
NOTES

ETHICAL POSTURES OF FUTILITY AND CALIFORNIA'S UNIFORM HEALTH CARE DECISIONS ACT

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I. INTRODUCTION: THE IMPORTANCE OF FUTILITY

Despite twenty years of development in patient rights, end-of-life decisions still trouble law and medicine. It is estimated that more than 14,000 patients live in a permanent unconscious state, often supported by artificial means.¹ Given that almost 80% of deaths occur in medical or nursing care institutions, and approximately 70% of these deaths result from an active decision to withdraw or withhold treatment,² our society is faced with difficult decisions about treatment at the end of life.

The past twenty years have mostly settled that patients' right to control their own care is founded upon the right to privacy and autonomy. Such increased patient autonomy and control, however, have given rise to new concerns. Rather than the patient's right to refuse care when physicians attempt to intervene, care providers now grapple with the patient's demand to continue medically inappropriate—or futile—

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1. Jeanine Lewis, *Chapter 658: California's Health Care Decisions Law*, 31 MCGEORGE L. REV. 501, 503 (2000).

2. Keith Shiner, *Medical Futility: A Futile Concept?*, 53 WASH. & LEE L. REV. 803, 805 (1996) (citing Helene L. Lipton, *Do-Not-Resuscitate Decisions in a Community Hospital: Incidence, Implications, and Outcomes*, 256 JAMA 1164, 1168 (1986)). Justice Brennan cited figures similar to these in his dissent in *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 302–03 (1990) (Brennan, J., dissenting).

treatment.³ While we commonly accept the proposition that the physician should give the “patient all necessary and continued attention as long as the case requires,”⁴ we have yet to determine what is required. In fact, what is required shifts with changing technologies and medical expectations. Given a dearth of clear legal and ethical definitions, health care providers must often struggle with decisions about the application of futile treatments that present novel legal challenges and implicate the ethical and moral role of physicians.

California’s Uniform Health Care Decision Act (“UHCDA”),⁵ which went into effect on July 1, 2000,⁶ presents a comprehensive codification of end-of-life decisions. It consolidates the typical common-law and modern statutory tools that have been adopted to manage end-of-life decisions: advance directives, surrogacy, and physician duties and institutional chains of command.⁷

Historically, California has been at the forefront of developments in medical decisionmaking. The UHCDA codifies and refines the essential precepts of patient autonomy that have developed over the past twenty-five years.⁸ In 1976, California became the first state to enact a “living will” statute, known as the Natural Death Act.⁹ In 1983, California enacted a durable power of attorney for health care law.¹⁰ The UHCDA, while a clear conglomeration of these previous California guides, must situate the futility provisions within the developments of the past twenty-five years and the attending ethical developments that have occurred in American medicine. It represents a unification of the legal and moral shift attending to patient autonomy, but requires further development to resolve the dilemma of futility adequately.

3. For the sake of convenience, I will frequently use the term “physician” in the place of the more generic term “health care provider.” The use of “physician” is not meant to exclude other caregivers, like nurses, psychotherapists, or clergy. When important distinctions arise, caregivers other than physicians are mentioned explicitly.

4. Eric M. Levine, *A New Predicament for Physicians: The Concept of Medical Futility, the Physician’s Obligation to Render Inappropriate Treatment, and the Interplay of the Medical Standard of Care*, 9 J.L. & HEALTH 69, 87 (1995).

5. CAL. PROB. CODE §§ 4600–4740 (West 2000).

6. *Id.*

7. Many of the same provisions were previously located in various sections of California’s Probate, Health, and Civil codes.

8. See Marshall S. Zolla & Deborah Elizabeth Zolla, *Lasting Wishes: California’s New Health Care Decisions Law Smooths the Procedural Path for Those Who Wish To Control Their Medical Treatment in Their Last Days*, L.A. LAW., Dec. 2000, at 42. See also Lewis, *supra* note 1, at 507–08.

9. Natural Death Act, ch. 1439, 1976 Cal. Stat. 6478 (enacting CAL. HEALTH AND SAFETY CODE § 7188 (repealed 2000)).

10. Act of Sept. 29, 1983, ch. 1204, 1983 Cal. Stat. 4610 (enacting CAL. CIV. CODE §§ 2430–2503.5 (repealed 1994)).

Since the high-profile case of Karen Ann Quinlan in 1976, the right to privacy has been read to include the patient's right to have life-sustaining treatments withdrawn.¹¹ Over the intervening twenty-five years, the right of patients to refuse medical care has become firmly entrenched. Today, all states have laws enabling patients to refuse medical care.¹² While the standards of proof required to demonstrate patient intent differ, all states allow for advance directives, allowing patients to determine in advance the course of their treatment should their decisionmaking capacities become diminished.¹³ The line of cases and commentaries establish a right of self-determination, meaning that patient choice has become central to medical decisionmaking.

As patients' rights to determine treatment solidified, more extreme requests, such as those for assisted suicide, became more prevalent. Similarly, there was a reversal in the dynamic of the application of life-sustaining treatments. Where paternalistic physicians once sought to push the frontier of their faith in science by applying every means possible, now autonomous patients are the ones who may request every life-sustaining procedure. For example, in 1991, the family of an eighty-seven year old Minnesota woman insisted on every means necessary to preserve her biological functioning.¹⁴ Despite some efforts by the hospital to transfer the patient or usurp the decisionmaking power of the family, the court seemingly affirmed the right of the patient and dictated the treatment that was deemed medically inappropriate.¹⁵

In the decade following this decision, numerous commentators have grappled with the moral position of the physician faced with a futile request. Few judges, however, have been faced with these problems and few states have passed legislation addressing this situation.¹⁶ No clearly

11. See *In re Quinlan*, 355 A.2d 647, 662-63 (N.J. 1976), *cert. denied*, Garger v. New Jersey, 429 U.S. 922 (1976).

12. See Levine, *supra* note 4, at 71.

13. See Bretton J. Horttor, *A Survey of Living Will and Advanced Healthcare Directives*, 74 N.D. L. REV. 233, 233 (1998).

14. *In re Wanglie*, No. PX-91-283 (Minn. Dist. Ct. 1991), *reprinted in* 2 BIOLAW § 12-6 (James F. Childress & Ruth D. Gaare eds., Aug.-Sept. 1991 Update).

15. See *id.* In *Wanglie*, the family of an eighty-seven-year-old woman sought to continue aggressive treatment against the advice of physicians. The physicians considered continued treatment medically ineffective. In an effort to circumvent the family's wishes, the hospital sought to appoint a conservator to replace Wanglie's husband. The court rejected this attempt and required continued treatment pending ultimate resolution. Wanglie died three days after the decision, preventing further litigation and resolution. It is not clear that this decision required continuing futile care in perpetuity. It does affirm that the family should be considered the best conservator rather than a physician or impartial third party.

16. See, e.g., MD. CODE ANN., HEALTH-GEN. I §§ 5-601 to 5-608 (1998); VA. CODE ANN. § 54.1-2990 (Michie 1998).

delineated approach has been adopted under the law, meaning there is little explicit legal guidance for futility. Absent factual development, all legislative efforts have also failed to account for the complexity of futility.

Specifically addressing futility, the UHCDA enumerates two situations in which physicians can decline to comply with an individual's or surrogate's health care decisions.¹⁷ First, health care providers can decline for personal reasons of conscience.¹⁸ Second, physicians can decline because the treatment would be medically ineffective in their opinion.¹⁹ The nexus of these the two situations, one moral and one technical, encapsulates and attempts to address the concept of futility.

Futility is not merely a technical decision, but a complex moral decision that is based upon a very individualized decision. While continuing life support for one person may serve a legitimate goal for both physician and patient, doing so may not for another with the same disease or disorder—but in a different context. The same *facts* may require different results. The challenge for the law governing such disparate decisions is to guide important life and death decisions while respecting divergent results. Developing such a framework requires a unique balancing of law and moral structures—one that enables the participants in such a decision to have their interest, expertise, and goals fairly represented.

Despite the seeming surety of the UCHDA's pronouncement that "medically ineffective" treatment can be withheld or withdrawn, the statute provides no clear standard regarding the propriety of such decisions. Matters of ethics and technical judgments generally merge in the delivery of medical care, and do so even more in end-of-life decisions.²⁰ The UHCDA provides a mere framework for medical actions along with the legal consequences of and enforcement mechanisms for those actions. It does not, however, provide a clear definition of futility and fails to supply adequate ethical context or constraints to guide difficult decisions. Rather, the law consolidates previous statutes and codifies a common law tradition that gives only broad platitudes to health care providers in the context of patient requests to withdraw treatment. While unable to provide a

17. For the purposes of this Note, I focus my examination on individuals, rather than institutions. The provisions that apply to individuals apply in similar fashion to institutions, with some minor differences. My focus on individual physicians adequately reveals the moral and legal issues salient for this preliminary consideration.

18. CAL. PROB. CODE § 4734 (West 2000).

19. *Id.* § 4735.

20. See Levine, *supra* note 4, at 75–76. The issue of the inability to separate technical and moral judgments is discussed further herein. See discussion *infra* Part III.

definitive answer to moral dilemmas of physicians faced with futility, a close examination of the UHCDA and its foundations can provide the preliminary outlines of a more conceptually rich approach.

This Note suggests that California's UHCDA adopts a process-driven approach to deciding end-of-life decisions. Rather than focusing on the virtue of a physician, deferring to the demands of a patient, mechanically relying on a contractual relationship, or adopting a strict rule-like approach, the UHCDA adopts a step-by-step process to allow a person to withdraw from treatment. It allows a physician to end treatment unilaterally, but still attempts to acknowledge the legitimate differences in the ethical interpretation of withdrawing treatment. It allows both the technical and moral differences of physician and patient to enter into the decision process.

The UHCDA attempts to address end-of-life judgments and physician conscience and morality.²¹ These sections seemingly create an open-ended excuse for a physician to withdraw treatment for *any* moral or technical reason. From the UHCDA and its precedents, however, we can infer the moral framework that informs the law and guides decisions. Furthermore, there are numerous ethical constraints, judicial or otherwise that restrain medical decisions beyond the statute. While justifiably creating space, the UHCDA falls short of complete resolution by failing to account adequately for some of the ethical developments in the legal-medical field over the past twenty-five years. By focusing exclusively on the rights and duties identified in the 1970s and 1980s, the ethical tools provided in the patient autonomy movement do not fully meet the challenge of futility.

If we can discern the ethical position codified in the UHCDA, we can uncover the moral assumptions adopted in the law. These assumptions reflect the contemporary challenge of futility. The past position can be stretched to explore the ethical and legal dialogue surrounding the ethical integrity of the medical profession and questions of the boundaries of end-of-life decisions. A critical reading of the law can provide some suggestions as to ethical positions that circumscribe the zone of ambiguity within which doctors can exercise discretion. Nevertheless, the law fails to incorporate some clear steps that could better support some of the best ethical processes enabling a clearer, more complete moral arena within which physicians should make decisions about futility.

In order to accomplish this, I will contextualize within four common ethical positions adopted in medical decisionmaking. The goal in doing so

21. See CAL. PROB. CODE §§ 4734–35 (West 2000).

will be to reveal the moral positions assumed by the California legislature and to expose potential areas where the law falls short or contradicts a more fully developed and appropriate moral guide for medical decisionmaking.

The first two ethical positions reflect the current, dominant paradigm both in legal reasoning and in medical ethics. As such, they also represent the outer boundaries of the futility debate. Within those boundaries there exists a realm of uncertainty. The attempts to define futility and to allow physicians to decline to provide futile care react to the uncertainty within the boundaries. I argue that the uncertainty about futility in a particular case means that no firm definition of futility can be adopted. Given equally autonomous agents with different perspectives, a patient and physician can disagree about futility and both be on firm ethical and legal footing. Contradicting an escape clause for physicians such as that in the UHCDA, this central uncertainty does not mean there can be no guidance. Rather, the second two ethical positions discussed can give some guidance through the uncertainty, while not imposing a precise definition of futility that would violate the boundaries of both patient and physician autonomy. As such, the definition of futility is realized through a process partially, but incompletely, adopted in the UHCDA.

Part II will identify the four common philosophical positions that frame the discussion. Part III will describe how a definitive, technical definition of futility is illusory and fails to account for the legitimate uncertainty and contradiction in end-of-life decisions. Part IV will closely examine the UHCDA and the implicit moral positions it seems to adopt. Finally, Part V will outline some suggestions that more carefully tailor the law to endorse and support a more fully developed medical ethic as applied to physicians' medical integrity and futility.

II. PHILOSOPHICAL POSITIONS

Within the bioethical dialogue there are four common positions adopted by physicians and commentators. For the purposes herein, these positions are labeled the utilitarian ethic, the rule-principled ethic, the virtue-role ethic, and the communicative-caring ethic. The utilitarian and rule-principled paradigms have shaped much of the past twenty years of law regarding medical decisionmaking. Given a reversal of roles between patient and physician as to who demands excessive care, the second two ethical positions suggest models that can mediate the potentially irreconcilable, though equally valid, positions as to end-of-life treatment. The four theories frequently overlap, and strains of each are commonly found both in theory and practice. When faced with questions of futility,

theorists, physicians, and legal scholars often invoke iterations of these theories. It is important to reveal the underlying assumptions, strengths, and weaknesses of each theory to achieve complete understanding.

This Note briefly outlines each ethical structure and describes the moral position each suggests for end-of-life decisions. We can then identify an ethical stance in regard to futility and hopefully discover how to overcome some of the theoretical and practical limitations imposed by the current law when confronting questions of futility.

A. UTILITARIANISM

Constrained utilitarianism is, perhaps, the common position taken in ethical decisionmaking in medicine. In addition, it also reflects the ascendancy of economic-styled reasoning in law and public discourse. Applying constrained utilitarianism, physicians and patients frequently balance a number of ends to maximize the good resulting from a decision.

Utilitarianism, an approach based on the theories of Jeremy Bentham and John Stuart Mill, balances good and bad consequences.²² It is essentially a cost-benefit analysis. Unlike Bentham and Mill, however, the utilitarian calculation need not be merely hedonistic. Rather, a broader view of the sum intrinsic good of an action or decision is used to assess the overall “good” of the decision.

The actual application of utilitarianism in common medical reasoning is not as broad as Bentham or Mill suggest. It is rare that medical utilitarianism merely relies on a cost-benefit analysis. It is not a pure, thoroughgoing calculus that determines the good of all decisions, but rather a *constrained* utilitarianism. Constrained utilitarianism preserves the cost-benefit balancing test, but only within a prescribed region. This avoids the pitfalls met by utilitarians facing blatantly immoral options not necessarily captured by a pure calculus.

Within utilitarianism, and even more clearly within medical ethics, there is a split between whether the utilitarian principle should be applied to particular circumstances or general rules. This contrast refers to the rule utilitarian versus the act utilitarian.²³ The rule utilitarian uses the principle of value maximization to formulate general rules to determine which acts are good or bad. In contrast, the act utilitarian applies value maximization

22. See generally JEREMY BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION (J.H. Burns & H.L.A. Hart eds., 1996); JOHN STUART MILL, UTILITARIANISM (George Sher ed., 1957).

23. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 50–52 (4th ed. 1994).

to justify specific actions in a particular factual scenario. A rule utilitarian requires that actions conform to a rule, while an act utilitarian justifies the individual act but considers the broader rule expendable.²⁴

Both of these positions are salient to modern ethical questions. Particularly in questions of allocation, the rule utilitarian approach holds great sway.²⁵ Furthermore, it is utilized to generate some general rules, such as general triage principles. In the complex situations facing physicians, the act utilitarian position—balancing the minute details of the individuals' physical, mental, and spiritual needs—is also prevalent. Physicians and patients subjectively weigh many interests, attempting to reach the best balance.

Utilitarian logic can be seen most concretely in proportionality reasoning.²⁶ In contrast to a dialectic, determinative ordinary/extraordinary distinction in the demand to apply medical technology, proportionality utilizes a balancing test to assess whether an intervention is too invasive or traumatic relative to the good achieved. As the religious roots suggest, the balancing need not be divorced from other moral considerations. In practice, however, the balancing becomes very clear.

Elements of utilitarian considerations are present throughout legal-medical decisionmaking. The utilitarian reasoning is most clearly exemplified in the prototypical case of do-not-resuscitate orders (“DNR”), where an individual in a persistent vegetative state (“PVS”) might elect not to undergo resuscitation. Applying a utilitarian calculus, the trauma of rib-cracking compressions and electric shocks could be considered not worth the countervailing goal of prolonging the life of a PVS. Of course, the factors considered might not be merely physical. A surrogate might swing the balance toward continuation of treatment by demanding consideration of a family member's desire to see the PVS patient before treatment is withdrawn. Both reasoning processes are clear instances of act utilitarianism.

The reasoning above has also been suggested to justify a broader rule of withdrawing treatment. A rule utilitarian would reason that any time a patient is in a PVS, a DNR is the default position. Even more explicitly,

24. *See id.* at 50–51.

25. Utilitarianism is particularly salient in questions of how moral problems at the end of life affect resource allocation. Indeed, there is a strong argument that the definition of futility has more to do with how society distributes limited medical care. Utilitarian perspectives are particularly prevalent in this macro question. An in-depth discussion is beyond the scope of this Note.

26. Proportionality reasoning stems from the ordinary/extraordinary distinction in Catholic Theology. *See, e.g.*, Sacred Congregation for Doctrine of the Faith, *Declaration on Euthanasia (1980)*, at <http://www.ncbuscc.org/prolife/tdocs/euthanasia.htm> (last visited Mar. 29, 2002).

the calculus of balancing the percentage of success against the cost of treatment—both internally to the patient and externally to society—certainly draws on the utilitarian position. On balance, the rule would promote less suffering and would minimize the application of costly and ineffective treatment. Even if an individual case may differ from the rule, the generalized concept would be preserved.

By applying a consistent principle, utilitarianism adopts a universalistic approach through a broadly applicable rule. Yet it is flexible enough that it can vary in the actual result to reflect the vagaries of the facts in an actual medical decision. Utilitarianism in its constrained version has been specifically used to promote beneficence—one of the central themes in modern bioethics. It does so, however, by balancing what is best given the factual situation.²⁷

B. RULE-PRINCIPLED ETHIC

A second form of moral reasoning in medical decisionmaking could be described as reasoned or principled decisionmaking. This theory is characterized by the application of abstract rules or principles to the particular facts of a situation. In contrast to utilitarianism, rule-principled ethics take a deontological approach to moral problems. Particularly relying on the scientific strain of the history of medicine, this structure treats moral questions like logical questions. According to this approach, a rational rule properly applied would result in a correct decision. Further, principled/logical approaches to the law, common in the Anglo-American tradition, draw heavily from the rule-principled ethic.

There are two primary strains within the rule-principled ethic: Kantian and principled. Kantian ethics requires that any decision be generalizable.²⁸ More specifically, any decision made at an individual level must be universally applicable. One Kantian formulation has extended this reasoning to require that people be treated as ends and never as means.²⁹ Thus, similarly situated people must be treated similarly. More importantly, Kantian ethics creates a rationalistic, legalistic framework for moral reasoning, which is attractive—particularly to a field like medicine that binds tightly to science. Furthermore, Kantian logic appeals to moral absolutes. Indeed, one of the criticisms of Kantian

27. See BEAUCHAMP & CHILDRESS, *supra* note 23, at 293–315.

28. See IMMANUEL KANT, *GROUNDWORK OF THE METAPHYSIC OF MORALS* 69–71, 74–77 (H.J. Paton trans., Harper & Row 1964).

29. See *id.* at 63–67.

reasoning is that it relies on a universal, external source of moral authority, like theology.

The second form of the rule-principled ethic is principled reasoning. Like Kantian ethics, there are certain rules that are deduced or selected. Decisions in a particular situation are derived from general principles. Also like Kantian ethics, this method presupposes reasonable concepts and assumes a reasoned process from the abstract to a decision in the particular. Unlike Kantian ethics, however, these rules need not rely on a strictly rational deduction. In a diverse society like ours, such principles are sometimes selected through democratic processes. Furthermore, some of the categorical character of Kantian thought is compromised in recognition of the potentially conflicting dictates of various theories. Historically, a litany, such as that in the Hippocratic oath, represents an instance of a principle-based ethic. The most common and prevalent form of this reason is the four-pronged principles commonly used in medicine: autonomy, nonmaleficence, beneficence, and justice. Without giving answers to individual problems, it provides multiple perspectives and issues to consider and gives tools to derive a class of resolutions.

The ascendancy of autonomy and beneficence in medical decisionmaking is exemplar of rule-principled decisionmaking.³⁰ Abstract principles are applied to a factual situation, a priori, to assess whether the decision is right or good. Allowing patients to express their interests in advance directives or through surrogates respects their right to control their bodies and not merely be treated as objects of medical technique. Similarly, the attempt to define futility quantitatively might represent an attempt to produce a reasoned, a priori criterion to be applied to end-of-life decisions. In application, the principles and definitions might provide a consistent and logical guide to determine what treatment is necessary. For example, a definition of futility of a certain procedure that depends on a statistical assessment based on the percentage of success in previous cases could be used to determine the appropriateness of that procedure in the current case. However, both autonomy and quantitative futility may be consistent without being correct. While they define a negative zone of refusal, they may not support a moral position to withhold care. Rather, these principles are considerations that may be overly legalistic or technical given the moral ambiguities in an end-of-life decision.

30. See DEREK HUMPHREY & MARY CLEMENT, FREEDOM TO DIE 27-34 (1998).

C. VIRTUE-ROLE ETHIC

A third position, one frequently championed by physicians, is that of a virtue ethic. Building on an Aristotelian tradition of wisdom, the virtue ethic seeks to promote the socially valuable quality of moral virtue. As opposed to the rationale programs of utilitarianism and rule-principled ethics, virtue ethics focuses on the actual experience of moral problem solving. Proper moral decisions are fostered through cultivated experience. The agent focuses not on ideals or principles, but on the practice and cultivation of virtue. It emphasizes the agents who combine motivation and action in performing deeds.³¹ In its simplest form, this doctrine is expressive of Aristotle's dictum that a person must both perform the right action and perform it from the proper motivation.³² In contrast to the theories above, this approach bases morality facts of actual human existence. According to this approach, morality is not realized through application of an idea or calculus, but is instead developed through regular practice and perfection of acts.

Virtue ethics can be extremely attractive to the medical profession because of its reliance on experience and actual human existence. Furthermore, it emphasizes the individual physician and suggests an area of discretion that depends on the physician's ongoing process of cultivating virtue. Edmund Pellegrino and David Thomasma describe the complex process of medical decisionmaking and establish a nuanced, virtue-based theory for medical ethics.³³ Combining abstract theory and practice, this approach is teleological in that it is aimed at treatment and cure, but is nevertheless centered on the agent. Throughout the complex interrelation of interview, diagnosis, prognosis, and therapy, Pellegrino and Thomasma identify the common element as the physician. Thus, a medical ethic is substantially based on the idea of "physician as good man."³⁴ Through a formal profession of being a healer,³⁵ the physician commits to the ongoing process of competently reaching right decisions.³⁶ Individual moral or medical decisions are not dictated; rather, the wisdom and experience of a physician is trusted and used to guide the process to reach the appropriate decision that meets the medical goals.

31. See BEAUCHAMP & CHILDRESS, *supra* note 23, at 62–63.

32. See *id.* at 64 (citing ARISTOTLE, NICOMACHEAN ETHICS 40 (Terence Irwin trans., Hackett Publ'g Co. 1985)).

33. See generally EDMUND D. PELLEGRINO & DAVID C. THOMASMA, A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE: TOWARD A PHILOSOPHY AND ETHIC OF THE HEALING PROFESSIONS (1981).

34. *Id.* at 194.

35. *Id.* at 209–10.

36. *Id.* at 213–14.

In application, the virtue ethic defers much to the judgment of the physician. The physician occupies the position of repository of the experiences needed to assess the factual issues when faced with potentially futile treatment. As the trained, experienced participant, the physician applies practical reason and knowledge to come to an appropriate decision. This does not mean that the physician is the sole decisionmaker, but rather an arbiter of the complexities contained in a decision.

D. COMMUNICATIVE-CARING ETHIC

A communicative ethic or ethic of caring relies on the idea that ethical meaning is created by the participants in a relationship. Caring is a fundamentally human project, one that is not captured by individual virtue or static principles. Frequently identified as a feminist theory, care emphasizes mutual interdependence in relationships, the role of emotion, and the development of communication that defines goals and creates appropriate meanings for all participants in a group. The morality of care is particularly emphasized in perspectives from nurses and incorporates affective, cognitive, and volitional aspects not well accounted for in other theories.³⁷

In response to some of the feminist critiques of moral understanding,³⁸ Nel Noddings has given more concrete form to this theory.³⁹ Central to this moral sense is that "one must meet the other in caring."⁴⁰ Collapsing a subject-object distinction, the communicative ethic requires both participants in a relationship to "become a duality" in which each is receptive of and feels a shared reality or experience.⁴¹ Both are engaged in a moral project, the product of which creates the proper context and meaning within the relationship. Unlike traditional ethical theories, caring is not a structured theory, but a guide. It does not "tell us as a mere form what to do but only how to conduct our deliberation."⁴² While rejecting a concept-based ethic, the guiding activities and postures are that of reciprocity and receptivity. Meanings and the content of the decisions call

37. The most common example of caring-communicative ethics in practice is palliative medicine. For a discussion, see LAWRENCE J. SCHNEIDERMAN & NANCY S. JECKER, *WRONG MEDICINE* 60 (1995).

38. See, e.g., CAROL GILLIGAN, *IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT* (1982); Annette C. Baier, *What Do Women Want in a Moral Theory?*, 19 *NOUS* 53 (Mar. 1985).

39. See NEL NODDINGS, *CARING: A FEMINIST APPROACH TO ETHICS AND MORAL EDUCATION* (1984).

40. *Id.* at 201.

41. *Id.* at 30.

42. *Id.* at 107.

forth a full range of human judgment, not just reason or moral calculus, filling out the moral deliberation.⁴³

Another theoretical perspective on this approach holds that communication is a process that supplies the determinative content of moral decisions. Rather than principles, pure reason, or power, it is the definitions and morality adopted by a group (a group as small as a family or as large as a society) and produced through communication that create a mutual understanding of the world.⁴⁴

Deciding the propriety of an end-of-life decision under the caring-communicative paradigm means focusing the process on approaching members of the immediate group involved to understand and meet the patient's fully formed interests. The physician also contributes to the meaning and is not simply saddled with an external decision against which he would react by withdrawing as physician. The physician does not merely give an answer, nor does the patient alone decide what is appropriate. While not definitive to a particular answer to futility, communicative-caring ethics requires a universal approach. The goals, aspirations, emotions, and meaning of all participants—patient, family, nurses, and physicians—are considered and contribute to the decision. A common definition of the goal is fostered and obtained. The actual result may be a mother rocking a dying infant into a permanent sleep,⁴⁵ or it may mean sustaining aggressive treatment until family members have come to terms with the death of their loved ones. Differences of opinion that threaten the understanding or do not share some of the defined goals indicate a failure in earlier communication. Merely opting out of treatment, as suggested in the UHCDA, implies an abandoning of the entire meaning conferred to ethical construction and a repudiation of the socially embedded nature of the participant.

In contrast to utilitarianism or rules-principles, caring-communication does not rely on excellence in reasoning, but instead on the practice of fostering communication. Beyond virtue ethics, with which it shares the paradigm of practical reasoning, caring-communication focuses not on agent ethics, but attunement and receptivity.⁴⁶ It moves beyond normative definitions and encourages the creation of shared meanings.

43. *See id.* at 37.

44. JURGEN HABERMAS, *Discourse Ethics: Notes on a Program of Philosophical Justification*, in *MORAL CONSCIOUSNESS AND COMMUNICATIVE ACTION* (Christian Lenhardt & Shierry Weber Nicholsen trans., MIT Press 1991).

45. *See* NODDINGS, *supra* note 39, at 46.

46. Patricia Benner, *A Dialogue Between Virtue Ethics and Care Ethics*, 18 *THEORETICAL MED.* 47, 47–49 (1997).

III. FUTILITY: THE IRRECONCILABLE CONFLICT?

Under the Hippocratic oath, a physician is accorded an “obligation to refuse to provide medical treatment when medicine cannot cure the disease or improve the patient’s condition.”⁴⁷ This postulate accurately reflects our impression that physicians should not pursue what is futile. Futility, however, is a difficult and nebulous concept. It appears to be a technical assessment of the limits of our technology, but these limits often become confused with the moral propriety of applying a particular technology. For example, a ventilator for a PVS patient is not futile in that it continues to maintain biological functioning. A person truly in a PVS state, however, would arguably not benefit in the long term from this ventilation. It merely preserves biological functioning. Depending on the perspective on the definition of futility, we come to very different moral conclusions as to what course of treatment to pursue.

Historically, the definition of futility shifted with the views on patient autonomy and the physician’s role. In the 1960s, the term futility was used by authors—focusing on the potential for medical advances—to identify situations in which CPR failed. Those using the term did not focus on the lack of hope or potential for recovery, but merely on the immediate efficacy of resuscitation. CPR was futile when it would start the heart but the patient would not recover in the long-term. Only some hinted at the possibility that CPR may not actually help a patient to recover.⁴⁸

Contemporaneous with this use of futility, lay knowledge of medicine began to shift. Society’s general knowledge about medicine increased and instances of patient experimentation galvanized individuals’ opposition to traditional medical paternalism.⁴⁹ In addition, the rights movements of the 1960s–70s generally promoted increased recognition of individual autonomy and self-determination.⁵⁰ This extended to medicine as a right to determine treatment. In 1976, the family of Karen Quinlan fought their doctors in order to prevent what they saw as futile treatment of a PVS. This case signaled the judicial affirmation of a patient’s rights and role in medical decisionmaking. In the 1980s, statistical analyses of CPR

47. Levine, *supra* note 4, at 85 (quoting James J. Murphy, Comment, *Beyond Autonomy: Judicial Restraint and the Legal Limits Necessary to Uphold the Hippocratic Tradition and Preserve the Ethical Integrity of the Medical Profession*, 9 J. CONTEMP. HEALTH L. & POL’Y 451, 466 (1993)); Edmund D. Pellegrino, *Ethics*, 270 JAMA 202, 202 (1993).

48. Robert M. Taylor & John D. Lantos, *The Politics of Medical Futility*, 11 ISSUES L. & MED. 3, 5 (1995).

49. Robert J. Dzielak, Note, *Physicians Lose the Tug of War to Pull the Plug: The Debate About Continued Futile Medical Care*, 28 J. MARSHALL L. REV. 733, 740 (1995).

50. *Id.* at 740–41.

indicated situations in which doctors concluded that applying CPR in some situations represented bad faith because the likelihood of benefit was *so* low.⁵¹ In response to the rights movement of the 1960s and 1970s, the public—with the support of the courts—decided that physicians should not continue futile treatment.

As we moved into the 1990s, however, patients became consumers of medical technology, often forcing the hands of their doctors by seeking to determine when treatment should be applied. In contrast to the power struggles of the 1960s where patients and families fought to prevent futile treatment, in the 1990s it was the doctors who increasingly fought against the application of futile treatment. Physicians thus began to adopt a technical position that not all treatment should be pursued. Finally, reversing the role of physician and patient in *In re Quinlan*, *Conservatorship of Wanglie*⁵² saw the family of a PVS patient resist the physician's efforts to discontinue ventilation.⁵³ In response to this role reversal and the emergence of the problem of futility, new approaches were and are needed to guide decisions.

One approach to resolving questions of futility has been a broad, systematic process that defines a technical answer to when treatment is futile. Such an approach often relies on the difference between two goals in medicine: effect and benefit. Treatment that produces an effect only measurably affects the patient.⁵⁴ Treatment that produces a benefit improves the patient's prognosis, comfort, well-being, or state of health.⁵⁵

Both qualitative and quantitative perspectives of futility are employed to interpret the effective or beneficial goals in order to define futility. Qualitative futility depends on an assessment of whether a patient can move from life-sustaining treatments or a PVS to a life free of intervention.⁵⁶ A quantitative assessment of futility depends on whether a treatment has worked beyond a reasonable probability of success in previous cases. Applying the two perspectives—effect and benefit—to the two goals—qualitative and quantitative—produces three definitions of futility. The first includes treatment that has no effect—like antibiotics being used to treat a viral infection.⁵⁷ A second definition is futility as

51. Taylor & Lantos, *supra* note 48, at 6.

52. No. PX-91-283 (Minn. Dist. Ct. 1991), *reprinted in* 2 BIOLAW § 12-6 (James F. Childress & Ruth D. Gaare eds., Aug.–Sept. 1991 Update).

53. *Id.* at 6–7.

54. Levine, *supra* note 4, at 75–76.

55. *Id.*

56. *Id.* at 76.

57. Mark Strasser, *The Futility of Futility?: On Life, Death, and Reasoned Public Policy*, 57 MD. L. REV. 505, 514–16 (1998).

nonbeneficial treatment, which would be exemplified by a treatment whose only effect is to increase pain.⁵⁸ A third definition is to efficacy by how well it meets the patient's goals.⁵⁹

These positions might be summarized as follows. Qualitative judgments assess the overall quality of life that might result from a particular treatment.⁶⁰ Quantitative judgments involve a more rigorous assessment of the likelihood of a particular outcome.⁶¹ To a large extent, this method of defining futility relies on a reasoned, rule-oriented vision of medico-ethical decisionmaking. An a priori decision is applied to facts to produce the right decision. Recognition and logical application of the rule in a situation may or may not activate the physician's duty. The quantitative method, in particular, relies on reasoned, quasi-scientific rationale to determine the right course. While a softer approach, the qualitative method also relies on a "yes duty" versus "no duty" heuristic.

These definitional approaches do result in consistency, but they rely too much on a static concept of what is appropriate. Before even considering the facts of the situation or the individual patient, a judgment has been made determining the duty and course of action. Such an approach fails to consider adequately the patient's goals and wishes. In *Wanglie*, for example, a strict definition would have absolved the physician from any duty on both quantitative and qualitative grounds. While this would have solved the case and allayed care-provider concerns about being forced to provide futile care, it ignores the complex ethical differences between designing treatment and deferring to the expert. Assuming that it was the appropriate course of action to withdraw treatment from Wanglie, doing so unilaterally defies our ethical sensibility about her and her surrogate's moral position, and reinvokes the specter of medical paternalism.

Another approach defers judgment to institutional policies that enable a nuanced exercise of medical judgment. One definition includes a four-part approach that defines a treatment as futile if: (1) current medical standards do not indicate reasonable probability of recovery; (2) it imposes a burden disproportionate to the benefit; (3) it does not mitigate discomfort; and (4) it artificially postpones death through "sustaining, supplanting, or restoring vital functions."⁶² Rather than a simple yes or no on whether treatment is futile, this approach incorporates a cost-benefit analysis. In

58. *Id.* at 516.

59. *Id.* at 520–21.

60. *Id.* at 526–29.

61. *Id.* at 529–30.

62. Levine, *supra* note 4, at 76.

accordance with the common law tradition of proportionality and balancing, it employs a utilitarian calculus to supplement definitional absolutes.

This ultimately places the decision process on the integrity of the care-provider to balance a variety of technical and moral decisions. Not predetermining an outcome, this approach focuses on the factual details, acknowledging the individual vagaries inherent at the nexus of moral and technical decisions at the end of life. The responsibility for the weighing of differences rests, however, on the care-provider. Given the twenty-year departure from paternalism in medicine—even the benevolent Hippocratic paternalism—it appears that this second approach does not fully capture an appropriate method to determine futility. Rather, it returns to absolute physician determination. While, unlike the first approach, it does allow for a more nuanced assessment of the situation, it still relies on technical and experiential expertise that might not eliminate the type of conflict seen in cases like *Wanglie*, where patient and physician come to an irreconcilable impasse.

A third approach suggests that treatment be judged on whether it helps the patient reach the benefit sought, but does not assume a narrowly defined benefit.⁶³ This approach relies more on the caring-communicative approach. A patient's goal, as reflected in the virtue approach suggested above,⁶⁴ is often full restoration of health. This assumes future life goals. Thus, simple surgery like an appendectomy is useful and not futile because it restores health and future life projects. At the frontier of end-of-life decisions, as when considering ventilation for someone in a PVS, the goals require refinement. As such, the refined goals of a conservator or an advance directive must be determined in the course of treatment—not only after the process has degenerated into conflict. If the goal for a PVS patient were full recovery, continued treatment would be futile. If the goal were allowing family contact before death, continued treatment would not be futile. Thus, futility in a caring-communicative sense depends on the reality and meaning created through communication.

In a broad sense, futile treatment need not be continued, because continued treatment would not conform to the goals. Anything futile need not be pursued. But determining what is futile in context is the true challenge. The determination of the goals of treatment, the real content of the futility determination, varies greatly. An approach that varies futility based on a shared definition—reflecting the variety—is fostered by the

63. See *id.* at 76–77.

64. See *supra* Part II.C.

caring-communicative method. Furthermore, more than the other approaches, it opens the door for goals that are impossible, not shared, or conflicting. While this ambiguity is intuitively problematic, it reflects the failure of society to resolve these troublesome issues. Counter to our legal intuition, opening this door to conflict does not mean that the approach is incorrect. The ironic fact that caring-communicative reasoning allows for irreconcilable conflict reflects society's irreconcilable differences and diversity in the arena of end-of-life decisions.

Futility is not merely a medical determination. It must include the patient, not merely the physician.⁶⁵ Honoring the ethical integrity of the medical profession may require some recognition of futility,⁶⁶ but this does not mean that this must be a firmly defined futility. Moreover, futility is not merely a technical decision. Indeed, any time a decision requires a determination of whether something is good or bad, or whether an action ought or ought not be done, it is likely that there is a moral decision being made.⁶⁷ Merely relying on a technical assessment suggests that the appropriate moral decision can be pushed back onto a factual determination. This is not true. Simply because a treatment *is* only of marginal success does not mean that it *ought* not be pursued. Such reasoning belies a moral decision being made about the value of percentages and scientific assessments of success and adopts the fundamental flaw in Kantian moral reasoning.

Futility also includes technical ambiguities about the goals of treatment and the aspirations of the caregiver and the cared-for. Given the inherently ambiguous moral, ontological, and existential issues surrounding futility, it cannot simply be defined away. The ambiguities must be allowed, though not given so formless an area of consideration that no guidance is provided. Law is challenged to create a space that enables the varied and diverse conclusions about futility but still ensures that neither patient's nor physician's rights are trammled. This requires a broad check on the form of reasoning, but one that permits differences among the outcomes.

65. See Levine, *supra* note 4, at 82–83.

66. See Shiner, *supra* note 2, at 830–31.

67. See Levine, *supra* note 4, at 78. Levine discusses this more extensively on pages 78–85. He makes a strong case that there is no statistical cutoff that is value-free. *Id.* at 80.

IV. CALIFORNIA'S UNIFORM HEALTH CARE DECISIONS ACT AND FUTILITY

The UHCDA does not actually use the term futility, opting instead for the terms “medically ineffective health care or health care contrary to the generally accepted standards.”⁶⁸ At the same time, however, it recognizes the moral component of the physician’s role, allowing the physician to object to treatment as a matter of conscience.⁶⁹ While not explicitly referencing futility, the UHCDA clearly enacts an approach to medical decisions that deal with the moral and technical ambiguities at the end of life. While avoiding the politically volatile term, the statute clearly intends to address the topic of futility. It foresees the conflict between the important considerations of patient autonomy and those of the physician’s role. An extension of patient autonomy suggests that any failure to follow the dictates would be medical paternalism.⁷⁰ Yet, the reverse—that a patient’s commands usurp the physician’s role and discretion—are also of concern. The UHCDA attempts to address these concerns by guiding some decisions through futility.

In an attempt to address end-of-life decisions, the UHCDA subsumes the physician’s technical and moral authority into traditional themes, common law traditions, and duties regarding patient decisions. It also attempts to set a new path that endorses a broad approach to addressing the diversity of challenges presented.

A. PURPOSE OF THE UHCDA

The UHCDA was passed primarily to codify the concept of a patient’s control over decisions that affect that patient’s life, particularly in an era of increased impact of medical technology.⁷¹ It adopts the position that medical technology factually extends life in a dying process. While seemingly basing the patient’s rights on ruled-principled ethics, in granting the physician’s right to decline treatment, the statute adopts a more complex moral position. Care-providers are expected to respect patient autonomy.⁷² Physicians are allowed, however, to invoke their own moral positions to trump the patient’s autonomy.

68. See CAL. PROB. CODE § 4735 (West 2000).

69. See *id.* § 4734.

70. SCHNEIDERMAN & JECKER, *supra* note 37, at 57 (citing Troyen A. Brennan, *Silent Decisions: Limits of Consent and the Terminally Ill Patient*, 16 L. MED. & HEALTH CARE 204, 204–09 (1988)).

71. See Zolla & Zolla, *supra* note 8, at 42.

72. See CAL. PROB. CODE § 4733 (West 2000).

Moral and technical disagreements between patient and provider lie at the heart of futility. Once a controversy exists between the end-of-life decisions of a physician and patient, a diverse set of actions, requiring patient-provider communication, proper identification of duties, and respect for the physician's independence and expertise are activated under the law. This statute ultimately needs further clarification if it is to provide adequate guidance.

B. FOUNDATIONS OF PATIENT'S AUTONOMY AND THE UHCDA

The justification for the UHCDA provides insight into the moral assumptions throughout the law. While in many ways merely codifying case law and consolidating previous statutes, the factual assumptions and identification of the problem being addressed determine the approach to end-of-life decisions:

The Legislature finds the following:

- (a) In recognition of the dignity and privacy a person has a right to expect, the law recognizes that an adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn.
- (b) Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.
- (c) In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment.⁷³

The legislature clearly begins from the assumption that a rule-principled reasoning serves as the foundation for end-of-life decisions. By referring to the rights of privacy and dignity, it invokes a rights-based regime as the moral underpinning. This moral assumption echoes the case law, which, since *In re Quinlan*, has relied on autonomy principles. The ethical position is further reinforced by the adoption of a potentially quantitative definition in subsection (b).⁷⁴ In moving toward questions of futility, however, it refers to the ontological fact of our own technical

73. CAL. PROB. CODE § 4650 (West 2000).

74. *See id.* § 4650(b).

limitations. It backs away from a purely theoretical determination, suggesting that decisions at the edge of the moral frontier that incorporate complex law and technology are beyond the reach of the court system. Nevertheless, the rights, limitations, and common law tradition are embedded as the constraint on ethical decisions. The patient's autonomy means that her direction in treatment must be respected, and against this, other considerations and decisions must be weighed.

C. UHCDA ADOPTION OF MALPRACTICE AND ABANDONMENT STANDARDS

While drawing on a tradition that circumscribes a care-provider's autonomy, the UHCDA seems to offer broad physician immunity even when the protected standards of ethical care are ambiguous. Section 4740 provides a standard for immunity and a non-exhaustive list of conduct immune from prosecution. Most broadly, section 4740 provides that "[a] health care provider . . . acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider . . . is not subject to civil or criminal liability or to discipline for unprofessional conduct for any actions in compliance with this division."⁷⁵ The section specifically offers immunity for actions taken under the provisions allowing a care-provider to withdraw for reasons of conscience.⁷⁶ Moreover, the comments to this section explicitly express the "good faith" and "in accordance with generally accepted" standards elements of the provision,⁷⁷ which invoke the negligence standard of malpractice.⁷⁸ The inclusion of this provision might further reinforce the impression that the law gives broad deference to the physician's decision by interfering only when an act is negligent. The malpractice standard does not, however, necessarily address the question of withdrawing futile care.

Given the long-standing common law tradition of malpractice and its failure to address futility properly, it appears that some recognition of its unique complexities is lacking. The law may be read to state that, if it is the standard practice to withdraw care, the doctor is not negligent. However, twenty-five years of patients' rights development indicate that unilateral actions are *not* the standard. The unilateral withdrawal of care merely because a physician believes it to be inappropriate violates our

75. *See id.* § 4740.

76. *See id.* § 4740(d).

77. Levine, *supra* note 4, at 88 (discussing generally accepted doctrine of physician abandonment standards).

78. *See* Cal. L. Revision Comm'n, *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 REPS. RECOMMENDATIONS & STUD. 1, 129 (1999) [hereinafter *Health Care Decisions*].

sense of patient autonomy and seems an abrogation of the joint enterprise into which both patient and physician participate. Further, withdrawing care requires some leap of faith that no prosecution would commence. Finally, it would also be unlikely to withstand judicial scrutiny that emphasizes individuals' rights to control their own destiny.

This sort of "good faith" reasoning also seems to rely on the virtue-character ethics. The deference to the medical field and its ability to set up standards and serve as a model of comparison relies on the practice of its practitioners. In the realm of end-of life decisions, the virtue model seems to be disfavored. While generally acceptable for assessing the propriety of affirmative acts, withdrawal of, or withholding care is particularly important and close to our moral and theological beliefs. Furthermore, applying the malpractice standard merely returns to a quantitative/qualitative determination of futility.⁷⁹ Physician practice and individual good faith action are no longer considered the measure of propriety in end-of-life decisions.

The withdrawal of care may be more similar to abandonment. The rule of common law abandonment requires that a physician continue treatment if in a physician-patient relationship. If there is a dispute about appropriateness, the physician can discharge the duty by providing notice and opportunity to seek treatment elsewhere.⁸⁰ The physician, under the rubric of a law to protect patients, is incidentally protected from being forced to participate in ethically objectionable or inappropriate treatment.⁸¹ This doctrine more adequately describes an instance of withdrawal, but does not rely on the virtue model as malpractice does. Rather, it refers to clear duties—a product of ruled-principled ethical decisionmaking. The UHCDA does seem to adhere to this model more closely, requiring that a patient be informed and that doctors allow the patient to seek treatment elsewhere when a futility disagreement arises. But, as argued above,⁸² such an abrupt termination of the relationship may be inappropriate.

Certainly in matters of more mundane treatment, abandonment and malpractice would be appropriate. A physician and patient disagreeing on the schedule of surgical treatment for a knee injury could certainly be resolved through termination of their relationship, because the consequences and moral ambiguities are less salient. When faced with end-of-life decisions, however, such a model does not do justice to the

79. *See supra* Part III.

80. *See* Levine, *supra* note 4, at 88.

81. *Id.*

82. *See supra* Part IV.C.

complex process that leads to life or death results. Withdrawal at the end of a process shuts the door on all the previous communication that helped formulate goals. Particularly when the patient is incapacitated or represented by a surrogate, withdrawal at a late stage nullifies the meanings created.

There is no consensus on when life-sustaining treatment should be withdrawn or withheld. While calls for a medical or statistical definition attempt to clarify this sort of professional standard of practice, it is not clear that such a consensus is possible. A merely statistical definition might violate the moral beliefs of doctors and certain institutions. The definition might suggest their goal of pursuing life-sustaining treatment in recognition of a patient's express beliefs is not just a different moral decision, but *medically* improper. Even if a majority of physicians agreed to a technically defined standard of care, it is not clear that such a definition can really account for distinctly moral questions. Defining a singular point of treatment merely adopts an absolutist position that hides moral questions within scientific trappings. Adopting an abandonment or malpractice standard would rationalize and dismiss the moral ambiguities inherent in questions of futility and would fail to preserve the meaning-creating process inherent in the doctor-patient relationship.

D. THE STATE INTEREST IN THE ETHICAL INTEGRITY OF THE MEDICAL PROFESSION

The theme codified in sections 4734 and 4735 is that physicians can decline to comply with the course chosen by an autonomous patient. The California legislature has seemingly adopted a position that promotes physicians' interests as a state interest, much as a patient's interests are protected. As a patient's autonomy entitles that person to direct treatment, so too the physician's autonomy entitles the doctor to direct those decisions he or she makes. While seemingly a contradictory position, the legal doctrine that protects a physician's integrity stems from the same legal traditions protecting the autonomy of patients. Like a patient, the physician cannot be forced into a course of action he or she deems immoral or useless. The development of the protection of physician autonomy, however, takes a circuitous path that does not produce a clear definition of what right is being protected. The result is a murky legal principle.

In addition to the patient's right of control, the common law has recognized other state interests, including the ethical integrity of the medical profession ("EIMP"). The earliest manifestation of the EIMP may

have been in *Superintendent of Belchertown State School v. Saikewicz*.⁸³ In *Saikewicz*, the Massachusetts Supreme Court consolidated previous rulings in Jehovah's Witness transfusion cases to hold that a patient could not refuse care despite other countervailing state interests in the following situations: (1) preservation of life; (2) protection of innocent third parties; (3) prevention of suicide; and (4) protection of the ethical integrity of the medical profession.⁸⁴ The case clearly stated that medical ethics were to be promoted.⁸⁵ Although this state interest was first directed at the individual doctor, it slowly transformed into an interest in the institution. *Saikewicz*' concern with ensuring that the individual physician was not forced to do something contrary to his moral system shifted to a concern with ensuring that medical institutions were preserved.⁸⁶

While promoting the EIMP, courts and legislatures have provided no clear definition or standard for what it entails. While *Saikewicz* suggested that the state has a strong interest in promoting the individual physician's integrity, other decisions suggest different approaches, while ostensibly utilizing the *Saikewicz* balancing test. In particular, subsequent cases like *In re Quinlan* support the EIMP through advocating or deferring to the position of official medical institutions, such as the American Medical Association ("AMA"). This confusion as to a standard is compounded by the extent to which the EIMP is truly a factor weighed against other interests. To understand how end-of-life decisions have honored the EIMP and how the EIMP might guide decisions in futurity, it is necessary to examine the concept of the EIMP more closely. While attempts to resolve this indeterminate and inconsistently applied standard do clarify the importance of EIMP, they have not produced standards by which physicians or other care-providers can guide decisions.

Brian Kalt suggests five interpretations of the standard entailed in the EIMP: (1) liability (doctors are not exposed to liability for doing the right thing); (2) full treatment goal (patients cannot ask to be treated while withholding consent to some treatments, thus tying a physician's hands in electing appropriate treatments); (3) appropriate treatment (the doctor's job is to treat fully, but patient can refuse some treatments); (4) individual conscience (doctor does not have to violate conscience); and (5) societal goal (society must guarantee that doctors maintain consistently high levels

83. 370 N.E.2d 417 (Mass. 1977).

84. *See id.* at 425.

85. *See id.* at 426.

86. *See* Brian C. Kalt, *Death, Ethics and the State*, 23 HARV. J.L. & PUB. POL'Y 487, 504-05 (2000).

of ethical conduct).⁸⁷ Kalt concludes that autonomy has been defined such that medicine does not require full treatment. Furthermore, the courts have not gone so far as to guarantee active maintenance and promotion of physician ethics, opting instead, as expressed in *In re Quinlan*, to defer to medical institutions' decisions.⁸⁸ Thus, courts ultimately support a concept of EIMP composed of a combination of liability, appropriate treatment, and individual conscience.

In the Karen Quinlan case, the New Jersey Supreme Court affirmed a decision to allow the withdrawal of life, trumping the interest in EIMP. In deciding that Quinlan's interest in withdrawal was allowed, the court concluded that EIMP was not a personal right, but was an external duty imposed by membership in the medical profession.⁸⁹ The individual doctor was not protected, but was seen as part of a profession that deserved protection. Continuing the lower court reasoning, the court accepted that the judiciary could defer to doctors, but only insofar as hospital ethics committees should decide such cases as Quinlan's.⁹⁰ The individual doctor's conscience was pushed aside and the patient's interests and desires ultimately prevailed.

In *Washington v. Glucksberg*, the Supreme Court did address the issue of the ethical integrity of the medical profession, albeit in the context of physician-assisted suicide.⁹¹ The Court suggested that EIMP could be used to promote ethical doctors in society.⁹² In explication, the Court deferred to the AMA's position that physician-assisted suicide is incompatible with the role as healer. This position essentially suggested that the role of a physician was that of a healer, and that this role was undermined by physician-assisted suicide.⁹³ Nevertheless, the Court, while noting the societal interest, ultimately deferred to a technical-medical decision that the treatment in the case was inappropriate.⁹⁴ Thus, while commenting on the promotion of values espoused by the AMA, it decided the case on different grounds. It applied the official, institutional ethic to derive a quasi-scientific decision; morality and the physician's conscience were superseded.

87. *Id.* at 514–15.

88. *See In re Quinlan*, 355 A.2d 665–66 (N.J. 1976).

89. *See id.* at 666. *See also* Kalt, *supra* note 86, at 499–500.

90. *See Quinlan*, 355 A.2d at 669–71.

91. *See Washington v. Glucksberg*, 521 U.S. 702, 705 (1997).

92. *See* Kalt, *supra* note 86, at 537–41.

93. *See id.* at 539.

94. *See Glucksberg*, 521 U.S. at 731.

The failure of the state interest in EIMP to allow doctors to refuse to comply with patient wishes may be due to the inadequacy of a balancing test that weighs the utility of a physician's ethical integrity against the close, deeply felt needs or wishes of a patient. The failure also stems from the absence of a clear standard for EIMP.⁹⁵ Despite strong rhetoric that the law supports the state interest in preserving the EIMP, this interest has rarely, if ever, trumped other interests.⁹⁶ The courts and legislatures have not defined what is the right treatment in the case of withholding or withdrawing end-of-life treatment. Given the complex balancing test invoked, there is no right decision absolving a physician of liability. Furthermore, the courts, by deferring to the AMA for ethical positions, have not supported the individual physician's conscientious withdrawal. When a vacuous concept is weighed against rights, it is predestined to fail.

This ultimately leaves "appropriate care" as the sole remaining definition of the interest protected by EIMP as provided by Kalt. The position that doctors should provide full treatment, but for refusal, merely instrumentalizes the physician and accepts the shift from full medical paternalism to full patient autonomy and direction. This final position seems too extreme. Indeed, by adopting UHCDA sections 4734 and 4735 and acknowledging the EIMP as *an* interest, the courts recognize that the physician's moral integrity cannot be usurped. We are thus left with an indeterminate standard and no clear definition of how the EIMP can give guidance to futility.

The integrity of medical professions has meant merely that the physician's decision must be consistent with broadly accepted ethics. The patient's interest ultimately trumps all other interests, suggesting that the EIMP is not really part of a balance, but is a nagging concern inevitably disregarded when weighed against patient autonomy. The interest in EIMP is merely noted by the courts, but is not necessarily given substance when applied to the individual physician's conscience. Rather than a balancing test, the development of patient autonomy has overpowered the EIMP.⁹⁷ Nevertheless, courts, and now legislatures, continue to reference the EIMP as a source of physician protection. While not effectuating actual decisions that defer to physicians, this continued reference and formalistic adoption of the balancing test may reflect lingering doubts. In the twenty years in which patients have gained the right to direct their medical care, concerns over what was seen as paternalistic medicine may have been swept aside. Now, the importance of the physician's ethical stance in the face of

95. See Kalt, *supra* note 86, at 516–18.

96. See *id.* at 516.

97. See *id.* at 520–21.

medically inappropriate care may be more salient, and the California legislature may have attempted to give this provision more substance.

In California, *Thor v. Superior Court* explicitly references *Saikewicz*, thus invoking the common law tradition of EIMP in California jurisprudence.⁹⁸ *Thor*, one of the cases explicitly adopted by the legislature in passing the UHCDA,⁹⁹ suggests that the complicated and conflicting legacy of EIMP has been adopted in the drafting of the UHCDA legislation. While a seemingly uncomplicated invocation of the right of a physician to have an ethical position properly weighed against patient interests, in reality, the calculus of state interests invokes a tradition that does little to protect the individual physician. The plain language of sections 4734 and 4735 would indicate a broad individual *and* institutional power, but the traditional definition of conscience and medical integrity are not rooted in balancing the particular position of the individual doctor and particular patient. Rather, the patient's autonomy is given high value. Moreover, the EIMP is protected only insofar as the patient's autonomy to decline treatment does not trump the institutional policies of the medical profession represented by the individual physician.

The tradition invoked in adopting the UHCDA attempts to protect the EIMP, but fails to do so in a substantive way when faced with futility. The reference to the EIMP is properly situated in the patient's right to decline treatment, ensuring that medical paternalism is kept at bay. But the jurisprudence adopted runs counter to the physician's right to deny futile care, even when interpreting sections 4734 and 4735 to grant such a right. The tradition that informs these sections has only protected physician ethical integrity incidentally when compared to patient's interests. While recognizing the specter of a physician being instrumentalized or their own ethical position disregarded, the UHCDA neither creates the tools nor adopts a tradition well enough equipped to dispel the problem. The application of the EIMP has failed to provide a usable, clear standard that protects the physician while balancing patient autonomy. The attempt relies only on vague references to confused cases. The courts have been unable to give weight to the physician's moral position in the ethically ambiguous realm of patient's end-of-life decisions, defaulting to an affirmation of patient's rights.

A rule-principled analysis cannot resolve the patient-physician conflict because each side relies on equally valid tools—the language and logic of inviolable rights. While the law recognizes this impasse, it has simply

98. See *Thor v. Superior Court*, 855 P.2d 375, 383 (Cal. 1993).

99. See *Health Care Decisions*, supra note 78, at 8 n.6.

opted to protect the party in the weaker position, the patient. This resolution does not resolve future conflicts. When the factual scenario shifts to a patient seeking extraordinary treatment, the tools are inadequate for the task. The failure to give substantive weight to a physician's integrity in the balance means there is little guidance when our intuition tells us that a physician's hand should not be forced. Certainly a model that relies on institutional pronouncements of the medical institution bears some weight, but the protection of *individual* integrity—both physicians' and patients'—is most directly salient to the decision being made.

E. CALIFORNIA'S COMMON LAW TRADITION OF END-OF-LIFE DECISIONS

In passing the UHCDA, the legislature has explicitly adopted common law traditions.¹⁰⁰ The cases referenced provide a glimpse at the ethical structure adopted by the courts, and consequently by the legislature, for end-of-life decisions. While almost exclusively focused on the rights of the patient to decline treatment, the ethical positions adopted and the standards applied reveal the position and weight given to the physician as opposed to the patient. The common law constraints clearly utilize rights to grant patients, not physicians, the discretion to determine their goals—particularly in assigning the discretion to make utilitarian calculations.

While affirming the patient as decisionmaker, the courts have only tangentially addressed the problem of a patient requesting futile treatment. There is an implicit assumption—perhaps now being reversed—that the physician will make every effort while the patient constrains the range of treatments. The common law that informs the UHCDA tells us that a physician need not do “everything possible” and that treatments must be the product of patient-directed goals. The close reasoning and justification of how patient goals, excessive treatment, and the physician role combine to resolve questions of futility are not fully developed. The result, perhaps by design, is a large realm of indeterminacy in which the physician and patient mediate goals and treatment. The courts ultimately rely, however, on firm, determined reasoning that predetermines future results by resolving these conflicts as a question of rights. While this has been useful in allowing patients to make decisions, the courts should adopt a model that ensures a fair, reasonable decision process in which both patients and physicians may develop and pursue their individual moral positions.

While not directly addressing the UHCDA, a recent California Supreme Court decision did reexamine the principles for end-of-life

100. *See id.*

decisions. In *Conservatorship of Wendland v. Wendland*, the Court held that a physician could not withdraw or refrain from reinserting a feeding tube into a severely disabled, though conscious, man.¹⁰¹ Robert Wendland was in coma for several months following a car accident. Although he eventually regained consciousness, he was severely mentally disabled. His feeding tube was surgically replaced three times. His wife, acting as her husband's conservator, asked that the feeding tube not be replaced a fourth time.¹⁰² Wendland's mother objected and legal proceedings arose. The Court decided that, even though a competent person had the right to refuse treatment, a conservator's power to make decisions for an incompetent person flows from the power of the state to protect people.¹⁰³ It set a high standard to allow withdrawal of hydration and food, requiring clear and convincing proof that the conservator's wishes were being met. It opted instead to mitigate risks. *Wendland* did not directly address the question of the physician's role. What it did show, however, was that the court maintained an interest in the results, rather than the process of patient decisionmaking. It focused on the ends, not means.

In *Thor v. Superior Court*,¹⁰⁴ the California Supreme Court specifically used utilitarian reasoning. In allowing a patient to make his own decision about treatment, the court used a proportionality test to conclude that a patient need not prolong his life if there was no hope of reversing his severely disabled and dependent state.¹⁰⁵ It should be noted, however, that the court merely seemed to affirm the patient's individual decisionmaking. The real decision underlying the futility debate is whether the court circumscribed physician intervention by relying on principles of informed consent and self-determination.¹⁰⁶ While affirming a utilitarian consideration for the individual patient to establish goals, the rights and principles invoked constrain the realm of the physician's autonomy to act. The utilitarian calculus is affirmed in that it can be employed to justify withdrawal or withholding of treatment, but only if the patient or surrogate performs the calculus. That calculus sets an outer limit on what technical treatment the physician can apply.

A second constraint on the physician is also affirmed in that the patient's rights of consent and autonomy assign to the patient, not the physician, the role of primary moral agent in the decision. When faced

101. See 28 P.3d 151 (Cal. 2001).

102. *Id.* at 154-55.

103. See *id.* at 161.

104. See *Thor*, 855 P.2d. at 375.

105. See *id.* at 384.

106. See *id.* at 381.

with the moral end-of-life challenges, the person most protected by the courts is the patient. Given a range of interventions, the patient can narrow the options, to some extent constraining the physician in a technical sense. Nonetheless, it is the patient who appears to be the ultimate moral arbiter of the propriety of applying various medical treatments. The court, however, appears to be silent on who selects the universe of possible treatments—futile or not—to be considered. While this might still be the physician's role, given a more informed patient population and a greater exercise of patient rights, it is not clear that the physician can narrow this. Furthermore, it may not be ethically appropriate for the physician to limit medical options prior to joint deliberations.

In *Barber v. Superior Court*, a California appellate court again used the proportionality test, but further expanded on the abrogation of a doctor's duty in some situations.¹⁰⁷ In *Barber*, the court held that physician's cessation, at the request of the family, of life support and food and hydration were not sufficient to sustain murder charges. First, the court held that the doctor's duty to sustain treatment ended when the treatment had become ineffective.¹⁰⁸ Relying on tort theory, the court determined that, once treatment could no longer cure or treat a pathology, it had become ineffective, thereby nullifying the physician's duty to continue treatment.¹⁰⁹ Second, weighing the benefit of treatment against the burden, the court affirmed that cessation of life-sustaining treatment without providing a cure for the vegetative state was not required.¹¹⁰ Here, the court affirmed the physician's decision to withdraw care when he or she complies with the patient's calculation of best interest. The court affirmed that this calculus—which ceased life-sustaining treatment—was legitimate and did not subject the physician to criminal prosecution. This court allowed a further extension of the physician's autonomy by saying that the duty to treat was discharged when aligned with the patient's wishes.

This holding, however, does not provide the freedom to withdraw care whenever it is futile. The discharge is narrowly constrained to situations where the patient-physician interests align. While seemingly allowing withdrawal for futile treatment, the court did not actually address patient-physician disagreement, suggesting a strict definition only where there is clear agreement by the parties. The court seemed to aspire to a firm, conclusive line beyond which ineffective treatment absolves responsibility. Such a quasi-scientific approach is certainly echoed in the scientific

107. See *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983).

108. See *id.* at 491.

109. See *id.* at 489.

110. See *id.* at 491–92.

approach to medical questions, and it conforms to a rule-principled ethic.¹¹¹ The court here was merely stating that no criminal charges could arise from ceasing futile treatment. Given the higher stakes, a clear, strict definition may have been appropriate. Rather than entering into the complex legal and medical decision process, the court was instead addressing criminal charges. Furthermore, this strong position was only adopted where both patient and physician concurred in the goals and agreed that treatment was futile.

In *Conservatorship of Drabick v. Drabick*, the court held that the statute that allows a conservator to give consent does not, in a plain language reading, allow withdrawal.¹¹² Nevertheless, *Drabick* extended the statute to maintain that giving consent includes, by necessary implication, the authority to withhold consent.¹¹³ *Drabick* reiterated the proportionality test¹¹⁴ but situated the strict definition of futility within the utilitarian balance, stating that the conservator's focal point in the decision should be the "prognosis as to the reasonable possibility of return to cognitive and sapient life."¹¹⁵ This reasoning, much like proportionality in general, used a "strict" definition only as a focus to the balancing test—an instrument in the calculation. Contrary to *Barber*, the strict definition of futility was not *the* answer to futility, but only a consideration in the complex balancing required in practice. When faced with moral disagreements in the course of treatment, the strict definition stating that treatment is ineffective becomes only one of a myriad of issues weighed.

The California courts' treatment of what actions should be considered in situations where patient and physician disagree seemed to indicate that patient's interests trump the physician's moral interests. Citing constitutional and common law rights to control treatment, the court in *Bartling v. Superior Court* held that a physician could not thwart a patient's well-reasoned desire to withdraw treatment.¹¹⁶ Essentially, the physician's hand was forced without allowing the physician's ethical integrity or conscience to override an unreasonable demand.

A potential escape from this situation, though, was indicated in factual dicta. The court found that withdrawing treatment was not tantamount to

111. See discussion *supra* Part II.A.

112. See *Conservatorship of Drabick v. Drabick*, 245 Cal. Rptr. 840, 859–60 (Ct. App. 1988) (superseded by statute as stated in *Conservatorship of Wendland v. Wendland*, 28 P.3d 151 (Cal. 2001)).

113. *Id.* at 860–61.

114. *Id.* at 846.

115. *Id.* at 856 (quoting *In re Quinlan*, 355 A.2d 647, 669 (N.J. 1976)).

116. See *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 230 (Ct. App. 1984). See also *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Ct. App. 1986).

suicide since the *underlying medical condition* caused death.¹¹⁷ Extending this reasoning to futility, this might indicate that disease, not the medical decision, causes death. In contrast to the facts in *Bartling*, but adopting the same reasoning, the medical condition, rather than a doctor's decision not to provide life-sustaining but medically ineffective treatment, would be the cause of death. This reversal of logic would probably not be sustained if the patient and physician roles were reversed as they are in cases of futile treatment. Accepting the given jurisprudence, a physician would probably not be allowed to withdraw unilaterally. Other court decisions have clearly constrained the physician's abilities to cease treatment. Applying proportionality reasoning, courts have said a *patient* could cease treatment, but the appropriate response for the physician was to attempt to withdraw from treatment.¹¹⁸

While making these strong pronouncements, the court has stated that the "decision to forego treatment for a persistently vegetative patient is primarily ethical and not legal."¹¹⁹ This indicates the court's reluctance to address these questions. Such a position emphasizes the moral ambiguity of end-of-life decisions, and a belief that, more so than a trial court, the patient and physician have the factual insight to make appropriate decisions. This suggests wide latitude in consideration, but a latitude that focuses on the individual moral realities in a given physician-patient relationship.

While the California courts insinuate that some treatments may be technically futile, they generally defer to a patient-initiated balancing test to determine the appropriate goal. The patient is at the heart of the decision, and, to some degree, the physician is instrumental to that decision. The courts do not absolutely chain the physician to the patient's end-of-life decisions, but provide, at best, only a common law option of opting out of the care-providing role or relationship. The focus on the patient indicates that non-technical decisions are at the heart of end-of-life decisions. Technical considerations and definitions of propriety are merely instrumental. While a physician might provide the range of options, the moral process at the end-of-life requires participation of patient and physician to determine appropriate care.

117. See *Bartling*, 209 Cal. Rptr. at 225.

118. See discussion *supra* Part IV.C. See also *Conservatorship of Morrison v. Abramovice*, 253 Cal. Rptr. 530 (Ct. App. 1988).

119. *Bowvia*, 225 Cal. Rptr. at 299-300.

F. CALIFORNIA'S JUDICIAL DETERMINATION OF END-OF-LIFE DECISIONS

Most of the UHCDA addresses the personal power of a patient to establish his or her own wishes in medical decisionmaking.¹²⁰ This reiterates previous law or refines the power of the individual to govern decisions without directly addressing the physician's role. When a patient's wishes are unknown, no surrogate is in place, and no conservatorship is defined, however, the statute explicitly allows courts to make determinations of best interest.¹²¹ It allows for withholding or withdrawing treatment, but requires consideration of two factors: (1) the extent to which the decision is in the patient's best interests, including personal value; and (2) the fact that the patient is clearly unable to consent independently.¹²²

This judicial position accepts a large degree of indeterminacy. For example, the first factor, which requires the pursuit of best interest, explicitly includes personal values. Personal values certainly vary, but are nonetheless the central consideration. No concrete right or wrong answer is prescribed. There is neither a proscription against withdrawal nor a requirement to withdraw. Instead, the court again adopts a very fact-based balancing test. Faced with ultimate, end-of-life decisions independent of patient input, the court uses patient autonomy to ensure that *the patient's* interests are considered and met. To define those interests, the law officially adopts a utilitarian balancing test as the outer edge of the boundary of medical-legal reasoning as it applies to end-of-life decisions.

This definition of the court role ultimately frames the decision of health care providers. Physicians frequently cite fear of suit as a rationale for the seemingly contradictory positions of overzealous treatment and reluctance to withdraw unnecessary treatment.¹²³ Despite statements that such judicial intervention is unlikely, cases that challenge the ethical questions at the margin of established practice often fall to the courts. When medical torts, malpractice, and even murder charges become published cases, there may be a reasonable degree of concern. Given these constraints, working within the legal framework is prudent. Despite the court's indication that end-of-life decisions are ethical, the public discourse—as expressed in judicial and legislative pronouncement—frames interpersonal relationships like that of doctor and patient. Thus, the law necessarily informs the communication.

120. For a summary, see Lewis, *supra* note 1, at 507–08; Zolla & Zolla, *supra* note 8, at 42–44.

121. CAL. PROB CODE § 3208(a)–(b) (West 2000).

122. *Id.* § 3208(c).

123. SCHNEIDERMAN & JECKER, *supra* note 37, at 85.

More importantly, judicial intervention expresses the legislative will regarding doubtful cases. If no doctor or surrogate is involved, the statute recommends a default position. This position defines an outside boundary for actions, but allows much variation as to the content of the particular decision. A physician must have some reasoning, at least as justified as the judicial balancing test, to withdraw treatment. This currently leaves a wide area of latitude that is without definitive form. If a judge is faced with the patient's request and no other physician or institution is willing to comply with it, the judge would seemingly have to adopt the default position commensurate with the common law tradition: Respect the patient's right to determine the course of her treatment.

The statute certainly leaves room for a doctor to withdraw, but a judge might reasonably be worried about safeguards to ensure this decision is not taken lightly and could very well value the strong state interest in promoting life and autonomy of the patient so as to compel continued treatment. If the determination that treatment is futile followed a carefully structured decisionmaking process, a judge might be more willing to allow withdrawal. Such an approach requires that the court abandon strictly principled or utilitarian calculations to arrive at the correct outcome. Instead, it asks the court to ensure that the decision process is complete and fair. While this is a shift in jurisprudence, it is not one that exceeds the ability or expertise of the court. Courts, familiar with balancing procedures and questions of due process, are capable of reviewing the schematic outline of a decision process while deferring judgment on the outcome. The courts can review the process rather than direct the moral decision. This process review approach would enable patients and physicians to create an appropriate approach—or even opt out of the relationship. Yet, it would not force one or the other to adopt a course of action simply because the court imposes a moral structure.

G. GENERAL DUTIES OF THE HEALTH CARE-PROVIDER UNDER THE UHCDA

Adopting a plain language reading of sections 4734 and 4735, it might appear that physicians can opt out of following a patient's directives. The statute does provide, however, some explicit constraints. Despite the focus on conscientious and medical futility, the UHCDA stresses the importance of the general responsibility to follow the wishes contained in advance directives and emphasizes that the patient's surrogate should not be

ignored. The physician has a responsibility to determine the patient's wishes and whether an advance directive or surrogate exists.¹²⁴

There are two possible foundations for this duty. First, the ascendance of the principles of autonomy and self-determination require that the physician affirmatively promote these patient rights. This denies a merely technical role for the physician. It relies on a principled sense of morality—the creation of affirmative duties requiring that the patient be treated as a source of duties that extend beyond the merely contractarian. The physician is not merely a technical adviser, but an agent ensuring that the rights of the patient are realized. It relies upon the “given” values that have been reasoned and esteemed in a western democracy. Courts, however, are unlikely to enforce affirmative duties. Given the unique relationship between a physician and patient, there may be a moral obligation for the physician to adopt and promote the patient's goals.

A second possible interpretation is that the duty to promote the patient's rights is merely a legal recognition that physicians and patients are inherently engaged in a human relationship. From a caring perspective, this requirement ensures that the physician be receptive to the patient and create an appropriate course of action based on a cocreated reality. This perspective again emphasizes the individualized differences in each factual situation and does not lionize a right or fundamental responsibility. One taking the caring position need not deny the fact that the individual does have some rights and autonomy, but these aspects would not be paramount. Rather, the fostering and legal affirmation of the communicative process would be emphasized and valued.

While a proponent of the caring ethic may champion the second approach, the legal philosophy seems unlikely to rely on such “fuzzy” moral reasoning. The statute does, however, give further affirmation of this position. First, by casting these decisions as ethical, not legal, the courts acknowledge the pantheon of possible goals and values.¹²⁵ Second, if a physician does not want to comply with advance directives, a process of communication is activated. The law recognizes that, within a relationship, the physician as well as the patient has a moral role that requires communication of goals.

Section 4733, which explains the general duties of a physician to comply with patient goals, explicitly lists sections 4734 and 4735 as exceptions to these general duties.¹²⁶ It would seem that this dismisses the

124. CAL. PROB. CODE §§ 4731, 4733 (West 2000).

125. *See, e.g.,* *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 230 (Ct. App. 1984).

126. CAL. PROB. CODE § 4733 (West 2000).

care-provider's entire duty to consider the patient's request if contrary to policy or conscience. It is clear, however, that to some degree, the care-provider must consider such a request, even if to determine that it does indeed differ from the conscience or accepted medical standard. Once this is determined, the care-provider's responsibility to consider the request has seemingly concluded. While there are steps to discharge this duty, the exception offers a clear cancellation of the ethical duty. In a rights-principled-based reasoning, such a blanket excuse may be acceptable. When given conflicting duties, the law offers a standard by which one duty could be discharged merely by invoking another valid right. Indeed, the law seems to recognize one of the conflicts within Kantian or principled reasons—that these principles and duties often do conflict and one must be relieved. The doctor need not violate one duty in order to fulfill another duty—to the patient.

When one considers the roots of opting out, such a rights-based abrogation is clearer. The preeminent statutory right of a physician's conscientious abstention stems from legislative intent to prohibit compelling doctors to perform abortions.¹²⁷ Given that some doctors have strong moral or religious-based objections to abortion, the law recognizes a right to decline to perform despite a conflict with the duty to treat the mother. Here, the law elects for an opting out by the care-provider when a conflict arises. In the absolutist terms of rights and principles, there appears to be a complete excuse to not fulfill a duty to treat.

In contrast, the care-communicative theory would approach this "opting out" more critically. Because the care-provider and patient are inherently engaged in a relationship, there cannot be a simple abandonment by the care-provider should conflict arise. Even though the law suggests that this right to leave unilaterally ends the relationship, such an exit would violate the caring model. In caring, it is incumbent upon the care-provider to discover with the patient (or surrogate) the source of the conflict and make clear the nature of the difference. It should be noted that the patient and surrogate have a reciprocal role to do the same. The "out" in section 4734 should not be seen as license to leave the relationship (no matter how gracefully), but to reexamine the meaning and purpose of the caring/cared-for relationship.

Within the UHCDA, there are some indications that this caring-communicative path is encouraged and promoted. Specifically, section 4736 requires that if the care-provider cannot comply, they must "[p]romptly so inform the patient, if possible, and any person then

127. See Levine, *supra* note 4, at 94–95.

authorized to make health care decisions for the patient.”¹²⁸ This provision seems to require the very communication foreseen by a caring-communicative ethic. The physician is expected to communicate the disagreement, attempt a transfer, and only then, withdraw. This appears to be a sensitive approach to futility, but a closer reading suggests otherwise. The approach seemingly starts from the assumption of conflict, pitting physician interest against patient. Rather than promote open communication, it uses conflict as the starting point. Ignoring the previous therapeutic and communicative relationship, communication becomes the *modus operandi* only after conflict. Rather than approaching the futility problem via a process of communication, the assumed conflict is framed as one autonomous agent against another, resulting in a termination of what should be a carefully fostered relationship. Perhaps, while preserving the integrity of the detached, lionized patient and physician autonomy, the relationship itself has been sacrificed. Over the past twenty-five years, it could be argued that the central role of the relationship has been adjusted to better reflect the patient’s interest and rights, incidentally resulting in a more formal, distant relationship. Likewise, increased time demands and medical management have attended or resulted in a decline in the central relationship between physician and patient.¹²⁹

The AMA guidelines on medical futility provide an approach similar to that of the UHCDA. The AMA promotes a more refined process to make appropriate decisions within the range of possible approaches to futility.¹³⁰ Rather than just informing a patient of the conflict, then making every effort to switch care, the guidelines provide a more nuanced enumeration of the communicative process that helps refine the conflict and seek a solution before terminating the relationship. Indeed, rather than resorting to the rights of the patient or physician, the AMA invokes a process of determining and resolving questions of futility.¹³¹ Where the UHCDA allows the physician to withdraw at any objection with a fleeting acknowledgment of a duty to facilitate transfer, the AMA recommends a seven-step process of attempting to resolve the futility dilemma.¹³²

In the first step, a communicative process of deliberation and mutual understanding is required of the physician and patient to help co-create goals in a way that avoids conflict.¹³³ This explicitly includes discussing

128. See CAL. PROB. CODE § 4736(a) (West 2000).

129. See HUMPHREY & CLEMENT, *supra* note 30, at 35–47.

130. See AMA Council on Ethical and Judicial Affairs, *Medical Futility in End-of-Life Care*, 281 JAMA 937, 937 (1999).

131. *Id.*

132. *Id.* at 939.

133. *Id.* at 939–40.

physician, family, and institutional goals.¹³⁴ If a question should arise, then the second step of attempting to make joint decisions is undertaken.¹³⁵ Third, an individual consultant is employed to negotiate an agreement between physician and patient.¹³⁶ Fourth, an institutional intervention utilizing an ethics committee attempts to resolve an impasse.¹³⁷ Only in the fifth step is the relationship severed. In that step, the patient's wishes trump, and a new physician within the same institution is sought.¹³⁸ Failing that, sixth, a new institution willing to comply with the patient's wishes is sought.¹³⁹ After all other steps are exhausted, the medical care is ceased.¹⁴⁰

Rather than a raw calculus or facile reliance on rights, the AMA process relies more on a communicative-caring process. The physician and patient create the meaning and attempt resolution. While the possibility to withdraw from the relationship exists, this is seen as a failure of the process, as opposed to the ultimate form of protection of the individual autonomy of both parties. Unlike a caring ethic, however, the ultimate reliance on the physician's experience seems to suggest a more virtue-based ethic. While certainly more sensitive than the UHCDA, the AMA model employs an "expertise" model of a physician, consultant, and ethics committee to decide appropriate actions. Furthermore, contrary to the communicative process, external agents are seen as arbitrators of decisions.

One attempt to further refine this position might be to amend the role of the individual consultant and institutional ethics board. Rather than envisioning the physician-patient disagreement as a conflict to be resolved by a consultant or review board, the process of decisionmaking should return to the trust at the core of the doctor-patient relationship. Currently, ethics panels are too much like arbitrators in that when conflict seems inevitable, an adversarial course is set, rather than a reinforcement of the trust relationship.¹⁴¹ Most medical decisions are made without conflict and as part of this relationship—and even where there is a disagreement, the overall care-giving relationship is valued.¹⁴²

134. *Id.*

135. *Id.* at 940.

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

140. *See id.*

141. Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships*, 79 B.U. L. REV. 1091, 1118–19 (1999). Gatter adopts a position very similar to that in caring ethics. *See id.*

142. *Id.* at 1099.

Consider in *Wanglie*, for example, where even after a complicated legal battle, the family praised the care provided by the physician and hospital. Rather than adversaries, patient and physician should be encouraged to trust each other and build a shared meaning to resolve conflict.¹⁴³ Empirical evidence has suggested that agreement is most often reached when frank, honest communication occurs.¹⁴⁴ A violation of a patient's trust is one of the problematic effects of a harsh cessation of the physician-patient relationship and subsequent adjudication. Now, the failure to respect the physician's moral position and medical expertise threatens to cause the same sort of rupture. Indeed, the old maxim—that ending up in court is a failure of the law—is increasingly true in this medical context. In order to encourage trust, the process of resolving questions of futility should focus not on arbitration, but on mediation. Mediation encourages collaboration, which in turn reaffirms the relationship in which appropriate decisions can be made.¹⁴⁵ Rather than setting the physician and patient's autonomy in opposition, rights and principles are balanced. Certainly these legal and moral rights affect the relationship, but cannot replace trust.¹⁴⁶

V. CONCLUSION: FUTILITY, THE INDETERMINATE AND THE LAW

The conundrum of how to resolve conflict regarding the propriety of futile treatments seems a hopeless morass. A patient's desires and rights to guide the processes of dying often clash irreconcilably with the physician's rights to not be used instrumentally to provide medically ineffective or unconscionable treatment. The courts and legislatures have indicated that patients have the absolute right to control these decisions, while in the same breath indicating that physicians' integrity must be protected. We appear to be left with a null solution to the problems.

California's UHCDA attempts to resolve this. While affirming and consolidating patients' rights, the law also seemingly provides physicians the right to opt out of care for broad technical and moral reasons. This blanket abrogation is constrained by the duties within the statute and in the common law informing it, requiring the realization of duties and minimal procedures to actually withdraw from treatment. Yet, these duties and procedures fail to address the factual situations actually confronted in

143. *Id.* at 1103–04.

144. *See* Shiner, *supra* note 2, at 844.

145. *See* Gatter, *supra* note 141, at 1105.

146. *Id.*

questions of futility. The lack of a clear demarcation of propriety within the new statute casts us back onto the tools previously developed for end-of-life decisions—a return to apparent conflict and lack of a definitive resolution.

This desire for a clear resolution, however, is misplaced. Merely technical definitions of futility, such as quantitative and qualitative positions seemingly adopted in the UHCDA, fail to address the moral differences inherent in end-of-life decisions. This ambiguity does not mean that no constraints on end-of-life decisions exist. The common law that fails to resolve end-of-life decisions creates an outside boundary on decisionmaking. The constraints invoke rights and principles requiring that a patient be involved in determinations of the course of treatment and that the patient be granted the right to use a utilitarian balancing test to help determine appropriate goals. The rights and utility invoked draw on traditional reasoned philosophies that formulate a rule or definition that is universally applied to facts to generate a *right* decision. While providing a framework, these philosophies fail to resolve the futility question adequately.

Given the moral and factual ambiguity inherent in a diverse population and in the meaning of a “good death,” a logical top-down analysis fails to compensate for differences sufficiently. The ambiguity plaguing futility is necessary. Merely stopping the analysis at a point that says each decision must be made individually and in respect of the patient’s rights would seemingly subject the physician to the whim of the patient. Theories that adopt a more factually sensitive position, however, can be employed within the sphere defined by rights—not to resolve what is objectively futile, but to ensure a process that produces the appropriate decision in a given situation. A communicative relationship that emphasizes a process that functions within ambiguity should be adopted not to determine futility, but to help guide the interaction that provides meaning without instrumentalizing the physician while preserving the patients’ rights that have been developed over the past twenty-five years.

Within the communication process, a model like that of the AMA can be adopted, either through legislative enactment or through mechanisms to encourage its adoption in all medical institutions. To move beyond a virtue-based ethic that seems to center on conflict and resolve it through the re-introduction of medical paternalism, the relationship framed by the AMA guidelines should focus upon the central doctor-patient relationship and creative process.

To promote this central meaning-providing process, an approach should adopt a mediation-model to better ensure a cocreation of meaning, rather than framing futility as a conflict requiring arbitration. This requires earlier and more thorough communication that transcends the merely contractual physician-patient relationship. Other agents are incorporated and differing perspectives are allowed to flourish without resulting in a collapse of the given relationship of those involved. For example, nurses, who are independent moral agents very close to futile decisions, often must accept both patient and physician positions regardless of their own moral position. An appropriate communication model would incorporate the various perspectives, including the technical, to adopt appropriate ends in treatment, and hopefully avoid the collapse of the relationship and the need for quitting treatment. If such a position is reached, the physician and hospital should remain obligated to affirmatively promote the transfer of the patient to either another physician or another facility; most clearly, the mediating ethics board should facilitate such transfers.¹⁴⁷

According to the AMA position, it might appear that if these steps fail to resolve the conflict, a medical consensus should absolve the physician from continuing treatment. Rather than abrogation, however, the final step should be one that returns to the judicial arena, but with a new assumption. Unlike the assumption in *Wanglie*—that physicians must defend their reasons for not continuing treatment—the presumption should now be that the patient or family seeking futile treatment is on the defensive. This shifts the common law position, but it removes the threat of medical paternalism. While not allowing unilateral withdrawal, this method does presume that the agents who have participated in a lengthy process, when faced with end-of-life decisions, would have a better grasp of the factual and moral meanings that have been adopted. Given that few conflicts about futility actually reach the courts, this posture would merely be a last-resort check on the adequacy of the process in determining the appropriate course of action when faced with futility. Twenty-five years of court scrutiny of end-of-life medical decisions have given us a rich tradition of rights and principles to apply to the difficult question of what course to pursue when faced with futile treatment. These traditions do not resolve the problem but only highlight the conflict of the core ambiguities that trouble us. Rather than shy away from ambiguity and grasp for false certainty, we can adopt a process that fosters the conceptually rich creation of meaning within the community of people generating medical decisions.

147. See Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1285 (1993).