 U.S. at 282). Without regard to the perceived momentum of the states toward qualifying their interests in preserving life or otherwise in practice narrowing the circumstances in which they might exercise it, that fact would not bear upon the issue when the patient has affirmatively requested treatment. Meisel has summarized the general judicial consensus concerning this right as follows: first, patients, whether competent or incompetent, have both a common law and a constitutional law right to refuse treatment. See generally MEISEL & CERMINARA, *supra* note 1, at 2-5. Second, the state's interest in opposing a competent patient's right to forgo life-sustaining treatment is "virtually nonexistent," and the state's interest is "very weak" with respect to incompetent patients who have a dim prognosis for recovery, although the state likely would not disavow that interest if the patient has chosen not to exercise his right to refuse treatment. *Id.* As noted by Professor Meisel, "the right of self-determination has . . . traditionally been thought to require that treatment *not* be forgone without the informed consent of one legally authorized to provide it." *Id.* at 2-25. Third, decisions about life-sustaining treatment generally should take place in the clinical setting, although the courts are available to resolve disputes about those decisions. *Id.* Fourth, surrogate decision makers for incompetent patients should express the patient's own preferences to the extent made known prior to the loss of capacity, and to the extent the patient's preference is unknown, decisions should be made on the basis of the patient's best interests. *Id.* Fifth, physicians and surrogates may rely on an incompetent patient's advance directive in ascertaining the patient's preferences concerning life-sustaining procedures. *Id.* Sixth, artificial nutrition and hydration is a form of medical treatment that may be withheld or withdrawn under the same conditions as other forms of medical treatment. *Id.* Seventh, the withholding or withdrawal of medical treatment is both morally and ethically distinct from euthanasia and assisted suicide, assuming that the patient has agreed to withhold or withdraw treatment. *Id.*

47. See, e.g., *Conroy*, 486 A.2d at 1223.

48. *Id.*

Although the Act represents the legislature's effort to balance these competing interests, the statute itself reflects the inherent difficulty of fulfilling that purpose. For example, the Act acknowledges in broad, general terms that patients have a fundamental right to control decisions relating to their medical care, and that this right encompasses the refusal of life-sustaining clinical interventions.⁵⁰ However, the law is vague in terms of defining the ultimate scope of this liberty, expressly recognizing only the right of terminally ill patients to refuse treatment that would merely postpone the moment of death, and leaving open the question of one's right to withhold or withdraw other forms of treatment that offer a reasonable prospect of reversing the dying process.⁵¹ Moreover, and in a

49. See, e.g., *Cruzan v. Dir.*, Mo. Dep't of Health, 497 U.S. 261, 273 (1990).

50. LA. REV. STAT. § 40:1151(A) (2016) provides:

(1) The legislature finds that all persons have the fundamental right to control the decisions relating to their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances where such persons are diagnosed as having a terminal and irreversible condition. (2) The legislature further finds that the artificial prolongation of life for a person diagnosed as having a terminal and irreversible condition may cause loss of individual and personal dignity and secure only a precarious and burdensome existence while providing nothing medically necessary or beneficial to the person . . . (4) In furtherance of the rights of such persons, the legislature finds and declares that nothing in this Subpart shall be construed to be the exclusive means by which life-sustaining procedures may be withheld or withdrawn, nor shall this Subpart be construed to require the application of medically inappropriate treatment or life-sustaining procedures to any patient or to interfere with medical judgment with respect to the application of medical treatment or life-sustaining procedures.

51. The Act, for example, expressly provides that a patient who has been diagnosed as having a "terminal and irreversible condition" has the right to withhold or withdraw "life-sustaining procedure[s]," which by definition serve only to prolong the dying process. LA. REV. STAT. § 40:1151.1(8), (14). The 1989 version of The Uniform Rights of the Terminally Ill Act is similarly limited to "treatment that is merely life-prolonging, and to patients whose terminal condition is incurable and irreversible, whose death will soon occur, and who are unable to participate in treatment decisions." UNIF. RIGHTS OF THE TERMINALLY ILL ACT, prefatory note (UNIF. LAW COMM'N 1989). According to Meisel, "several" states have adopted the URTIA in either its 1985 or 1989 version. MEISEL & CERMINARA, *supra* note 1, at 7-54-7-55. Other statutory schemes, however, are broader in scope. For example, the Uniform Health-Care Decisions Act "acknowledges the right of a competent individual to decide all aspects of his or her own health care in all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues. . . . The Act

manner consistent with the state's interest in preserving life, the Act expressly states that one's right to refuse treatment is a voluntary matter that rests solely within the patient's discretion.⁵² In this manner, the statute establishes that the law does not authorize, nor does it require, the withholding or withdrawal of treatment in any particular case absent the patient's consent.⁵³ Likewise, the law provides that it is not to be construed as authorizing or condoning euthanasia.⁵⁴ Taken together, it might be fair to say that these provisions suggest a legislative intent to affirm and retain the state's traditional interest in preserving life when the patient has not exercised his right to refuse treatment.

To give practical effect to the patient's right of self-determination and to encourage physicians to respect patient preferences, the statute incorporates an immunity provision that insulates physicians from liability when they withhold or withdraw treatment in accordance with their

recognizes and validates an individual's authority to define the scope of an instruction or agency as broadly or as narrowly as the individual chooses." UNIF. HEALTH-CARE DECISIONS ACT, prefatory note (UNIF. LAW COMM'N 1993). According to the Uniform Law Commission's Legislative Fact Sheet, the UHCDA had been adopted by Alaska, Delaware, Hawaii, Maine, Mississippi, New Mexico, and Wyoming as of 2014, although the advance directive statutes of some states appear to be modified forms of the UHCDA. *Legislative Fact Sheet—Health-Care Decisions Act*, UNIFORM L. COMMISSION, <http://www.uniformlaws.org/LegislativeFactSheet.aspx?title=Health-Care%20Decisions%20Act> [<https://perma.cc/3LWA-5NAV>] (last visited Oct. 27, 2016). See generally MEISEL & CERMINARA, *supra* note 1, at 7-32–7-33, 7-63–7-89 (summarizing the law in this regard in other jurisdictions). Notwithstanding the narrow scope of this statutory right, however, the Louisiana statute, like similar schemes in other jurisdictions, expressly states that its provisions are "cumulative with existing law." See LA. REV. STAT. § 40:1151.9(C). According to Meisel, these schemes "are intended to preserve and supplement existing common law and constitutional rights and not to supersede or limit them." See MEISEL & CERMINARA, *supra* note 1, at 7-33–7-34.

52. LA. REV. STAT. § 40:1151(B)(1) & (2).

53. LA. REV. STAT. § 40:1151(B) provides:

(1) The legislature intends that the provisions of this Subpart are permissive and voluntary. The legislature further intends that the making of a declaration pursuant to this Subpart merely illustrates a means of documenting a patient's decision relative to withholding or withdrawal of medical treatment or life-sustaining procedures. (2) It is the intent of the legislature that nothing in this Subpart shall be construed to require the making of a declaration pursuant to this Subpart.

54. LA. REV. STAT. § 40:1151.9(A). See also MEISEL & CERMINARA, *supra* note 1, at 7-102–7-103.

patients' wishes.⁵⁵ Finally, the statute expressly denies any intent to interfere with the exercise of "medical judgment"⁵⁶ or to require the provision of "medically inappropriate treatment."⁵⁷ These core provisions of the Act directly shape both patient rights and physician obligations during the course of the physician–patient relationship.

Although the legislature adopted the Act to recognize and further the right of individuals to control decisions related to their medical care, physicians occasionally have relied upon the statute not only to justify their acquiescence to a patient's decision to refuse treatment, but also to substantiate their own decisions to deny treatment that a patient or his authorized surrogate has expressly requested.⁵⁸

*Causey v. St. Francis Medical Center*⁵⁹ is an interesting example of such a case. Sonya Causey, a 31-year-old quadriplegic who was comatose and suffering from end-stage renal disease, was totally dependent on a ventilator, regular hemodialysis, and the continuous provision of artificial nutrition and hydration.⁶⁰ These interventions constituted "life-sustaining procedures" as defined in the Act, which expressly recognized the authority of Sonya's surrogate decision maker to refuse treatment on her behalf.⁶¹

Although Sonya's attending physician believed that continued treatment could preserve her life for at least two additional years, he was

55. See LA. REV. STAT. § 40:1151.7(A)(1), (C)(1); see also *id.* § 40:1151.8(B) (subjecting to criminal prosecution any persons who act in various ways to cause the withholding or withdrawal of life-sustaining treatment contrary to the patient's wishes). For similar immunity schemes in other jurisdictions see UNIF. RIGHTS OF THE TERMINALLY ILL ACT, § 9 and UNIF. HEALTH-CARE DECISIONS ACT, § 9. According to Meisel, "statutes do not confer wholesale immunity; rather, most confer qualified immunity conditioned on the physician's acting in good faith and pursuant to reasonable medical standards." MEISEL & CERMINARA, *supra* note 1, at 7-149.

56. LA. REV. STAT. § 40:1151(B)(3).

57. *Id.* In contrast with the language of the Act, the UHCDA does not require the provision of treatment that would be "medically ineffective." UNIF. HEALTH-CARE DECISIONS ACT, §§ 7(f), 13(d) (the comments to which define "medically ineffective" as "treatment which would not offer . . . any significant benefit," or treatment that would be "contrary to generally accepted health-care standards"). The URTIA similarly does not require the provision of treatment that would be "contrary to reasonable medical standards." UNIF. RIGHTS OF THE TERMINALLY ILL ACT, § 11(f).

58. See Pope, *supra* note 5.

59. 719 So. 2d 1072 (La. Ct. App. 1998).

60. *Id.* at 1073, 1075–76.

61. LA. REV. STAT. § 40:1151.1(8).

of the opinion that Sonya had an insignificant chance of ever regaining consciousness.⁶² He therefore recommended that treatment be withdrawn and that Sonya be allowed to die.⁶³ When her family insisted that treatment be continued, the physician presented the case to the hospital's Morals and Ethics Board, which concurred with his recommendation.⁶⁴ Treatment was then withdrawn over the strong objection of Sonya's family, and she died shortly thereafter.⁶⁵

In response to this action, members of Sonya's family initiated a legal proceeding in which they sought damages from the physician and the hospital under the theory that they had committed an intentional tort in the form of a battery.⁶⁶ However, the trial court concluded that the case was grounded in medical malpractice because the physician's actions reflected his "professional opinions and professional judgment."⁶⁷ The court thus determined that the case was subject to the Medical Malpractice Act,⁶⁸ which required that it be submitted for consideration by a medical review panel before judicial proceedings were initiated.⁶⁹ The trial court then dismissed the action as premature from a procedural perspective.⁷⁰

On appeal, the Second Circuit affirmed the trial court's decision.⁷¹ As the case concerned the legal consequences of withdrawing life-sustaining

62. *Causey*, 719 So. 2d at 1073.

63. *Id.* at 1074.

64. *Id.* The hospital had in place a "Futile Care Policy" that provided for treatment to be discontinued if it had only a slight probability of improving the patient's condition. *Id.* at 1075.

65. *Id.* at 1074.

66. *Id.*

67. *Id.* at 1073.

68. LA. REV. STAT. § 40:1231.1 (2016).

69. *Id.* Louisiana conditions the jurisdiction of the courts in actions grounded in medical malpractice and informed consent law upon the case first having been submitted for review by a Medical Review Panel. *See id.* § 41:1231.8(A)(1)(a)–(B)(1)(a). The Medical Practice Act defines "malpractice" as "any unintentional tort or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient." *Id.* § 40:1231.1(A)(13). "Health care means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient." *Id.* § 40:1231.1(A)(9). A physician's failure to obtain either a patient's informed consent or refusal for treatment would constitute such a claim, and thus would be subject to the medical review panel process. *See id.* § 40:1157.1(D).

70. *Causey*, 719 So. 2d at 1073.

71. *Id.* at 1076.

treatment, the court logically began its analysis with reference to the Act.⁷² Noting that the legislature had grounded its recognition of that right in the concepts of patient autonomy, self-determination, and informed consent,⁷³ the court pointed out that the facts of *Causey* were diametrically opposed to those of the customary end-of-life dispute, in which physicians were reluctant to accede to a surrogate's request that treatment be withdrawn and the patient be allowed to die.⁷⁴ In *Causey*, the court said, "the roles are reversed":

Patients or, if incompetent, their surrogate decision-makers, are demanding life-sustaining treatment regardless of its perceived futility, while physicians are objecting to being compelled to prolong life with procedures they consider futile. The right or autonomy of the patient to refuse treatment is simply a severing of the relationship with the physician. In this case, however, the patient (through her surrogate) is not severing a relationship, but demanding treatment the physician believes is "inappropriate." The problem is not with care that the physician believes is harmful or literally has no effect. For example, radiation treatment for Mrs. Causey's condition would not have been appropriate. This is arguably based on medical science. Rather, the problem is with care that has an effect on the dying process, but which the physician believes has no benefit. Such life-prolonging care is grounded in beliefs and values about which people disagree. Strictly speaking, if a physician can keep the patient alive, such care is not medically or physiologically "futile;" however, it may be "futile" on philosophical, religious or practical grounds.⁷⁵

Finding the issue of futility to be "a subjective and nebulous concept which, except in the strictest physiological sense, incorporates value judgments," and concluding that it would be "confusing" and "generate[] polemical discussion" to focus on that concept, the court "turn[ed] instead to an approach emphasizing the standard of medical care."⁷⁶ In doing so,

72. *Id.* at 1074.

73. *Id.* (citing *In re Quinlan*, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976)).

74. *Id.*

75. *Id.*

76. *Id.* at 1075. The *Causey* court set the framework for its opinion on the professional standard of care with an inferential reference to the doctrine of informed consent, noting that "[t]he physician has an obligation to present all medically acceptable treatment options for the patient or her surrogate to consider and either choose or reject; however, this does not compel a physician to provide

the court focused on the physician's professional obligations as described in the Act, which provides:

In furtherance of the rights of [terminally ill] persons, the legislature finds and declares that nothing in this Subpart shall be construed to be the exclusive means by which life-sustaining procedures may be withheld or withdrawn, *nor shall this Subpart be construed to require the application of medically inappropriate treatment or life-sustaining procedures to any patient or to interfere with medical judgment with respect to the application of medical treatment or life-sustaining procedures.*⁷⁷

The court then concluded that “[a] finding that treatment is ‘medically inappropriate’ by a consensus of physicians practicing in that specialty translates into a standard of care”⁷⁸ and affirmed the trial court’s decision that the plaintiff’s claim should have been considered by a medical review panel before litigation was initiated.⁷⁹

It is not surprising that the court sought to evade the issue of medical futility, particularly in light of the widely acknowledged difficulty of

interventions that in his view would be harmful, without effect or ‘medically inappropriate.’” *Id.*

77. LA. REV. STAT. § 40:1151(A)(4) (2016) (emphasis added).

78. *Causey*, 719 So. 2d at 1076.

79. *Id.* There also was evidence that the physician based his defense, at least in part, on his opinion that continued treatment would have been “medically inappropriate” because he considered it to be inhumane. *Id.* at 1076 n.3. That fact arguably would raise only the question of whether the patient would have given consent to continuation of the treatment at issue. It is interesting to note that *Causey* arose after treatment had been withdrawn and the patient had died. *Id.* at 1073. Had the defendants sought judicial sanction for the withdrawal of treatment prior to acting, it is difficult to envision the court referring the case to a medical review panel. Rather, one might expect the case to have received an expedited judicial review to address the issue of whether the patient would have refused continued treatment under the particular circumstances of the case. Although resolution of that question might have required the same sort of expert testimony that would inform the opinion of a medical review panel concerning whether the patient suffered from a “terminal and irreversible condition,” and whether the treatment at issue was a “life-sustaining procedure,” the ultimate issue would focus on determining whether the patient would have given consent to continued treatment if she were capable of expressing a reasoned decision on the matter. That said, it is interesting to consider how the court might have approached the issue had it been raised prospectively, rather than after the fact.

defining that concept in the abstract.⁸⁰ However, a careful analysis of the Act reveals that the court improperly invoked the Medical Malpractice Act as the appropriate procedural reference point for resolving the case. More specifically, the court's error arose out of its conclusion that the physician's decision to withdraw treatment was grounded in the sort of "medical judgment" with which the Act was intended not to interfere.⁸¹ By shifting its focus to the Medical Malpractice Act, the court in effect adopted the professional standard of care to resolve an issue that the Act would have addressed with reference to the patient's subjective preference.⁸²

80. It is not surprising that the court sought an opportunity to demur in a case such as this, which the courts have long considered to be more appropriately within the realm of the legislature. *See, e.g., In re Farrell*, 529 A.2d 404, 407–08 (N.J. 1987) (citing *In re Conroy*, 486 A.2d 1209, 1221 (N.J. 1985)) ("We recognize, as we did in *Conroy*, and as have numerous other courts, that given the fundamental societal questions that must be resolved, the Legislature is the proper branch of government to set guidelines in this area[.] 'Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type [of] issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.'"); *see also Betancourt v. Trinitas Hosp.*, 1 A.3d 823, 833 (N.J. Super. Ct. App. Div. 2010) ("The issues presented are profound and universal in application. They warrant thoughtful study and debate not in the context of overheated rhetoric in the battlefield of active litigation, . . . but in thoughtful consideration by the Legislature as well as Executive agencies and Commissions charged with developing the policies that impact on the lives of all.").

81. *Causey*, 719 So. 2d at 1075.

82. According to the Medical Malpractice Act, "the standard of care required of every health care provider . . . in rendering professional services or health care to a patient, shall be to exercise that degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his best judgment, in the application of his skill." LA. REV. STAT. § 40:1231.1(A)(22).

A. The Role of “Medical Judgment” in the Act and the Relationship Between “Medically Inappropriate Treatment” and “Medical Futility”

Contrary to the court’s demurrer in *Causey*, a reasonable argument can be made that the Act provides a meaningful reference point for reducing the admittedly abstract philosophical notion of medical futility to a workable legal standard. This argument is primarily grounded in a reading of the statute in the context of its original purpose. More specifically, it reflects the logical correlation between the concept of medical futility, the state’s interest in the preservation of life, and the limited extent to which the Act recognized the patient’s right either to accept or refuse treatment. Just as the statute establishes an objective threshold for defining a patient’s unqualified right to refuse treatment, but without establishing the ultimate scope of that right in the abstract, it likewise establishes the objective point at which treatment becomes so “futile” that a physician has no obligation to provide it, though without identifying the outside boundary of that duty.

Contemporary questions of medical futility tend to arise when surrogates for patients who suffer from a “terminal and irreversible condition” affirmatively request forms of treatment that would be classified as “life-sustaining procedures” under the Act.⁸³ Such interventions, by definition, will not reverse the dying process brought about by the patient’s underlying condition; rather, they will only postpone the moment of an inevitable, though not necessarily impending, death. Futility issues are most commonly encountered in the context of patients like Sonya Causey who are believed to be permanently unconscious and whose lives might be extended indefinitely through the use of clinical interventions such as mechanical ventilation and the artificial administration of nutrition and hydration.⁸⁴ These questions directly implicate the law of informed consent

83. The Act defines a “life-sustaining procedure” as “any medical procedure or intervention which, within reasonable medical judgment, would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition, including such procedures as the invasive administration of nutrition and hydration and the administration of cardiopulmonary resuscitation.” *Id.* § 40:1151.1(A)(8). A “terminal and irreversible condition” is defined as “a continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death.” *Id.* § 40:1151.1(A)(14).

84. *Causey*, 719 So. 2d at 1073.

and the patient's correlative right to refuse treatment,⁸⁵ as well as the state's recognized interest in the preservation of life.

As noted by the Second Circuit in *Causey*, the Act expressly disavows any intention to interfere with the exercise of "medical judgment" or to require that physicians provide "life-sustaining procedures" or treatment that otherwise would be "medically inappropriate."⁸⁶ The court's decision to invoke the medical review panel process thus appears to rest on a perceived link between the physician's exercise of "medical judgment" and his conclusion that it would have been "medically inappropriate" to continue treatment under the circumstances.⁸⁷

Although questions about the clinical propriety of a treatment protocol inevitably bear upon the physician's exercise of "medical judgment," not all determinations made by a physician in the course of the treatment relationship necessarily fall within the scope of that term as it is employed in the Act. This point is most apparent when a physician grounds a decision to withdraw treatment based upon a subjective value judgment about certain patient characteristics rather than a professional conclusion based on medical expertise. It would be incoherent, for example, to argue that a decision to withdraw treatment from a patient believed to permanently lack decisional capacity is based on the physician's exercise of "medical judgment" unless he also would withdraw treatment from a similarly situated patient who has a reasonable prospect of returning to a sapient state.

Moreover, a reasonable argument can be made that the Act does not employ the term "medically inappropriate treatment" in a manner that necessarily calls into question the professional standard of care that applies under the Medical Malpractice Act.⁸⁸ Rather, the meaning of that term as

85. The right of self-determination traditionally is understood as requiring the patient's consent before treatment is either withheld or withdrawn. *See, e.g.*, MEISEL & CERMINARA, *supra* note 1, at 2-25 & n.107. As a practical matter, it is arguable that these cases are unlikely to be raised on the basis that the patient did not give an informed consent because the patient would either have known, or should have known, the risk or, more accurately, the certainty that accompanies the withholding or withdrawal of treatment necessary to sustain life.

86. *Causey*, 719 So. 2d at 1075.

87. *Id.*

88. As noted above, the *Causey* court demurred on the substantive issue posed by the facts of that case by employing the procedural rules of the Medical Malpractice Act to deny jurisdiction pending a consideration of the case by a medical review panel. *Id.* at 1076. Louisiana Revised Statute section 40:1231.8(A)(1)(a) provides that "[a]ll malpractice claims against health care providers covered by this Part . . . shall be reviewed by a medical review panel." LA. REV. STAT. § 40:1231.8(A)(1)(a). Section 40:1231.8(B)(1)(a)(i) provides that "[n]o action against a health care provider . . . may be commenced in any court

before the claimant's proposed complaint has been presented to a medical review panel." *Id.* § 40:1231.8(B)(1)(a)(i). Section 40:1231.1(A)(13) defines "malpractice" as "any unintentional tort or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient." *Id.* § 40:1231(A)(13). Cases concerning the scope of the Medical Malpractice Act, however, suggest that it would have been inapposite to *Causey* because it involved the sort of intentional tort not subject to the Act. *See, e.g., Sewell v. Doctors Hosp.*, 600 So. 2d 577, 578 (La. 1992) (noting that the Medical Malpractice Act's limitation on the liability of a health care provider is a form of special legislation that is "in derogation of the rights of tort victims," that the Act should be strictly construed and thus limited to cases of malpractice as expressly defined in the statute, and that "[a]ny other liability of the health care provider to the patient is not subject to these limitations"); *Coleman v. Deno*, 813 So. 2d 303, 315 (La. 2002) ("[E]ven though all medical malpractice claims [subject to the medical review panel process] are personal injury claims, 'the opposite is not true: every personal injury claim is not a medical malpractice claim.'" (quoting Scott E. Hamm, Note, *Power v. Arlington Hospital: A Federal Court End Run Around State Malpractice Limitations*, 7 *BYU J. PUB. L.* 335, 347–48 (1993)); *id.* at 315–16 (setting forth a six-factor test to determine whether a physician's intentional tort is subject to the Medical Malpractice Act, one of which is whether expert testimony is required in order to establish a physician's breach of duty); *Pfiffner v. Correa*, 643 So. 2d 1228, 1233 (La. 1994) ("[T]here are situations in which expert testimony is not necessary [to establish a physician's breach of his professional obligations to a patient]. Expert testimony is not required where the physician does an obviously careless act."); *Hastings v. Baton Rouge Gen. Hosp.*, 448 So. 2d 713, 719 (La. 1987); *Lagasse v. Tenet Health Sys. Mem'l Med. Ctr. Inc.*, 83 So. 3d 70, 72 (La. Ct. App. 2011) (holding that an allegation of euthanasia is an intentional tort that is not covered by the Medical Malpractice Act and, thus, need not be presented to a medical review panel prior to initiating legal action for a judicial remedy). In the context of medical malpractice, the issue of futility would go to a physician's erroneous conclusion about the efficacy of a particular treatment protocol, either because of an error in the underlying diagnosis or concerning the efficacy of the regimen to improve the patient's condition. Absent any such error, it is arguable that a physician who concludes that he has no obligation to honor a patient's request for a particular treatment regimen that would be expected to extend life would not be liable for malpractice when he refuses to provide it, but for an intentional tort that is not subject to the medical review panel process. The Medical Malpractice Act would, however, apply to medical determinations concerning whether a patient suffers from a "terminal and irreversible condition" or whether a proposed clinical intervention constitutes a "life-sustaining procedure." The facts recited in *Causey*, however, do not indicate that such issues were raised.

employed in the Act should be informed primarily by the statute's intended purpose of ensuring respect for the individual's right of self-determination while maintaining the integrity of the state's interest in preserving life.⁸⁹

B. The Sole Purpose of the Act was to Ensure Respect for the Patient's Preference Without Compromising the State's Interest in Preserving Life

The Act was enacted with the singular purpose of giving effect to the patient's right to control decisions relating to his own medical care at the end of life.⁹⁰ Because this right is not conditioned on one's decisional capacity, the Act also recognizes the authority of a surrogate to refuse treatment on behalf of a patient who did not express his wishes while capable of doing so.⁹¹ Finally, a prospective refusal of treatment by a capable person will survive a subsequent loss of capacity.⁹² Thus, the statute reflects the legislative intent that the right to refuse treatment is a matter that rests solely within the patient's discretion and without regard

89. Reason suggests that the state's interest in the integrity of the medical profession is merely an extension of the state's broader interest in the preservation of life. Viewed from that perspective, one might say that when we talk about the discretion of physicians in end-of-life care, we really are talking about them as the point persons in giving effect to the state's interest in preserving life as reflected in various provisions of the Act. It is important to focus on the fact that this is not a question of the physician's interest versus the patient's interest, but the state's interest versus the patient's interest that the Act was intended to balance and the Act's increasing significance in light of financial constraints. *Causey* must be viewed in that light.

90. LA. REV. STAT. § 40:1151(A)(1). More specifically, the statute recognizes the right of terminally ill patients to refuse treatment that, by definition, would serve only to postpone the moment of death. *See id.* § 40:1151(A); *id.* § 40:1151.1(8) (defining the "life-sustaining procedures" to which the Act applies); *id.* § 40:1151.1(14) (defining a "terminal and irreversible condition" upon a finding of which application of the statute depends); *id.* § 40:1151.1(11) (defining a "qualified patient" on behalf of whom the statute authorizes a declaration to be made by a surrogate). Read together, these provisions indicate that the statute does not apply to any form of treatment that would reverse a patient's terminal condition, although the statute expressly incorporates one's right to refuse treatment under general principles of law. *See id.* § 1151.9(C) (providing that the provisions of the Act "are cumulative with existing law pertaining to an individual's right to consent or refuse to consent to medical or surgical treatment"). Thus, the legislature did not intend to limit the existence of a patient's right to the narrow circumstances described in the statute, but merely to limit its express recognition of the right to these most obvious cases.

91. *Id.* § 40:1151.4(A).

92. *Id.* § 40:1151.2(A).

to whether the patient refuses treatment directly or indirectly through a surrogate who speaks on his behalf.

The statute reflects this emphasis on the patient's will in several ways. For example, it declares that "all persons have the fundamental right to control decisions relating to their own medical care,"⁹³ that this right is "permissive and voluntary,"⁹⁴ and that the Act is not to be construed to require any patient to make a declaration concerning the refusal of treatment.⁹⁵ Moreover, although the Act does not require patients to declare their intentions concerning life-sustaining treatment in any particular form, the statute sets forth an illustrative model that expressly invites them *not* to give consent to the withholding or withdrawal of treatment should they lack capacity when a decision becomes necessary.⁹⁶ Contrary to these express provisions of the statute, the court's analysis in *Causey* would subject the patient's right *not* to refuse treatment to the consent of his physician.

93. *Id.* § 40:1151(A)(1).

94. *Id.* § 40:1151(A)(1), (B)(1)–(2).

95. *Id.* § 40:1151(B)(2).

96. 2005 La. Acts 2134. A patient's declaration concerning life-sustaining procedures may be in the following illustrative form:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedure would serve only to prolong artificially the dying process, I direct (initial one only):

__That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

__That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

LA. REV. STAT. § 40:1151.2(C)(1) (emphasis added). Although this illustrative form expressly addresses only the patient's decision either to receive or forego the invasive administration of nutrition and hydration, the scope of the patient's acknowledged right to accept or refuse treatment under the Act would encompass any intervention that constitutes a life-sustaining procedure which, by definition, "would serve only to prolong the dying process." *Id.* § 40:1151.1(A)(8). Thus, in the case of Sonya Causey, that right would have related not only to the provision of artificial nutrition and hydration, but also to dialysis and mechanical ventilation.

The holding in *Causey* also is inconsistent with the statute's immunity scheme, which insulates physicians from liability when they act to withhold or withdraw life-sustaining treatment in accordance with their patients' wishes.⁹⁷ The legislature granted this immunity to alleviate a physician's concern about adverse legal and professional consequences that might attend the withholding or withdrawal of life-sustaining treatment, even when he acted at the patient's request.⁹⁸ Although this provision only implicitly reflects the voluntary nature of the patient's right of refusal, it does so with a very practical force: the granting of immunity is qualified by thinly veiled threats of civil and criminal liability to a physician who withholds or withdraws treatment without the patient's consent.⁹⁹ In this way, it reinforces the patient-centered focus of the law.¹⁰⁰

The analysis in *Causey* is noticeably silent with respect to these key provisions, each of which suggest that the court granted an undue deference to the physician's discretion. Finding the facts of the case to present a question concerning the physician's exercise of "medical judgment"—because the physician had withdrawn treatment he considered to be "medically inappropriate"—the court in effect shifted the legal theory of the case from the Natural Death Act, which emphasizes the "voluntary and permissive" nature of a patient's right to accept or refuse life-sustaining procedures,¹⁰¹ to the Medical Malpractice Act, which invokes the professional standard of care to resolve allegations of malpractice.¹⁰² By invoking the professional care standard of care, however, the court made the patient's right to direct the provision of care subject to the physician's approval. In light of that result, it is difficult to

97. LA. REV. STAT. § 40:1151.7.

98. See *id.* § 40:1151.7(A)(1)–(2) (granting physicians and other health care providers immunity from criminal prosecution, civil liability, and professional sanctions, but only with respect to the withholding or withdrawal of life-sustaining procedures with the consent of the patient or an authorized surrogate). See also *id.* § 40:1151.7(C)(1) (expressly denying immunity if it is shown that "the person authorizing or effectuating the withholding or withdrawal of life-sustaining procedures . . . did not act in good faith compliance with the intention of the . . . patient"); *id.* § 40:1151.8(B) (subjecting to criminal prosecution any persons who act in various ways to cause the withholding or withdrawal of life-sustaining treatment contrary to the patient's wishes); *id.* § 40:1151.8(A) (subjecting to civil liability persons who conceal a patient's declaration reflecting an intent to refuse treatment, presumably in order to circumvent the patient's choice to refuse treatment).

99. See *supra* note 98 and accompanying text.

100. See *supra* note 98 and accompanying text.

101. LA. REV. STAT. § 50:1151.1(B).

102. *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072, 1076 (La. Ct. App. 1998).

reconcile the court's construction of the terms "medical judgment" and "medically inappropriate treatment" with the legislative intent underlying the Natural Death Act.

A careful construction of the Act indicates that the legislature did not employ these terms to recognize a physician's unilateral authority to deny life-sustaining treatment when the patient has not exercised his right to refuse it. To the contrary, these terms must be construed in a manner that furthers, rather than contradicts, the fundamental purpose of the statute. When one considers the terms "medical judgment" and "medically inappropriate treatment" in that context, reason suggests that the legislature employed them only to deny a physician's professional obligation to provide interventions that are futile in a physiological sense or that the patient has refused.

Under this construction, the statute implicitly would require the application of life-sustaining procedures that a patient or an authorized surrogate has requested.¹⁰³ Although questions remain about the ultimate scope of one's right to refuse treatment in a constitutional sense, the jurisprudence out of which the Act arose clearly establishes that these decisions belong to the patient alone, and the terms of the Act lend themselves to the same conclusion.¹⁰⁴ Moreover, even if one were to find ambiguity in the Act's silence concerning the patient's positive right to compel the provision of "life-sustaining procedures" and, conversely, concerning the physician's unilateral authority to deny them, the statute expressly provides that any ambiguities in the law are to be resolved in a way that preserves human life.¹⁰⁵

103. This would not be so with respect to interventions that are not medically indicated because they are futile in an objective, physiological sense. The physician would have no duty to provide such measures, nor would the patient have the right to demand them.

104. See LA. REV. STAT. §§ 40:1151(A)(1), 40:1151(A)(3), 40:1151(B); *see generally* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990); *In re* Quinlan, 355 A.2d 647 (N.J. 1976); *Bouvia v Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *In Re* Conroy, 486 A.2d 1209 (N.J. 1985).

105. LA. REV. STAT. § 40:1151.9(D). It is interesting to note that the Second Circuit did not address the provisions of the Act that indicate the legislature's intention that the patient be recognized as the sole bearer of this right. Several express provisions of the Act thus negate any argument that it would sanction the withholding or withdrawal of life-sustaining treatment that a patient or his surrogate has requested. Rather, the court rested its opinion entirely on the legislature's more general expression of its "purpose, findings and intent" for enacting the statute:

Finally, not only does the Act contradict the *Causey* court's construction of the terms "medical judgment" and "medically inappropriate treatment," it employs those terms in a manner that informs the inquiry about the definition of "medical futility" in the context of life-sustaining procedures.

C. The Statutory Meaning of the Term "Medical Judgment"

In a colloquial sense, and broadly speaking, the term "medical judgment" might commonly be understood to reflect the outcome of the clinical decision process. Although one might be inclined to see that process as objective in nature, it is widely acknowledged that medical judgment is not purely objective in an abstract, scientific sense, even when it concerns the physiological efficacy of a particular intervention. Rather, the process of interpreting data and determining the appropriate course of action in a particular case is so inherently equivocal that it has been described as "a science of uncertainty and an art of probability."¹⁰⁶

Although these uncertainties inevitably require physicians to exercise professional discretion when analyzing objective data about the efficacy of a clinical protocol, it is apparent from both the text and structure of the Act that the legislature did not intend for the term "medical judgment" to encompass all professional opinions in the end-of-life clinical setting. By its very purpose, the Act directly and intentionally interferes with physician judgments concerning the provision of life-sustaining procedures simply by

In recognizing a terminal patient's right to refuse care, La. R.S. 40:1299.58.1(A)(4) states that the statute is not to be construed "to require the application of medically inappropriate treatment or life-sustaining procedures to any patient or to interfere with medical judgment with respect to the application of medical treatment or life-sustaining procedures."

Causey, 719 So. 2d at 1075. Louisiana Revised Statute section 40:1299.58.1(A)(4) was re-codified without revision as section 40:1151(A)(4) in 2015. Then, noting that the statute did not define either "medical judgment" or "medically inappropriate treatment," the court concluded that a determination of whether treatment is "medically inappropriate" necessarily entails the application of the sort of "medical judgment" with which the Act was intended not to interfere. *Id.*

106. One oft-cited adage illustrates this uncertainty in these terms: "Heaven knows; who can tell? [W]ho shall decide when doctors disagree?" Quote of unknown origin, cited in PETER MARK ROGET, ROGET'S THESAURUS 154 (1941). Clinical medicine has been described as "a science of uncertainty and an art of probability," with "[t]he central task of clinicians [being] to reduce uncertainty to the extent possible by using clinical data, medical science, and reasoning to reach a diagnosis and propose a plan of care." CLINICAL ETHICS, *supra* note 10, at 26.

recognizing that patients possess the unqualified right to refuse them.¹⁰⁷ From the opposite perspective, the Act would interfere with the clinical judgment of a physician who might prescribe a lethal agent as a palliative measure after determining that there is no other way to relieve a patient's unrelenting and intolerable pain. The Act directly interferes with a physician's judgment in these cases by expressly providing that it does not authorize or condone either euthanasia or assisted suicide.¹⁰⁸ In these ways, the statute recognizes and constrains the scope of both the patient's autonomy and the physician's discretion with respect to health care decisions at the end of life.

These legislative boundaries implicitly reflect the law's intended deference to a physician's judgment under the Act. For example, a physician's diagnosis of a "terminal and irreversible condition" or classification of an intervention as a "life-sustaining procedure" would clearly reflect the sort of judgment with which the statute is intended not to interfere. Professional judgments concerning the physiological efficacy of potential clinical interventions would also operate independently of the Act.¹⁰⁹ Disputes about such professional judgments, therefore, would be subject to the legal standards and procedural requirements of the Medical Malpractice Act.

However, such professional judgments are unlike the profound personal decisions that patients and their families face when considering whether to accept or refuse life-sustaining interventions. As these decisions implicate intensely personal considerations that are both unique to the patient and wholly unrelated to the exercise of medical judgment, the statute expressly places them within the sole discretion of the patient

107. LA. REV. STAT. §§ 40:1151.2(A)(1), 40:1151.4(A)(1), 40:1151.4(A)(2) (2016). The Act expressly recognizes the authority of a surrogate to refuse such treatment on behalf of a patient who lacks decisional capacity.

108. *Id.* § 40:1151.9(A).

109. It is interesting to note that *Causey* did not involve a dispute about such matters of professional discretion. Although the court did not expressly hold either that the patient suffered from a "terminal and irreversible condition" or that the procedures at issue constituted "life-sustaining procedures" as defined in the Act, the facts of the case, together with the inference drawn from the court's reference to the Act as the appropriate rule of law for deciding it, strongly imply that the case did fall within the scope of the statute. *See Causey*, 719 So. 2d at 1074 (Sonya Causey was believed to be permanently unconscious, and she was dependent on hemodialysis, mechanical ventilation, and artificially administered nutrition and hydration, all of which constituted "life-sustaining procedures."). The opinion further suggests that, in framing the issue, the court considered the physician's decision to withdraw treatment as a reflection of his "medical judgment" about whether it would have been "medically inappropriate" to continue it under the circumstances. Though not expressly stated, the court's analysis clearly rests on these premises.

or an authorized surrogate.¹¹⁰ Although the need for these decisions arises out of a physician's exercise of professional medical judgment concerning the patient's status under the Act, the statute invokes the patient's preference as the sole reference point for deciding whether treatment should be provided.¹¹¹

In essence, it might be said that the statute implicitly recognizes a meaningful distinction between the patient's right to refuse treatment and the physician's authority to bring about death, whether directly by employing an active intervention or indirectly by refusing to honor a request for treatment that reasonably would be expected to prolong the patient's life. The narrow statutory definition of a "life-sustaining procedure" reflects this fundamental distinction, which the Act reinforces by expressing the voluntary and permissive nature of the patient's right to refuse treatment.¹¹² Thus, the Act consummates its intended purpose by limiting the definition of "medical judgment" to clinical decisions that reflect a physician's professional, clinical opinion, rather than his personal or philosophical perspective. The expansive view of medical judgment adopted in *Casey*, however, would contradict the legislative purpose of the Act.

D. The Statutory Meaning of the Term "Medically Inappropriate Treatment" and its Relationship to the Concept of Medical Futility

In addition to expressing a virtually boundless view of "medical judgment," the opinion in *Casey* rested on the premise that a physician necessarily employs such judgment when determining if it would be "medically inappropriate" to provide a life-sustaining procedure.¹¹³ It is self-evident that all clinical decisions inevitably reflect the exercise of some degree of medical judgment. Nevertheless, the underlying purpose of the Act suggests that the professional standard of care by which

110. LA. REV. STAT. §§ 40:1151.2, 1151.4.

111. *Id.* §§ 40:1151(A)(1), 1151(A)(3), 1151(B)(1)(2).

112. *Id.* § 40:1151(B)(1), (2).

113. According to the court,

Standards of medical malpractice require a physician to act with the degree of skill and care ordinarily possessed by those in that same medical specialty acting under the same or similar circumstances. Departure from this prevailing standard of care, coupled with harm, may result in professional malpractice liability. A finding that treatment is "medically inappropriate" by a consensus of physicians practicing in that specialty translates into a standard of care.

Casey, 719 So. 2d at 1076 (citing LA. REV. STAT. § 40:1299.41).

expressions of medical judgment are measured does not inform the intended meaning of “medically inappropriate treatment.”¹¹⁴ Rather, considered in context, the term should be construed first in contrast to the term “life-sustaining procedure,” against which it is juxtaposed in the statute, and second with reference to treatment—whether life-sustaining or not—that the patient has, in fact, refused.¹¹⁵ Considered within these parameters, a medical intervention would be found inappropriate under the Act either if the patient has refused it, or if it is futile in an objective, physiological sense. By definition, a “life-sustaining procedure” that a patient has requested would satisfy neither of these tests.¹¹⁶

The specific statutory provision at issue in *Causey* provides that it is “not to be construed ‘to require the application of medically inappropriate treatment *or* life-sustaining procedures to any patient.’”¹¹⁷ The statute’s use

114. LA. REV. STAT. § 40:1151(A)(4).

115. *Id.* § 40:1151(B)(3). Under this construction, the term “medical judgment” would have meaning for purposes of determining whether a patient’s condition is “terminal and irreversible,” or if the treatment at issue is a “life-sustaining procedure.” *Id.* § 40:1151(A)(2). Once those determinations have been made, the question of whether treatment should be provided would require not the exercise of medical judgment, but the consent of the patient. *Id.* § 40:1151(A)(2).

116. With respect to the patient’s right to refuse measures that lie beyond the narrow scope of the Act, however, the question is somewhat more nebulous because it is sprinkled with a less certain mix of traditional principles of law concerning end-of-life care. Nevertheless, the Act expressly provides that its terms are “cumulative with existing law” concerning the patient’s right to accept or refuse treatment, the threshold of which, theoretically, would arise at the point where the individual’s interest in autonomy outweighs the state’s interest in the preservation of life. LA. REV. STAT. § 40:1151.9(C). For example, *In re Quackenbush* involved a patient with decisional capacity who refused an amputation that his physician expected to save his life, and without which death was certain. 383 A.2d 785 (N.J. Morris Cty. Ct. 1978). Although this procedure was not futile in a physiological sense, the court found that he had the right to refuse it. *Id.* at 790. One might expect the same result in Louisiana. In such cases, the procedure would be “medically inappropriate” simply because the patient refused it, even though it would not have been a life-sustaining procedure under the Act and thus not subject to the absolute right of refusal as recognized in the statute.

117. *Causey*, 719 So. 2d at 1075 (first quoting LA. REV. STAT. § 40:1151(A)(4), and then quoting LA. REV. STAT. § 40:1299.58.1(B)(3)) (emphasis added). Under this construction, the term “medical judgment” would have meaning for purposes of determining whether a patient is terminally ill or if the treatment at issue is a “life-sustaining procedure.” Once those determinations have been made, the question of whether the treatment should be provided would require not the exercise of medical judgment, but the consent of the patient.

of the disjunctive “or” to separate these terms suggests quite strongly a legislative intent to treat them independently.¹¹⁸ This grammatical basis for the distinction is buttressed by the fact that a synonymous construction would yield a result contrary to the stated purpose of the law by creating an obligation on the part of the patient to refuse treatment, rather than merely recognizing one’s right to do so.¹¹⁹ By construing the statute as recognizing a physician’s authority to declare a life-sustaining procedure as “medically inappropriate,” the court’s analysis in *Causey* would effectively condition a patient’s right to refuse treatment on the physician’s consent, thus negating the voluntary nature of that right as expressly defined in the law, and rendering the statute internally inconsistent.¹²⁰ This result could be avoided only by construing these terms separately. This is not to deny that there are occasions when it might be medically inappropriate for a physician to provide a life-sustaining procedure, but to say merely that these terms need not universally be construed as synonymous, and that they sometimes must be distinguished to give effect to the statute’s underlying purpose.

The necessity of drawing a distinction between a life-sustaining procedure and treatment that is medically inappropriate can also be demonstrated by categorizing treatment modalities in terms of their expected efficacies and then correlating them with the patient’s right to accept or refuse treatment, the state’s countervailing interest in the preservation of life, and the physician’s professional obligations. This approach not only clarifies the meaning of these key terms in the statute, but also leads to a very practical definition of futility that comports with the voluntary nature of the patient’s right as recognized in the Act.¹²¹

As the Act was intended to establish a reasonable balance between the competing interests of the individual in exercising his autonomy and the state in the preservation of life, reason posits that the state waived that interest to the extent the legislature expressly recognized a patient’s unqualified right to refuse treatment.¹²² Logic further suggests that the state’s interest in preserving life is, by definition, a function of the

118. See LA. REV. STAT. §§ 40:1151(A)(4), 40:1151(B)(3).

119. See *id.* § 40:1299.58.1(B)(1)–(2).

120. *Causey*, 719 So. 2d 1072; LA. REV. STAT. § 40:1151(A)(4). The holding in *Causey* also would deny the term “medically inappropriate treatment” any substantive effect. It would be meaningless to say that it encompasses clinical interventions that lack physiological efficacy simply because the law has never obligated physicians to provide measures that are futile in an objective, physiological sense.

121. See LA. REV. STAT. § 40:1151(B)(1).

122. *Id.* §§ 40:1151(A), 1151.2, 1151.4.

professional expectation that a clinical intervention will positively affect a patient's injury, illness, or disease in a physiological sense.

The concept of medical futility can be seen as an inverted function of the same expectancy. Under this view, the state's interest and the concept of futility would lie at opposite ends of the same spectrum: as the expected benefit from a particular treatment protocol increases, the state's interest grows and futility dims. Likewise, the state's interest becomes ever more dim as the expected benefit declines, making it increasingly futile. This gradation of treatment along the spectrum of futility versus efficacy is similar to the correlation historically drawn by the courts between the individual's right to refuse treatment and the state's interest in preserving life—the individual's right grows and the state's interest diminishes as the degree of invasiveness increases and as the prognosis dims.¹²³

In this sense, the concept of medical futility and the scope of a patient's abstract, constitutional right to refuse treatment are correlative and thus subject to equal degrees of ambiguity. Yet, this analysis offers a meaningful and workable definition of futility in the context of the Act, and it does so without violating the purpose of the statute. It is self-evident that the law would universally define as both "medically inappropriate" and objectively "futile" any intervention that offers no prospect of relieving, mitigating, or deterring the progression of a patient's illness, disease, or injury.¹²⁴ Such interventions would be absolutely futile in a physiological sense. It follows that neither the professional standard of care nor the state's interest in preserving life would obligate a physician to provide such measures, nor would the law recognize a patient's right to demand them.¹²⁵

123. See, e.g., *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976) ("The nature of Karen's care and the realistic chances of her recovery are quite unlike those of the patients discussed in many of the cases where treatments were ordered. In many of those cases the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good. We think that the state's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest.").

124. Physicians are not ethically obligated to provide care that has no reasonable chance of benefiting their patients. See, e.g., AM. MED. ASS'N, CODE OF MEDICAL ETHICS (2016) ("Chapter 5: Opinions on Caring for Patients at the End of Life"), [http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2035.page? \[https://perma.cc/V3CY-TPA7\]](http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2035.page? [https://perma.cc/V3CY-TPA7]).

125. The President's Commission on Bioethics explains a physician's ethical duties in this regard as follows:

A health care professional has an obligation to allow a patient to choose from among medically acceptable treatment options (whether provided by the

However, such objectively inappropriate interventions differ significantly from life-sustaining procedures. These measures, by definition, yield an identifiable physiological effect in the sense that they postpone the moment of death, though without offering any hope of an ultimate remedy.¹²⁶ In light of this benefit, it would seriously distort the traditional balance in the physician–patient relationship if the law were to place a patient’s affirmative request for such measures at the discretion of his physician by treating them as a matter subject to the exercise of medical judgment. This conclusion is grounded both in the doctrine of informed consent and in the statute, which clearly recognizes that the patient’s right to direct the withholding or withdrawal of life-sustaining procedures is a permissive right rather than a legal duty.¹²⁷ It also is in accord with fundamental principles of bioethics that reflect the patient’s right of self-determination. According to the President’s Commission on Bioethics,

Respect for the self-determination of competent patients is of special importance in decisions to forego life-sustaining treatment because different people will have markedly different needs and concerns during the final period of their lives; living a little longer will be of distinctly different value to them. Decisions about life-sustaining treatment, which commonly affect more than one goal of a patient (for example, prolongation of life and relief of suffering) create special tensions. Nonetheless, a process of collaborating and sharing information and responsibility between care givers and patients generally results in mutually satisfactory decisions. Even when it does not, the primacy of a patient’s interests in self-determination and in honoring the patient’s own view of well-being warrant leaving with the patient the final authority to decide.¹²⁸

Two legal consequences might be inferred from a patient’s decision to exercise this right: first, that the state’s interest in preserving life is implicitly and automatically waived when a patient refuses a life-

professional or by appropriate colleagues to whom the patient is referred) or to reject all options. No one, however, has an obligation to provide interventions that would, in his or her judgment, be countertherapeutic.

PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 44 (1983).

126. LA. REV. STAT. § 40:1151.1(8), (14).

127. *Id.* § 40:1151(B)(1), (2).

128. *Id.*

sustaining procedure; and second, that it would be “medically inappropriate” for a physician to provide such treatment after the patient has refused it. In this sense, the patient’s refusal of treatment would reflect his own subjective determination that it would be “futile” for him to receive a life-sustaining procedure, without regard to the unique, personal reasons that might have led him to make that choice. In effect, this approach would define futility with reference to the patient’s subjective preference, as justified by the voluntary nature of his right under the statute either to accept or refuse treatment. Thus, the law would define any “life-sustaining procedure” as both “medically inappropriate” and “futile” if, in fact, the patient has declined it.¹²⁹

129. *Id.* § 40:1151(A)(4). The same logic would support a definition of treatment as futile if it would cause such intolerable and interminable pain to a patient who, though conscious, permanently lacks decision-making capacity. In those circumstances, the courts might infer the patient’s decision to refuse treatment under either the pure or the limited objective tests as developed by the court in *In re Conroy*, 486 A.2d 1209 (N.J. 1985). The facts of *Casey* also raise the issue of whether the physician’s unilateral act of withdrawing life-sustaining procedures would be legitimated by the fact that continued treatment would have been inhumane. *Casey v. St. Francis Med. Ctr.*, 719 So. 2d 1072 (La. Ct. App. 1998). The professional standard arguably would be relevant if the patient has not directed the withdrawal of treatment and is suffering in which event it might be appropriate to apply a version of either the “pure objective” or “limited objective” tests developed by the New Jersey Supreme Court in *Conroy* when addressing the propriety of a physician’s unilateral decision to withdraw a life-sustaining procedure; a determination that the patient was suffering arguably would be subject to the professional standard and, thus, to review by a medical review panel. *Conroy*, 489 A.2d 1209. The *Conroy* court employed these tests to find a presumption that the patient would have refused treatment if he were capable of arriving at a reasoned decision. *Id.* Under the “pure objective” test, treatment may be withheld or withdrawn even in the absence of any evidence that the patient would have refused care as long as he is suffering intolerable and intractable pain, such that treatment would be inhumane. The related “limited objective” test would apply where there exists “some evidence” that the patient would have refused treatment, and where the burdens of treatment “clearly and markedly outweigh” the benefits of that treatment. Neither the “pure objective” or “limited objective” test, however, would justify a physician’s unilateral decision to withhold or withdraw a “life-sustaining procedure.” Rather, these tests would be consistent with the voluntary nature of the patient’s decision to refuse treatment, because they merely provide a means of inferring whether the patient would exercise that right if he were capable of expressing a reasoned choice. Further, the objective tests developed in *Conroy* are interesting when applied to a case like *Casey*, because they were devised to address the withholding or withdrawal of life-sustaining treatment from conscious, but incompetent patients in a nursing home

Reason compels the opposite conclusion when a patient or his surrogate requests a life-sustaining procedure.¹³⁰ The Act reflects the legislature's intent to retain the state's interest in preserving life in such cases, as evidenced by the narrow scope of the term "life-sustaining procedure," the explicitly voluntary nature of the patient's right to refuse such measures, and the requirement that any doubt concerning application of the statute be resolved in favor of preserving life.¹³¹

Finally, a rational extension of this logic also suggests something further—that the Act reflects the legislative intent not only to retain the state's interest in preserving life when the patient has not exercised his right to refuse a life-sustaining procedure, but implicitly to translate that interest into the patient's correlative right to insist that the physician provide it. In short, the voluntary nature of a patient's "negative" right to refuse treatment that will merely postpone the moment of death implicitly affords a corresponding "positive" right to compel its provision, and the state's interest in preserving life continues unabated with respect to those interventions until such time as the patient has, in fact, refused them. To construe the law in any other manner would permit physicians to unilaterally withhold or withdraw life-sustaining procedures, thereby defeating both the voluntary nature of the patient's decision either to accept or refuse such treatment and the very purpose of the Act.

who tend to be subjected to a more significant risk of abuse than patients in the hospital setting. The patient in *Causey*, however, not only was unconscious, but she was in the hospital where regular physician consultations and ethics committee reviews were available. *Causey*, 719 So. 2d 1072. The hospital in fact had submitted the case for review by the ethics committee, which found that treatment should be withdrawn even over the objection of the patient's surrogate decision maker, and the physician defended his decision to withdraw treatment on the grounds that the patient was suffering. *Id.* To withhold treatment from a patient who is suffering would be justified, however, not on the grounds of "futility," but by the inference that the patient would have refused it.

130. This is not to say that the patient's silence is to be taken either as an implicit acceptance or as a refusal of treatment, but that the core issue relates to the determination of whether the patient would have refused or accepted the treatment if he were capable of expressing a reasoned decision. As a matter of custom, such determinations are made with reference to the substituted judgment standard. *See, e.g., In re Quinlan*, 70 A.2d 647 (N.J. 1976).

131. *See* LA. REV. STAT. § 40:1151.9(E). ("It is the policy of the state of Louisiana that human life is of the highest and inestimable value through natural death. When interpreting this Subpart, any ambiguity shall be interpreted to preserve human life . . .").

III. RESOLVING THE UNCERTAIN STATE OF THE LAW CONCERNING THE RELATIONSHIP BETWEEN THE ACT AND MEDICAL FUTILITY

The Second Circuit's opinion in *Causey* reflects the law's continuing struggle with the notion of medical futility, both in the abstract and in the context of the statute. Although the *Causey* court was understandably reluctant to address the issue from a philosophical perspective, it found no greater comfort in the specific provisions of the Act. As argued in this Article, however, the case might have been resolved with greater certainty had the court considered the definition of "medically inappropriate treatment" both as a sui generis term and in light of the statute's structure and purpose.¹³² In this manner, the court could have concluded that the treatment at issue was neither futile nor medically inappropriate.

Although the Act can be construed in a way that effectively defines futile care with reference to the patient's decision to accept or refuse treatment, it is important to bear in mind that it would do so more by coincidence than design. The correlation of the patient's choice to the definition is inferential rather than direct because the statute was drafted not to provide an express definition of medical futility, but to give effect to a patient's basic right to grant or deny consent to treatment.¹³³ However, construing the statute in such a way that recognizes a physician's authority to deny the very treatment it places at the patient's discretion would be inconsistent with the statute's purpose. Thus, while a patient's refusal of a particular form of treatment might establish a basis for defining it as both futile and medically inappropriate, it is the exercise of his right to accept or refuse treatment on which those definitions turn. In short, the mere fact that treatment would be considered futile if the patient were to refuse it does not render it inherently futile and therefore beyond his right to accept. It is this subtle point that the *Causey* court overlooked.¹³⁴

132. LA. REV. STAT. § 40:1151(A)(4); see Pope, *supra* note 5, at 41–42 nn.214–217, 72–74 nn.423–437, 78 n.466.

133. See generally MEISEL & CERMENARA, *supra* note 1, at 7–16.

134. *Causey*, 719 So. 2d 1072. Although this construction of the Act would have equal merit under similar schemes in other states, the literal terms of some statutes, such as the Uniform Act, do not as readily lend themselves to that view. Some commentators strongly contend that the literal terms of the Uniform Act accommodate a physician's unilateral withholding or withdrawal of life-sustaining treatment. For a comprehensive discussion of this view see generally Pope, *supra* note 5. This potential disparity among the states is ironic when one considers the fact that many bioethicists initially were concerned that the complexity and limited immunity provisions found in these schemes might lead physicians to construe them narrowly, thus effectively constraining rather than

The *Causey* court's construction of the Act as conferring unilateral decision-making authority on physicians neither resolves nor informs the substance of the ongoing futility debate. Nor does it relieve physicians of the potentially significant legal consequences that would follow a unilateral decision to withhold or withdraw treatment from a patient who has not refused it. Moreover, to construe the statute in that manner would not reduce the likelihood of judicial involvement in these questions, which the courts have long regarded as more amenable to resolution in the clinical setting by consensus among physicians, patients, and family members than in the adversarial environment of litigation. To the contrary, it likely would generate litigation in a significant number of cases.

The conflicting arguments about how the statute should be construed in the context of questions about medical futility suggest that the law might not offer a certain resolution to this significant issue. Perhaps in recognition of that continuing uncertainty, statutory methods have been proposed to resolve, on an ad hoc basis, the impasse created when patients or their surrogates request treatment that physicians believe to be inappropriate under the circumstances.¹³⁵ For example, Texas has enacted a statute under which a physician who opposes a request for life-sustaining treatment may initiate a review of the case by the hospital ethics committee.¹³⁶ Perhaps to ensure due process and enhance the opportunity of building a consensus about the appropriate course of action, the law confers upon the patient's surrogate the right to attend the meeting.¹³⁷ If the committee concludes that it would be inappropriate to continue treatment under the circumstances of the case, the physician would be obligated both to make a reasonable attempt to transfer the patient to another facility that is willing to comply with his directive¹³⁸ and to continue providing care for ten days after the ethics committee's

reinforcing the patient's ability to refuse treatment without first seeking judicial approval. The potential for such mischief in the codification of these schemes was seen, not in the risk that physicians would deny care that a patient had requested, but that they would insist on providing care the patient did not want. *See generally* MEISEL & CERMINARA, *supra* note 1. The contemporary argument that advance directive statutes should be construed to remove end-of-life decisions from the subjective preference of patients and place them within the professional discretion of physicians is difficult to reconcile to this history.

135. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2016).

136. *Id.* § 166.046(a). The Texas statute does not attempt to define medical futility, but provides a legal process for resolving disputes about the propriety of continued treatment. *See* Pope, *supra* note 5, at 80.

137. HEALTH & SAFETY § 166.046(b)(2), (4).

138. *Id.* § 166.046(d).

decision.¹³⁹ The statute authorizes the termination of treatment if the patient has not been not transferred within the prescribed ten-day window.¹⁴⁰

Although this process-based approach appears to have been well received, questions have been raised about certain provisions of the Texas statute. For example, some suggest that the ten-day transfer window might not provide a meaningful period of time within which to locate a facility and effect the patient's transfer.¹⁴¹ Questions also have been presented about whether the judicial authority¹⁴² to extend the transfer deadline is deficient in terms of process.¹⁴³ Finally, concerns have been expressed about potential due process implications arising from conflicts of interest posed by the composition of the ethics committee charged with reviewing a physician's denial of treatment.¹⁴⁴

These questions aside, a process-based approach would seem to offer a more practical and meaningful way to resolve disputes about medical futility than an ambiguous advance directive statute such as the Act would afford. Such a scheme would be most meaningful if the Act minimized the potential for disputes at the outset. In the context of life-sustaining modalities, the potential for conflict most likely would arise if the statute were construed to accord physicians the unilateral authority to withhold or withdraw treatment from a patient who has not refused it.¹⁴⁵ As a

139. *Id.* § 166.046(e).

140. *Id.* Although commentators report that this scheme appears to have significantly increased ethics consultations in Texas, they also note that providers rarely invoke their authority under the statute to withdraw treatment unilaterally in cases that ultimately prove to be intractable. *See* Pope, *supra* note 5, at 69 (noting that Texas providers decided to unilaterally stop life-sustaining medical treatment only in 2% of intractable cases).

141. Pope, *supra* note 5, at 80.

142. HEALTH & SAFETY § 166.046(g).

143. *See* Nikolouzos v. St. Luke's Episcopal Hosp., 162 S.W.3d 678, 684 (Tex. App. 2005) (Fowler, J., concurring) (recommending that the statute be clarified with respect to the court's authority to grant an extension by identifying the court in which the petition to extend the time for transfer must be filed by specifying the process for an appeal when a court refuses to grant an extension).

144. *See* Pope, *supra* note 5, at 80.

145. Several amici in the assisted suicide cases of *Washington v. Glucksberg* and *Vacco v. Quill* emphasized the importance of insulating physicians from increasing pressures brought to bear on them by society to assist patients in ending their lives when nothing further can be done for them. *See, e.g.*, Brief for Bioethics Professors as Amicus Curiae Supporting Petitioners, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110), 1996 WL 657754; Brief of Family Research Council as Amicus Curiae in Support of Petitioners, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 96-110, 95-1858), 1996 WL 656275. For

preliminary matter, a dispute resolution scheme would be most effective in Louisiana if it were coupled with a provision in the Act that clearly negates any such authority.

Having established that foundation, a scheme along the lines of the Texas statute might offer a viable framework for establishing a process to resolve futility-related disputes in Louisiana, but with three modifications. First, the scheme should abate the potential for conflicts of interest due to the composition of the ethics committee by ensuring that it is composed of persons not affiliated either with the health care facility or the physicians involved in the patient's care in a way that would call their independence into question and thus compromise, by perception, the integrity of the review process. Second, it should give the committee sufficient flexibility and time either to build a consensus concerning the appropriate course of treatment or to shape a practical compromise when no consensus is possible.¹⁴⁶ Third, it should provide for an expedited process for judicial

example, Professors Annas, Glanz, and Mariner stated, “[P]hysician assisted suicide is recognized, even by the two Circuit Courts of Appeal that have asserted that it is a constitutional right, as far too dangerous a right to be exercised by patients and physicians alone.” Brief for Bioethics Professors, *supra*, at 29. The Family Research Council made a similar point: “[The Hippocratic Oath’s proscription against a physician doing harm to patients] . . . is a priceless possession which we cannot afford to tarnish, but society is always attempting to make the physician into a killer—to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient . . . [I]t is the duty of society to protect the physician from such requests.” Brief of Family Research Council, *supra*, at 4 (quoting MAURICE LEVINE, *PSYCHIATRY & ETHICS* 324–25 (1972)).

146. One of the most significant ways to enhance the potential for building a consensus is by refusing to charge the physician with the responsibility that inevitably would attend the unilateral authority to deny treatment. Moreover, the very fact that an independent committee would be available to review a proposal to withhold or withdraw care might be likely to avoid the creation of adversarial relationships as the course of treatment progresses. Knowledge that a committee will be available for review might itself either enhance the development of trust or diminish the likelihood of distrust as care progresses. Like many conflicts, disagreements about the provision of treatment are often based on personal misunderstandings between the parties and distrust. Two of the key factors likely to engender a lack of trust in the medical profession in the context of a physician’s denial of life-sustaining treatment are the potential for financial conflicts of interest and the diminished respect perceived by terminally ill, disabled, and elderly patients relative to those who are young and healthy. According to the American Geriatrics Society, in light of how concerns about physician-assisted suicide are magnified by managed care cost constraints,

Patients nearing death are generally quite disabled and their care is costly. . . . Decreasing availability and increasing expense in health care

review should the committee be unsuccessful in forging either a consensus or a practical compromise to which both physicians and patient surrogates agree.

A statutory protocol possessing these features would recognize that questions about a patient's right either to accept or refuse treatment do not directly relate to the exercise of professional medical judgment. Rather, questions of a professional nature relate primarily to conclusions about whether a particular form of treatment constitutes a life-sustaining procedure within the meaning of the Act, or whether the patient either suffers from a terminal and irreversible condition or is in a continual and profound comatose state with no reasonable chance of recovery.

Non-diagnostic questions concerning whether a life-sustaining procedure should be applied in a particular case, on the other hand, pose issues of fact about whether the patient would have accepted or refused treatment had he possessed the capacity to express a reasoned decision about the matter. Because those questions are more subject to legal evidentiary standards than professional medical standards, they are not properly the subject of a physician's professional discretion.

and the uncertain impact of managed care may intensify pressure to choose [physician-assisted suicide]. . . . [Physician-assisted suicide] may become inherently coercive in a society in which supportive services and medical care are often unavailable. It would be ironic, indeed, to have a constitutional right to [physician-assisted suicide] when there is no guarantee of access to health care.

Brief of the American Geriatrics Society at 24–25, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110), 1996 WL 656290. The National Catholic Office for Persons with Disabilities and the Knights of Columbus raised a similar concern about the compounded risks posed by the inter-working of managed care cost constraints and discrimination based on disabilities:

In the end, a condition-based rule in favor of assisted suicide would pour into the Constitution a poisonous concoction of warm-hearted, misguided pity and cold-hearted utilitarianism. . . . Who stands to benefit most from a constitutional policy by which the right to live of vulnerable persons is reduced to an alienable interest? Is it the person with a terminal condition bent on suicide regardless of what the Constitution holds, or is it a cost-conscience society seeking more ways to ration its generosity?

Brief of the National Catholic Office for Persons with Disabilities and the Knights of Columbus at 22, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110), 1996 WL 656342. Although these are arguments related to physician-assisted suicide, the same concerns would seem relevant to the more passive means of inducing death by vesting in physicians the unilateral authority to deny life-sustaining treatment.

Finally, by subjecting unresolved cases to judicial review, such a statutory process would give effect to the well-established rule of law that a patient's right either to accept or refuse treatment survives the loss of capacity, thus clearly denying any lawful authority on the part of a physician to unilaterally withhold or withdraw life-sustaining treatment based on the patient's lack of capacity or any other perceived deficit in terms of quality of life.

CONCLUSION

Cases in which terminally ill patients request life-sustaining procedures that their physicians would deny on the grounds of medical futility are inevitably more challenging for physicians than the more customary end-of-life cases in which the patient refuses such measures. Although these forms of treatment, by definition, have no curative properties and thus will serve only to prolong the patient's dying process, the Act inferentially measures the physician's professional obligations solely by the patient's choice.¹⁴⁷ By defining life-sustaining procedures as the least common denominator of the patient's absolute right to refuse treatment and by expressly providing that the patient's right is "permissive and voluntary," the legislature effectively tied the hands of physicians with respect to these decisions.

This result reflects both the Act's theoretical grounding in the doctrine of informed consent and the logical basis for distinguishing between a physician who accepts a patient's refusal of treatment and one who engages in an affirmative act that brings about death. More fundamentally, it reflects the manner in which the legislature chose to balance the inherent conflict between the individual's right of self-determination and the state's interest in preserving life.

The law has traditionally recognized that a terminally ill patient does not act with the intent to die when he refuses treatment that will serve only to prolong the dying process.¹⁴⁸ Rather, the law considers death in such

147. LA. REV. STAT. §§ 40:1151A(1), (3); 1151B(1), (2) (2016).

148. The *Glucksberg* Court specifically addressed the distinction between the passive refusal of unwanted medical treatment and the active demand for assistance in committing suicide by relying on its holding in *Quill* for the proposition that "the two acts are widely and reasonably regarded as quite distinct." *Washington v. Glucksberg*, 521 U.S. 702, 725 (1997). In *Quill*, the Supreme Court had rejected the view that the two were entitled to be treated the same because the ultimate result in either case was to hasten the patient's death. Rather, the Court found that the distinction between suicide and the refusal of treatment "comports with fundamental legal principles of causation and intent." *Vacco v. Quill*, 521 U.S. 793, 801 (1997). The Court found the distinction relevant

cases as the natural progression of the underlying injury or disease that precipitated the need for treatment.¹⁴⁹ For that reason, a physician who withholds or withdraws life-sustaining treatment pursuant to a patient's request is not imputed with the intent to cause death.¹⁵⁰

However, this rationale breaks down when a physician refuses to satisfy a patient's affirmative request for life-sustaining treatment. A physician who withholds or withdraws treatment under those circumstances could not logically deny an intent to cause death, without regard either to the benevolence of his motive or the strength of his conviction that the requested treatment would be "futile" in the sense that it would not remedy the underlying condition.

Moreover, the futility argument is subject to a significant impediment in fact when the case involves a patient who is believed to be permanently unconscious.¹⁵¹ A physician who denies such patients the same treatment that he would offer to others who are similarly situated, but not incapacitated, would find it difficult to sustain an argument that he considered the treatment to be futile and thus "medically inappropriate" or "medically ineffective" in a physiological sense.¹⁵²

from a causation perspective by noting that a patient who refuses life-sustaining treatment will die from the natural progression of the underlying disease, while a person who ingests a lethal concoction will die from his body's reaction to that substance. *Id.* In terms of intent, the Court found that a physician who complies with a patient's decision to withhold or withdraw treatment does not necessarily intend the patient's death. *Id.* Nor did the Court believe that such an intent could be inferred from a physician's affirmative act of providing aggressive palliative care that unavoidably hastens death. *Id.* at 802. The Court did, however, ascribe a different intent to a physician who assists a patient in committing suicide, finding that they "must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.* (citing *Assisted Suicide in the United States, Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 104th Cong. 367 (1996) (testimony of Dr. Leon R. Kass)).

149. See, e.g., *Glucksberg*, 521 U.S. 702, 724–25; *Quill*, 521 U.S. at 802, 807–08.

150. See MEISEL & CERMINARA, *supra* note 1, at 12–33.

151. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Baby K*, 16 F.3d 590 (4th Cir. 1994); *In re Jane Doe*, 418 S.E.2d 3 (Ga. 1992); *In re Wanglie*, 7 ISSUES L. & MED. 369 (1991); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

152. The state's interest in preserving life also would directly challenge a physician's reliance on the concept of medical futility to justify the withholding or withdrawal of life-sustaining treatment that either a patient or his surrogate has requested. This conclusion is consistent with the Supreme Court's recognition in *Washington v. Glucksberg* and *Vacco v. Quill* that a state's interest in preserving life is not subject to "judgments about the 'quality' of life that a particular individual may enjoy," and that a state may assert that interest "even for those

Finally, in light of the significance that would attend a physician's unilateral authority to withhold or withdraw life-sustaining treatment, and considering the Act's fundamental purpose of furthering the patient's right to control decisions related to his or her own health care, it stands to reason that the legislature would have expressly recognized such authority in the statute if it had intended to confer it. Instead, the Act expressly provides that the patient's right is "permissive and voluntary"¹⁵³ and that any ambiguities in the statute "shall be interpreted to preserve human life."¹⁵⁴ To infer a contrary intent would contradict these express provisions of the statute.

These arguments suggest that the Act need not and should not be construed to vest in physicians the sole decision-making authority concerning the provision of life-sustaining treatment. This interpretation is not to deny the importance of these decisions to physicians and other members of the health care team, but to recognize that entrusting these matters to the sole discretion of the medical profession would merely beg a question of profound significance to a variety of interested parties. It would be unrealistic to expect such a deference to adequately address the interests of the patient, his family, and society in these matters. Just as physician-assisted death has been recognized as "far too dangerous a right to be exercised by patients and physicians alone,"¹⁵⁵ it would be even more dangerous to place in a physician's hand the unilateral authority to withhold or withdraw life-sustaining treatment from a patient who has requested it. To do so would effectively condone involuntary euthanasia, which the statute expressly disavows.¹⁵⁶

Although one might be inclined to consider questions of medical futility as raising merely abstract matters of law, bioethics, and the professional standard of medical care, at the core of these cases lies a fundamental question about the value the law ascribes to human beings. As a matter of law, does an individual possess an inherent and unchanging value that exists independently of his decisional capacity at any point in time during life? Or, is one's worth derived not from his nature as a human

who are near death." *Glucksberg*, 521 U.S. at 729–30 (quoting *Cruzan*, 497 U.S. at 282). Although a state's advance directive statute might reflect an implicit waiver of its interest in preserving life to the extent the law expressly acknowledges an individual's unqualified right to refuse treatment, reason posits that the state would have retained its interest with respect to forms of treatment and circumstances that fall beyond the express scope of the law.

153. LA. REV. STAT. § 40:1151(B)(1)–(2) (2016).

154. *Id.* § 40:1151.9(E).

155. Brief for Bioethics Professors, *supra* note 145, at 29.

156. LA. REV. STAT. § 40:1151.9(A).

being, but from the benefit others might find in his continued biological existence?¹⁵⁷ Only under the first of these perspectives would the rule of law have meaning. The alternative thesis would define “law” as the tyranny of a majority, relegating to their subjective preference one’s right to continue his or her physical existence. The rule of law would be especially precarious in a world so ordered.

Professor Budziszewski has said that to define any animate being or inanimate thing with reference to its functional capacity would be “appropriate for things that have no inherent nature, whose identity is dependent on our purposes and interests—things that do not intrinsically deserve to be regarded in a certain way, but which may be regarded in any way which is convenient.”¹⁵⁸ C. S. Lewis expressed the same concept in this manner: “When we understand a thing analytically and then dominate and use it for our own convenience, we reduce it to the level of ‘Nature’ in the sense that we suspend our judgements [sic] of value about it, ignore its final cause (if any), and treat it in terms of quantity.”¹⁵⁹ As applied to human beings, therefore, both Budziszewski and Lewis would reject the functional, relative view of value. In fact, Lewis went so far as to suggest that a society deceives itself when it comes to regard man as a mere object of relative value, or as mere “nature . . . which knows no values as against that which both has and perceives value,” and that it does so at its peril:

Man’s conquest of Nature turns out, in the moment of its consummation, to be Nature’s conquest of man. Every victory we seemed to win has lead us, step by step, to this conclusion. All Nature’s apparent reverses have been but tactical withdrawals. We thought we were beating her back when she was luring us on. What

157. By holding that a competent person’s right to refuse medical treatment survives the loss of capacity, the jurisprudence concerning patient rights at the end of life has consistently acknowledged that all persons have an inherent value that exists independently of their decision-making capacity at any point during their biological existence. It follows that a person’s inherent value derives from his nature as a human being rather than from his physical or intellectual capacity. *Quill*, 521 U.S. at 808–09; *Cruzan*, 497 U.S. at 261; *In re Conroy*, 486 A.2d 1209, 1229 (N.J. 1985); *In re Quinlan*, 355 A.2d at 664. *See also Glucksberg*, 521 U.S. at 732 (stating that the prohibition against assisted suicide “reflects and reinforces [a state’s] policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy”). *See also* Frederick R. Parker, Jr., *Washington v. Glucksberg and Vacco v. Quill: An Analysis of the Amicus Curiae Briefs and the Supreme Court’s Majority and Concurring Opinions*, 43 ST. LOUIS U. L.J. 469, 526 n.174 (1999).

158. BUDZISZEWSKI, *supra* note 34, at 71–72.

159. C.S. LEWIS, *THE ABOLITION OF MAN* 69 (HarperOne 2001).

looked to us like hands held up in surrender was really the opening of arms to enfold us forever. . . . [A]s soon as we . . . reduc[e] our own species to the level of mere Nature . . . the being who stood to gain and the being who has been sacrificed is one and the same.¹⁶⁰

Although Lewis penned these thoughts more than 60 years ago, their portent is assuming an increasing reality in the United States as illustrated by decisions in cases such as *Causey*¹⁶¹ and related legal arguments that advance directive statutes should be construed to vest in physicians with the unilateral authority to withhold or withdraw life-sustaining treatment that a patient or his surrogate has requested. These developments suggest the ironic possibility that one's right to refuse treatment as set forth in the Act might be transmuted into an obligation to do so, effectively condoning involuntary euthanasia, an intent which the statute expressly refutes.¹⁶²

The manner in which the law responds to these renditions of medical futility has the potential to influence the future of health care in ways that cannot completely be foreseen, but that Lewis suggests portend consequences that society would both regret and find difficult to reverse. These risks can be avoided if the law remains grounded in the common thread that underlies the principles enunciated by the courts in *In re Quinlan*,¹⁶³ *Cruzan*,¹⁶⁴ *In re Conroy*,¹⁶⁵ *Glucksberg*,¹⁶⁶ and *Quill*.¹⁶⁷ Each of these cases reflect the law's recognition of the inherent value of human life as reflected in two prisms: first, the enduring right of each individual either to accept or refuse medical treatment, whether through his own voice or that of a surrogate, and without regard to his state of decisional or functional capacity; and second, the corresponding unqualified interest of the state in the preservation of life, including the lives of the weakest and most vulnerable among us.

Both the Act and this body of jurisprudence implicitly recognize that each member of the species *homo sapiens* is by definition a bearer of rights and a subject to be held in absolute regard, not because of what he can do, but because of what he is by nature.¹⁶⁸ In this way, the law presupposes that one's standing as a person who possesses inherent value is not a

160. *Id.* at 68.

161. *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072 (La. Ct. App. 1998).

162. LA. REV. STAT. § 40:1151.9(A) (2016).

163. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

164. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

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

166. *Washington v. Glucksberg*, 521 U.S. 702 (1997).

167. *Vacco v. Quill*, 521 U.S. 793 (1997).

168. LEE & GEORGE, *supra* note 22.

function either of his condition, his stage of development at any point in time, or the value that others might ascribe to him in light of those characteristics. In the context of the specific issues addressed in this Article, it would follow that a permanently unconscious patient would be subject to the same regard as any other person whose capacity is not compromised.