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Dispute Resolution Mechanisms for Intractable Medical Futility Disputes

58 N.Y.L. SCH. L. REV. 347 (2013–2014)

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I. INTRODUCTION

In January 2008, seventy-three-year-old Ruben Betancourt was admitted to Trinitas Hospital, in Elizabeth, New Jersey, for surgery on a thymus gland tumor.¹ While the surgery was successful, during his post-operative recovery, Mr. Betancourt's endotracheal tube became dislodged. This resulted in severe, irreversible brain damage. Mr. Betancourt was subsequently discharged to other health care facilities.²

In July 2008, Mr. Betancourt was readmitted to Trinitas with a diagnosis of renal failure. He remained there for the next year, in a persistent vegetative state, dependent for survival on mechanical ventilation, hemodialysis, and tube feedings. During this time, Mr. Betancourt developed increasingly severe decubitus ulcers and recurrent infections. He remained a full code, meaning that clinicians would attempt to resuscitate him if either his heart or breathing stopped.³

In light of his deteriorating status, Mr. Betancourt's physicians determined that he was beyond medical rescue.⁴ They judged that it was medically inappropriate and outside the standard of care to continue Mr. Betancourt's life-sustaining treatment.⁵ Indeed, they determined that it would be ethically inappropriate—and even inhumane—to artificially sustain Mr. Betancourt.⁶ He had no prospect of recovery.⁷ He could not communicate or otherwise interact with his environment.⁸ Additionally, his body was decomposing.⁹

Accordingly, Mr. Betancourt's treatment team wanted to discontinue dialysis and issue a do-not-attempt-resuscitation (DNAR) order.¹⁰ Since Mr. Betancourt lacked decisionmaking capacity, the team carefully explained their proposed treatment plan to Mr. Betancourt's surrogate, his daughter.¹¹ But, even after many conferences, she would not consent.¹² She instead demanded that Trinitas continue her father's dialysis.¹³

1. See *Betancourt v. Trinitas Hosp.*, 1 A.3d 823, 825 (N.J. Super. Ct. App. Div. 2010); see also Thaddeus M. Pope, *Responding to Requests for Non-Beneficial Treatment*, MD ADVISOR, Winter 2012, at 12, 13 [hereinafter Pope, *Non-Beneficial Treatment*].

2. See *Betancourt*, 1 A.3d at 825.

3. See *id.* at 826.

4. See *Betancourt v. Trinitas Hosp.*, No. C-12-09, slip op. at 4 (N.J. Super Ct. Ch. Div. Mar. 4, 2009), available at http://www.thaddeuspope.com/images/Betancourt_v_trinitas_3-4_2.pdf.

5. See *id.*

6. See *id.*

7. See *id.* at 6.

8. See *id.* at 2.

9. See *id.* at 4.

10. See *id.* at 2.

11. See *Betancourt v. Trinitas Hosp.*, 1 A.3d 823, 827 (N.J. Super. Ct. App. Div. 2010).

12. See *id.*

13. See *id.*

This is a medical futility dispute, and such disputes occur frequently in health care facilities across the United States.¹⁴ They have even been called “one of the most contentious issues in health care.”¹⁵ In this article, I both describe and assess the mechanisms that health care providers can use to resolve medical futility disputes.

In Part II, I identify three distinctive features of medical futility disputes. First, they usually concern life-sustaining medical treatment (such as dialysis) for a patient in a hospital’s intensive care unit (ICU). Second, the patient typically lacks decisionmaking capacity. Mr. Betancourt, for example, was permanently unconscious. Consequently, a surrogate must make treatment decisions on the patient’s behalf. Third, the surrogate and the patient’s physician disagree over the treatment plan. The surrogate wants to continue life-sustaining treatment, but the physician thinks that this treatment is non-beneficial and that continuing it would be medically and ethically inappropriate. Accordingly, the physician wants to stop such interventions and instead focus on comfort measures only.

Such conflicts occur frequently. Yet, in Part III, I establish that medical futility disputes can usually be prevented or resolved informally. With better communication and better documentation of patients’ end-of-life treatment preferences, there will be fewer conflicts.¹⁶ Even to the extent that futility disputes continue to arise, they can almost always be resolved informally within the hospital. The parties are able to eventually reach consensus in 95% of medical futility disputes. Only around 5% remain intractable.¹⁷

In Part IV, I address the resolution of these intractable futility conflicts. Most of them can be resolved through what I call “surrogate replacement.” The clinician may not be able to get consent from the current, authorized surrogate to stop life-sustaining treatment. But the clinician can often replace that surrogate with a new decisionmaker who will provide consent. After all, when the surrogate demands aggressive measures that offer the patient little or no benefit yet impose significant burdens, it is likely that she is exceeding the scope of her decisionmaking authority by failing to act consistently with the patient’s wishes or best interests.¹⁸

14. See, e.g., Terrah J. Paul Olson et al., *Surgeon Reported Conflict with Intensivists About Postoperative Goals of Care*, 148 JAMA SURGERY 29, 29 (2013) (“[M]ore than 70% of ICU clinicians report experiencing conflict weekly.”); John M. Luce & Douglas B. White, *The Pressure to Withhold or Withdraw Life-Sustaining Therapy from Critically Ill Patients in the United States*, 175 AM. J. RESPIRATORY & CRITICAL CARE MED. 1104, 1104–07 (2007) (“[D]isagreements between families and clinicians on end-of-life care are commonplace in the United States.”); Keith M. Swetz et al., *Report of 255 Clinical Ethics Consultations and Review of the Literature*, 82 MAYO CLINIC PROC. 686, 689–90 (2007) (finding that futility disputes are one of the primary reasons for hospital ethics consultations); Thaddeus M. Pope, *Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes*, 3 ST. LOUIS U. J. HEALTH L. & POL’Y 183, 203–04 (2010) (collecting studies).

15. Ruth A. Mickelson et al., *The Barnes Case: Taking Difficult Futility Cases Public*, 41 J.L. MED. & ETHICS 374, 377 (2013) (citing J. Breslin et al., *Top 10 Health Care Ethics Challenges Facing the Public: Views of Toronto Bioethicists*, 6 BMC MED. ETHICS 5 (2005)).

16. See *infra* Part III.A.

17. See *infra* Part III.B.

18. See *infra* Part IV.A.

But there are limitations to surrogate replacement as a dispute resolution mechanism.¹⁹ Some surrogates cannot be replaced. For example, the surrogate, often for religious reasons, may be making the very same treatment decisions that the patient would have made for herself. Such a surrogate is a faithful and loyal agent. The conflict arises not from a discord between the patient and her surrogate, but rather from discord between the patient (or at least her wishes and values) and her clinician. In such cases, the clinician may want to take unilateral action and stop life-sustaining treatment without either patient or surrogate consent.

In Part V, I outline the three main legal approaches that the states have taken with respect to health care providers unilaterally withholding or withdrawing life-sustaining medical treatment. First, some states affirmatively permit clinicians to stop life-sustaining treatment without patient or surrogate consent. I refer to these as “green light” states.²⁰ Second, some states categorically prohibit clinicians from stopping life-sustaining treatment without consent. I refer to these as “red light” states.²¹ Third, some states provide vague and uncertain guidance about whether clinicians may stop life-sustaining treatment without consent. I refer to these as “yellow light” states.²²

I conclude Part V by evaluating these three dispute resolution procedures. Both red light and green light states increase the risk of error. Red light states constrain clinician discretion because they mandate life-sustaining treatment even in circumstances where the administration of such treatment is medically and ethically inappropriate. On the other hand, green light states give too much unaccountable discretion to clinicians because they permit clinicians to stop life-sustaining treatment with minimal oversight, increasing the risk that clinicians will stop even medically and ethically appropriate treatment. I argue that yellow light states offer the greatest opportunity for improvement. They have not only the legal safe harbor immunity of green light states, but also the oversight and accountability that green light states lack.

In the face of incommensurable value conflict, a pure process-based dispute resolution is the best we can hope for. The trick lies in striking the right balance between fairness and efficiency. On the one hand, we want a dispute resolution process that is accessible, quick, convenient, and cost-effective. On the other hand, we want a process that provides the important safeguards of expertise, neutrality, and careful deliberation. The status quo is unacceptable. Green light states are efficient, but insufficiently fair. Yellow light states are fair, but insufficiently efficient.

I propose that the adjudicatory authority of intramural hospital ethics committees be relocated to multi-institutional ethics committees. That way, no single institution’s ethics committee would have a controlling voice in the adjudication of its own dispute. A multi-institutional ethics committee preserves the expertise and extrajudicial nature of ethics committees. But in contrast to an intramural ethics

19. *See infra* Part IV.B.

20. *See infra* Part V.B.

21. *See infra* Part V.A.

22. *See infra* Part V.C.

committee, a multi-institutional ethics committee possesses better resources, a greater diversity of perspectives, and the neutrality and independence required by procedural due process.

II. WHAT IS A MEDICAL FUTILITY DISPUTE?

A medical futility dispute is one in which the parties disagree over whether a current or proposed medical intervention is medically and ethically appropriate.²³ The paradigmatic medical futility dispute is one in which the surrogate requests aggressive treatment interventions for an imminently dying or catastrophically chronically ill patient. However, that patient's health care providers consider such treatment to be medically or ethically inappropriate.

Medical futility disputes can concern any type of medical intervention.²⁴ But most of the relevant legislative and judicial activity, as well as most of the academic commentary, involve disputes over life-sustaining medical treatment.²⁵ There are three distinctive features of such disputes.

First, disputes over life-sustaining medical treatment involve life-and-death stakes. They usually concern patients in a hospital ICU. Life-sustaining medical treatment utilizes mechanical or other artificial means to sustain, restore, or supplant an individual's spontaneous vital function. Life-sustaining medical treatment procedures include: assisted ventilation, renal dialysis, cardiopulmonary resuscitation (CPR), antibiotics, chemotherapy, and artificial nutrition and hydration.²⁶ Typically, withholding or withdrawing life-sustaining medical treatment will result in the patient's death.

Second, ICU patients dependent on life-sustaining medical treatment almost never have decisionmaking capacity.²⁷ They lack the "ability to understand the

23. See generally Thaddeus M. Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Stop Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 6–42 (2007) [hereinafter Pope, *No Safe Harbor*]; Thaddeus M. Pope, *Medical Futility*, in GUIDANCE FOR HEALTHCARE ETHICS COMMS. 88, 89–97 (Micah D. Hester & Toby Schonfeld eds., 2012) [hereinafter Pope, *Medical Futility*].

24. See, e.g., The Ethics Comm. of the Am. Soc'y for Reproductive Med., *Fertility Treatment When the Prognosis Is Very Poor or Futile: A Committee Opinion*, 98 FERTILITY & STERILITY e6, e7 (2012).

25. See generally Thaddeus M. Pope, *Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases*, 9 MARQUETTE ELDER'S ADVISOR 229 (2008) [hereinafter Pope, *Involuntary Passive Euthanasia*].

26. AMA CODE OF MEDICAL ETHICS § 2.20 (1989). Other life-sustaining treatments include vasopressors, pacemakers, and intra-aortic balloon pumps. See Kathleen M. Stacy, *Withdrawal of Life-Sustaining Treatment: A Case Study*, 32 AM. ASS'N OF CRITICAL CARE NURSES 14, 20 (2012).

27. See Simon Cohen et al., *Communication of End-of-Life Decisions in European Intensive Care Units*, 31 INTENSIVE CARE MED. 1215, 1216 (2005) ("Of the total 4,248 patients 195 (5%) were mentally competent at the time a decision was made to perform CPR, withhold or withdraw therapy or shortening of the dying process."); Marshall B. Kapp, *Legal Liability Anxieties in the ICU*, in MANAGING DEATH IN THE ICU: THE TRANSITION FROM CURE TO COMFORT 231, 236–37 (J. Randall Curtis & Gordon D. Rubenfeld eds., 2001); Alexandre Lautrette et al., *Surrogate Decision Makers for Incompetent ICU Patients: A European Perspective*, 14 CURRENT OPINIONS CRITICAL CARE 714, 716 (2008) (discussing the capacity of patients and the use of surrogates in the ICU); Thomas J. Prendergast et al., *A National Survey of*

DISPUTE RESOLUTION MECHANISMS FOR INTRACTABLE MEDICAL FUTILITY DISPUTES

significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.”²⁸ They cannot direct their own medical treatment. Consequently, medical treatment decisions for ICU patients must be made by a substitute decisionmaker or surrogate.²⁹

Third, the typical futility dispute is between the attending physician and the surrogate.³⁰ The clinician says “stop,” but the surrogate says “go.” The clinician thinks that life-sustaining measures are no longer medically indicated and that the appropriate treatment plan is for comfort measures only.³¹ The surrogate, on the other hand, rejects this proposed treatment plan, and directs the clinician to continue life-sustaining measures.³²

III. PREVENTION AND INFORMAL DISPUTE RESOLUTION

A. Prevention

It is better to prevent futility disputes from arising in the first place than to work at resolving them after they have arisen. In fact, prevention is not terribly complicated or difficult. Most patients do not even *want* aggressive treatment at the end of life.³³ Suppose that these patients still had capacity and could make their own treatment

End-of-Life Care for Critically Ill Patients, 158 AM. J. RESPIRATORY CARE MED. 1163, 1166 (1998); Susan M. Parks & Laraine Winter, *End-of-Life Decision Making for Cancer Patients*, 36 PRIMARY CARE CLINICAL OFFICE PRAC. 811, 813 (2009) (“Most Americans are decisionally incapacitated at the time of death, usually because of dementia, delirium, coma, or PVS [(persistent vegetative state)].”); Maria J. Silveira et al., *Advance Directives and Outcomes of Surrogate Decision Making Before Death*, 362 NEW ENG. J. MED. 1211, 1214 (2010); Elizabeth K. Vig et al., *Beyond Substituted Judgment: How Surrogates Navigate End-of-Life Decision Making*, 54 J. AM. GERIATRICS SOC’Y 1688 (2006).

28. DEL. CODE. ANN. tit. 16, § 2501(d) (West 2013).

29. The surrogate can be appointed either by the patient (agent) or by the court (guardian or conservator). Most surrogates are appointed by the attending physician pursuant to statutory default rules. See Thaddeus M. Pope, *Legal Fundamentals of Surrogate Decision Making*, 141 CHEST 1074 (2012) [hereinafter Pope, *Legal Fundamentals*].

30. While medical futility disputes are paradigmatically between the responsible physician and the surrogate, there are three other types. First, there is intra-professional conflict, between members of the treatment team. Second, there is intra-familial conflict, between members of the patient’s family. Third, there are questions regarding patients without any available surrogates.

31. “More often . . . it is the medical team that [first] comes to the moment of declaring futility, concluding that further aggressive interventions are not accomplishing the patient’s goals of care, and often that additional medical interventions will only cause pain and suffering. When the family disagrees and insists that treatment continue, dispute arises.” CMTY. ETHICS COMM., *MEDICAL FUTILITY: STRATEGIES FOR DISPUTE RESOLUTION WHEN EXPECTATIONS AND LIMITS OF TREATMENT COLLIDE* 6 (2013).

32. For a summary of the reasons and causes of medical futility disputes, see Pope, *No Safe Harbor*, *supra* note 23, at 10–20.

33. See Thaddeus M. Pope, *Clinicians May Not Administer Life-Sustaining Treatment Without Consent: Civil, Criminal, and Disciplinary Sanctions*, 9 J. HEALTH & BIOMED. L. 213, 230–31 (2013) [hereinafter Pope, *Life-Sustaining Treatment*] (“In one recent survey, 67% would prefer to ‘die a natural death’ if their heartbeat or breathing stopped while only 7% would want medical providers to ‘use everything to prolong life.’”).

decisions. They and their clinicians would agree on the appropriate treatment plan, and there would be no conflict.³⁴

But the patients who are the subjects of futility disputes lack capacity and cannot make their own treatment decisions. In such circumstances, they are presumed to want life-sustaining treatment unless they have adequately rebutted that presumption. Unfortunately, most patients have not “opted out” of pro-life default rules. As a result, they receive treatment that they would not have wanted and that their clinicians do not want to administer.

Fortunately, rapidly expanding initiatives are helping patients to better understand their options and to better document their treatment preferences.³⁵ Here are just four of these initiatives: First, clinicians are getting better at engaging patients in end-of-life treatment discussions.³⁶ They are fostering more realistic expectations through establishing goals of care early on and evaluating them routinely. And, increasingly, this education and training on end-of-life communication is legally mandated.³⁷

Second, some states specifically require clinicians to disclose treatment options like palliative care and hospice.³⁸ When patients are aware of the risks and benefits of, and alternatives to, continued curative-directed treatment, most decline such treatment. Most of us prioritize quality of life over quantity of life.³⁹

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34. See Dominic J.C. Wilkinson, *Ethics in Medicine: Is It a Futile Exercise?*, 198 MED. J. AUSTL. 220, 220 (2013) (“Advance care planning increases the chance that patients’ own wishes are known and respected at the end of life. This is likely to reduce the provision of unwanted and inappropriate treatment and may reduce disputes.”); Cameron L. Stewart, *Legal Perspective on Consent in Disputes About Futile Care*, 98 MED. J. AUSTL. 225, 225 (2013) (arguing that an advance directive can prevent conflict); Press Release, Winnipeg Health Region, Access to End-of-Life Supports and Resources to Increase for Patients, Families and Professionals (Mar. 25, 2011), available at <http://www.wrha.mb.ca/media/releases/2011/110325.php> (rejecting a “legislated or internal review process” in favor of a focus on prevention).
35. Sometimes conflict is avoided because certain treatment options are never even presented to the surrogate. See, e.g., John D. Lantos & William L. Meadow, *Should the “Slow Code” Be Resuscitated?*, 11 AM. J. BIOETHICS 8, 11 (2011); David A. Asch et al., *Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians’ Practices and Patients’ Wishes*, 151 AM. J. RESPIRATORY CRITICAL CARE MED. 288 (1995). While there is no conflict, there is, arguably, a lack of adequate informed consent.
36. See, e.g., Jeffrey M. Peppercorn et al., *American Society of Clinical Oncology Statement: Toward Individualized Care for Patients with Advanced Cancer*, 29 J. CLINICAL ONCOLOGY 755 (2011); Anne Rinehart, *Beyond the Futility Argument: The Fair Process Approach and Time-Limited Trials for Managing Dialysis Conflict*, 8 CLINICAL J. AM. SOC’Y NEPHROLOGY 2000 (2013).
37. See, e.g., N.Y. Assemb. A. 8176A, 47th Gen. Assemb., Reg. Sess. (N.Y. 2012).
38. See, e.g., Palliative Care Information Act, N.Y. PUB. HEALTH L. § 2997-c (McKinney 2013); CAL. HEALTH & SAFETY CODE § 442.5 (West 2013); VT. STAT. ANN. tit. 18, § 1871 (2013).
39. See Daren K. Heyland et al., *Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning*, 173 JAMA INTERNAL MED. 778 (2013), available at www.ncbi.nlm.nih.gov/pubmed/23545563; Pope, *Life-Sustaining Treatment*, supra note 33, at 221; *Views on End-of-Life Medical Treatments*, PEW RES. CTR. (Nov. 21, 2013), <http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/>.

DISPUTE RESOLUTION MECHANISMS FOR INTRACTABLE MEDICAL FUTILITY DISPUTES

Third, with the growth of patient decision aids, both patients and surrogates better understand and appreciate the available choices.⁴⁰ Decision aids are educational tools that help patients understand the various treatment options available to them, including the risks and benefits of each choice.⁴¹ These tools include evidence-based educational literature with graphics, photographs, and diagrams.⁴² They also take the form of videos, website-based interactive programs such as sequential questions with feedback, and “structured personal coaching.”⁴³

Patients who use decision aids are more knowledgeable about treatment options, less conflicted about their decisions, and more likely to play an active role in decisionmaking than patients who do not use decision aids.⁴⁴ Consequently, the patients who use decision aids may be better able to align their care with their preferences and values. Moreover, patients using decision aids are more likely to choose conservative treatment options, are less likely to choose surgical interventions, and are less likely to be admitted to the hospital.⁴⁵ They are also less likely to choose CPR.⁴⁶

Fourth, the Physician Orders for Life-Sustaining Treatment (POLST) helps to address all of these problems. Meant to supplement, not replace, traditional advance directives for those patients expected to die within the next year, POLST has several advantages that help ensure that patients’ treatment preferences are documented in a manner that clinicians will find, understand, and honor.⁴⁷

First, POLST is usually created with a health care provider at or near the time when an acute or serious chronic condition develops. It addresses the patient’s current situation, not a possible future scenario. Consequently, POLST has a greater chance of being more informed and more relevant to the specific medical situation at hand. Second, since the POLST form is highly visible, portable, and travels with the patient’s medical records, it is more likely available at the time that a decision must be made. Third, since POLST is written in precise medical language on a standardized

40. See Thaddeus M. Pope & Melinda Hexum, *Legal Briefing: Shared Decision Making and Patient Decision Aids*, 24 J. CLINICAL ETHICS 70 (2013).

41. See Martha Hostetter & Sarah Klein, *Quality Matters, Helping Patients Make Better Treatment Decisions with Decision Aids*, THE COMMONWEALTH, <http://www.commonwealthfund.org/Newsletters/Quality-Matters/2012/October-November/In-Focus.aspx> (last visited Dec. 24, 2013).

42. See, e.g., Nadia N. Sawicki, *Patient Protection and Decision-Aid Quality: Regulatory and Tort Law Approaches*, 54 ARIZ. L. REV. 621, 631 (2012); Marshall H. Chin, *The Patient’s Role in Choice of Medications: Direct-to-Consumer Advertising and Patient Decision Aids*, 5 YALE J. HEALTH POL’Y L. & ETHICS 771, 782 (2005).

43. Pope & Hexum, *supra* note 40.

44. *See id.*

45. *See id.*

46. *See id.*

47. See Thaddeus M. Pope & Melinda Hexum, *POLST: Physician Orders for Life-Sustaining Treatment*, 23 J. CLINICAL ETHICS 353 (2012).

form, it is better understood by health care providers. Fourth, since POLST is signed by a provider, there is a greater chance of compliance by other providers.⁴⁸

Most patients do not want continued life-sustaining treatment when they are chronically critically ill. If these patients documented their treatment preferences, most futility disputes could be avoided. Nevertheless, most patients still fail to record their wishes before losing capacity. Consequently, most ICU treatment decisions are made by surrogates. But here, too, there is room to implement preventative measures.

Most surrogates find themselves performing a new role, for the first time, under difficult circumstances. Therefore, health care providers should advise the surrogate of the duties of a good substitute decisionmaker and provide statistical information on patient preferences.⁴⁹ When surrogates are adequately trained and supported, they make decisions that better align with patient preferences, reducing the likelihood of medical futility disputes.⁵⁰

B. Informal Dispute Resolution

If prevention has failed and conflict has obtained, informal dispute resolution mechanisms work almost all of the time. Through further communication and mediation, consensus is reached in over 95% of medical futility cases.⁵¹ If the treatment team is not getting anywhere with the surrogate, it can invite the intervention of ethics consultants, social workers, chaplains, palliative care clinicians, the ethics committee, external second opinions, and other experts.⁵²

Only around 5% of disputes remain intractable.⁵³ In these cases, the physician and surrogate cannot find common ground. But there are still alternatives. Consensus can still sometimes be reached by “replacing” the physician or hospital. While the

48. *See id.*

49. *See, e.g.,* ABA COMM’N ON LAW & AGING, MAKING MEDICAL DECISIONS FOR SOMEONE ELSE: A HOW-TO GUIDE (2009).

50. *See supra* Part III.A.

51. *See, e.g.,* Craig M. Nelson & Blanca Arriola Nazareth, *Nonbeneficial Treatment and Conflict Resolution: Building Consensus*, 17 PERMANENTE J. 23 (2013) (reporting consensus in eighty-seven of ninety-two cases); Robert L. Fine, *Point: The Texas Advance Directives Act Effectively and Ethically Resolves Disputes About Medical Futility*, 136 CHEST 963 (2009); Robert L. Fine & Thomas W. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANNALS INTERNAL MED. 743 (2003); Daniel Garros et al., *Circumstances Surrounding End of Life in a Pediatric Intensive Care Unit*, 112 PEDIATRICS e371 (2003); Emily Ramshaw, *Bills Challenge Care Limits for Terminal Patients*, DALLAS MORNING NEWS, Feb. 15, 2007; Thomas J. Prendergast & John M. Luce, *Increasing Incidence of Withholding and Withdrawal of Life Support from the Critically Ill*, 155 AM. J. RESPIRATORY & CRITICAL CARE MED. 15 (1997).

52. *See generally* Thaddeus M. Pope & Ellen A. Waldman, *Mediation at the End-of-Life: Getting Beyond the Limits of the Talking Cure*, 23 OHIO ST. J. ON DISP. RESOL. 143 (2007); Thaddeus M. Pope, *Medical Futility*, in GUIDANCE FOR HEALTHCARE ETHICS COMMITTEES 88 (Micah D. Hester & Toby Schonfeld eds., 2012).

53. This is still a substantial number of disputes. For example, take just the one thousand tertiary hospitals in the United States. Each has roughly one futility case per month. That is twelve thousand futility disputes. If 5% of those are intractable, that is six hundred cases.

current health care provider may be unwilling to administer the surrogate-requested treatment, it is sometimes possible to transfer the patient to another physician or facility that is willing to provide the disputed treatment, thereby “replacing” the physician or hospital.⁵⁴

IV. SURROGATE REPLACEMENT: OBTAINING CONSENT FROM ANOTHER DECISIONMAKER

Clinicians do not want to act contrary to their professional judgment. Nor do they want to act without patient or surrogate consent. In a medical futility dispute, these two objectives come into conflict. But they are not irreconcilable or mutually exclusive.

Consistent with both of these objectives, there are three ways to reach consensus in a futility dispute.⁵⁵ First, as discussed above, the clinician might eventually get consent from the surrogate.⁵⁶ Second, also discussed above, the clinician might find a new health care provider willing to provide the treatment that the surrogate wants.

Third, if neither of these solutions is possible, the clinician is often able to replace the current surrogate with a new surrogate who will consent to the recommended treatment plan. This is the mirror image of the second path to consensus. Instead of transferring the patient to a new *health care provider* who agrees with the surrogate, the clinician replaces the current surrogate with a new *surrogate* who agrees with the clinician.

A. Surrogate Replacement

A surrogate is an “extension of the patient” and stands in the shoes of the patient. Accordingly, the surrogate must make the choice that the patient, if competent, would have made for herself.⁵⁷ The standards for surrogate decisionmaking are substantially uniform across the country. There is generally a two-step hierarchy. First, the surrogate should try to infer the patient’s wishes from her prior statements

54. See, e.g., Kate Dubinski, *Baby Joseph Flown to U.S. Hospital*, TORONTO SUN (Mar. 13, 2011, 10:48 PM), <http://www.torontosun.com/news/canada/2011/03/13/17601961.html> (reporting that the parents of Joseph Maraachli transferred him from London Health Sciences Centre in Toronto to Cardinal Glennon Children’s Hospital in St. Louis); Todd Ackerman, *Teen’s Transfer Defuses Life Support Battle*, HOUSTON CHRON. (July 1, 2011), <http://www.chron.com/news/houston-texas/article/Teen-s-transfer-defuses-life-support-battle-2078227.php> (reporting that Jordan Allen was transferred from Texas Children’s Hospital to a long-term acute-care facility just five days before the hospital’s plan to remove his life support).

55. A fourth way in which consensus might be reached is that the surrogate might convince (or intimidate) the clinician. After all, “in many instances, doctors who are eager to avoid a fight submit to a family’s request, even if they believe the patient is beyond care.” Nicholas Hune-Brown, *A Life Interrupted*, TORONTO LIFE, Dec. 2012, at 65, 67. See also Robert Sibbald et al., *Perceptions of ‘Futile Care’ Among Caregivers in Intensive Care Units*, 177 CANADIAN MED. ASS’N J. 1201 (2007); Pope & Waldman, *supra* note 52, at 170–85.

56. See Hune-Brown, *supra* note 55, at 67 (“After a few days of seeing their loved ones on life support, some families acquiesce.”).

57. In fact, surrogates are not very good at carrying out this duty. Numerous studies confirm that the choices surrogates make for patients are often not the same choices that patients would make for themselves. See Thaddeus M. Pope, *Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes*, 3 ST. LOUIS U. J. HEALTH L. & POL’Y 183, 215–23 (2010) (collecting studies).

and conduct, and make decisions that conform as closely as possible to what the patient would have done under the circumstances. Second, in the absence of reliable evidence of the patient's expressed wishes, values, or preferences, the surrogate must rely on more objective grounds and shift her focus from the wishes of the patient to the welfare of the patient.⁵⁸

Surrogates who deviate from these decisionmaking standards, which they are supposed to employ, can and should be replaced.⁵⁹ Indeed, courts across the United States have replaced surrogates in four types of situations. First, they have replaced surrogates who have a material conflict of interest. For example, parents who are accused of child abuse may not consent to stopping life support for their abused (and often catastrophically brain-injured) child, because they want to avoid homicide charges.⁶⁰

Second, courts have replaced surrogates who make treatment decisions that contradict written instructions in the patient's advance directive.⁶¹ For example, the Hennepin County, Minnesota probate court removed Lana Barnes as her husband's surrogate.⁶² The court determined that she was requesting the same treatment that her husband had specifically refused in his advance directive.⁶³ Unless the patient has granted permission for such deviation, surrogates exceed the scope of their authority when they act inconsistently with the patient's advance directive.⁶⁴

These two types of surrogate replacement cases are reasonably straightforward. It is relatively easy to make the case for replacing both those surrogates who have material conflicts of interest and those surrogates who act in contravention of the patient's clearly applicable advance directive. But courts have been replacing surrogates in even the more difficult cases.

The third type of case in which courts have replaced surrogates is one in which the surrogate makes treatment decisions in contradiction of the patient's known preferences, wishes, or values.⁶⁵ For example, a West Virginia court approved a settlement in which the hospital intended to "remove the Plaintiff as surrogate"

58. *See id.* at 212–14.

59. *See id.*; *see also* Cameron L. Stewart, *A Defence of the Requirement to Seek Consent to Withhold and Withdraw Futile Treatment*, 196 MED. J. AUSTL. 406, 407 (2012). To be clear, I am not advocating that clinicians immediately move to replace surrogates in all conflict situations. They should first try to avoid and informally resolve such conflict. *See* Douglas B. White, *Rethinking Interventions to Improve Surrogate Decision Making in Intensive Care Units*, 20 AM. J. CRITICAL CARE 252, 252–57 (2011); Christian J. Wiedermann et al., *From Persistence to Palliation: Limiting Active Treatment in the ICU*, 18 CURRENT OPINIONS CRITICAL CARE 693, 693–99 (2012).

60. *See, e.g.*, *Alberta v. D.L.*, 2012 ABCA 275 (Can.).

61. *See, e.g.*, *Strong Memorial Hosp. v. Livadas*, No. 08-03730, slip op. (N.Y. Sup. Ct. Monroe Cnty. Apr. 28, 2008), *available at* http://www.thaddeuspope.com/images/Livadas_-_ruling_08-2008.pdf.

62. *See, e.g.*, *In re Emergency Guardianship of Barnes*, No. 27-GC-PR-111-16 (Minn. Dist. Ct. 4th Feb. 4, 2001) (order appointing emergency guardian), *available at* http://www.thaddeuspope.com/images/Barnes_Court_Ruling_02-04-11.pdf.

63. *See id.*

64. *See* Pope, *Life-Sustaining Treatment*, *supra* note 33, at 232–34.

65. *See id.* at 234–37 (collecting cases).

DISPUTE RESOLUTION MECHANISMS FOR INTRACTABLE MEDICAL FUTILITY DISPUTES

because of evidence that the patient “would refuse the level of medical intervention and treatment decided by the Plaintiff.”⁶⁶

Fourth, courts have replaced surrogates even when there is no evidence of patient preferences, wishes, or values. Unable to apply a subjective standard, the court instead applies an objective standard and replaces surrogates who fail to make treatment decisions in the patient’s best interests.⁶⁷ For example, in a medical futility case at the Massachusetts General Hospital, a Boston judge told the patient’s daughter that her “own personal issues” were impacting her decision and urged her to “refocus” her assessment.⁶⁸

In a second case, the same hospital successfully moved the local probate court to “override” a health care agent’s refusal to consent to a DNAR order.⁶⁹ In granting the hospital’s petition, the court explained that since the agent was “in denial” about his mother’s deterioration and distrustful of her providers, he had not given “full consideration of acceptable medical alternatives.”⁷⁰

While this guidance from courts is useful, it is important to emphasize that clinicians can almost always replace surrogates without judicial intervention.⁷¹ First, most states permit clinicians to decline to comply with the health care decision of a surrogate if the clinician believes in good faith that the surrogate lacks the authority to make such a decision.⁷² Second, some states permit the physician to unilaterally recognize the authority of a new surrogate.⁷³ Third, other states authorize the hospital’s own ethics committee to adjudicate disputes between and among surrogates.⁷⁴

B. Limitations of Surrogate Replacement

While the courts have been willing to replace surrogates in medical futility disputes, they will not, and probably cannot, replace surrogates in all such cases.⁷⁵ Similarly, clinicians cannot replace surrogates in all such disputes.

66. Verified Complaint and Motion at 5, *Kisner v. W. Va. Univ. Hosps. Inc.*, No. 10-C-190 (W. Va. Cir. Ct. Mar. 25, 2010).

67. See Pope, *Life-Sustaining Treatment*, *supra* note 33, at 229–41 (collecting cases).

68. See Liz Kowalczyk, *Plan to Take Woman off Life Support Is Halted*, BOS. GLOBE, Feb. 23, 2005, at B1; *Daughter Explains Agreement to End Care*, BOS. GLOBE, Mar. 23, 2005, at B2.

69. See *In re Guardianship of Mason*, 669 N.E.2d 1081 (Mass. App. Ct. 1996).

70. *Id.* at 1082.

71. Replacing a rogue surrogate is not only an option, but also a duty. See, e.g., *Cardoza v. USC Univ. Hosp.*, No. B195092, 2008 WL 3413312 (Cal. Ct. App. Aug. 13, 2008).

72. See, e.g., ALASKA STAT. § 13.52.030(h) (2013); CAL. PROB. CODE § 4740(b) (West 2013).

73. See, e.g., TENN. CODE ANN. § 68-11-1806(c)(1) (West 2013).

74. See, e.g., DEL. CODE ANN. tit. 16, § 2507(b)(8) (West 2013); MD. CODE ANN. HEALTH-GEN. § 5-605(b)(1) (West 2013).

75. See, e.g., *Cuthbertson v. Rasouli*, 2013 SCC 53 ¶¶ 148–50 (Can.) (Karakatsanis, J., dissenting); *Scardoni v. Hawryluck*, 2004 ONSC 34236 (Can.) (reversing tribunal’s replacement of surrogate, because there was evidence that the patient really did desire the treatment requested by her surrogate); *In re Cobb*, No. 2011-0805 (Pa. Ct. Comm. Pl. Lehigh Cnty. Dec. 5, 2012), *aff’d*, No. J-A15634/13 (Pa. July 31, 2013).

In some cases, clinicians cannot establish that the surrogate is deviating from the applicable decisionmaking standard. There are two main reasons that clinicians cannot establish surrogate deviation. First, the evidence regarding the patient's preferences or best interests may be non-existent or ambiguous.⁷⁶ Since too few individuals engage in adequate advance-care planning, applicable instructions and other evidence regarding patient preferences are rarely available. Consequently, it is often difficult or impossible to detect or demonstrate a contradiction between the patient's preferences and the surrogate's decision.

Second, even when there is evidence of the patient's preferences, the surrogate may be acting faithfully and consistently with them.⁷⁷ For example, the surrogate may be requesting continued life-sustaining treatment because the patient's religion mandates it.⁷⁸

V. UNILATERAL ACTION: STOPPING WITHOUT CONSENT

If the clinician cannot get consent from the current surrogate and cannot replace that surrogate (and get consent from a new surrogate), then the clinician may want to take unilateral action.⁷⁹ While the clinician would prefer to act with consent, she may be professionally and personally concerned that the burdens of continued treatment for the patient seriously outweigh any potential benefits. Consequently, the clinician may want to stop life-sustaining treatment even without consent.

Whether a clinician can take such unilateral action without risking sanctions is a matter of state law. The states have taken three main approaches. These three approaches can be conveniently represented by the colors of a traffic light: red, green, and yellow. Red light states specifically prohibit clinicians from stopping life-sustaining treatment without surrogate consent. Green light states specifically allow it. And yellow light states provide uncertain guidance.

A. Red Lights: Clinicians May Not Stop Treatment Without Consent

Some states forbid physicians from stopping life-sustaining treatment without surrogate consent. In New York, for example, a clinician who objects to a surrogate's

76. See Pope, *Life-Sustaining Treatment*, *supra* note 33, at 247–50; Pope, *Legal Fundamentals*, *supra* note 29, at 1079.

77. See Pope, *Life-Sustaining Treatment*, *supra* note 33, at 244–47; Pope, *Legal Fundamentals*, *supra* note 29, at 1078.

78. See, e.g., *Golubchuk v. Salvation Army Grace Hosp.*, 2008 MBQB 49 (Can.). In such cases, surrogates cannot be replaced. See, e.g., *In re S.S.*, 2011 CanLII 5000 (Can. Ont. C.C.B.); *In re D.W.*, 2011 CanLII 18217 (Can. Ont. C.C.B.) (showing that most of the intractable cases are religiously motivated); see also Lucas Zier et al., *Surrogate Decision Makers' Responses to Physicians' Predictions of Medical Futility*, 136 CHEST 110 (2009), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2716715/>.

79. Procedurally, clinicians could pursue a fourth path. They could seek permission directly from a court. But the analysis would be similar to surrogate selection. Moreover, such requests are often unsuccessful. See Pope, *Involuntary Passive Euthanasia*, *supra* note 25, at 248–51. But see *Aintree Univ. Hosp. NHS Found. Trust v. James*, [2013] EWCA (Civ) 65 (Eng.), *aff'd*, [2013] UKSC 67. In short, it is usually easier for clinicians to beg for forgiveness than to ask for permission.

DISPUTE RESOLUTION MECHANISMS FOR INTRACTABLE MEDICAL FUTILITY DISPUTES

request for life-sustaining treatment “shall nonetheless comply.”⁸⁰ In Minnesota, a provider who is “unwilling to provide directed health care” must “take all reasonable steps to ensure provision of the directed health care until the [patient] is transferred.”⁸¹

A number of other states have been swinging from yellow to red. For example, in 2012, Idaho enacted the Discrimination in Denial of Life-Preserving Treatment Act.⁸² This statute mandates that health care “may not be withdrawn or denied if its provision is directed” by a surrogate.⁸³ Oklahoma enacted similar legislation, the Nondiscrimination in Treatment Act, in 2013.⁸⁴ And comparable bills were considered in Alaska⁸⁵ and Virginia.⁸⁶

In addition to these statutory “substantive” red lights, there are also “procedural” red lights. In futility disputes, surrogates can, and often do, go to court and obtain temporary restraining orders and temporary injunctions.⁸⁷ Courts traditionally consider four factors in determining whether to grant such relief: (1) the probability of the plaintiff’s success on the merits, (2) the irreparable nature of harm to the plaintiff, (3) the balance of hardship between the parties, and (4) the public interest.⁸⁸

Plaintiffs can usually satisfy these factors, given the life-and-death stakes, the relative vulnerability of the patient, and the uncertainty of the law and facts.⁸⁹ So judges preserve the status quo (the administration of life-sustaining treatment) until arguments and evidence can be mustered for adjudication. But this often results in a *fait accompli*. The judicial process is so slow and cumbersome that the patient often

80. N.Y. PUB. HEALTH L. §§ 2994-f(3), 2984 (McKinney 2013).

81. MINN. STAT. ANN. § 145C.15 (West 2013). While the New York statute applies to both surrogates and agents, the Minnesota statute applies only to agents.

82. S.B. 1348, 65th Leg., 2d Reg. Sess. (Idaho 2012) (codified at IDAHO CODE ANN. § 39-4514(3) (West 2013)).

83. IDAHO CODE ANN. § 39-4514(3). The statute does contain a “futile care” exception, but it is very narrow and inapplicable to almost all futility disputes. “Nothing in this chapter shall be construed to require medical treatment that is medically inappropriate or futile.” This is defined as treatment for a patient for whom “death is imminent within hours or at most a few days” or treatment the denial of which “will not result in or hasten the patient’s death.” *Id.* § 39-4514(6).

84. H.B. 1403, 54th Leg., 1st Reg. Sess. (Okla. 2013) (codified at OKLA. STAT. tit. 63, § 3090.2 (2013)). Similar legislation failed the previous year. S.B. 1695, 53d Leg., 2d Reg. Sess. (Okla. 2012).

85. S.B. 172, 27th Leg., 2d Sess. (Alaska 2012); H.B. 309, 27th Leg., 2d Sess. (Alaska 2012).

86. H.B. 2068, 2011 Leg., Reg. Sess. (Va. 2011).

87. See Pope, *Involuntary Passive Euthanasia*, *supra* note 25, at 251–54 (collecting cases).

88. See 11A CHARLES A. WRIGHT ET AL., FEDERAL PRACTICE AND PROCEDURE § 2947 (2d ed. 2013); 13 JAMES MOORE, MOORE’S FEDERAL PRACTICE § 65 (Matthew Bender 3d ed. 2013).

89. See, e.g., Complaint for Injunctive Relief and Declaratory Judgment, *In re* M.B., No. 1:08-CV-01898-HHK (D.C. Super. Ct. Fam. Div. 2008). *But cf.* Sweiss v. Alberta Health Serv., 2009 ABQB 691 (Can.) (granting only five days); Alberta CYFEA v. D.L., 2012 ABQB 562 (Can.); Alberta CYFEA v. D.L., 2012 ABQB 562 ¶¶ 71–74 (Can.) (denying, after the case had already been before the court for six weeks, the parents’ request to further delay withdrawal of treatment from Baby M).

dies before the court reaches the merits of the dispute.⁹⁰ The surrogate gets what she wants, a de facto win, a red light.⁹¹

B. Green Lights: Clinicians May Stop Treatment Without Consent

While red light states specifically prohibit clinicians from stopping life-sustaining treatment without consent, green light states specifically allow it. There are three green lights in the United States. One is provided in the 1999 Texas Advance Directives Act (TADA). One is provided in some states' statutes and regulations specific to CPR. And a third green light is provided by conscience clause statutes in some states.⁹²

1. Texas Advance Directives Act

TADA permits physicians to refuse life-sustaining treatment without consent, for any reason, so long as an institutional committee agrees.⁹³ A hospital must give the surrogate forty-eight hours' notice before the institutional committee meeting occurs.⁹⁴ If the committee agrees with the attending physician that life-sustaining treatment is inappropriate, the hospital must give the surrogate ten days after the meeting to find a facility that will provide the treatment desired.⁹⁵ If the clinician follows these procedures, the statute provides civil, criminal, and disciplinary immunity to providers who stop life-sustaining treatment on the eleventh day.⁹⁶

90. See CMTY. ETHICS COMM., *supra* note 31, at 14 (“A guaranteed day in court to resolve a dispute is a darkly comic idea when that day is nine months away and the patient will not live more than weeks.”); ROYAL SOC’Y OF CAN. EXPERT PANEL, END-OF-LIFE DECISION MAKING 92 (2011) (“[G]iven the physical condition of most patients involved in such cases and given the time required for a case to work its way through the court system (especially for a matter of unsettled law), the results of litigation are often deeply unsatisfying for all involved.”).

91. See, e.g., *Golubchuk v. Salvation Army Grace Gen. Hosp.*, 2008 MBQB 49 (Can.). The *Betancourt* case is a rare case in which the patient survived and the court reached the merits. See *Betancourt v. Trinitas Hosp.*, No C-12-09, slip op. (N.J. Super. Ct. Ch. Div. Mar. 4, 2009), available at http://www.thaddeuspope.com/images/Betancourt_v_trinitas_3-4_2.pdf. But even in *Betancourt*, the patient died before appellate briefing could be completed. The court dismissed the appeal as moot. Douglas B. White & Thaddeus M. Pope, *The Courts, Futility, and the Ends of Medicine*, 307 JAMA 151 (2012).

92. There may be other green lights that apply in specific situations in other states. See, e.g., *Marin v. Cleveland Clinic*, No. 1:09-CV-2090, 2010 WL 359699, at *6 (N.D. Ohio Jan. 29, 2010) (“Ohio law allows a doctor or health care facility to refuse to comply with the instructions of an attorney-in-fact for any basis.”).

93. See TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2012). See generally Robert L. Fine, *Point: The Texas Advance Directives Act Effectively and Ethically Resolves Disputes About Medical Futility*, 136 CHEST 963 (2009); Robert D. Truog, *Counterpoint: The Texas Advance Directives Act Is Ethically Flawed: Medical Futility Disputes Must be Resolved by a Fair Process*, 136 CHEST 968 (2009); Robert L. Fine, *Rebuttal from Dr. Fine*, 136 CHEST 971 (2009); Robert D. Truog, *Rebuttal from Dr. Truog*, 136 CHEST 972 (2009).

94. TEX. HEALTH & SAFETY CODE ANN. § 166.046(b)(2).

95. See *id.* § 166.046(e).

96. See *id.* § 166.045(d).

DISPUTE RESOLUTION MECHANISMS FOR INTRACTABLE MEDICAL FUTILITY DISPUTES

TADA offers a clear, unambiguous legal safe harbor. Physicians in most U.S. jurisdictions are afraid to refuse surrogate-requested treatment that they deem inappropriate or even cruel. In contrast, TADA has proven effective at allowing physicians to avoid providing such treatment. Accordingly, other jurisdictions have been looking to TADA as a model.⁹⁷

2. *DNAR Orders and POLST*

While Texas is the only state that expressly authorizes clinicians to unilaterally refuse any form of life-sustaining treatment, a few states authorize clinicians to unilaterally refuse one particular form of life-sustaining treatment: specifically, these states permit clinicians to refuse CPR by writing a DNAR order without consent.

In Vermont, for example, clinicians can complete a Clinician Order for Life-Sustaining Treatment (COLST) directing that health care professionals not administer CPR to a patient who is not breathing or who has no pulse.⁹⁸ Normally, the basis for a DNAR order is the informed consent of the patient or surrogate. But Vermont also allows the basis to be “futility.”⁹⁹ The clinician can complete a COLST directing that no CPR be administered to a patient experiencing cardiopulmonary arrest if “resuscitation would not prevent the imminent death” of the patient.¹⁰⁰

3. *Conscience-Based Objections*

TADA and the Vermont POLST regulations provide a green light for clinicians with *professional* objections to the requested treatment. In contrast, the third green light focuses on clinicians’ *personal*, conscience-based objections.

Almost every state has a health care conscience clause.¹⁰¹ These laws permit clinicians to decline the provision of services that violate their religious or moral beliefs. For example, California law provides that “healthcare providers may decline to

97. See, e.g., S.B. 1114, 60th Leg., Reg. Sess. (Idaho 2009); CAL. MED. ASS’N, RESOLUTION 506-09: END-OF-LIFE CARE AND FUTILE TREATMENT, 2009 HOUSE OF DELEGATES (2009), available at <http://sdcms.org/files/2009HODCommERes.pdf>; WASH. STATE MED. ASS’N, RESOLUTION A-2: WSMA OPINION ON MEDICAL FUTILITY IN END-OF-LIFE CARE, 2010 HOUSE OF DELEGATES (Aug. 23, 2011), available at http://www.wsma.org/files/Downloads/AboutUs/pdf/Official_Actions_2010.pdf; Brief for N.J. Hosp. Ass’n et al. as Amici Curiae Supporting Appellant, *Betancourt v. Trinitas Hosp.*, 1 A.3d 823 (N.J. Super. Ct. App. Div. 2010); N.Y. STATE BAR ASS’N HEALTH LAW SECTION, SUMMARY REPORT ON HEALTHCARE COSTS: LEGAL ISSUES, BARRIERS AND SOLUTIONS (Sept. 2009), available at <http://www.nysba.org/AM/Template.cfm?Section=Home&ContentID=31639&Template=/CM/ContentDisplay.cfm>.

98. See VT. DEP’T OF HEALTH, ADVANCE DIRECTIVES FOR HEALTH CARE RULES, available at http://healthvermont.gov/regs/ad/Advance_Directives_Rules.pdf.

99. *Id.*

100. *Id.* Maryland also permits clinicians to write a Medical Orders for Life-Sustaining Treatment (MOLSTs) on the basis of “medical ineffectiveness.” MD. CODE ANN., HEALTH-GEN. § 5-611 (West 2013); MD. CODE REGS. 10.01.21 (2013); 39 Md. Reg. 1087–89 (Aug. 10, 2012) (rejecting comments expressing concern about this “medical ineffectiveness” path).

101. See Thaddeus M. Pope, *Legal Briefing: Conscience Clauses and Conscientious Refusal*, 21 J. CLINICAL ETHICS 163 (2010); Thaddeus M. Pope, *Conscientious Objection by Health Care Providers*, 18 LAHEY CLINIC MED. ETHICS J. 4 (2011).

comply with an individual healthcare instruction or healthcare decision for reasons of conscience.¹⁰² And the provider is afforded civil, criminal, and disciplinary immunity in exercising this refusal.¹⁰³ Because some clinicians equate the administration of “futile” treatment with torture and inhumanity, they may make conscience-based refusals pursuant to such laws.¹⁰⁴

But conscience clauses are usually materially limited to balance clinician rights against patient needs. Accordingly, most conscience clauses require “treat ‘til transfer.” That is, they condition the provider’s right to refuse on transferring the patient to another provider who is willing to comply with the patient’s or surrogate’s treatment request. In most intractable futility disputes, transfer is not possible.¹⁰⁵ Therefore, clinicians cannot effectively implement their right to conscientiously object and refuse treatment.

But some states, like Mississippi, more broadly permit providers to not “participate in a healthcare service that violates his or her conscience.”¹⁰⁶ The 2004 Mississippi Healthcare Rights of Conscience Act provides civil, criminal, and administrative immunity.¹⁰⁷ And it does not require treat ‘til transfer or even referral to another provider.¹⁰⁸ Other states have been considering similar unconditional conscience clauses.¹⁰⁹

C. Yellow Lights: Uncertainty Whether Clinicians May Stop Treatment Without Consent

There are only a handful of red light and green light states. Most states provide clinicians with a yellow light. Statutes in these states neither clearly forbid nor clearly permit clinicians to unilaterally stop life-sustaining treatment. They leave clinicians uncertain about the legality of stopping without consent. Most yellow light states have statutes that purport to provide green lights. These statutes, like TADA, appear to provide legal safe harbor immunity.¹¹⁰ But, in contrast to TADA, this immunity depends upon the satisfaction of standards and conditions that clinicians cannot be sure are really satisfied.

102. CAL. PROB. CODE § 4734(a) (West 2013).

103. *Id.* § 4740(d).

104. *See, e.g.*, Liz Kowalczyk, *Hospital, Family Spar over End-of-Life Care*, Bos. GLOBE, Mar. 11, 2005, at A1, available at http://www.boston.com/news/local/massachusetts/articles/2005/03/11/hospital_family_spar_over_end_of_life_care/ (“This inhumane travesty has gone far enough This is the Massachusetts General Hospital, not Auschwitz.”) (quoting *In re Howe*, No. 03PI255, 2004 WL 1446057, at *11 (Mass. Prob. & Fam. Ct. Mar. 22, 2004)).

105. *See* Pope, *No Safe Harbor*, *supra* note 23, at 59–61.

106. MISS. CODE ANN. § 41-107-5(1) (West 2013).

107. *See id.* § 41-107-5(2).

108. *See id.* § 41-107-3.

109. *See, e.g.*, H.B. 2460, 53d Leg., 2d Sess. (Okla. 2012); H.B. 279, 2013 Reg. Sess. (Ky. 2013); S.B. 136, 2013–2014 Sess. (Mich. 2013); L.B. 461, 102d Leg., 1st Sess. (Neb. 2011).

110. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.044 (West 2013).

DISPUTE RESOLUTION MECHANISMS FOR INTRACTABLE MEDICAL FUTILITY DISPUTES

For example, the California Probate Code states that a health care provider “may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider.”¹¹¹ And so long as the provider is acting in good faith, she will not be “subject to civil or criminal liability or to discipline for unprofessional conduct” for refusing to comply.¹¹²

This California statute looks substantially similar to TADA at first. But closer examination shows it to be materially different. The conditions in TADA are concrete and measurable, for example: (a) give forty-eight hours’ notice of the ethics committee meeting, and (b) wait ten days.¹¹³ Texas clinicians know exactly if and when they have earned safe harbor immunity.

In contrast, California clinicians can never be as confident, as it is unclear when the conditions in the California statute are satisfied. California permits clinicians to refuse surrogate treatment requests that are either “medically ineffective” or “contrary to generally accepted healthcare standards.”¹¹⁴ But these categories are practically useless. “Medical ineffectiveness” is so exceedingly narrow that it almost never applies.¹¹⁵ “Generally accepted healthcare standards” may be broader. But it is unclear which, if any, end-of-life health care standards are “generally accepted.”¹¹⁶

Medically ineffective treatment is that which will not offer the patient “any significant benefit.”¹¹⁷ The clinician need not make any evaluative assessment that the treatment’s effect is too unlikely, too small, or not worthwhile. The clinician can ascertain “medically ineffective” treatment based solely on objective clinical evidence. But while it is easy to identify, “medically ineffective” treatment is almost never the subject of futility disputes.¹¹⁸

Therefore, the California safe harbor is practically limited to situations in which the surrogate requests life-sustaining treatment contrary to “generally accepted

111. CAL. PROB. CODE § 4735 (West 2013). The statute also requires that a provider declining to comply must: (a) promptly inform the patient and surrogate, (b) make all reasonable efforts to assist in the transfer of the patient, and (c) provide continuing care until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. *See id.* § 4736.

112. *Id.* § 4740(d).

113. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.046.

114. CAL. PROB. CODE § 4735.

115. Pope, *No Safe Harbor*, *supra* note 23, at 28–31.

116. *Id.* at 72–75; *see also* Pope & Waldman, *supra* note 52, at 175–80.

117. CAL. PROB. CODE § 4735. There are only a few situations in which treatments are medically ineffective: brain death, anencephaly, and neonates under twenty-two weeks gestation. *See* Pope, *No Safe Harbor*, *supra* note 23, at 57.

118. Pope, *No Safe Harbor*, *supra* note 23, at 58. *But see* Winkfield v. Children’s Hosp. Oakland, No. C13-5993-SBA (N.D. Cal. filed Dec. 30, 2013); Winkfield v. Children’s Hosp. Oakland, No. RP13-707598 (Cal. Super. Ct. Alameda Cnty. Dec. 30, 2013) (order continuing temporary restraining order).

healthcare standards.” The problem is that there simply are no such standards.¹¹⁹ There is significant variability in practice.¹²⁰

Moreover, most clinicians do, in fact, provide the inappropriate treatment that surrogates demand.¹²¹ Clinicians are thereby creating and reinforcing the very standard of care with which they do not want to comply. They are legally painting themselves into a corner. The consequence is that generally accepted health care standards now include the very treatment that surrogates demand and that clinicians deem inappropriate. In short, the boundaries of the safe harbor are unclear at best and non-existent at worst.¹²²

And a safe harbor is important. As the volume of defensive medicine illustrates, health care providers are risk averse.¹²³ While they have won almost all lawsuits for non-consensual withholding or withdrawing of life-sustaining treatment, the risk is not zero. There have been some settlements and judgments.¹²⁴ And religiously affiliated organizations, such as the Alliance Defense Fund, litigate even low- or no-value cases to advance policy objectives. Additionally, there are few physicians willing to test the law. So the absence of adverse cases may not be due as much to favorable rulings as to an overall paucity of cases being brought in the first place.

Finally, providers are not just liability-averse; they are also litigation-averse. The process is itself punishment because even prevailing parties pay transaction costs such as time, emotional energy, and stress.¹²⁵ Consequently, without a safe harbor, clinicians accede to surrogate demands. Given the combination of risk averseness and legal uncertainty, clinicians perceive yellow lights as red lights.

119. See Pope, *Non-Beneficial Treatment*, *supra* note 1, at 14; see also Brief for N.J. Hosp. Ass’n et al. as Amici Curiae, *supra* note 97, at 21; Brief and Appendix on Behalf of Appellant at 17, *Betancourt v. Trinitas Hosp.*, 1 A.3d 823 (N.J. Super. Ct. App. Div. 2010).

120. See, e.g., Dominic J.C. Wilkinson & Robert D. Truog, *The Luck of the Draw: Physician-Related Variability in End-of-Life Decision-Making in Intensive Care*, 39 *INTENSIVE CARE MED.* 1128 (2013); Caroline Helwick, *End-of-Life ICH Treatment Highly Variable Among Physicians*, *MEDSCAPE* (Oct. 17, 2013), <http://www.medscape.com/viewarticle/812767>; Allan Garland et al., *Physician-Attributable Differences in Intensive Care Unit Costs*, 174 *AM. J. RESPIRATORY & CRITICAL CARE MED.* 1206 (2006); Deborah Cook et al., *Determinations in Canadian Healthcare Workers of the Decision to Withdraw Life-Sustaining Treatment from the Critically Ill*, 273 *JAMA* 703 (1995).

121. See Sibbald et al., *supra* note 55.

122. See Thaddeus M. Pope, *Physicians and Safe Harbor Legal Immunity*, 21 *ANNALS HEALTH L.* 121 (2012). *But cf.* Daniel Merenstein, *Winners and Losers*, 291 *JAMA* 15 (2004) (illustrating how the controlling standard of care is determined by clinician conduct and not by what is actually best for patients).

123. See Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 *HEALTH AFF.* 1569 (2010); *Ternovsky v. Hungary*, No. 67545/09 (Eur. Ct. H.R. Dec. 14, 2010) (Sajó, J. & Tulkens, J., concurring) (“[R]egulation is the default, and only what is regulated is considered safe and acceptable.”).

124. See Pope, *Involuntary Passive Euthanasia*, *supra* note 25, at 255–66.

125. See Pope, *Life-Sustaining Treatment*, *supra* note 33, at 261.

D. Assessing the Traffic Lights

When I first started writing about medical futility disputes seven years ago, I was confident that more states would implement green lights.¹²⁶ That has not happened. Indeed, there appears to be a trend in precisely the opposite direction, toward the implementation of more red lights.

That is an unwelcome development because it mandates the continuation of life-sustaining treatment even when it is medically and ethically inappropriate. This might be characterized as a “false negative” error. By eliminating clinician discretion, red light states eliminate the option of positively identifying the treatment as “futile.”¹²⁷ Patients continue to suffer. Clinicians continue to experience moral distress. Other patients are exposed to increased risks. And scarce health care resources are wasted.¹²⁸

Green light states also pose a risk of error. But instead of producing false negatives like red light states, green light states increase the risk of “false positives.” As a result, life-sustaining treatment may be wrongly identified as inappropriate or futile. For example, TADA lacks essential elements of procedural due process, such as appellate review and an independent and neutral decisionmaker.¹²⁹ Consequently, it fails to mitigate risks of corruption, bias, carelessness, and arbitrariness. It fails to minimize the risk of error in ending life-sustaining treatment.¹³⁰ Clinicians and ethics committees may inappropriately determine that the burdens of treatment outweigh the benefits, because they judge the patient’s quality of life to be far lower than the patient herself would judge it to be.

Yellow light states offer the greatest immediate opportunity for improvement. In contrast to the green light states, the yellow light safe harbors include oversight and accountability to the standard of care. Admittedly, that accountability is ominous and chilling, because of uncertainty over the standard of care. But greater clarity is on the way. Professional medical associations are working to develop guidelines that should help clarify the standard of care.¹³¹

126. Pope, *No Safe Harbor*, *supra* note 23, at 18–19.

127. Even in red light states, surrogate replacement may remain an option. *See supra* Part IV.

128. *See* Pope, *No Safe Harbor*, *supra* note 23, at 13–19.

129. In 2013, several bills proposed improvements to the fairness of TADA, for example, by expanding the notice periods. *See, e.g.*, H.B. 1444, 83d Legis., Reg. Sess. (Tex. 2013); S.B. 303, 83d Legis., Reg. Sess. (Tex. 2013). But these bills did not address problems concerning the lack of decisionmaker neutrality or the lack of appellate review.

130. *See* Thaddeus M. Pope, *Multi-Institutional Healthcare Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism*, 31 CAMPBELL L. REV. 257 (2009) [hereinafter Pope, *Multi-Institutional Healthcare Ethics Committees*]; Thaddeus M. Pope, *The Case of Samuel Golubchuk: The Dangers of Judicial Deference and Medical Self-Regulation*, 10 AM. J. BIOETHICS 59 (2010); Thaddeus M. Pope, *Legal Briefing: Medically Futile and Non-Beneficial Treatment*, 22 J. CLINICAL ETHICS 277 (2011).

131. *See, e.g.*, OFFICIAL ATS/AACN/ACCP/ESICM/SCCM STATEMENT: RESPONDING TO REQUESTS FOR FUTILE AND INAPPROPRIATE TREATMENTS IN INTENSIVE CARE UNITS (forthcoming); Anna Skold et al., *Ethics and Health Policy of Dialyzing a Patient in a Persistent Vegetative State*, CLINICAL J. AM. SOC’Y NEPHROLOGY (forthcoming).

VI. CONCLUSION

The life-sustaining treatment at issue in most medical futility disputes is physiologically effective. It can probably sustain the patient's life for some period of time. Consequently, the clinician does not make a purely medical or scientific judgment. Instead, she makes a value-laden judgment. The clinician judges that administering life-sustaining treatment is not worthwhile, because the risks and burdens of treatment are disproportionate to the diminished or non-existent opportunities for benefit.

This is a controversial decision. There exists no general understanding about what sort of life, what sort of existence, is worth the deployment of medical resources. We are fundamentally at odds on the question of who gets to decide when enough is enough. Because we are flummoxed by these questions, as a society we are unable to come up with a "real" definition of "futile care." We are not yet prepared to specify the proper ends of medicine, the acceptable criteria for rationing, or the legitimate restrictions on patient autonomy.¹³²

But while we have been unable to fruitfully address the *substantive* issues raised by medical futility disputes, we can at least address the *procedural* issues. We can address how such conflicts are settled. "When we lack consensus on principles . . . we may nevertheless find a process or procedures that most can accept as fair to those who are affected by such decision."¹³³

Like TADA, many hospital policies give a central decisionmaking role to the institutional ethics committee. Specifically, these policies give the ethics committee not only a role to mediate but also a role to adjudicate futility disputes. An ethics committee's decision is legally binding only in Texas. But for practical reasons such as costs and judicial deference, the ethics committee often may be the forum of last resort in other states, too.¹³⁴

The traditional hospital ethics committee is not up to this adjudicatory task. It lacks the necessary independence, diversity, composition, training, or resources. Ethics committees are overwhelmingly intramural bodies, comprised of professionals employed directly or indirectly by the very same institution whose decisions the ethics committee adjudicates. In short, ethics committees can make decisions that are corrupted, biased, careless, and arbitrary.¹³⁵

132. Pope & Waldman, *supra* note 52, at 192–93.

133. NORMAN DANIELS & JAMES E. SABIN, *SETTING LIMITS FAIRLY* (2002); *see also* CARRIE MENKEL-MEADOW, *DISPUTE PROCESSING AND CONFLICT RESOLUTION: THEORY, PRACTICE AND POLICY*, at xiii (2003) ("[E]ven if we cannot all agree on substantive norms and goals, we can probably [at least] agree on some processes for making decisions that will enable us to go forward and act.") (citing STUART HAMPSHIRE, *JUSTICE AS CONFLICT* (2000)); Robert A. Burt, *The Medical Futility Debate: Patient Choice, Physician Obligation, and End-of-Life Care*, 5 J. PALLIATIVE MED. 249, 253 (2002) ("The absence of hard resolving principle shifts our attention to the interactive processes . . . negotiated settlement . . .").

134. *See* Thaddeus M. Pope, *The Growing Power of Healthcare Ethics Committees Heightens Due Process Concerns*, 15 CARDOZO J. CONFLICT RESOL. (forthcoming 2014).

135. *See* Pope, *Multi-Institutional Healthcare Ethics Committees*, *supra* note 130, at 274–75.

DISPUTE RESOLUTION MECHANISMS FOR INTRACTABLE MEDICAL FUTILITY DISPUTES

Reconstituting intramural ethics committees as multi-institutional committees can significantly mitigate these risks.¹³⁶ Multi-institutional committees are equipped with the collective strength of multiple institutions' financial, professional, educational, and disciplinary resources. And they are detached from what is often the unduly persuasive influence of individual supporting institutions. Consequently, the multi-institutional ethics committee can operate as a diverse, accountable, and independent decisionmaking body that can ensure difficult bioethical dilemmas are addressed with enhanced uniformity and care.

136. *See id.* at 302. Alternatively, an independent quasi-judicial tribunal like the Ontario Consent and Capacity Board might be an equally effective yet fair mechanism for resolving intractable medical futility disputes. *See Cuthbertson v. Rasouli*, 2013 SCC 53 ¶¶ 28, 98–103 (Can.).

