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DEATH WISH: RESUSCITATING SELF-DETERMINATION FOR THE CRITICALLY ILL

Kathleen M. Boozang*

TABLE OF CONTENTS

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* Assistant Professor of Law, Seton Hall University School of Law; B.S. 1981, Boston College; J.D. 1984, Washington University; L.L.M. 1990, Yale University. I am grateful to Charles Sullivan, Jesse Goldner, Rev. Dennis Brodeur, Ph.D., and Marc Poirier for their helpful comments on earlier drafts, as well as Joelle Weiss (Class of 1993), Kelly Guariglia and Leslie Cascone (Class of 1995) for their invaluable assistance.

INTRODUCTION

People ought to be allowed that which is their own—their death.[1]

After nearly three decades of experience with cardiopulmonary resuscitation (CPR),[2] medical professionals are rediscovering what they already knew when CPR was first introduced as a standard of care—CPR is a desperate, invasive medical intervention which for many patients has a remote chance of success.[3] Originally, CPR was developed to prevent sudden unexpected death[4]

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[1] Michael R. Flick, *The Due Process of Dying*, 79 CAL. L. REV. 1121, 1152 (1991).

[2] CPR "provides artificial ventilation and circulation until advanced cardiac life support can be provided and spontaneous cardiopulmonary function restored." James T. Niemann, *Cardiopulmonary Resuscitation*, 327 NEW ENG. J. MED. 1075, 1075 (1992). Health care professionals understand Emergency Cardiac Care (ECC) to consist of two phases: basic life support (BLS) and advanced cardiac life support (ACLS).

> BLS is that phase of ECC that either (1) attempts to prevent arrested or inadequate circulation or respiration through prompt recognition and intervention, early entry into the EMS system, or both, or (2) attempts to support the circulation and respiration of a victim of cardiac or respiratory arrest through CPR. BLS can and should be initiated by any person present when cardiac or respiratory arrest occurs.
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> ACLS includes BLS plus the use of adjunctive equipment in supporting ventilation, the establishment of intravenous access, the administration of drugs, cardiac monitoring, defibrillation or other control of arrhythmias, and care after resuscitation. It also includes the establishment of communication necessary to ensure continued care. A physician must supervise and direct ACLS efforts (1) in person at the scene, (2) by direct communication, or (3) by a previously defined alternative mechanism such as standing orders.

Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, 268 JAMA 2171, 2177 (1992) [hereinafter *1992 Guidelines for CPR*]. For purposes of this Article, however, CPR refers to all actions designed to restore heart and lung function after respiratory or cardiac arrest, thus including both BLS and ACLS.

In 1960, CPR was introduced as a means of restoring circulation in cardiac arrest victims. Council on Ethical and Judicial Affairs, American Medical Association, *Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders*, 265 JAMA 1868, 1868 (1991) [hereinafter Council on Ethical and Judicial Affairs]. Since then, this procedure has become standard practice in hospitals. Donna L. Miller et al., *Cardiopulmonary Resuscitation: How Useful?*, 152 ARCHIVES INTERNAL MED. 578, 578 (1992). Although first endorsed as a medical procedure in 1962, medical practitioners reclassified CPR as an "emergency" procedure in 1965. The Ad Hoc Committee on Cardiopulmonary Resuscitation of the Division of Medical Sciences, National Academy of Sciences-National Research Council, *Cardiopulmonary Resuscitation*, 198 JAMA 372, 372 (1966) [hereinafter Committee on Cardiopulmonary Resuscitation]. In 1966, the American Heart Association, the American National Red Cross, the Industrial Medical Association, and the United States Public Health Service recommended and endorsed the use of CPR by all health professionals. *Id.* Thereafter, CPR became an accepted practice throughout the country despite the lack of widespread CPR training facilities and resources. *Standards and Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)*, 255 JAMA 2905, 2905 (1986) [hereinafter *1986 Standards and Guidelines for CPR*]. In accordance with such ubiquitous CPR acceptance and endorsement, many hospitals established the requirement of CPR performance in all cases, except where an order not to resuscitate existed. Alvin H. Moss, *Informing the Patient About Cardiopulmonary Resuscitation: When the Risks Outweigh the Benefits*, J. GEN. INTERNAL MED., July–Aug. 1989, at 349, 353. Finally, recognizing the need for consistent and universal CPR training, the Journal of the American Medical Association, in 1974, issued a supplement setting forth CPR guidelines and standards. *1986 Standards and Guidelines for CPR*, *supra*, at 2906. The 1986 guidelines were most recently updated at the 1992 National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care.

[3] Leslie J. Blackhall, *Must We Always Use CPR?*, 317 NEW ENG. J. MED. 1281, 1284 (1987). *See also* Niemann, *supra* note 2, at 1079 (reevaluation of CPR shows that CPR is

and was never intended to delay the impending death of a patient suffering from a terminal illness.[5] Despite the select patient population for which CPR was originally intended, hospitals[6] subsequently classified CPR as an "emergency" procedure for which consent is presumed and now require patients who experience cardiac arrest to be resuscitated in the absence of express contrary directives.[7] In fact, some state legislatures, in an effort to ensure the administration of CPR to hospital inpatients, have specifically enacted laws codifying the expectation of resuscitation.[8]

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a "desperate effort that will help only a limited number of patients"). Recent studies have revealed that "[d]espite advances in the technology of cardiopulmonary resuscitation ..., the percentage of patients successfully resuscitated in the hospital and discharged has remained essentially unchanged during the past 20 years." Robert Burns et al., *Prediction of In-Hospital Cardiopulmonary Arrest Outcome*, 149 ARCHIVES INTERNAL MED. 1318, 1318 (1989). Overall, CPR has a 15% chance of success; in particular patient categories, however, the success rate drops significantly. *See infra* notes 22–24 and accompanying text.

[4] The CPR procedure was originally "designed to resuscitate the victim of an acute insult, whether it be from drowning, electrical shock, untoward effect of drugs, anesthetic accident, heart block, acute myocardial infarction, or surgery." John H. Talbott, *Introduction* to JAMES R. JUDE & JAMES O. ELAM, FUNDAMENTALS OF CARDIOPULMONARY RESUSCITATION 1, 3 (1965). *See also 1986 Standards and Guidelines for CPR*, *supra* note 2, at 2907–08 (recommending CPR for coronary heart disease, drowning, electrocution, suffocation and drug intoxication). Indeed, victims of these traumas receive the most benefit from CPR treatment. Blackhall, *supra* note 3, at 1284.

[5] *See, e.g.*, Barbara B. Ott & Rose M. Nieswiadomy, *Support of Patient Autonomy in the Do Not Resuscitate Decision*, 20 HEART & LUNG 66, 66 (1991).

[6] Although some of the problems with DNR orders and arguments for an alternative policy may apply in contexts other than hospitals, such as nursing homes, this Article deals only with hospital inpatients. *See, e.g.*, Miller, *supra* note 2, at 581.

[7] PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 234 (1983) [hereinafter PRESIDENT'S COMMISSION]; Blackhall, *supra* note 3, at 1281; S. Buchanan et al., *Implementation of DNR Orders in the Department of Medicine, The Johns Hopkins Hospital*, 37 MD. MED. J. 461, 461 (1988).

Development of code teams which, pursuant to hospital policy, apply CPR to any person without a pulse, irrespective of the underlying illness, substantially accounts for the universal use of CPR. Blackhall, *supra* note 3, at 1282; George E. Taffet, *In-Hospital Cardiopulmonary Resuscitation*, 260 JAMA 2069, 2071 (1988). As further evidence of widespread CPR usage, one commentator observed:

> Almost every dying person is a potential candidate for CPR, because cardiopulmonary arrest is the final common pathophysiologic event in the dying process. Since 80 percent of the 2 million people who die in the United States each year die in acute or chronic facilities, approximately 1.6 million persons are potential candidates for CPR each year.

Stuart J. Youngner, *Do-Not-Resuscitate Orders: No Longer Secret, But Still a Problem*, 17 HASTINGS CENTER REP. (Feb. 1987), at 24. To a certain extent, the medical, ethical and legal principles that in uncertain life-threatening situations it is best to err in favor of saving a life than not has perpetuated the presumption in favor of CPR. PRESIDENT'S COMMISSION, *supra*, at 239. *See also* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 283 (1990) ("An erroneous decision to withdraw life-sustaining treatment ... is not susceptible of correction.").

[8] Some state laws expressly provide for presumed consent to CPR absent a DNR order. *See, e.g.*, 1992 FLA. LAWS ch. 199 (every person presumed to consent to CPR unless consent to DNR order in form required by statute); N.Y. PUB. HEALTH LAW § 2962.1 (Consol. Supp. 1989) (every person admitted to hospital presumed to consent to CPR unless DNR order exists which complies with state laws). Other state statutes, however, imply a presumption in favor of resuscitation by specifically authorizing physician implementation of Do Not Resuscitate orders. *See, e.g.*, GA. CODE ANN. § 31–39–4(a) (1991) (physician may issue DNR order subject to consent requirements); 1991 N.J. LAWS 201(16) (physician may institute DNR order if consistent with advance directive).

Not surprisingly, the pervasive, indiscriminate CPR usage resulting from the presumption of consent to CPR, coupled with physicians' concern about the inappropriate imposition of CPR on dying patients, prompted hospitals and physicians to devise ways to circumvent the CPR presumed consent model. Specifically, hospitals developed "Do Not Resuscitate" (DNR) policies,[9] whereby patients can overcome the presumption of resuscitation by explicitly consenting to the withholding of CPR in the event of cardiac arrest. Unfortunately, physicians have been reluctant to engage in the discussions necessary to obtain patient consent to DNR orders, and instead have increasingly exercised the therapeutic privilege which grants physicians great latitude in withholding potentially distressing information from patients. As a result, relatively few patients make informed decisions not to be resuscitated. This, in turn, has generated another problem. Dissatisfied with the CPR presumed consent/DNR actual consent model, and recognizing that CPR produces the best outcomes in patients for whom it was initially developed and recommended, a growing number of physicians support a "futility" exception to DNR policies, which allows physicians to withhold CPR from patients without their consent or knowledge if the physician determines that resuscitation would not be medically beneficial.

This result represents the worst scenario: some patients who would choose a DNR order if asked are resuscitated, while other patients who would opt for CPR are denied it. The presumption of patient consent to CPR and unilateral physician determinations that resuscitation need not be discussed with the patient strip patients of self-efficacy and self-determination. Accordingly, medical professionals must adopt a different approach to resuscitation and other end-of-life treatment decisions in order to restore and promote patients' independent decision-making with respect to such medical procedures. Although the futility exception might address the issue of over-resuscitation, it exacerbates the problem of patient non-participation in end-of-life medical

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[9] Traditional DNR policies (also known as "no-code" policies) define the "Do Not Resuscitate Order" as one which "specifically instructs that no blow to the chest, compressions of the chest, cardiac massage, defibrillation, administration of cardiotonic or vasoactive drugs, or any form of artificial ventilation be undertaken should cardiopulmonary arrest occur." Buchanan et al., *supra* note 7, at 461–62. Furthermore, some DNR policies allow for partial resuscitative techniques depending on the patient's condition. Carol Ann Mooney, *Deciding Not to Resuscitate Hospital Patients: Medical and Legal Perspectives*, 1986 U. ILL. L. REV. 1025, 1052. In addition, although professional literature states that a DNR order should not affect the provision of other care to the patient, confusion seemingly exists about whether and how a DNR order impacts the other care a patient should receive. *See, e.g.*, PRESIDENT'S COMMISSION, *supra* note 7, at 251. *See generally* Daniel P. Sulmasy et al., *The Quality of Mercy: Caring for Patients with "Do Not Resuscitate" Orders*, 267 JAMA 682 (1992). *See also* Troyen A. Brennan, *Do-Not-Resuscitate Orders for the Incompetent Patient in the Absence of Family Consent*, 14 LAW, MED. & HEALTH CARE 13, 16 (1986); Mooney, *supra*, at 1036; Donald J. Murphy, *Do-Not-Resuscitate Orders*, 260 JAMA 2098, 2098 (1988); Youngner, *supra* note 7, at 26. *Cf.* Cynthia J. Stolman et al., *Evaluation of the Do Not Resuscitate Orders at a Community Hospital*, 149 ARCHIVES OF INTERNAL MED. 1851, 1855 (1989). Some physicians do not know or agree that DNR orders were meant to cover only resuscitative measures. To some, a DNR order represents a decision to withhold or withdraw all or some means of life support. Giles R. Scofield, *Is Consent Useful When Resuscitation Isn't?*, 21 HASTINGS CENTER REP., Nov.–Dec. 1991, 28, 31. Overall, the conventional DNR order was not intended to implicate the provision of other treatment; however, a growing debate exists about whether a patient with a DNR order should otherwise continue to be vigorously treated. *See* Tom Tomlinson & Howard Brody, *Sounding Board, Ethics and Communication in Do-Not Resuscitate Orders*, 318 NEW ENG. J. MED. 43, 44 (1988); Youngner, *supra* note 7, at 31.

choices by granting physicians unilateral authority to make DNR decisions without regard to patient values or desires. Consequently, any change to resuscitation decision-making must address two problems: (i) inappropriate CPR over-use, and (ii) patient exclusion from CPR decision-making.[10] I suggest that the more appropriate solution to accomplishing these goals rests upon the abolition of the CPR presumed consent/DNR actual consent model in favor of a model that specifically calls for informed patient consent prior to the performance of CPR. Thus, as with any other invasive treatment with substantial risk and uncertain benefits, no hospital inpatient should be resuscitated without prior informed consent.

Part I of this Article surveys the recent studies of CPR success rates and discusses the ineffectiveness of the CPR presumed consent/DNR actual consent model. A careful review and analysis of the statistical data discloses that CPR is appropriate only for a discrete inpatient population in limited circumstances. Additional studies evidence that the CPR presumed consent/DNR actual consent model is ineffective in achieving patient involvement in resuscitation decisions. Part II provides an overview of the doctrine of informed consent as it has developed to protect patient self-determination and discusses why the CPR presumed consent/DNR actual consent model vitiates self-determination. More specifically, I argue that physicians should no longer rely on the emergency or therapeutic exceptions to informed consent in the context of making resuscitation decisions because such exceptions not only interfere with the *procedural* aspects involved in a patient's decision-making process, but also with the *substantive* aspects implicated in a patient's right to exercise informed consent. In addition, I contend that the law should not recognize a futility exception to the doctrine of informed consent and that physicians should not rely on futility determinations to deny patients the right to make their own decisions regarding resuscitation. Finally, in Part III, I propose that because the CPR presumed consent/DNR actual consent model inappropriately maximizes physician control of patient care and living wills are inadequate substitutes for competent patient decision-making, that resort to the conventional informed consent model will better enable patients to make their own end-of-life treatment decisions.

I. USE AND EFFICACY OF CPR AND DNR POLICIES

A. CPR Success Rates

Studies suggest that CPR is attempted in about one-third of the two million hospital deaths that occur annually in the United States.[11] A survey of

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[10] I suspect that many other end-of-life therapies are probably provided, reduced, or eliminated without prior patient consent in conjunction with a DNR order and without explicit patient discussion. *See, e.g.*, Linda M. Emanuel, *Does the DNR Order Need Life Sustaining Intervention: Time for Comprehensive Advance Directives*, 86 AM. J. MED. 87, 88 (1989) (both emergency and non-emergency life-sustaining treatments initiated with little or no discussion). Although the analysis set forth in this Article would also apply to these therapies, I will limit my discussion to CPR treatment.

[11] Council on Ethical and Judicial Affairs, *supra* note 2, at 1868. *See also* Susanna E. Bedell & Thomas L. Delbanco, *Choices About Cardiopulmonary Resuscitation in the Hospital*, 310 NEW ENG. J. MED. 1089, 1089 (1984) (study found that one-third of the patients who die at Beth Israel Hospital undergo CPR); Alfred L. George et al., *Pre-Arrest Morbidity and Other*

recent studies of CPR survival rates indicates that approximately one-third of the patients who receive CPR initially survive the resuscitation,[12] and about one-third of these patients, some of whom are resuscitated multiple times,[13] survive to discharge.[14] Among patients who receive CPR, but who do not live long enough to be discharged from the hospital, the time of survival generally ranges from two to fourteen days.[15] Furthermore, the risk of chronic vegetative state after CPR was estimated to be two percent in one study and approximately three percent in another.[16] In many disease categories, the CPR survival rate is nearly equivalent to the rate of chronic vegetative state following CPR.[17]

One commentator observed that the low success rate of CPR suggests "either poor resuscitation techniques or inappropriate selection of candidates for CPR."[18] A more accurate assessment is that CPR candidates are not "selected" at all, despite increasing evidence that certain patients have a remote chance of being successfully resuscitated. Many health care providers fail to advise patients of CPR survival rates and never give patients the opportunity to decline resuscitation.

Studies indicate that CPR survival rates vary depending on the patient's underlying condition[19] and may be affected by other factors such as location

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Correlates of Survival After In-Hospital Cardiopulmonary Arrest, 87 AM. J. MED. 28, 30 (1989) ("of all hospital deaths during the ... study period, 36% received CPR").

[12] Council on Ethical and Judicial Affairs, *supra* note 2, at 1868. *See also* Bedell & Delbanco, *supra* note 11, at 1090 (73 of 154 study patients initially survived; 48 subsequently died; and 25 were discharged); Burns et al., *supra* note 3, at 1319 (66 of 122 patients died following first resuscitation; 34% of the total number of patients alive 24 hours after resuscitation); Alfred L. George et al., *Pre-Arrest Morbidity and Other Correlates of Survival after In-Hospital Cardiopulmonary Arrest*, 87 AM J. MED. 28, 28 (1989) (in study of 140 patients, 55% successfully resuscitated initially).

[13] Burns et al., *supra* note 3, at 1319 (48% of initial CPR survivors resuscitated two or more times while 52% had subsequent DNR orders written). *See also* THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, DO NOT RESUSCITATE ORDERS 8 (2d ed. 1988) [hereinafter TASK FORCE] (in some reported cases, patients resuscitated as many as 52 times in a four to six week period before death).

[14] *See generally* Council on Ethical and Judicial Affairs, *supra* note 2, at 1868. *See also* Susanna E. Bedell et al., *Survival After Cardiopulmonary Resuscitation in the Hospital*, 309 NEW ENG. J. MED. 569, 574 (1983) (14% of resuscitated patients were discharged from the hospital); Burns et al., *supra* note 3, at 1319 (7% of resuscitated patients survived to discharge); George et al., *supra* note 11, at 30 (24.3% of study patients discharged alive); John J. Gregory & Dorethea Dunn, *Letters, In-Hospital Cardiopulmonary Resuscitation*, 261 JAMA 1579, 1579 (1989) (a 15.5% CPR survival rate: 24.5% for patients younger than age 70 and 12.7% for patients 70 and older); Taffett, *supra* note 7, at 2071 (10% of general hospital patients who receive CPR live to discharge).

[15] Blackhall, *supra* note 3, at 1283. *See also* George et al., *supra* note 11, at 30 (median interval between arrest and death three days; one-third died within 48 hours of resuscitation; six of 43 patients had prolonged hospital stays of up to 130 days).

[16] Blackhall, *supra* note 3, at 1283.

[17] *Id. See also* Bedell et al., *supra* note 14, at 571–72 (98% mortality rate for patients with severe left ventricular dysfunction before cardiopulmonary arrest; 93% mortality among patients with cancer; 97% mortality among patients with renal failure; 100% mortality for patients with pneumonia).

[18] Buchanan et al., *supra* note 7, at 461.

[19] Two specific diagnoses have been found to be associated with poor outcome: in Taffet's study, 37% of cancer patients were successfully resuscitated but did not survive to discharge; 45% of patients with sepsis were successfully resuscitated but only one patient lived to discharge. Taffet, *supra* note 7, at 2070. The researchers concluded that "patients with cancer or sepsis should be identified as CPR candidates only after considerable reflection." *Id.* at 2072.

within the hospital at time of arrest,[20] length of resuscitation attempt,[21] age,[22] and low birth weight.[23] Specifically, "patients with a relatively high burden of chronic disease rarely survive to hospital discharge after CPR (0% to 4%), whereas patients with acute coronary events and few other problems have a reasonable chance (12% to 32%) of surviving to hospital discharge."[24]

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[20] At least one study indicates that "arrest location in the ICU increase[s] the chances of initial survival of CPR 2.8 times." Burns et al., *supra* note 3, at 1320–21. *But see* Bedell et al., *supra* note 14, at 574 (location of in-hospital arrest did not affect outcome); George et al., *supra* note 11, at 31 (noting "no difference in the frequency of initial CPR success between intensive care unit patients and general ward patients ..., but patients admitted to intensive care units had significantly poorer short-term survival than general ward patients" probably due to the fact "that pre-arrest morbidity is a major determinant of CPR outcome.").

[21] One study found successful resuscitation in 86.7% of patients undergoing resuscitation for 15 minutes or less while only 26% of patients requiring CPR for more than 30 minutes survived. George et al., *supra* note 11, at 30. "Of the fifty patients who received CPR for 45 minutes or longer, only two survived to discharge." *Id. See also* Bedell et al., *supra* note 14, at 574 (suggesting that resuscitation attempts lasting more than thirty minutes should be abandoned, as they "appear to be uniformly unsuccessful").

[22] Advanced age is an extremely controversial factor that may contraindicate CPR. Taffet found that the age of 70 or greater was associated with poor outcome after in-hospital resuscitation. Taffet, *supra* note 7, at 2072. Sixteen percent of the resuscitation efforts in patients under 70 led to live discharge; none of the patients over 70 who were successfully resuscitated lived to discharge. *Id.* Table 4, at 2071. Patients between ages 40 and 70 have 2.7 times greater resuscitation survival. Burns, *supra* note 3, at 1320. Taffet does not recommend that CPR "be withheld from all patients older than 70 years; however, selection of candidates for this emotionally and physically injurious procedure must be made carefully." Taffet, *supra* note 7, at 2072. *See also* George et al., *supra* note 11, at 30 (concluding that "age was significantly associated with ultimate in-hospital mortality."); Gregory & Dunn, *supra* note 14, at 1579 (study finding a survival rate of 24.5% for patients younger than age 70 and 12.7% for patients 70 and older); David L. Schiedermayer, *The Decision to Forego CPR in the Elderly Patient*, 260 JAMA 2096, 2096 (1988) (concluding that "[w]hen the impact of increased age on survival was evaluated while controlling for the estimate of severity of illness, age alone persisted as a significant variable.").

[23] Recent studies indicate that CPR "is a nonvalidated therapy in babies of very low birth weight" and such babies

> should not be subject to a standing order for CPR during the first days of life. ... Another approach to CPR as a nonvalidated therapy would be to offer it to babies of very low birth weight as a potentially life-saving, but experimental therapy. Consent to a standing order for CPR could then be obtained after discussions with parents that focused on their willingness to allow their children to participate in clinical trials.

John D. Lantos et al., *Survival After Cardiopulmonary Resuscitation in Babies of Very Low Birth Weight*, 318 NEW ENG. J. MED. 91, 95 (1988).

Carol Ann Mooney's study of DNR policies found that most hospitals did not separately address DNR orders for children and the few that did basically adapted their policies for incompetent adults to children. Mooney, *supra* note 9, at 1047–48. This Article focuses on adults and not neonates or children. However, it is interesting to note the contrast between the proposal to treat CPR as experimental in neonates, with the proposal for no consent where a physician makes a futility determination in an adult. If CPR is experimentally used for neonates, physicians would be required to utilize the maximum level of informed consent procedures required by law.

[24] Murphy, *supra* note 9, at 2098. *See also* Blackhall, *supra* note 3, at 1283 (best resuscitation success associated with acute myocardial infarctions or complications due to anesthesia). George and his colleagues have concluded that

> Hospitalized patients most likely to benefit from CPR are those with sudden, unexpected circulatory collapse or abrupt respiratory insufficiency in the setting of acute cardiovascular illness. The least likely survivors are patients with irreversible organ failure, widespread malignancy, or other severely debilitating conditions. Outside these two clinical extremes are a large number of patients with

B. Patient Participation in DNR Decisions

Hospitals devised the DNR actual consent model to enable patients to refuse resuscitative measures. Appropriately, the widely understood goal of DNR policies is to ensure patient involvement in deciding the appropriate medical and ethical use of resuscitation *before* it is needed and *before* the patient becomes incompetent.[25] Accordingly, physicians are expected to obtain patient consent prior to implementing a DNR order;[26] however, hospital policies vary widely in their approach in enforcing this expectation.[27] Despite the

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> less well-defined prognoses and less predictable chances for long-term survival after resuscitation.

George et al., *supra* note 11, at 32 (citations omitted). *See also* Blackhall, *supra* note 3, at 1282–83 (conditions associated with poor CPR outcomes include cancer, repeated arrests, or chronic illness and total dependence; CPR almost never successful in patients with chronic debilitating illnesses).

It is important to note that these findings may be overly optimistic due to selection bias. For example, George notes that:

> A source of selection bias was recognized when the diagnostic categories of patients dying without resuscitation were reviewed. Among patients with do-not-resuscitate status, advanced malignancy, extensive cerebral injury, and end-stage heart disease are the most prevalent diagnoses. Exclusion of these poor prognostic subsets form the CPR study population constitutes a bias favoring survival rate. Despite this favorable selection bias, a significant majority (79%) of all attempted resuscitations in our study did not result in long-term patient survival.

George et al., *supra* note 11, at 32 (citations omitted).

[25] PRESIDENT'S COMMISSION, *supra* note 7, at 249–50; Buchanan et al., *supra* note 7, at 462; Andrew L. Evans & Baruch A. Brody, *The Do-Not-Resuscitate Order in Teaching Hospitals*, 253 JAMA 2236, 2236 (1985).

[26] New York Governor Mario Cuomo convened a task force in response to a 1982 grand jury investigation of DNR abuse in New York and mounting evidence of medically inappropriate resuscitation. TASK FORCE, *supra* note 13, at i. The task force observed that "unless proper consent to a DNR order has been obtained, the failure to provide CPR when it is medically indicated may subject a physician to civil liability, professional sanctions and, if sufficiently egregious, criminal penalties." *Id.* at 13.

[27] Notwithstanding that in 1974 the medical industry began encouraging health care facilities to develop DNR policies, hospitals were slow to respond. Tracy E. Miller, *Do-Not-Resuscitate Orders: Public Policy and Patient Autonomy*, 17 LAW, MED. & HEALTH CARE 245, 245 (1989). Hospitals' hesitant implementation of DNR policies prompted the Joint Commission on Accreditation of Health Care Organizations (JCAHO) (previously known as Joint Commission on Accreditation of Hospitals) to conduct a survey to determine the status of DNR policies in health care facilities. The survey disclosed that 30.7% had formal policies; 28% had informal policies; and 41% had no policies. *Id.* Moreover, although hospitals were most likely to have policies, only 56.9% had formal policies at the time of the survey. *Id.* A 1984 study indicated that the majority of the hospitals gave decision-making authority in the form of approval to the patient, if competent. Mooney, *supra* note 9, at 1041. These hospitals, however, were inconsistent as to whether patient "approval" must rise to the level of traditional informed consent. *Id.* at 1042. *See infra* notes 121–23 and accompanying text (discussing informed consent requirements). The study also indicated that a minority of hospitals view the DNR order as "a matter of the doctor's clinical judgment." Mooney, *supra* note 9, at 1038–39. Some of the policies required or encouraged physician "discussion" with the patient and family before entering the order. *Id.* at 1039–40. These hospital policies may have been revised since the 1988 institution of JCAHO standards requiring DNR policies.

Having set forth the substantive requirements for a DNR order, hospital policies procedurally require that the attending or primary physician write and sign the DNR order, which is to be included in the patient's chart. *Id.* at 1050. Additionally most hospital policies also require further documentation such as a summary of the patient's competence, and an indication of consent by or discussions with the patient, family or guardian. *Id.* at 1051.

articulated goals of DNR policies, studies indicate that very few patients are actually consulted regarding the DNR decision. As many as sixty-eight percent of patients dying in the hospital have a DNR order,[28] but in some studies, as few as twenty percent of these patients were consulted about the order.[29] Thus, the fundamental goal of DNR policies—patient participation in the DNR decision—is not being achieved, and the notion of actual consent to DNR orders is a fallacy.[30]

Physicians' general failure to raise the question of resuscitation until a patient's condition is so deteriorated that she is incompetent contributes to the lack of patient involvement in DNR decision-making. In one study, only twenty-six percent of the patients with DNR orders were competent at the time the order was authorized.[31] However, other studies have indicated that only about eleven percent of DNR patients have abnormal mental status at the time of hospital admission.[32] This change in mental status is probably attributable to the time lapse between admission and the DNR order discussion since physicians generally do not address resuscitation issues early in a patient's hospital stay. Instead, physicians typically raise the possibility of a DNR order seven days after admission and write the order in the patient's chart two days later.[33]

Physicians' unwillingness to seek input directly from the patient further perpetuates patient exclusion from CPR decision-making. Rather than initiating discussion concerning end-of-life treatment with the patient to gain insight into her[34] perspective, physicians usually prefer to discuss the possibility of a DNR

In 1988, JCAHO added to its accreditation standards the existence of a DNR policy. The standard requires "(a) hospitalwide policy on the withholding of resuscitative services from patients," and stipulates that the policy must describe:

> the mechanism(s) for reaching decisions about the withholding of resuscitative services from individual patients; the mechanism(s) for resolving conflicts in decision-making, should they arise; and the role of physicians and, when applicable, of nursing personnel, other appropriate staff, and family members in the decision to withhold resuscitative services.
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> The policy includes provisions designed to assure that patients' rights are respected when decisions are made to withhold resuscitative services.
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> The policy includes the requirement that appropriate orders be written by the physician primarily responsible for the patient and that documentation be made in the patient's medical record if resuscitative services are to be withheld.

JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS 90 (1988).

[28] Mark H. Ebell et al., *The Do-Not-Resuscitate Order: Outpatient Experience and Decision-Making Preferences*, 31 J. FAM. PRAC. 630, 630 (1990).

[29] *See, e.g.*, Bedell & Delbanco, *supra* note 11, at 1090; Stolman et al., *supra* note 9, at 1855. Tomlinson and Brody, proponents of a futility exception to obtaining consent to DNR orders, charge that studies such as these are unhelpful in determining the extent to which inappropriate exclusion of patient input is actually occurring because they fail to take into account what Tomlinson and Brody argue is legitimate failure to consult the patient or family where CPR would be of no medical benefit. Tomlinson & Brody, *supra* note 9, at 45.

[30] Evans & Brody, *supra* note 25, at 2238.

[31] Stolman et al., *supra* note 9, at 1854. *See also* Ebell et al., *supra* note 28, at 630.

[32] Bedell et al., *supra* note 14, at 235–36.

[33] *Id.* at 234. *See also*, Stolman et al., *supra* note 9, at 1853 (DNR patients in hospital for average of 10.8 +/- 16.4 days prior to DNR order).

[34] I have chosen to use the feminine pronoun to refer to the patient and the masculine pronoun to refer to the physician not only to emphasize a situation in which medical paternalism is most pervasive but also to highlight potentially acute differences between patient and physician values and valuative processes. Women outlive men by an average of 7.5 years and are therefore disproportionately represented among the old. Nancy S. Jecker, *Age-Based Rationing and Women*, 226 JAMA 3012 (1991). Of those 75 to 84, 62% are women; of those over 85, 71%

order with the family,[35] even if the patient is competent.[36] Thus, the patient is frequently excluded from the physician's decision to implement a DNR order, even when the physician does obtain DNR consent. Moreover, when the physician consults with a patient who does not accept his recommendation for a DNR order, the physician may not adhere to the patient's expressed desires.[37]

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are women. Emily Friedman, *Health Care's Changing Face: The Demographics of the 21st Century*, 65 HOSPITALS (Apr. 5, 1991). Currently, 84% of physicians are male. *Id.*

A number of factors make elderly women a particularly vulnerable group in society. The poverty among these women is the highest of any group in society, at 19%. Jecker, *supra*, at 3014. Older women's higher rates of widowhood not only frequently exacerbate their economic instability but also have a greater affect on their ability to maintain autonomy because they are more likely to define themselves in terms of their relationships to others. *Id.* Older women suffer on a number of levels from the pervasive sexism of society in general and the medical profession in particular. Within society-at-large, women are considered old earlier than men which causes them to experience not only the general stereotyping and loss of value associated with old age but the additional loss of societal value and status connected with women's loss of beauty and youth, as well as their sexuality and reproductive functions. *Id.* The history of medicine is a chronicle of the displacement of women as their own caregivers, the association of invalidism and femininity, and male supremacy in the female patient-physician relationship. *See generally* SUE FISHER, IN THE PATIENT'S BEST INTEREST: WOMEN AND THE POLITICS OF MEDICAL DECISIONS (1988); CHERYL BROWN TRAVIS, WOMEN AND HEALTH PSYCHOLOGY (1988).

Physicians today continue to engage socially-constructed notions of female passivity and dependency when treating female patients. Doubting the ability of women to make their own choices about health care, physicians commandeer these decisions and execute them from a biased perspective about their female patients' needs. Physicians continue to view women who attempt to assert their independence by seeking information, asserting their autonomy, and attempting to make their own choices as "problem patients." TRAVIS, *supra*, at 27. Although older women experience more medical symptoms than older men in their daily lives, Jecker, *supra*, at 3014, physicians are more likely to view women's physical complaints as symptomatic of emotional rather than physical problems, which may result in physicians' provision of inadequate care to women. *Gender Disparities in Clinical Decision Making*, 266 JAMA 559, 561 (1991).

For example, recent studies indicate that physicians pursue less aggressive treatment for women than they do for men diagnosed with certain diseases. *See, e.g.*, John Z. Ayanian & Arnold M. Epstein, *Differences in the Use of Procedures Between Women and Men Hospitalized for Coronary Heart Disease*, 325 NEW ENG. J. MED. 221 (1991) (women hospitalized for coronary heart disease undergo fewer major diagnostic and therapeutic procedures than men); Phillip J. Held et al., *Access to Kidney Transplantation*, 148 ARCH. INTERN. MED. 2594 (1988) (women undergoing renal dialysis 30% less likely to receive kidney transplant than men); Richard M. Steingart et al., *Sex Differences in the Management of Coronary Artery Disease*, 325 NEW ENG. J. MED. 226 (1991) (women with coronary heart disease undergo cardiac catheterization and coronary bypass surgery less often than men). The AMA has speculated that these differences may be attributable to social value judgments of gender or gender roles such as the perception that men have greater obligations than women or make greater societal as well as familial contributions. *Gender Disparities in Clinical Decision Making*, *supra*, at 560.

[35] Cynthia J. Stolman et al., *Evaluation of Patient, Physician, Nurse, and Family Attitudes Toward Do Not Resuscitate Orders*, 150 ARCHIVES INTERNAL MED. 653, 657 (1990) (30% of the physicians reported they were uncomfortable discussing resuscitation with patients but only 9% uncomfortable discussing issue with families).

[36] Bedell et al., *supra* note 14, at 235 (86% of patient families acted as surrogate decision-makers; patients involved in only 22% of the cases); Evans & Brody, *supra* note 25, at 2237 (in 13 of 72 decisions not to resuscitate, decision discussed with family and not patient, even though patient was competent); Stolman et al., *supra* note 9, at 1855 (as many as 57% of the patients competent at the time of the DNR order may not have been given opportunity to participate in the decision).

[37] Most of the studies of DNR decision-making include cases where the patient's decision was overridden by the physician. *See, e.g.*, Bedell et al., *supra* note 17, at 235 (for five patients who had requested resuscitation, the family and physician agreed on the DNR order after the patient became unresponsive and unable to participate in the decision); Evans & Brody, *supra* note 25, at 2238 (five patients in study designated to "receive basic CPR without active

Studies indicate that when a disagreement exists between patient and physician, the ultimate decision regarding resuscitation almost always comports with the physician's views.[38]

This lack of patient involvement in DNR decision-making is of particular concern because recent studies indicate that patients have specific opinions[39] about resuscitation, and that family members and health care professionals do not accurately predict patients' desires about resuscitation.[40] Studies reveal that although many patients have specific feelings about resuscitation,[41] they will not

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medications and without intubation even though decision had been made to resuscitate...." For example: two patients had requested resuscitation but the physicians felt prognosis was poor; one incompetent patient's family had directed the physician to do everything but had not visited the patient since admission to the hospital); Stolman et al., *supra* note 35, at 658 (study included six patients who insisted on resuscitation which would be futile so physicians "bypassed the competent patient and obtained consent from the family for the DNR order.").

[38] David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101, 2102 (1992). The author speculates that physicians' values dominate the decision-making for a number of reasons: physicians do a poor job of eliciting patient values and preferences and are therefore unaware of what the patient really wants; the physician waits to raise the resuscitation issue until the patient is incompetent; the physician chooses to discuss the issue with the family rather than the patient; physicians believe that patients cannot understand the medical complexity of the issues. *Id.* According to the author, physicians are more inclined to talk with patients most like themselves. "Patients who seem more intelligent and better educated receive more time and more explanations from their physicians." *Id.* Other reasons why physicians dominate treatment decisions may be that the dialogue between patient and physician occurs in such a way that the physician presents the information to the patient to influence the patient's decision; physicians may simply override patient choices; and physicians can override requests for futile treatment. *Id.* at 2102–03. *See also* Cathy J. Jones, *Autonomy and Informed Consent in Medical Decision-Making: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 397–406 (1990) (discussing how physicians "slant" information to ensure that the patient chooses the treatment alternative desired by the physician). Many physicians see informed consent as a charade because of their perceived ability to manipulate consent by how they divulge the information to be discussed. Howard Brody, *Transparency: Informed Consent in Primary Care*, 19 HASTINGS CENTER REP., Sept.–Oct. 1989, at 5.

[39] *See generally* Howard Brody, Commentary, *Do-Not-Resuscitate Order*, 31 J. FAM. PRAC. 635 (1990). The results of one study showed that 93.9% of older patients preferred to preserve a good quality of life over a life extended without regard for quality. Ebell et al., *supra* note 28, at 632. The study also indicated that 6.1% preferred to live as long as possible, regardless of quality. *Id.* "The presence of increasing age, dementia, drug use, severe pain, alcoholism and wheelchair use all reduced the likelihood that respondents would recommend resuscitation...." *Id.* at 633. Another study showed that 81.5% of patients would want CPR if survival is greater than 90% while 37% would want CPR if survival is less than 10%. Miller et al., *supra* note 2, at 581. Most patients had learned of CPR from television (only 10% had learned about it from a physician) and had the impression of a CPR survival rate of at least three times higher than actual survival rates. *Id.* at 581–82. *See also*, Ronald S. Schonwetter et al., *Educating the Elderly: Cardiopulmonary Resuscitation Decisions Before and After Intervention*, 39 J. AM. GERIATRIC SOC'Y 372, 375 (1991).

[40] Bedell & Delbanco, *supra* note 11, at 1091. Eight of 25 patients who had been resuscitated had not desired CPR and did not want it in the future. Only one of the 16 physicians caring for these patients believed the patient did not want to be resuscitated. *Id.* "[P]hysicians are more likely to recognize the preferences of patients who desire resuscitation than preferences of those who do not." *Id.* at 1092. In a study by Uhlmann and Pearlman, neither physicians nor nurses accurately predicted patient preference. Richard F. Uhlmann et al., *Understanding of Elderly Patients' Resuscitation Preferences by Physicians and Nurses*, 150 W.J. MED. 705, 706 (1989). Nurses were more likely than physicians to think that patients preferred resuscitation. *Id.* at 707. Overall, the agreement between what patients actually wanted and what health care professionals thought the patients wanted for a variety of life-sustaining treatments ranged between 59–84% for physicians and 53–78% for nurses. *Id.* at 706.

[41] In a study by Stolman of competent patients with DNR orders, only three of 97 patients did not want to participate in the decision-making; 64 wanted shared decision with family and/or physician; and 14 wanted to decide with the physician alone. Stolman et al., *supra*

initiate discussion with their physicians, but rather, generally wait for the physician to broach the subject,[42] which rarely occurs.[43] Poor communication and lack of understanding between the physician and patient also interfere with effectuating patient desires regarding CPR treatment. Indeed, physicians' frequent use of obtuse language or euphemisms to discuss a poor diagnosis or end-of-life treatment[44] often results in situations where physicians believe they have discussed resuscitation with patients who do not recall that such discussion has occurred.[45]

The reasons for physicians' avoidance of resuscitation discussions with their patients are partially rooted in the historically paternalistic and authoritarian model of the patient-physician relationship.[46] Some physicians simply feel that the resuscitation decision is a medical one solely within the physician's discretion.[47] A large number of physicians believe that the patient's realization that her condition is terminal coupled with discussion of resuscitation would provoke anxiety that could cause the patient's condition to further deteriorate.[48] Other physicians, however, seeking certainty of prognosis, will not advise against resuscitation even in those cases where the patient's condition is hopeless as long as there exists the remotest statistical probability of survival.[49]

Physicians' general hesitation to counsel patients about CPR decisions may also stem from their tendency to equate a patient's death with professional failure. By postponing the discussion of end-of-life treatment decisions with patients and their families, physicians can avoid admitting their failure to the patient and their families (and to themselves).[50] Physicians' fear and misunderstanding of potential civil and criminal liability from withholding or withdrawing end-of-life treatment also causes them to carefully sidestep withdrawal of treatment discussions with patients. Accordingly, many

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note 35, at 654–55. Twenty-four patients had living wills but only six had been recorded in the patients' records and only 10 physicians were aware of the living wills. *Id.* at 655.

[42] Schonwetter et al., *supra* note 39, at 375.

[43] Ebell et al., *supra* note 28, at 634.

[44] For example, terms such as "extraordinary measures" and "heroics" are vague and lead to misunderstanding about what actually is being discussed. The term "aggressive therapy" is also fraught with ambiguity: "'Aggressive' therapies would better be called 'invasive' therapies since they range from surgery through cardiopulmonary resuscitation to nasogastric or intravenous feeding, and have in common *invasion* of the patient's bodily integrity." Kathleen Nolan, *In Death's Shadow: The Meanings of Withholding Resuscitation*, 17 HASTINGS CENTER REP., Oct.–Nov. 1987, at 9, 13.

[45] Stolman et al., *supra* note 35, at 657 (58% patients said resuscitation discussed compared with 73% of their physicians). Wanzer observes, however, that "[d]isease, pain, drugs, and a variety of conditions altering mental states may severely reduce the patient's capacity for judgment." Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 955 (1984) (discussing David L. Jackson & Stuart Youngner, *Patient Autonomy and "Death with Dignity": Some Clinical Caveats*, 301 NEW. ENG. J. MED. 404–08 (1979)).

[46] *See, e.g.*, JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 1–29 (1984) (summarizing the history of the patient-physician relationship as one of authoritarian values in which physicians purported to act in patients' welfare by not recognizing patient rights to make health care decisions).

[47] Bedell & Delbanco, *supra* note 11, at 1091.

[48] *Id.*; John LaPuma et al., *Advance Directives on Admission*, 266 JAMA 402, 403 (1991); Stolman et al., *supra* note 9, at 1855; Youngner, *supra* note 7, at 28.

[49] Wanzer et al., *supra* note 45, at 956.

[50] *See id.*

physicians continue treatment against the patient's or family's expressed wishes.[51]

The question of "eligibility" for withholding potentially life-saving treatment causes a final point of confusion among physicians which results in their inconsistent application of DNR policies to patients. Many DNR policies require that the physician, in conjunction with a DNR order, document that the patient is terminally ill or dying, or that life-saving treatment would be futile.[52] Indeed, under many states' living will laws, a patient's directive to discontinue treatment does not become effective unless the physician documents that the patient is terminally ill.[53] In these states, a DNR order could not be implemented

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[51] Miller, *supra* note 27, at 247; Wanzer et al., *supra* note 45, at 956.

[52] Stolman et al., *supra* note 9, at 1851. In the Stolman study, reasons for DNR orders included 32.7% because of imminent death and 31.9% because of limited life expectancy. *Id.* at 1854. A 1984 survey of three teaching hospitals' DNR policies found that about 50% of the policies specified what conditions must precede a DNR order (usually terminal illness) while the remaining half made no such statements. Mooney, *supra* note 9, at 1037–38.

In *In re* Browning, 568 So. 2d 4, 9 (Fla. 1990), the 90 year-old stroke victim's living will could not be relied upon to withdraw nutrition and hydration because she could live for an indeterminate time with treatment, and therefore death was not imminent. It is unclear whether living will laws were influenced by hospital policies or vice versa. The common law does not require a terminal condition or imminent death for withholding of life-sustaining treatment. *See, e.g., id.* at 10 ("A competent individual has the constitutional right to refuse medical treatment regardless of his or her medical condition"); State v. McAfee, 385 S.E.2d 651, 652 (Ga. 1989) (non-terminally ill patient to whom Living Will Act does not apply may be disconnected from ventilator); McKay v. Bergstedt, 801 P.2d 617, 624 (Nev. 1990) (even if not terminally ill, irreversibly ill person suffering physical and mental pain and suffering may choose termination of respirator); *In re* Peter, 529 A.2d 419, 423 (N.J. 1987) (all mentally competent patients, terminally ill or not, have right to choose whether or not they want life-sustaining treatment); Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677 (App. Div. 1987) (33-year-old man in persistent vegetative state may decline continuing treatment "under circumstances considered degrading, demeaning and totally nonpurposeful"). Physicians' needs for certainty of hopelessness before they are willing to approach a patient about a DNR order may result from the conservatism of many hospitals' DNR policies.

[53] Although the language of the statutes differs, at least 13 states have statutes which limit the effect of living wills to terminal conditions only: ALA. CODE §§ 22–8A–2–4 (1991) (patient must be terminally ill or injured, where terminally ill means that death is imminent or the condition is hopeless unless the patient is artificially supported, *but* a life-sustaining procedure is defined as one which will only "prolong the dying process" where according to a physician the patient will die "whether or not the procedure or intervention is utilized"); ILL. REV. STAT. ch. 110 1/2, par. 701–702 (1991) (terminal condition is one where death is imminent, and dying process would be prolonged by "death delaying procedure"); IND. CODE ANN. § 16–8–11–9 (Burns 1991) (terminal condition is one from which there can be no recovery and as a result of which, without life-supporting treatment, death will occur shortly); KY. REV. STAT. ANN. § 311.622 (Baldwin 1992) (terminal condition "will result in death within a relatively short time" and the dying process would be prolonged by the use of life-support); MD. CODE ANN. HEALTH–GEN. § 5–601 (1991) ("The Living Will Law, this subtitle, applies only when death is imminent as a result of a terminal illness," which is such that death is imminent, and "from which, despite the application of life-sustaining procedures, there can be no recovery."); 1992 Minn. Laws 535 (terminal condition as condition of execution of directive; however, the actual Health Care Declaration allows the patient to "state the circumstances under which this declaration applies," potentially expanding the definition of a terminal condition); MO. REV. STAT. § 459.010 (1990) (terminal condition is an incurable or irreversible state from which death will result shortly whether or not treatment is used); MONT. CODE ANN. § 50–9–102 (1992) (compliance with declaration for withholding life-support appropriate for patient with terminal condition, which is an incurable or irreversible state which will result in death without the administration of life-sustaining treatment); N.D. CENT. CODE §23–06.4–03 (1991) (terminal condition and imminent death with or without life-sustaining treatment necessary); UTAH CODE ANN. § 75–2–1103 (1992) (requirement for effect of living will is terminal condition, defined as condition which would result in death regardless of the application of life

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support); VT. STAT. ANN., tit. 18, § 5251–52 (1992) (terminal state is an incurable condition which will result in death regardless of the use of life-sustaining processes); WIS. STAT. § 154.03 (1990) (terminal condition necessary for withdrawal of life-sustaining procedures which would prolong dying); WYO. STAT. § 35–22–101 (1991) (terminal condition is one from which "there can be no recovery and death is imminent"). Terminal condition is thus not defined by any definitive characteristic or quantitative imminence of death, but through subjectivity and interpretation of the statutes' language. Often the status depends on the effectiveness of life-sustaining procedures, and whether or not the application of such treatment is considered as part of the evaluation of a patient's chances of survival.

Although the statutes above may be construed to include chronic illnesses or unconscious states, 17 states have enacted statutes which explicitly permit living wills to be effective for patients in permanent unconsciousness, coma or persistent vegetative state (PVS), in addition to those with terminal conditions. ARK. CODE ANN. § 20–17–201 (Michie 1992) (patient must be terminally ill or permanently unconscious, where terminally ill means "an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, ..., result in death within a relatively short time," and permanently unconscious is defined as "a lasting condition, indefinitely without change in which thought, feeling, sensations, and awareness of self and environment are absent."); CAL. HEALTH & SAFETY CODE §§ 7185.5–.6 (West 1991) (Natural Death request valid in situations of terminal conditions or permanent unconscious conditions, in which permanent unconscious condition indicates the incurable, irreversible state of irreversible coma or persistent vegetative state, and a terminal condition is one that will result in death in a relatively short time without life-sustaining treatment); FLA. STAT. ch. 765.101–102 (1992) (patient must have a terminal condition, which is defined as "a condition caused by injury, disease, or illness from which there's no reasonable probability of recovery and which, without treatment, can be expected to cause death, or a persistent vegetative state"); GA. CODE ANN. § 31–32–1 (Michie 1992) (right to make a directive to withhold or withdraw life-sustaining treatment in "event of terminal condition, a coma, or a persistent vegetative state," where death will result without life-supporting procedures); IDAHO CODE § 39–4504 (1991) (living will effective for terminally ill or patient diagnosed in persistent vegetative state); 1990 La. Acts 749 (patient qualified for effect of living will is one diagnosed with a terminal condition or one in "a continual profound comatose state with no reasonable chance of recovery"); ME. REV. STAT. ANN. tit. 18–A, § 5–701 (West 1991) (terminal condition or persistent vegetative state a requirement for effect of living will); MISS. CODE ANN. §§ 41–41–107 & 113 (1991) (declaration applicable for patient with "a terminal physical condition which causes ... severe distress or unconsciousness," and without life-support techniques the patient will not "regain consciousness or a state of health that is meaningful to the declarant."); N.H. REV. STAT. ANN. § 137–H:1 (1991) (requirement of terminal condition or state of permanent unconsciousness); 1991 N.J. Laws 201 (requires terminal condition or permanent unconsciousness, which "includes without limitation a persistent vegetative state or irreversible coma"); OHIO REV. CODE ANN. § 2133.01 (Baldwin 1991) (requirement of terminal condition or permanent unconsciousness, where terminal condition is one which will result in death in a short time without life-support, and permanently unconscious state is characterized by the patient's condition of being "irreversibly unaware of himself" and the "total loss of cerebral cortical functioning"); 1992 Okla. Sess. Laws 1893 (declaration is called "Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act" and permits withholding or withdrawal of life-sustaining treatment when the patient's prognosis is death within six months, even with the application of life support; persistently unconscious is an irreversible condition "in which thought and awareness of self and environment are absent"); S.C. CODE ANN. § 44–77–210–50 (Law. Co-op. 1991) (terminal condition or permanent unconsciousness the criteria for valid declaration, where permanent unconsciousness is persistent vegetative state or another condition in which the patient has "no neocortical functioning, but only involuntary vegetative or primitive reflex functions controlled by the brain stem"; prognosis must be that death will occur whether or not life-sustaining procedures are used, *but* a terminal condition is defined as one which will "cause death within a reasonably short period of time if life-sustaining procedures are not used"); S.D. CODIFIED LAWS ANN. § 34–12D–1 (1992) (terminal condition is an incurable and irreversible condition or a coma or any other state of permanent unconsciousness, and life-sustaining treatment will postpone death); TENN. CODE ANN. § 32–11–103 (1991) (terminal condition defined as "any disease, illness, injury or condition, including, but not limited to, a coma or persistent vegetative state"); 1992 Va. Acts 748 (definition of terminal condition includes persistent vegetative state); W. VA. CODE § 16–30–2–3 (1992) (allows for withholding or withdrawal of life-support treatment which would merely prolong the dying process of patients with terminal condition or maintain patients in a persistent vegetative state).

solely on the basis of the living will[54] if the physician is unwilling or unable to document that the patient's condition is terminal.[55]

Many patients[56] and physicians[57] deem "quality of life" a legitimate basis for a DNR order.[58] However, the extent to which this basis is recognized by hospital policy and courts is unclear, particularly when the patient is incompetent.[59] Many argue that a quality of life decision, in contrast to an assessment that the patient is terminally ill or dying, is a value judgment solely within the patient's discretion for which there can be no substitute when the patient becomes incompetent.[60] Evidence indicates, however, that the

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Some of these statutes were only recently expanded to include these conditions. (*e.g.*, California, 1991; Georgia, 1992; New Hampshire, 1991; Virginia, 1992).

[54] A DNR order may still be permissible under state common law, another state statute, or a state or federal constitutional privacy right or liberty interest. A patient's living will which requests withdrawal or withholding of treatment even if the patient is not terminally ill may serve as evidence of the patient's intent under one of these other legal bases for a DNR order.

[55] Statutory definitions of terminal condition are frequently too broad to provide physicians with sufficient guidance in determining when a living will becomes effective. Ben A. Rich, *The Values of History: A New Standard of Care*, 40 EMORY L.J. 1109, 1114 (1991).

[56] Ebell et al., *supra* note 28, at 634. *See also* Stolman et al., *supra* note 35, at 656 (50% of patients identified quality of life as reason for DNR decision).

[57] Stolman et al., *supra* note 9, at 1854 (28.7% physicians documented unacceptable quality of life as reason for DNR order).

[58] George Annas, a law professor in bioethics, identifies two situations in which a DNR order is appropriate: 1) Poor prognosis—where there is a terminal irreversible illness and CPR will do no good, the patient will die soon anyway and nothing can be done to stop the disease and 2) Poor quality of life—where the patient's quality of life is so poor that preventing death by CPR is not justified. George J. Annas, *CPR: When the Beat Should Stop*, 12 HASTINGS CENTER REP., Oct. 1982, at 30, 31.

[59] Courts are generally supportive of competent patients' requests to refuse treatment for quality of life reasons. *See, e.g.*, Bouvia v. Superior Ct. of Cal., 179 Cal. App. 3d 1127 (Ct. App. 1986); McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990). Courts are not consistent, however, in dealing with refusal of treatment requests on quality of life grounds for incompetent patients. *See, e.g.*, Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990) ("[A] State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual."); Brophy v. New Eng. Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986) ("It is antithetical to our scheme of ordered liberty and to our respect for the autonomy of the individual for the State to make decisions regarding the individual's quality of life. *It is for the patient to decide such issues.*") (emphasis added). *Cf.* Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677, 691 (App. Div. 1987) (absence of terminal illness may reinforce decision to withdraw treatment because of potentially long and indefinite period of suffering); *In re* Guardianship of L.W., 482 N.W.2d 60, 74 (Wis. 1992) (as the quality of life diminishes the state's interest in preserving life decreases).

New York's DNR statute appears to recognize a quality of life basis for a DNR order. When judicial approval is sought because no surrogate is available to consent to a DNR order, a judgment to issue a DNR order may be rendered if the "patient has a terminal condition, is permanently unconscious, or *resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient.*" N.Y. PUB. HEALTH LAW § 2976.1 (Consol. 1992) (emphasis added).

[60] For example, Professor Annas argues:

> [W]hen DNR decisions are based on quality of life, *only*, the patient's own view should be relevant. Physicians obviously have no special expertise in this area and since most DNR decisions are probably based on quality-of-life assessments, it is critical that their nonmedical nature be recognized so that such decisions are based on proper criteria and made by those qualified to assess the situation. Only in this way can we protect the patient's dignity and autonomy.

Annas, *supra* note 58, at 31 (emphasis added).

physician's judgment about the patient's quality of life frequently clouds his determination of whether CPR should be provided to the patient. For example, the presence of nonmedical factors such as mental retardation, dementia, age, institutionalization, or a history of violent crime and drug abuse have been found to affect physician decisions to resuscitate patients.[61]

C. Physicians Debate Futility

Proposals to create a futility exception to the requirement of informed consent to DNR orders have sparked much controversy among medical professionals. A growing segment of the medical community, armed with data about the low CPR success rates in certain patient populations, argues that CPR is clearly "futile"[62] in certain situations. Thus, they conclude that CPR should not even be offered to such a patient or surrogate decision-maker as a treatment option.[63] Futility proponents further argue that physicians should have authority to refuse to comply with a patient request for CPR which the physician deems futile.[64] Futility critics, on the other hand, assert that the futility exception undermines patient autonomy and will lead to a return to a paternalistic physician-patient relationship[65] by removing critical issues concerning CPR treatment from the purview of patient decision-making.

Tomlinson and Brody, proponents of the futility exception, identify three rationales for the DNR order: (i) no medical benefit; (ii) poor quality of life after CPR; and (iii) poor quality of life before CPR.[66] When no medical benefit can result from CPR, they and others conclude that patient consent to a DNR

The concern is that when a surrogate is deciding on behalf of an incompetent patient, the patient's own values about quality of life (assuming they are known) will in reality become secondary to "the value of the life of the patient to the community." Susan Braithwaite & David C. Thomasma, *New Guidelines on Foregoing Life-Sustaining Treatment in Incompetent Patients: An Anti-Cruelty Policy*, 104 ANNALS INTERNAL MED. 711, 714 (1986). Family members or other surrogates, physicians, and courts are all susceptible to such an abuse of decision-making power.

[61] Ebell et al., *supra* note 28, at 630 (citing Neil J. Farber et al., *Cardiopulmonary Resuscitation: Patient Factors and Decision Making*, 144 ARCHIVES INTERNAL MED. 2229 (1984)).

[62] The definition of futility varies. *See infra* text accompanying note 82. Veatch and Spicer discuss two types of futile care: "1) care that produces no demonstrable effect; and 2) care that produces an effect that is believed by the speaker to be of no net benefit." Robert M. Veatch & Carol M. Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J. LAW & MED. 15, 16 (1992). They state that treatment which is subjectively judged to be producing no benefit "should not be referred to as futile on *medical* grounds." *Id.* at 16–17.

[63] *See* Howard Brody & Tom Tomlinson, Letters, *In-Hospital Cardiopulmonary Resuscitation*, 261 JAMA 1579, 1581 (1989); Buchanan et al., *supra* note 7, at 462; J. Chris Hackler & F. Charles Hiller, *Family Consent to Orders Not to Resuscitate*, 264 JAMA 1281, 1282 (1990); Murphy, *supra* note 9, at 2099; Stolman et al., *supra* note 35, at 658; Tomlinson & Brody, *supra* note 9, at 43.

[64] Some of the DNR studies indicate that physicians currently override patient requests for CPR with which they disagree. *See supra* note 37. This position is contrary to that taken by the President's Commission which recommended that when the patient requests CPR which in the physician's judgment would be of no medical benefit, the patient's rights of self-determination would supersede. PRESIDENT'S COMMISSION, *supra* note 7, at 245.

[65] Tom Tomlinson & Howard Brody, *Futility and the Ethics of Resuscitation*, 264 JAMA 1276, 1276 (1990).

[66] Tomlinson & Brody, *supra* note 9, at 44.

order is unnecessary.[67] A determination that CPR has no medical benefit for the patient is predicated on the physician's conclusion that CPR will do no good or will do more harm than good.[68] Thus, futility proponents argue that communication with the patient or family about the DNR order "should aim at securing an understanding of the decision the physician has already made,"[69] since the decision is based on medical expertise,[70] rather than eliciting the patient's values or involving the family in the decision.

Tomlinson and Brody further acknowledge three value judgments the physician must make in reaching a conclusion of futility. First, the physician must identify the goal of CPR and judge futility against this goal. Second, the physician must determine that the treatment will not accomplish this goal.[71] Finally, the physician's judgment that treatment will do no good is not a judgment of certainty, but one of probability: The physician decides that the probability is not worth pursuing.[72]

In addition, despite recognizing that "[e]ven the most doomed CPR attempt might have symbolic or psychological significance[73] for the patient or family, who perhaps think it spiritually imperative to 'never give up,'"[74] Tomlinson and Brody assert that the physician's moral autonomy in deciding the purposes for which his skills will be used outweighs the patient's or family's

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[67] Hackler & Hiller, *supra* note 63, at 1282. Hackler and Hiller would appear to go even further than eliminating family discussion when treatment is clearly futile. *Id.* They also propose that hospital policy be changed so that when treatment is not clearly futile, discussion with patient or family should still be required but *family* agreement to the treatment plan should not be required in every case. *Id.* The authors explain that they are

> not suggesting that the proper role of surrogates be reduced. ... But when the family does not and will not deliberate in an appropriate manner, or when their views about suffering and quality of life differ substantially from those of most reasonable people (and there is no indication that the patient shared such views), then physicians should not be forced by hospital policy to adhere to family preference.

Id. at 1283.

Donald Murphy has proposed that physicians should have the authority to make unilateral DNR decisions for residents of long term care facilities "who are severely demented and for those chronically ill patients for whom CPR is believed to be futile." Murphy, *supra* note 9, at 2098. The severely demented category of patients to whom the unilateral DNR policy applies encompasses Tomlinson and Brody's poor quality of life after CPR category, even if CPR is not otherwise futile. *Id.* at 2100. Murphy recognizes that this approach can be criticized as paternalistic; he responds that paternalism may be justified in certain situations—where it protects patients from harm. *Id.* at 2100.

[68] Tomlinson & Brody, *supra* note 65, at 1277.

[69] *Id.* Allan S. Brett & Lawrence B. McCullough, *Sounding Board, When Patients Request Specific Interventions*, 315 NEW ENG. J. MED. 1347, 1350. The physician is obligated to "offer an explanation and diagnostic or therapeutic alternatives." *Id.*

[70] Tomlinson & Brody, *supra* note 9, at 44. When a DNR order is justifiable for quality of life reasons, rather than a physician's determination of futility, Tomlinson and Brody believe the patient has the legal and moral right to accept or refuse treatment in accordance with his or her values and that the DNR order requires patient consent. *Id.*

[71] Tomlinson & Brody, *supra* note 65, at 1277. These judgments necessarily incorporate the professional's views about risk taking and about the significance of the benefit being pursued. *Id.*

[72] *Id.*

[73] Tomlinson and Brody note that subjective symbolic value can exist anywhere and could make any limits on patient demands impossible to justify. *Id.* at 1278.

[74] *Id.*

pursuit of hope.[75] They contend that, since the physician has the authority to make these kinds of value judgments in other areas of medicine when deciding what treatments to offer a patient, he also must have the authority to do so in deciding whether to offer CPR.[76]

In support of this position, futility proponents identify two bases for the physician's authority over treatment: (i) the physician's judgment that a treatment is futile absolves doctors from the moral obligation to provide care and patients from the obligation to seek care,[77] and (ii) the principle of autonomy, which allows patients to refuse any procedure or choose among different beneficial procedures, does not allow them to demand nonbeneficial and potentially harmful procedures.[78] The proponents of the futility exception appear to disagree only on the question of whether the patient or family need be advised at all of the physician's decision that the patient will not receive CPR. Some proponents contend that because futility is a medical judgment, the patient's and family's values are not relevant factors, and therefore, the DNR order need not be discussed with the patient or family.[79] Tomlinson and Brody

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[75] *Id.* Veatch and Spicer explicitly reject this argument as making no sense "when society is granting the authority to make decisions about whether someone else's life is worth prolonging." Veatch & Spicer, *supra* note 62, at 27. They argue that society would not grant a monopoly to physicians to control access to life-prolonging technology and then "license the profession to choose death when we consider life worth pursuing." *Id.*

[76] Tomlinson & Brody, *supra* note 65, at 1277. The authors give the example of the physician who weighs the risks and burdens of a patient's life with angina against death in surgery and decides not to offer surgery as a treatment. *Id.* They reject the argument that CPR is different because the alternative is certain death, saying this "difference would assume that whenever there is the merest possibility of extended life, the decision belongs with the patient." *Id.* at 1278. When a patient falls within the "no medical benefit" category, "the value that the patient or the patient's family might place on the patient's life after arrest is irrelevant" because the patient's life will not be meaningfully prolonged. The authors contend that the real question is not whether value judgments can be placed on the provision of CPR but which value judgments the physician may use in deciding to meet patient demands. *Id.* "Certain kinds of symbolic values must be judged worth recognizing and others not. This change in direction signifies a turn away from *individual* conceptions toward *social* conceptions of reasonableness and of the worthy ends of medicine." *Id.*

[77] John D. Lantos et al., *The Illusion of Futility in Clinical Practice*, 87 AM. J. MED. 81, 81 (1989). The authors contend that classical Greek and Jewish moral law and Christian ethics agree that the moral obligations of physician and patient change when therapy is deemed futile and that no moral obligation exists to pursue treatments which merely prolong the dying or interfere with the natural dying process. *Id.* at 81–82.

[78] Blackhall, *supra* note 3, at 1283. *See also*, Brody & Tomlinson, *supra* note 63, at 1581; Lantos et al., *supra* note 77, at 82; Tomlinson & Brody, *supra* note 65, at 1278. Brett and McCullough view patient autonomy as encompassing a negative right, that unwanted therapy not be imposed, and a positive right, that the patient's selected treatment be provided. Brett & McCullough, *supra* note 69, at 1347. They observe that most of the common law has focused on defining the patient's negative right, the right to refuse treatment. According to the authors a tension exists when a patient attempts to exercise the positive right by requesting treatment that is medically inappropriate. They contend that the legal system promotes autonomy as the predominant value in medical decision-making, and that if patient autonomy is always overriding, patient determination of best interest would always rule. *Id.* at 1349.

The question becomes what, if any, limits exist on a patient's exercise of his or her positive rights? Brett and McCullough identify at least two limits on patient autonomy: the physician's autonomy or moral principles, and an established or theoretical medical basis for the patient's request. *Id.* As a necessary part of the physician-patient dyad, the physician's "moral and medical values obviously are not extraneous factors in clinical decision-making." *Id.* "[I]f the physician facilitates the patient's request for an unnecessary or harmful intervention to satisfy a principle of respect for patient autonomy, the action reciprocally undermines the physician's autonomy." *Id.*

[79] Hackler & Hiller, *supra* note 63, at 1282.

distinguish between whether CPR is offered and whether CPR is discussed with the patient or family, concluding that the patient has a "right to information about the plan of care, and a DNR order is a significant aspect of that plan,"[80] although she is not permitted to actually partake in the CPR decision-making process.

In responding to these arguments, a major problem in assessing a futility exception is definitional. Critics argue that, at the very least, implementation of the futility exception to informed consent should be delayed until a professional and societal consensus is reached about what futility means.[81] In fact, Stuart Youngner poses five variations of the definition of futility to illustrate the problem: (i) Purely Physiological: CPR will not reestablish spontaneous heartbeat; (ii) Postponing Death: additional treatment may fail to postpone death for even a few minutes; (iii) Length of Life: the patient may live a week but will die before discharge; (iv) Quality of Life; and (v) Probability: highly unlikely though not impossible that any of the above goals will be achieved.[82] Youngner believes that all of these conceptions of futility, except for physiological futility and an absolute inability to postpone death, also involve value judgments which are solely within the patient's discretion.[83]

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[80] Brody & Tomlinson, *supra* note 63, at 1581. *See also*, Buchanan et al., *supra* note 7, at 462 (DNR order may be entered without soliciting patient or surrogate opinion where no medical benefit but courtesy requires that the physician inform the patient or the surrogate of the DNR and this rationale).

The JCAHO Accreditation Manual for Hospitals requires recognition of basic rights and responsibilities of patients which would seem to require advising the patient about her DNR status:

> The patient has the right to obtain, from the practitioner responsible for coordinating his care, complete and current information concerning his diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

THE 1991 JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS xii (1990).

[81] Stuart J. Youngner, Commentaries, *Who Defines Futility?*, 260 JAMA 2094, 2095 (1988).

[82] *Id.* at 2094. *See also* Buchanan et al., *supra* note 7, at 462 (no medical benefit used to mean physiological benefit; a patient in whom resuscitation would lead to no likelihood of survival); Hackler & Hiller, *supra* note 63, at 1282 (futility defined as when there is "no possibility that it will accomplish its intended physiological effect."). Veatch and Spicer reconceptualize Youngner's definition of physiologically futile care as care that will not produce the effect envisioned or pursued, which they distinguish from "care that will produce the envisioned effect, but is believed by some to be of no net benefit." Veatch & Spicer, *supra* note 62, at 18.

New York's do not resuscitate statute includes the following definition of "medical futility": "cardiopulmonary resuscitation will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest in a short time period before death occurs." N.Y. PUB. HEALTH LAW § 2961.9 (Consol. 1992).

[83] Youngner, *supra* note 81, at 2094–95. Youngner concedes, however, that "[p]hysicians should not offer treatments that are physiologically futile or certain not to prolong life, and they could ethically refuse patient and family requests for such treatments." *Id.* at 2095. The recently published updated Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care adopt parameters for a futility determination:

> Medical futility justifies unilateral decisions by physicians to withhold or terminate resuscitation under the following circumstances:
>
> 1. Appropriate basic life support (BLS) and advanced life support (ALS) have already been attempted without restoration of circulation and breathing.

Futility critics are also concerned that the exception relies on too many assumptions upon which there is little agreement, including what is meant by "resuscitation" and a "DNR order." Additionally, it is uncertain that physicians can make futility judgments accurately, reliably and consistently.[84] Finally, futility opponents question the statistics upon which futility arguments rely, noting that survival statistics based on live discharge from the hospital ignore the additional days or hours the patient may have lived as a result of the resuscitation even though the patient did not live long enough to leave the hospital.[85] These extra days or hours may have unique value to the patient which the physician cannot second guess or ignore, particularly when the physician's futility assessment is linked to quality of life judgments.[86]

Informed consent, rooted in patient autonomy, is not solely a requirement of medical ethics, but is also a legal standard of care that physicians owe to their patients. Notwithstanding the common law's nominal recognition of the right to self-determination in health care, physicians have relied on judicially and statutorily created exceptions to the doctrine of informed consent to avoid the effect of presumed consent to CPR and the requirement of actual consent to DNR orders. In practice, physicians have forged a wide gap between the theory of patient autonomy and the reality of patients' exercise of their rights to end-of-life decision-making. Health care providers' over-use of the emergency, therapeutic and futility exceptions to informed consent have virtually removed CPR decision-making beyond the scope of patient control and into the realm of physician authority.

> 2. No physiological benefit from BLS and ALS can be expected because a patient's vital functions are deteriorating despite maximum therapy. For example, CPR would not restore circulation in a patient who suffered a cardiac arrest despite optimal treatment for progressive septic or cardiogenic shock.
>
> 3. No survivors after CPR have been reported under the given circumstances in well-designed studies. For example, when CPR has been attempted in patients with metastatic cancer, several large series have reported that no patients survived to hospital discharge.
>
> In these strictly defined situations, the decision to stop or withhold resuscitation is appropriately a medical judgment. Patients (or surrogates of incompetent patients) should be informed of the no-CPR order but not offered the choice of CPR.

1992 Guidelines for CPR, *supra* note 2, at 2283. The Guidelines specifically state that physicians should reject any looser meanings of futility and should not be the sole decision-maker in any circumstances except those listed above. *Id.* Veatch and Spicer argue that even purely scientific conclusions have nonscientific components:

> The conception of the problem, the choice of language to describe it, the choice of data to observe it and the choice of ways to report it are all inevitably shaped by the scientist's system of beliefs and values. There simply is no such thing as a value-free and concept-free fact.

Veatch & Spicer, *supra* note 62, at 19.

[84] Scofield, *supra* note 9, at 30. Veatch and Spicer argue that when a physician claims that a treatment will have no relevant effect, he is making a probabalistic prediction at some unstated level of probability: "[B]ased on the clinician's understanding of the medical science, the chance of the effect occurring is so low as to be not worth considering. The patient may accept the clinician's estimate of the probability, but nevertheless claim that, considering the risks, benefits and alternatives, the intervention is worth pursuing." Veatch & Spicer, *supra* note 62, at 18–19.

[85] Tomlinson & Brody, *supra* note 65, at 1276.

[86] Miller, *supra* note 27, at 251.

II. LEGAL ASPECTS OF RESUSCITATION AND SELF-DETERMINATION

Most states recognize and protect a patient's right to refuse death-prolonging[87] treatment under either the common law right to informed consent or a federal constitutional liberty interest.[88] The legal doctrine of informed consent purports to rest on classical liberal theories of self-determination and to embody the ethical principle of respect for individual autonomy. The ethical concept of personal autonomy encompasses the idea of "personal self-governance"[89] — the freedom to do as one pleases,[90] with certain limitations.[91] Respect for autonomy requires recognition of another person's rights to hold certain views, to make her own choices, and act on the bases of her personal values and beliefs,[92] even when it is thought that the person is mistaken.[93] According to medical ethicists, protection of autonomy is the primary function of informed consent,[94] and therefore establishes an obligation of health care

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[87] Discussions of end-of-life treatment vary in referring to the technologies involved as "death-prolonging" or "life-sustaining," the choice of which, to many, probably has philosophical implications or depends upon the circumstances in which the technologies are being employed. Because this Article focuses on the terminally ill, I use the term "death-prolonging." Obviously, CPR is life-sustaining in other contexts to which my proposals and arguments also apply, including the chronically ill. Consequently, the right to participate in resuscitation decisions extends to all patients.

[88] Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 277 (1990). Furthermore, some state constitutions also recognize a right to refuse treatment based on a liberty or privacy interest. *See, e.g*, Rasmussen v. Fleming, 154 Ariz. 207, 218, 741 P.2d 674, 682 (1984) (privacy interest); *In re* Barry, 445 So. 2d 365, 370 (Fla. Dist. Ct. App. 1984) (privacy interest); *In re* Lawrance, 579 N.E.2d 32, 38 (Ind. Ct. App. 1991) (liberty interest). This Article analyzes resuscitation decision-making exclusively under the doctrine of informed consent. However, the Supreme Court has recognized that a competent person has a constitutionally protected liberty interest, grounded in the Fourteenth Amendment, in refusing unwanted medical treatment, including life-sustaining treatment. *Cruzan*, 497 U.S. at 261. Thus, following *Cruzan*, it is clear that patients have a liberty interest in refusing resuscitation. Whether this liberty interest is violated, however, is determined by weighing the liberty interest against the relevant state interests. *Id.* at 278–79. Whether presumed consent to CPR or the failure to obtain consent to a DNR order violates procedural or substantive Due Process are beyond the scope of this Article, and therefore, are not further discussed.

[89] RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 8 (1986). This discussion assumes the existence of autonomous persons capable of rational choice and autonomous action.

[90] PAUL S. APPELBAUM ET AL., INFORMED CONSENT 23 (1987).

[91] The principles which may be balanced against autonomy, beneficence and justice, are discussed *infra* at notes 124–26 and accompanying text.

[92] FADEN & BEAUCHAMP, *supra* note 89, at 8. The claim to autonomy was most compellingly expressed by John Stuart Mill:

> [T]he only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. ... [T]he conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of any one for which he is amenable to society, is that which concerns others. *In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his mind and the body, the individual is sovereign.*

JOHN STUART MILL, ON LIBERTY 13 (Stefan Collini ed., 1989) (1859) (emphasis added).

[93] TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 58 (1979).

[94] *Id.* at 63. Within the patient-physician relationship, autonomy is protected by allowing the patient to make her own decisions, despite the greater training and expertise of her physician. *Id.* Informed consent also protects the autonomy of each member of society by

professionals to respect patient's rights to make their own treatment decisions.[95] Thus, the ethical principle of respect for autonomy imposes two obligations on the physician: first, the physician must not coerce or compel a patient to undergo (or forego?) a particular therapy; and second, the physician must provide his patient with sufficient information to make a rational, autonomous decision.[96]

The legal embodiment of respect for autonomy is most frequently expressed in terms of the patient's right to self-determination and the physician's corresponding duty to obtain consent prior to invading the patient's bodily integrity.[97] The concepts of bodily integrity and self-determination were best articulated by the Supreme Court in *Union Pacific Railroad Co. v. Botsford*: "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference by others, unless by clear and unquestionable authority of law."[98] Contemporary advocates of self-determination as reflected in the doctrine of informed consent expound upon the principles enunciated in *Botsford* by portraying the doctrine as

> the guardian of individualism in the medical context: it protects the patient's right to determine his own destiny in medical matters; it promotes his status as an autonomous human being; it guards against overreaching on the part of the physician; it protects his physical and psychic integrity and thus his privacy; and it compensates him both from affronts to his dignity and from the untoward consequences of medical care.[99]

A. The Doctrine of Informed Consent

The common law has historically imposed upon physicians a legal duty to obtain patient consent to medical care[100] and relies on the theory of battery to compensate the patient whose physician has violated her right to self-determination by rendering unauthorized medical care.[101] Until the latter half

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protecting against institutional violations of autonomy, fostering trust in medical professionals and encouraging self-scrutiny by physicians and researchers. *Id.* at 64.

[95] *See generally* APPELBAUM ET AL., *supra* note 90, at 23–36; Jones, *supra* note 38, at 385.

[96] APPELBAUM ET AL., *supra* note 90, at 26–27.

[97] *See id.* at 35–36; FADEN & BEAUCHAMP, *supra* note 89, at 25–26.

[98] 141 U.S. 250, 251 (1891). Justice Cardozo, during his tenure on the Court of Appeals of New York, further defined the concept of self-determination in the context of health care: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable." Schloendorff v. Society of N.Y. Hosp., 105 N.E.2d 92, 93 (1914).

[99] Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking,* 1979 WIS. L. REV. 413, 414–15; Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision,* 39 U. PITT. L. REV. 137, 148–49 (1977).

[100] The earliest case identified for this proposition is a 1767 English case. Slater v. Baker & Stapleton, 95 Eng. Rep. 860 (K.B. 1767) cited in APPELBAUM ET AL., *supra* note 90, at 36–37. Cases involving unconsented medical treatment did not appear in the United States until the early 1900's. *See, e.g.,* Pratt v. Davis, 118 Ill. App. 161 (1905); Schloendorff v. New York Hosp., 105 N.E. 92 (N.Y. 1914).

[101] Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation,* 1988 U. ILL. L. REV. 607, 610.

of this century, the duty to obtain consent merely required the physician to advise his patient what procedure he proposed to perform.[102]

It was not until 1957, in *Salgo v. Leland Stanford Jr. University Board of Trustees*,[103] that a court established a duty of physicians to obtain "informed consent."[104] Specifically, the court declared that "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."[105] The court qualified the physician's duty of disclosure, however, by recognizing that physicians must have discretion to withhold discussion of risks which may create such apprehension as to increase the risks of treatment.[106] Interestingly, the court nowhere explained the source, rationale, or limitations of this startling new doctrine.[107]

Three years later, in *Natanson v. Kline*,[108] the Kansas Supreme Court confronted the first malpractice claim in that state alleging negligence by a physician who failed to warn the plaintiff of the substantial risks involved with cobalt radiation treatment.[109] As in *Salgo*, the *Natanson* court struggled with an apparent desire to recognize a duty of disclosure on the part of physicians without encroaching upon the physician's authority to withhold information he believes may unduly upset the patient.[110] Thus, after balancing the principle that "man is considered to be master of his own body," which supports the right to refuse treatment,[111] against the need to allow the physician sufficient authority to act in his patient's best interests,[112] the court concluded that the decision as to what constitutes adequate disclosure to achieve informed consent is "primarily a question of medical judgment."[113] As long as the physician appears motivated by his patient's best interests, the *Natanson* court opined, "the physician's choice of plausible courses should not be called into question."[114]

The 1972 case of *Canterbury v. Spence*[115] is most frequently cited as the genesis of the current doctrine of informed consent, primarily because of the court's significant departure from prior consent jurisprudence, by rejecting "prevailing medical practice" as the basis for determining whether the physician violated his disclosure obligations.[116] Recognizing that reliance on professional custom to define the physician's duty to disclose ignores individual patient's needs and accords the physician exclusive authority for deciding the parameters

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[102] Katz, *supra* note 99, at 148–49.

[103] 317 P.2d 170 (Cal. Ct. App. 1957).

[104] *Id.* at 181.

[105] *Id.*

[106] *Id.*

[107] Dr. Katz has discovered that the rule of informed consent elucidated by the *Salgo* court was actually proposed in an *amicus curiae* brief submitted by the American College of Surgeons. KATZ, *supra* note 46, at 60–61.

[108] 350 P.2d 1093 (Kan. 1960).

[109] *Id.* at 1101. The cobalt radiation treatment followed a radical mastectomy for the treatment of a cancerous tumor in the plaintiff's left breast and was part of a precautionary treatment plan which included removal of the plaintiff's ovaries and fallopian tubes. *Id.* at 1106.

[110] *Id.* at 1103.

[111] *Id.* at 1104.

[112] *Id.* at 1106.

[113] *Id.*

[114] *Id.*

[115] 464 F.2d 772 (D.C. Cir. 1972).

[116] *Id.* at 783.

of legal doctrine,[117] the court concluded that "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."[118] The *Canterbury* court did not entirely eliminate the value of "expert" opinions regarding appropriate disclosure, however, stating that when medical judgment is relevant, "prevailing medical practice must be given its just due."[119]

Since *Canterbury*, the legal doctrine of informed consent has remained relatively stable,[120] requiring that the physician advise the patient of (i) her diagnosis, prognosis and the nature and purpose of a proposed procedure; (ii) the likelihood of successful treatment; (iii) the risks and consequences of the procedure; (iv) any alternative forms of treatment; and (v) the prognosis without treatment.[121] Traditionally, this duty of risk-disclosure arose when the physician sought consent to undertake a particular treatment procedure.[122]

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[117] *Id.* at 784.

[118] *Id.*

[119] *Id.* at 785.

[120] Currently, only Georgia has expressly refused to recognize the doctrine of informed consent. *See* Spikes v. Heath, 332 S.E.2d 889 (Ga. Ct. App. 1985); Butler v. Brown, 290 S.E.2d 293 (Ga. Ct. App. 1982). Among the remaining states, the major point of differentiation revolves around the standard for determining what and how much the physician must disclose. The traditional medical community or "objective" rule requires the physician to disclose what the physician thinks is important for the patient to know. FAY A. ROZOVSKY, CONSENT TO TREATMENT 43 (2d ed. 1990). The patient need or "subjective" rule requires the physician to disclose what a reasonable person in the patient's position would want to know. *Id.* For an extensive discussion and critique of the law of informed consent, see FADEN & BEAUCHAMP, *supra* note 89; Jones, *supra* note 38, at 388–406; Katz, *supra* note 99, at 137; Marjorie M. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985).

[121] *See, e.g.*, Logan v. Greenwich Hosp. Ass'n, 465 A.2d 294, 300 (Conn. 1983); Palmer v. Biloxi Regional Medical Ctr., 564 So. 2d 1346, 1363 (Miss. 1990); Hook v. Rothstein, 316 S.E.2d 690, 694–95 (S.C. Ct. App. 1984). *See also* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 190 (5th ed. 1984); Meisel, *supra* note 99, at 420. In an attempt to enunciate the rationale underlying the informed consent disclosure requirements, the court in *Canterbury v. Spence* stated that "[t]rue consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." 464 F.2d at 780.

[122] It has been very difficult for patients to recover damages for the unconsented provision of lifesaving treatment. However, a few courts have recognized the possibility of recovery for unconsented provision of life-sustaining or death-prolonging treatment in what are referred to as "wrongful living" suits. Estate of Leach v. Shapiro, 469 N.E.2d 1047 (Ohio Ct. App. 1984), represents one of the earliest suits recognizing the potential of recovery for unconsented administration of life-sustaining treatment. In *Leach*, a suit was brought on behalf of Mrs. Leach after being placed on a respirator without patient or family consent following in-hospital resuscitation which resulted in chronic vegetative state. *Id.* at 1051. In reversing the lower court's dismissal of the claim, the appellate court concluded that a patient may recover for violation of her right to refuse medical treatment. *Id.* at 1051–52.

In Winter v. St. Francis-St. George Hosp., No. C–910574, 1992 WL 336523 (Ohio Ct. App. Nov. 18, 1992), Mr. Winter filed a wrongful living suit against the hospital at which he suffered cardiac arrest for resuscitating him despite the DNR order he had requested and which his physician had placed in his chart. Rich, *supra* note 55, at 1172. The hospital contended that it was simply "erring on the side of life, for which no liability should attach" Rich, *supra* note 55, at 1176 (quoting Defendant's Motion for Summary Judgment at 20, *Winter*, 1992 WL 336523 (Ohio Ct. App. Nov. 18, 1992) (No. C–910574)); that Winter had executed a generic consent to treatment upon admission to the hospital, *id.* (quoting Defendant's Motion for Summary Judgment at 7, *Winter*, 1992 WL 336523 (Ohio Ct. App. Nov. 18, 1992) (No. C–910574)); and that DNR orders are only permissible for patients who are "irreversibly, inevitably, and/or

However, case law involving death-prolonging treatment indicates that risk disclosure and informed consent are necessary conditions to withholding or withdrawing death-prolonging treatment.[123]

The doctrine of informed consent does not ensure unquestioned adherence to a patient's treatment decision. Neither the ethical precept of respect for autonomy nor the legal right to self-determination are absolute. Instances may occur in which societal demands or interests must be balanced against, and may outweigh, patient autonomy. However, moral philosophy

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imminently dying." *Id.* (quoting Defendant's Motion for Summary Judgment at 5 n.2, *Winter*, 1992 WL 336523 (Ohio Ct. App. Nov. 18, 1992) (No. C–910574)). Commentators support the recovery of damages when a physician interferes with the patient's right to refuse treatment which the physician should have known the patient asserted. *See, e.g.*, Developments in the Law, *Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1673 (1990); William C. Knapp & Fred Hamilton, *"Wrongful Living": Resuscitation as Tortious Interference with a Patient's Right to Give Informed Refusal*, 19 N. KY. L. REV. 253, 261 *passim* (1992); A. Samuel Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625, 637 *passim* (1986); Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 430 (1988). Courts, however, have been slow to respond to this theory. *See* Bartling v. Glendale Adventist Medical Ctr., 229 Cal. Rptr. 360 (Dist. Ct. App. 1986) (pro-life hospital's refusal to withdraw life support from patient despite request to the contrary in living will not foreseeable to defendant hospital as "conscious disregard" of patient's rights and fails to fulfill outrageous conduct element of tort of intentional infliction of emotional distress); Iafelice v. Luchs, 501 A.2d 1040 (N.J. Super. Ct. Law Div. 1985), *aff'd sub. nom.* Iafelice v. Zarafu, 534 A.2d 417 (N.J. Super. Ct. App. Div. 1987) (physician had no duty to inform parents of infant with life-threatening condition of option to withhold treatment and let child die); *In re* Clark, 524 A.2d 448 (N.J. Super Ct. App. Div. 1987) (hospital which refused to terminate life support because patient not brain dead not liable for medical costs or emotional suffering because no breach of duty).

Rhoden argued that the judiciary's unresponsiveness to wrongful living suits reflects the legal system's uncritical endorsement of the medical profession and its reluctance to sanction the medical profession's interventionist instincts. Rhoden, *supra*, at 430.

[123] Payne v. Marion, 549 N.E.2d 1043 (Ind. Ct. App. 1990) (physician has duty to obtain informed consent before implementing a DNR order). The New Jersey Supreme Court has observed that "society must ensure that a patient who has decided to forego life-sustaining treatment is competent; is informed about his or her prognosis, the medical alternatives available, and the risk involved; and has not been coerced." *In re* Farrell, 529 A.2d 404, 414 (N.J. 1987). *See also* Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1052–54 (Ohio Ct. App. 1984) (failure to disclose material information about patient's condition may be actionable not only as malpractice, but may constitute misrepresentation). Moreover, Professor Mooney contends that the right to die cases "necessarily imply that a competent patient has a right to participate in such decisions. This implication arises from the courts' attempts to preserve that right for the incompetent patient." Mooney, *supra* note 9, at 1076–77.

The New York legislature expressly adopted this viewpoint in the context of CPR decision-making by enacting a law which requires consent prior to the implementation of a DNR order. N.Y. PUB. HEALTH LAW § 2964.1(a) (Consol. 1992).

> Before obtaining ... the consent of the patient, or of the surrogate of the patient, or parent or legal guardian of the minor patient, to an order not to resuscitate, the attending physician shall provide to the person giving consent information about the patient's diagnosis and prognosis, the reasonably foreseeable risks and benefits of cardiopulmonary resuscitation for the patient, and the consequences of an order not to resuscitate.

Id. § 2962.3. Current evidence suggests that this legislation is procedural rather than substantive in its effect. One study has found that the New York statute has not increased patient autonomy in DNR decision-making. Russell S. Kamer, *Effect of New York State's Do-Not-Resuscitate Legislation on In-Hospital Cardiopulmonary Resuscitation Practice*, 88 AM. J. MED. 108 (1990). Patients are involved in the DNR decision in only 13% to 16% of cases studied. *Id.* at 110. According to the authors, "[t]here appears to have been little change in the common practice of deferring decisions regarding CPR status until later in the hospital course, at which time the patient's deteriorating physiologic status often renders him or her incapable of making an informed decision." *Id.*

requires that a societal restriction on individual autonomy be justified by "some competing moral principle such as beneficence or justice."[124] The principle of beneficence is aimed at promoting the welfare of others and imposes upon physicians the duty to "do no harm."[125] The principle of justice arises out of norms of social cooperation and requires that citizens be "treated according to what is fair, due or owed."[126]

The law also requires that certain state interests must be weighed against the right to self-determination, particularly in the context of death-prolonging treatment. The states generally agree that four state interests must be balanced against the patient's common law right to refuse unwanted life-sustaining medical care: preservation of life, prevention of suicide, protection of innocent third parties, and maintenance of the integrity of medical ethics.[127]

State courts have consistently stated that preservation of human life is the most significant state interest.[128] This interest embraces not only the protection of the individual but the sanctity of all life as well[129] and is generally strongest "when it is attempting to protect its citizens from abuse or infringement of their rights."[130] In the case of a person who desires to refuse death-prolonging treatment, however, the state must also vindicate the individual's right to terminate treatment.[131] While some courts view an individual's right to refuse treatment as a conflict with the state interest in life which must be resolved in

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[124] FADEN & BEAUCHAMP, *supra* note 89, at 9.

[125] *Id.* at 10. The principle of beneficence enjoins physicians from pursuing treatments which will "inflict unnecessary pain and suffering on patients." *Id.* at 12. "Beneficence assumes an obligation to weigh and balance benefits against harms, benefits against alternative benefits, and harms against alternative harms." *Id.* at 13. This balancing, of course, implicates the problem of medical paternalism when physicians override an autonomous patient decision in the name of beneficence. *Id.*

[126] *Id.* at 14. Thus, allocation of scarce health care resources implicates the principle of justice. *Id.* at 15.

[127] Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977) (distilling these four interests from other cases). The 1964 case *In re* President & Directors of Georgetown College, Inc., 331 F.2d 1000, 1007–10 (D.C. Cir. 1964), delineated three of the state interests: the prevention of suicide, the protection of minor children from "abandonment" by a parent, and protection of the medical profession's desire to preserve life without liability. These interests were adopted by a vast majority of states confronted with right to refuse treatment cases. *See, e.g.*, Brophy v. New Eng. Sinai Hosp., Inc., 497 N.E.2d 626, 635 (Mass. 1986); John F. Kennedy Memorial Hosp. v. Heston, 279 A.2d 670, 673 (N.J. 1971); *In re* Quinlan, 355 A.2d 647, 663 (N.J. 1976). *Cf.* Meisel, *supra* note 99, at 423–25. The courts balance the state interests against the patient's right to refuse treatment irrespective of whether the state bases the right to refuse treatment on informed consent, liberty interest, or both. *See In re* Conroy, 486 A.2d 1209, 1221–22 (N.J. 1985) (right to refuse treatment based on informed consent); *In re* Storar, 420 N.E.2d 64, 71 (N.Y. 1981) (right to refuse treatment based on Constitution); *In re* Colyer, 660 P.2d 738, 743 (Wash. 1983) (right to refuse treatment based on informed consent and Constitution).

The court in McKay v. Bergstedt, 801 P.2d 617, 621 (Nev. 1990), identified a fifth state interest: "encouraging the charitable and humane care of those whose lives may be artificially extended under conditions which have the prospect of providing at least a modicum of quality living."

[128] *Saikewicz*, 370 N.E.2d at 425. *See also* Gray v. Romeo, 697 F. Supp. 580, 588 (D.R.I. 1988); Rasmussen v. Fleming, 154 Ariz. 207, 217, 741 P.2d 674, 683 (1987); *In re* Conroy, 486 A.2d at 1223.

[129] *Rasmussen*, 154 Ariz. at 217, 741 P.2d at 683.

[130] *In re* Doe, 583 N.E.2d 1263, 1269 (Mass. 1992).

[131] *See id.*

favor of the individual's right,[132] other courts avoid any analytical conflict by circumscribing the state's interest to preservation of "meaningful life."[133]

The courts which have considered patient refusals of potentially lifesaving medical treatment have overwhelmingly and consistently agreed that refusal of death-prolonging treatment "is not a euphemistic exercise in suicide."[134] Although some concern about suicide has arisen in refusal of treatment cases involving young competent adults who suffered from extreme physical debilitation, but who were not terminally ill, the courts concluded that the right to refuse treatment outweighed the state interest in prevention of suicide.[135] Courts have generally agreed that the refusal of treatment does not constitute suicide by reasoning that it is not the withdrawal of the treatment that causes the death of the patient but the underlying illness from which the patient suffers.[136] Thus, the courts have construed a patient's refusal of treatment not as an expression of a desire to die but merely as a decision to allow the disease to run its natural course.[137]

The state interest in protecting the interests of innocent third parties is intended to protect dependent minors. Throughout the 1960's and 1970's, courts relied upon this state interest to compel Jehovah's Witnesses with young children to receive blood transfusions.[138] More recently, most courts have acceded to Jehovah's Witnesses' refusals of blood transfusions, even when minor children exist.[139] Several courts, however, have declined to protect the right of a pregnant non-terminally ill woman to refuse medical treatment,

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[132] *See, e.g.*, Brophy v. New Eng. Sinai Hosp., 497 N.E.2d 626, 636–37 (Mass. 1986); *In re* Conroy, 486 A.2d 1209, 1225 (N.J. 1985).

[133] *See, e.g.*, McKay v. Bergstedt, 801 P.2d 617, 626 (Nev. 1990).

[134] *Id.* (citing prior cases which have discussed the issue). *But see* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 292–98 (1990) (Scalia, J., concurring) (Justice Scalia makes a singularly unique argument that refusal to undergo medical treatment constitutes suicide).

[135] Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986) (court reverses trial court's conclusion that quadriplegic had suicidal motives for removal of feeding tubes); State v. McAfee, 385 S.E.2d 651 (Ga. 1989) (quadriplegic successfully asserted right to discontinue respirator and receive sedatives at time ventilator discontinued but neither State of Georgia nor court determined that state interest against suicide implicated); *McKay*, 801 P.2d at 617 (quadriplegic whose sole support and caretaker was about to die successfully asserted right to withdrawal of respirator to avoid life without his father).

[136] *See, e.g.*, *In re* Longeway, 549 N.E.2d 292, 296 (Ill. 1989); Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677, 692 (N.Y. App. Div. 1987).

[137] *See, e.g.*, *McKay*, 801 P.2d at 625–26. The *McKay* court stated:

> Unlike a person bent on suicide, Kenneth sought no affirmative measures to terminate his life; he desired only to eliminate the artificial barriers standing between him and the natural processes of life and death that would otherwise ensue with someone in his physical condition.

Id.

[138] *See, e.g.*, Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (1964) (ordering hospital to administer transfusions to 7-month old child's mother); United States v. George, 239 F. Supp. 752 (D.C. Conn. 1965) (ordering a blood transfusion for father of four); Hamilton v. McAuliffe, 353 A.2d 634 (Md. 1976) (authorizing treatment because father was sole support of two year-old).

[139] *See, e.g.*, *In re* Osborne, 294 A.2d 372 (D.C. 1972) (patient had two young children, but court found this was insufficient to compel treatment, as provisions had been made for the children); Public Health Trust v. Wons, 541 So. 2d 96 (Fla. 1989) (child's right to be reared by two parents not sufficient to override rights of privacy and religion); St. Mary's Hosp. v. Ramsey, 465 So. 2d 666 (Fla. Dist. Ct. App. 1985) (minor child's primary residence with mother, extended family to support child and presence of annuity enabled patient refusing transfusions to overcome state interest in protecting third parties).

finding that the state interest in fetal life outweighs the woman's right to refuse treatment.[140] In cases involving terminally ill patients, courts have subordinated a state's interest in protecting innocent third parties or a fetus to a patient's right to refuse death-prolonging treatment.[141]

Finally, the prevailing medical standards which do not "require medical intervention at all costs" have substantially reduced the state's interest in safeguarding the ethical integrity of the medical profession.[142] Initially, courts attempted to avoid a conflict between health care professionals' moral objections to the withdrawal of treatment and patient interests in refusing treatment[143] by applying a procedural solution. These courts procedurally accommodated the health care professionals by allowing them to transfer the patient's care to other providers who were willing to adhere to the patient's directives.[144] Notably, when such a procedural accommodation cannot be

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[140] Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964) *cert. denied*, 377 U.S. 985 (1964) (ordering transfusion for pregnant patient if necessary to save her life or the life of fetus because life of mother and child "so intertwined and inseparable that it would be impracticable to attempt to distinguish between them"); *In re* Melideo, 88 Misc. 2d 974 (N.Y. Sup. Ct. 1976) (acknowledging necessity of forced treatment for parent or pregnant woman); *In re* Jamaica Hosp., 128 Misc. 2d 1006 (N.Y. 1985) (blood transfusion ordered against religious beliefs of pregnant woman, on basis of state's significant interest in protecting life of fetus). *But see* Mercy Hosp., Inc. v. Jackson, 489 A.2d 1130 (Md. Ct. Spec. App. 1985) (First Amendment right of pregnant woman refusing blood transfusion outweighs state interest in well-being of minors); Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1989) (state's interest in protecting children does not override pregnant woman's right to refuse blood transfusions where surviving parent and extended family exist).

[141] *See, e.g., In re* A.C., 573 A.2d 1235 (D.C. 1990) (en banc) (after patient with terminal cancer died following court ordered C-Section, appellate court reversed, holding that a patient's treatment wishes must be followed absent extraordinary or compelling reasons); *In re* Deel, 729 F. Supp. 231 (N.D.N.Y. 1990) (although the competent patient had sons aged 19, 17, and 11, no state interest outweighed his constitutional right to discontinue life-saving treatment). However, many states' advance directive laws explicitly state that a patient's request for withdrawal of treatment shall not be effective if she is pregnant. *See, e.g.*, ALA. CODE § 22-8A-4(a) (1991); 1991 Cal. Stat. 7189.5(c); FLA. STAT. ch. 765.113(2) (Supp. 1993); 1991 Ky. Rev. Stat. & R. Serv. 311.624(7)(c) (Baldwin); MISS. CODE ANN. § 41-41-107(1) (Supp. 1992); OKLA. STAT. tit. 63, §§ 3101.4 & 3101.7(c) (Supp. 1993); S.C. CODE ANN. § 44-77-70 (Law. Co-op. Supp. 1992); UTAH CODE ANN. § 75-2-1109 (Supp. 1992); N.D. CENT. CODE § 23-06.4-03.3 (1991); MO. REV. STAT. § 459.025 (1990). *Cf.* ILL. REV. STAT. ch. 110 1/2, par. 3(b) (1991) (living will not effective if physician determines that fetus could develop to live birth with continued death delaying procedures); 1991 N.J. Laws 6(5) (patient may indicate limitations on power of health care representative if patient is pregnant); OHIO REV. CODE ANN. § 2133.06 (Baldwin Supp. 1991) (physician may not withhold treatment from pregnant patient unless physician documents that fetus would not be born alive); S.D. CODIFIED LAWS ANN. § 34-12D-10 (1991) (life-sustaining treatment to be provided pregnant woman unless treatment will not sustain woman to permit live birth or will be physically harmful to the woman or prolong severe pain which cannot be alleviated by medication).

[142] Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677, 693 (N.Y. App. Div. 1987).

[143] *See, e.g.*, Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 427 (Mass. 1977) (noting that right to bodily integrity is superior to institutional considerations of medical profession and hospitals).

[144] The court in *In re Longeway* stated:

> [T]he ethical integrity of the medical profession can be ensured by not compelling (by court order or any other means) any medical facility or its staff to act contrary to their moral principles. The patient can be transferred to a different facility or a new physician can be appointed to carry out the patient's wishes, if the current staff or physician cannot.

achieved, recent decisions deem a patient's interest in controlling her health care as superior to the integrity of medical ethics.[145] Most recently, a few courts have ordered the objecting health care facilities to comply with patient requests, in some cases, even if transfer was possible.[146]

The patient's right to self-determination, even when balanced against the state's interests, clearly entitles a patient to reject[147] or request[148] resuscitation. However, the patient's only means to exercise her substantive right to determine whether she desires CPR, the mechanisms of informed consent, are procedurally thwarted by the CPR presumed consent/DNR actual consent model.[149]

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549 N.E.2d 292, 299 (Ill. 1989). *See also Brophy*, 497 N.E.2d at 638–39 (Mass. 1986) (no justification to force medical professionals willing to transfer patient to act contrary to their ethics); Childs v. Abramovia, 206 Cal. App. 3d 304, 311 (Cal. Ct. App. 1988) (no physician should be forced to act against personal moral beliefs if patient can be transferred). Several states' advance directive laws specifically exempt health care providers from having to participate in withdrawal of treatment to which they object. *See, e.g.*, FLA. STAT. ch. 765.308(1) (1991) (health care provider who refuses to comply with surrogate's treatment decision shall "make every effort" to transfer patient; providers not required to violate moral or ethical beliefs if patient non-emergent, and was advised of moral policies upon admission); ILL. REV. STAT. ch. 110 1/2, par. 3(d) (1991) (if physician unwilling to comply with living will, burden on patient or patient's representative to effect transfer); IND. CODE ANN. § 16–8–11–14(e) (Burns 1991) (physician unwilling to comply with living will must transfer patient to another physician); 1992 KY. REV. STAT. & R. SERV. 311.634(1)&(2) (Baldwin) (no providers required to act against moral religious, or professional code; objecting provider may not impede transfer of patient to another provider); ME. REV. STAT. ANN. tit. 18, § 5–708 (West Supp. 1991) (provider unwilling to comply with patient request must transfer patient's care); MO. REV. STAT. § 459.030 (1990) (providers unwilling to comply with patient request must take steps to transfer patient); 1991 N.J. Laws 10(b)(c) (providers who object to withholding or withdrawing treatment must affect transfer); OHIO REV. CODE ANN. §§ 2133.02(D)(2) & 2133.10 (Baldwin 1991) (physician unwilling to comply with patient's declaration may not prevent or delay transfer of patient's care); VA. CODE ANN. § 54.1–2987 (Michie 1992) (physician who refuses to comply with patient request shall make reasonable efforts to transfer care). *See also*, Mooney, *supra* note 9, at 1075 (doctor who disagrees with patient decision to forego resuscitation should be permitted to withdraw from patient's care).

[145] *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580, 589 (D.R.I. 1988) ("Indeed, medical ethics incorporates the principle that the patient, not the health care provider, determines what the course of care should be.").

[146] *See, e.g.*, *Gray*, 697 F. Supp. at 590–91 (if patient cannot be promptly transferred to a health facility that will respect her wishes, current facility must comply with treatment request); *In re* Jobes, 529 A.2d 434, 450 (N.J. 1987) (family had no notice of treatment restrictions and was therefore entitled to rely on nursing home's willingness to defer to treatment requests); *In re* Requena, 517 A.2d 869, 870 *passim* (N.J. Super. 1986) (nursing home must comply with treatment request despite existence of alternative facility willing to comply); Elbaum v. Grace Plaza of Great Neck, Inc., 544 N.Y.S.2d 840, 848 (N.Y. App. Div. 1989) (if patient cannot be transferred to facility willing to remove gastrointestinal tube within 10 days, facility must find a physician willing to do so at its premises).

[147] *See, e.g.*, *In re* Dinnerstein, 380 N.E.2d 134 (Mass. Ct. App. 1978).

[148] The *O'Connor* court stated that "[e]very person has a right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline [medical] treatment ...." O'Connor v. Hall, 531 N.E.2d 607, 613 (N.Y. 1988).

[149] One commentator provides an analytical framework for these rights by describing the patient interest in participating in treatment decisions as procedural in nature, and the patient interest in protecting her privacy and bodily and psychic integrity as substantive in nature. The informed consent doctrine is the means for protecting these values in the practice of medicine. Meisel, *supra* note 99, at 418–19. *See also* Twerski & Cohen, *supra* note 101, at 649 (arguing that "informed choice is first and foremost a *process* right," which protects the right of the patient to evaluate all material information in making decisions).

B. CPR Presumed Consent Model

Most states' statutory[150] or common law[151] as well as the Principles of Medical Ethics[152] recognize an emergency exception to the doctrine of informed consent.[153] The exception basically provides that an emergency exists

> when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment. When a genuine emergency of that sort arises, it is settled that the impracticality of conferring with the patient dispenses with the need for it.[154]

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[150] The codification of exceptions to the informed consent doctrine appears in both criminal statutes and civil health codes. Criminal statutes allow lack of consent in an emergency as a defense to the use of force. ALA. CODE § 13A-3-24 (1991); ALASKA STAT. § 11.81.430 (1991); ARIZ. REV. STAT. ANN. § 13-403.5 (1991); ARK. CODE ANN. § 5-2-605 (Michie 1992); COLO. REV. STAT. § 18-1-703 (1991); CONN. GEN. STAT. § 53a-18 (1990); KY. REV. STAT. ANN. § 503.110 (Baldwin 1992); ME. REV. STAT. ANN. tit. 17-A, § 106 (West 1991); N.H. REV. STAT. ANN. § 627:6 (1991); N.D. CENT. CODE § 12.1-05-05(4) (1991).

Public health statutes exempt physicians from liability for treatment provided without informed consent in emergency situations. ALASKA STAT. § 09.55.556 (1991) (provides defense to failure to obtain informed consent if "under the circumstances consent by or on behalf of the patient was not possible"); CAL. BUS. & PROF. CODE § 2397 (Deering 1992) (no liability for failure to inform in an emergency situation if patient unconscious, if there is insufficient time to inform patient, or if other person authorized to consent); FLA. STAT. ch. 401.445 (1991) (no recovery from physician for treatment without informed consent if medical emergency); GA. CODE ANN. § 31-9-3 (1991) (consent implied if emergency exists); HAW. REV. STAT. § 671-3 (1991) (informed consent not required if emergency); IDAHO CODE § 39-136 (1992) (no civil liability for failure to obtain consent in emergency when patient or authorized decision-maker unable to consent); ILL. REV. STAT. ch. 91 1/2, para. 2-111 (1991) (no liability for "non-negligent good faith determination" and treatment of emergency); IOWA CODE § 147A.10 (1991) (no liability for failure to obtain consent if emergency and no opportunity for patient or other consent); KAN. STAT. ANN. § 65-2891 (1990) (no liability for good faith rendering of emergency health care); KY. REV. STAT. ANN. § 304.40-320 (Michie/Bobbs-Merrill 1991) (no requirement of previous consent in emergency circumstances); LA. REV. STAT. ANN. § 40:1299.54 (West 1991) (consent to treatment implied in emergency); MISS. CODE ANN. § 41-41-7 (1991) (consent implied in emergency if no protest or refusal by authorized decision-maker); MO. REV. STAT. § 431.063 (1990) (consent implied in emergency if no protest or refusal by person authorized to consent); NEB. REV. STAT. § 71-5512 (1990) (no liability for failure to obtain consent for emergency treatment); N.Y. PUB. HEALTH LAW § 2805-d(2) (Consol. 1992) (recovery based on lack of informed consent limited to non-emergency situations); UTAH CODE ANN. § 26-8-11(3) (1992) (no liability for basic or advanced life support person who renders emergency care without consent); VT. STAT. ANN. tit. 18, § 1852(4) (1991) (patient has right to give informed consent except in emergency); WASH. REV. CODE § 7.70.050(4) (1991) (consent to treatment implied in emergency if no possible consent by patient or one authorized to consent).

[151] *See* ROZOVSKY, *supra* note 120, at 259.

[152] The Principles of Medical Ethics provide an exception to informed consent "where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent." COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION ¶ 8.07 (1986).

[153] Since the inception of the doctrine of informed consent, the law has recognized four exceptions: emergency, waiver, incompetence and therapeutic privilege. Meisel, *supra* note 99, at 432-33; Eric A. Plaut, *The Ethics of Informed Consent: An Overview*, 14 PSYCHIATRIC J. U. OTTAWA 435, 436 (1989); Charles L. Sprung & Bruce J. Winick, *Informed Consent in Theory and Practice: Legal and Medical Perspectives on the Informed Consent Doctrine and a Proposed Reconceptualization*, 17 CRITICAL CARE MED. 1346, 1349 (1989).

[154] Canterbury v. Spence, 464 F.2d 772, 788-89 (D.C. Cir. 1972). *See also* Cobbs v. Grant, 502 P.2d 1, 10 (Cal. 1972). Actually, courts' definitions of emergency have varied greatly, with some jurisdictions establishing a high threshold of imminent threat to life and limb

When an emergency exists, consent is implied at law.[155] This implication arises out of an assumption that under the circumstances, if the patient were competent and understood the situation, she would consent to treatment.[156]

The law justifies the emergency exception to informed consent as society's attempt to balance the state's interests in the promotion and protection of health[157] and the individual's right to self-determination.[158] Since the physician retains complete discretion in identifying an emergency situation, he becomes the guardian of both the patient's life and her autonomy. As a result, a physician's inappropriate or overbroad definition of an emergency situation threatens the balance between society's interests and patient self-determination.[159]

Healthcare providers consider cardiac arrest an emergency condition for which consent to CPR is presumed.[160] This continued classification of cardiac arrest as an emergency and the routine unconsented provision of CPR represents an overbroad application of emergency as an exception to the requirements of informed consent. Since the dying process ultimately concludes with the cessation of heartbeat and respiration, the rationale supporting the emergency exception does not apply to the chronically ill or terminally ill patient because cardiac arrest is anticipated. Hospitals' encouragement of physicians to obtain consent to DNR orders for patients in certain disease categories, coupled with the increasingly accepted belief that CPR is frequently "futile," undercut the premise of the emergency exception that cardiac arrest is unpredictable. Patients' increased knowledge about the "right-to-die" and the costs of end-of-life treatment rebut another assumption upon which the

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and others requiring a showing that suffering or pain was alleviated by immediate treatment. APPELBAUM ET AL., *supra* note 90, at 67–68.

[155] Sprung & Winick, *supra* note 153, at 1349.

[156] *Id.*

[157] The value of protecting health evidences society's respect for humanity. APPELBAUM ET AL., *supra* note 90, at 29. Society is also interested in preserving the health of its citizens to benefit society as a whole by ensuring each member's ability to productively participate in the labor pool. *Id.*

[158] *See* Meisel, *supra* note 99, at 433. In the totality, individualism or self-determination predominates, but in particular circumstances societal interest in health usurps. *Id.*

[159] A patient has little recourse against a physician who provides unconsented treatment under the emergency exception where the patient suffers no physical or economic harm. Threat of malpractice liability, therefore, "may not exert much pressure to maintain the theoretical balance between the societal interests in individualism and health which the doctrine of informed consent contemplates." *Id.* at 472.

Werth v. Taylor, 475 N.W.2d 426 (Mich. Ct. App. 1991), exemplifies a case in which a court found the abusive use of the emergency exception to informed consent irrelevant because the plaintiff patient had not experienced any physical harm. In *Werth*, the plaintiff, a Jehovah's Witness, filed a battery claim against the defendant-physician for administering blood to the plaintiff despite repeated refusals by both plaintiff and her husband, even if plaintiff might die (which plaintiff seemed to have been assured she would not). *Id.* at 427–29. The appellate court affirmed the trial court's dismissal of the claim, concluding that only a "fully informed, contemporaneous decision ... suffices to override ... medical necessity." *Id.* at 430. Because the plaintiff was unconscious at the time the blood transfusions were needed, her prior refusals were inapplicable to the present life-threatening situation, thereby justifying the defendant's reliance on the emergency exception to provide blood. *Id. But see* Fosmire v. Nicoleau, 551 N.E.2d 77, 80 (N.Y. 1990) (emergency exception not applicable because patient clearly stated before hospital admission and throughout stay that she would not consent to blood transfusions).

[160] Scofield, *supra* note 9, at 29.

emergency exception relies, that if the patient was competent she would consent to CPR.

As a result of the classification of cardiac arrest as an emergency condition, the performance of CPR has never been subjected to the standard of actual informed consent which is legally and ethically a condition precedent to the provision of other invasive treatment with risks and uncertainties equivalent to those associated with resuscitative treatment. The CPR presumed consent model frees physicians from the need to disclose the possibility of unsuccessful resuscitation, the quality of the patient's life after resuscitation,[161] and the cost of continuing care if the patient survives resuscitation.[162] Consequently, the presumption of consent to CPR has become "medicine's license to intervene at will."[163]

Three decades of experience with end-of-life technologies have taught patients and physicians that simply caring for a chronically or terminally ill patient can be more compassionate than availing the patient of multiple state-of-the-art treatments, including CPR. Thus, consistent with this recognition, hospitals' reclassification of resuscitation as an optional treatment which requires patient consent would be an important step to sparing patients from the indignities of a prolonged death.

C. DNR Actual Consent Model

The physician's implementation of a DNR order without his competent patient's consent is the most clear example of a breach of the duty to obtain informed consent to the withholding of death-prolonging treatment. In the first case to address the precise issue, the Indiana Court of Appeals held in *Payne v. Marion General Hospital*[164] that a physician's failure to consult a competent patient before implementing a DNR order constitutes negligence.[165] Mr. Payne was a 65-year old alcoholic admitted to the hospital for malnutrition and uremia.[166] After a several minute visit, Mr. Payne's sister advised the nurse that if the patient arrested, he should not be resuscitated.[167] Upon being advised of this by a telephone call from a nurse, the defendant physician directed the nurse to enter a "no-code" on Payne's chart.[168] Subsequent to the DNR order, Mr.

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[161] The risks of inappropriate CPR include chronic vegetative state or days to weeks in the intensive care unit with "multiple, invasive, painful, dehumanizing procedures" until death. Blackhall, *supra* note 3, at 1283.

[162] *See* Scofield, *supra* note 9, at 29. This observation provokes particular interest given that older people estimate the survival rate of CPR to be at least three times higher than actual survival statistics. Miller et al., *supra* note 2, at 581.

[163] Scofield, *supra* note 9, at 29.

[164] 549 N.E.2d 1043 (Ind. Ct. App. 1990). Strickland v. Deaconess Hosp., 735 P.2d 74 (Wash. Ct. App. 1987), also involved alleged unconsented entry of a no-code order. The court did not decide the case on its merits, however, but dismissed the estate's and family's claims on the grounds that they did not survive the decedent. *Id.* at 76.

[165] Payne v. Marion Gen. Hosp., 549 N.E.2d 1043, 1045 (Ind. Ct. App. 1990). The appellate court reversed the lower court's summary judgment in favor of defendant-physician, concluding that a genuine issue of material fact existed as to the deceased's competence. *Id.* at 1048.

[166] *Id.* at 1044.

[167] According to the attorney for Payne's estate, the family believed that the sister was extremely concerned that she would become liable for the costs of Payne's continued care. Telephone Interview with Mr. Rittman, Attorney for Mr. Payne's estate (Aug. 27, 1992).

[168] *Payne*, 549 N.E.2d at 1044.

Payne was awake and alert. He "was conscious and capable of communicating with the nurses until moments before his death."[169] Pursuant to the DNR order, Mr. Payne was not resuscitated when he died.

When Mr. Payne's treating physicians sued the estate for compensation, the estate counter-claimed, alleging malpractice in issuing the no-code order without Mr. Payne's consent.[170] In reversing the trial court's summary judgment, the court held that "a physician has the duty to make reasonable disclosure of material facts relevant to the care of a patient,"[171] and that the court could not accept the physician's "claim that no duty to obtain ... consent was owed to Payne"[172] because evidence existed that Mr. Payne was competent and not terminally ill.[173]

Payne establishes that a physician's issuance of DNR orders without his competent patient's consent may contravene the doctrine of informed consent. Further, I believe that physicians' frequently unjustified reliance on the therapeutic privilege and invocation of the legally unsanctioned futility exception similarly violate patient self-determination. Consequently, the DNR actual consent model should be reconsidered to eliminate physicians' use of informed consent exceptions to circumvent patient decision-making.

1. The Therapeutic Privilege

Hubert Smith first proposed the therapeutic privilege in 1946 as an exception to the legal requirement of consent to medical treatment.[174] Smith suggested that

> the physician should be recognized to have a therapeutic privilege to withhold part or all of the facts regarding a dread illness, when he has reason to believe that communicating them freely to the patient will involve risks of causing his death or serious impairment of his health without any countervailing gain.[175]

Smith's conception of the therapeutic privilege does not exempt the physician from obtaining consent but merely exempts him from having to disclose all information about the patient's condition. Smith suggested that partial disclosure of the patient's condition was legally justified, as long as there was "no fundamental concealment or misrepresentation as to the general nature or

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[169] *Id.*

[170] *Id.*

[171] *Id.* at 1046.

[172] *Id.* at 1050. The case settled after the appellate court decision. Telephone Interview with Mr. Rittman, Attorney for Mr. Payne's estate (Aug. 27, 1992).

[173] *Payne*, 549 N.E.2d at 1050. Regretfully, the court's language raises the question of whether it would have reached a different conclusion if Mr. Payne had been terminally ill.

[174] Hubert W. Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349, 349 (1946).

[175] *Id.* at 351. Smith believed that "[t]o tell the patient the truth and the whole truth often causes violent psychological reactions in the patient and an undermining of morale without any countervailing gain." *Id.* at 354. Smith opined that the physician has a duty to use care in not making the patient untreatable by "tearing down the fabric of his psychic resistance." *Id.* The primary example Smith used to support his rationale is a situation where the physician failed to take "proper pains to explain" the disease and that it could easily be cured (the patient committed suicide upon leaving the doctor's office). *Id.* Smith's own argument raises the question of whether the better solution to the problem of adverse patient reaction to a serious diagnosis is improved physician communication.

extent of the surgery to be done."[176] Smith cautioned against the dangers of an overly broad therapeutic privilege, however, by warning of the dangers of allowing physicians to use "misrepresentation or concealment to gain ... consent to ... treatment [based] on the theory that 'doctor knows best' or 'it would only make the patient ... sicker to hear [bad news]."[177] The therapeutic privilege was adopted by courts, though not in the form contemplated by Smith, and retained as the consent to treatment requirement expanded to a duty of *informed* consent.[178] The common law conception of the privilege apparently rests on the notion that physicians' obligation "to do what is best for his patient"[179] may require that information be withheld where full disclosure would be "detrimental to the patient's total care and best interest."[180]

Courts' elucidation of the therapeutic privilege, however, has provided more confusion than clarification. Smith proposed the selective withholding of information about the patient's condition, whereas the court in *Canterbury v. Spence*[181] discussed the privilege as one allowing limited disclosure of *risks*[182] when the patient's psychological distress upon hearing the risks would preclude the patient from making a rational decision, interfere with the patient's treatment, or cause psychological damage.[183] The *Canterbury* court then drastically extended the privilege by excusing the physician from obtaining consent.[184]

The court in *Natanson v. Kline*[185] did not excuse the physician from obtaining consent but discussed the therapeutic privilege as one which allows

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[176] *Id.* at 354–55.

[177] *Id.* at 351. The court in *Canterbury* also warns against an over-expansive privilege:

> The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.

Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972) (citations omitted).

[178] *See, e.g., Canterbury*, 464 F.2d at 789; Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 317 P.2d 170, 181 (Cal. Ct. App. 1957); Natanson v. Kline, 350 P.2d 1093, 1103 (Kan. 1960).

[179] Nishi v. Hartwell, 473 P.2d 116, 119 (Haw. 1970). *See generally* APPELBAUM ET AL., *supra* note 90, at 73.

[180] *Nishi*, 473 P.2d at 119. The court also noted that a conflict between the duty to act in the patient's best interest and a frightening disclosure should be resolved in favor of the patient's best interest. *Id.*

[181] 464 F.2d at 772.

[182] *Id.* at 789. As contemplated by the *Canterbury* court, the privilege would only operate "where the patient's reaction to risk information, as reasonable [sic] foreseen by the physician, is menacing." *Id. Cf. Nishi*, 473 P.2d at 119 (withholding information regarding "untoward consequences").

[183] *Canterbury*, 464 F.2d at 789. *Cf.* Cornfeldt v. Tongen, 262 N.W.2d 684, 700 (Minn. 1977) (therapeutic privilege excuses disclosure of information where it would be "unhealthful," hinder treatment, preclude a rational decision, or cause psychological harm).

[184] *Canterbury*, 464 F.2d at 789. The court stated that in appropriate situations, the physician would be justified "in action he deems ... warranted." *Id.* This conclusion is bolstered by the court's suggestion that the physician reveal the undisclosed information to a close relative "with a view to securing consent to the proposed treatment ...." *Id. See also* Meisel, *supra* note 99, at 464–65 (unclear whether therapeutic privilege suspends duty of disclosure and consent).

[185] 350 P.2d 1093 (Kan. 1960).

the physician to withhold the *diagnosis*[186] where disclosure would "seriously jeopardize the recovery of an *unstable, temperamental or severely depressed patient*."[187] This conception would not permit the physician to rely on the privilege when the average patient might become extremely distressed but only when information would upset a patient who is at greater psychological risk. The courts have created additional confusion about the standard to be used in determining whether the physician has appropriately relied on the privilege. Some courts consider the decision to invoke the therapeutic privilege as "primarily a question of medical judgment"[188] while other courts use a reasonable person standard.[189]

In 1972, the President's Commission on Foregoing Life Sustaining Treatment specifically recommended reliance on the therapeutic privilege to physicians treating terminally ill patients for whom a DNR order may be appropriate. The Commission feared that patients would be harmed by discussions of resuscitation procedures and consequences, and accordingly, recommended that the physician might discuss the patient's condition in more general terms, in an attempt to determine the "individual's general preferences concerning 'vigorous' or 'extraordinary' efforts ...."[190]

Less than a decade after this recommendation, the Task Force which drafted New York's DNR legislation expressed concerns about physician reliance on the therapeutic privilege:

> Where the decision relates to the withholding of life-saving treatment such as CPR, the rationale for the therapeutic exception is strained; a patient is spared the harm of a discussion about CPR and is thereby denied the right to insist upon or to refuse its application. Moreover, physician reluctance to discuss resuscitation with patients heightens

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[186] *Id.* at 1103. *Cf.* Meisel, *supra* note 99, at 464–65 (therapeutic privilege does not necessarily contemplate complete non-disclosure, but usually deals only with non-disclosure of risks of treatment).

[187] *Natanson*, 350 P.2d at 1103 (emphasis added).

[188] Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965). The *Aiken* court stated that "[t]his determination [of what to disclose] involves medical judgment as to whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy, no matter how expertly performed." *Id. See also* Nishi v. Hartwell, 473 P.2d 116, 121 (Haw. 1970); Hook v. Rothstein, 316 S.E.2d 690 (S.C. Ct. App. 1984).

[189] *See, e.g.*, Cobbs v. Grant, 502 P.2d 1 (Cal. 1972).

[190] PRESIDENT'S COMMISSION, *supra* note 7, at 241. The Commission supported its conclusion with an excerpt from a physician's perspective on discussing the resuscitation issue with a terminally ill patient:

> Sometimes it seems cruel and unnecessary. Other times it is just difficult, in the midst of what is usually a very emotional and difficult time, to get around to the question of whether you want us pumping on your chest when you die. ... Having taken care of someone for some period of time has usually generated prior tacit, if not overt, understanding between the patient and me on these issues.

Id. at n.41 (quoting Michael Van Scoy-Mosher, *An Oncologist's Case for No-Code Orders*, *in* LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS 16 (A. Edward Doudera & J. Douglas Peters eds., 1982). Much has been learned about patients' feelings regarding CPR since 1982. The studies discussed in Part I of this Article do not support the notion that patients are unwilling to discuss resuscitation. *See, e.g.*, Murphy, *supra* note 9, at 2099 (no patient in Murphy's study refused to discuss resuscitation because uncomfortable with the issue). The studies also established that physicians are not particularly insightful about their patients' end-of-life treatment preferences. *See supra* note 40 and accompanying text. Finally, physicians' use of general phrases and euphemisms in discussing resuscitation and other end-of-life treatments does not effectively involve patients in decision-making. *See supra* notes 44–45 and accompanying text.

> concern about the exception. Unless workable limits can be established, the exception will swallow the rule and deny persons with capacity the right to decide whether or not they will be resuscitated in the event of cardiopulmonary arrest.[191]

The physician's avoidance of patient consultation in favor of familial consent,[192] use of deliberately vague explanations,[193] and usurpation of his patient's decision to be resuscitated[194] deprive the patient of her right to self-determination. The therapeutic privilege encourages the continued occurrence of these activities and protects physicians from any legal liability which would otherwise result from unconsented DNR orders. Although patient studies indicate that most patients for whom physicians would recommend against CPR would decline resuscitation if properly informed and given the opportunity to choose, the prospect that many patients will decline CPR does not ameliorate the physician's duty to ensure that his patient has an opportunity for independent informed choice.[195] A chronically ill or dying patient's decision to reject a DNR

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[191] TASK FORCE, *supra* note 13, at 26. The New York law does not completely prohibit reliance on the privilege, however. The statute provides that when the physician determines that a patient "would suffer immediate and severe injury" from discussing CPR, the physician may issue a DNR order without patient consent after: (1) obtaining the concurrence of a second physician that such injury would result; (2) "ascertaining the wishes of the patient to the extent possible without subjecting the patient to a risk of immediate and severe injury"; (3) documenting reasons for not consulting the patient; and (4) obtaining the consent of a substitute decision-maker. N.Y. PUB. HEALTH LAW § 2964.3 (Consol. 1992). The physician must consult the patient as soon as the medical basis for invoking the therapeutic privilege no longer exists. *Id.* The Task Force Report refers to this exception as applying where the discussion may be "life-threatening." TASK FORCE, *supra* note 13, at 26. This is not immediately apparent in the statutory language, however. The Task Force Report specifically excludes potential psychological harm as being an appropriate circumstance for reliance on the therapeutic privilege. TASK FORCE, *supra* note 13, at 27. A minority report to the Task Force Report dissented from the limitations on the therapeutic privilege proposed by the task force, claiming that they were so stringent as to virtually eliminate the privilege. TASK FORCE, *supra* note 13, at 66–71.

I agree with those who call for elimination of the therapeutic privilege entirely, as a means to foster patient self-determination. For example, Meisel observes that "[t]he danger that the therapeutic privilege poses to self-determination in medical decision-making is so great that we should seriously consider its abolition." Meisel, *supra* note 99, at 467. The abolition of the therapeutic privilege hopefully would be viewed by physicians as a "withdrawal of the legitimation of their natural reticence to disclose information." *Id.* at 469. The narrow situations of patient desire not to receive adverse information or inability to make a rational decision as a result of despair about her condition are sufficiently covered by remaining exceptions to the informed consent doctrine. If a patient specifically declines risk information about a procedure, the physician is excused from providing that information under the waiver exception to informed consent. The physician who finds his patient too distraught to make a decision may seek consent to the plan of care from a surrogate decision-maker under the incompetency exception to the doctrine.

> Another reason for the abolition of the privilege is that its application, in effect, permits the standard of disclosure to be determined by the medical profession. Thus, even in those jurisdictions which claim to have established a 'lay' standard of disclosure, the existence of the therapeutic privilege vitiates the standard.

Id. at 467 n.181 (citations omitted).

[192] *See supra* notes 35–36 and accompanying text.

[193] *See supra* notes 44–45 and accompanying text.

[194] *See supra* notes 37–38 and accompanying text.

[195] *See* KATZ, *supra* note 46, at 79. Katz believes that

> [i]nterferences with self-determination occur in all situations in which a person's dignitary interests have been violated. They are not limited to those in which physical harm has occurred. Lack of informed consent is itself a violation. It is the harm. The additional presence of physical harm only adds injury to insult.

order recommended by her physician implicates patient self-determination as significantly as the decision to accept a DNR order, and therefore, deserves equal respect and protection.[196] Implementation of a DNR order without the knowledge or consent of a patient who desires CPR deprives her of her right to life.

Obviously, the therapeutic privilege was never intended to cause harm to patients, but derives from physicians' long-held belief that deception frequently promotes the patient's best interest.[197] In actuality, the privilege enables physicians to use deception to perpetuate the notion that they must always instill "faith, hope and reassurance" in their patients, and frustrates the patient's ability to realistically and informatively make end-of-life decisions. Another explanation for physicians' invocation of the privilege emanates from their own discomfort in discussing death and not from their desire to shelter their patients from the psychological consequences from knowledge of a terminal prognosis.[198] Though the reality may be that the physician uses the therapeutic privilege to deceive himself, the greater harm of the deception falls on the patient.

Id. Shultz agrees with Katz that choice deserves independent protection and that the issue should be "whether the patient's right to choose had been encroached upon as a result of a doctor's failure to disclose." Shultz, *supra* note 120, at 249–51. *See also* Twerski & Cohen, *supra* note 101, at 101.

Under conventional informed consent doctrine, however, this wrong is not compensable without attendant personal injury and causation—proof that the patient would not have made the same decision if fully informed. *See generally* KATZ, *supra* note 46; Shultz, *supra* note 120; Twerski & Cohen, *supra* note 101. Thus, a patient who would have chosen not to be resuscitated if consulted would not have a cause of action for a physician's failure to involve the patient in a DNR decision.

[196] Several state legislatures which have enacted provisions to enable patients to express their end-of-life treatment preferences have explicitly provided that patients may request either withdrawal or continuation of death-prolonging treatment. For example, many states' living will laws explicitly recognize the patient's right to request all or some death-prolonging treatment. *See, e.g.*, 1992 Minn. Laws 535 (allows for a request of specific treatment, and withdrawal of other specified procedures and life-support); 1992 Va. Acts 748 (allows for the declarant to state a "specific procedure or treatment to be provided," as well as to direct procedures or treatment to be withheld); N.D. CENT. CODE § 23-06.4-03 (1991) (allows for a request to *continue* treatment even if the patient is terminal); 1991 N.J. Laws 201 (stipulates that a declarant may state "specific wishes regarding the *provision*, withholding or withdrawal of any form of health care") (emphasis added); OHIO REV. CODE ANN. § 2133.02 (Baldwin 1991) (allows for the execution of a declaration specifying the "use or continuation" as well as the withdrawal or withholding of life-sustaining treatment); S.D. CODIFIED LAWS ANN. § 34-12D-3 (1992) (setting forth options for treatment directives: "no treatment," "treatment for restoration," "treat unless permanently unconscious," or "maximum treatment").

[197] Veatch explains the historical basis for physicians' tendency to withhold information from patients:

> Physicians are strongly committed, in the ideal at least, to protecting patients from potential harm, both physical and mental. Traditionally, this has often manifested itself in a paternalism that has led to decisions by clinicians to withhold disturbing information from patients. ... [P]hysicians for the most part have been dedicated morally to the principle of judiciously withholding information that they feel would do serious harm to the patient.

ROBERT M. VEATCH, DEATH, DYING, AND THE BIOLOGICAL REVOLUTION: OUR LAST QUEST FOR RESPONSIBILITY 167 (1989). Veatch argues that the principle to do no harm by withholding information must be weighed against the duty to tell the truth. He relies upon Kant to conclude that the moral worth of an action (not revealing) does not depend on the expected result (not upsetting the patient). *Id.* at 169.

[198] *See* Meisel, *supra* note 99, at 461; *see generally* Murphy, *supra* note 9, at 29.

Although outright lying to patients appears to be less acceptable among contemporary physicians,[199] physician deception continues in the form of vague speech and non-disclosure.[200] Many commentators argue that non-disclosure is psychologically harmful to a patient[201]

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[199] A 1961 study revealed that 90% of the physicians surveyed frequently refrained from telling patients they had cancer. Donald Oken, *What to Tell Cancer Patients*, 175 JAMA 1122 (1961), purportedly out of fear that the patient would commit suicide. *Id.* at 1126. By 1979 reports indicated that 98% of study respondents indicated a general policy of disclosure of a cancer diagnosis. Dennis H. Novack et al., *Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems*, 261 JAMA 2980, 2984 (1989) (citing Dennis H. Novack et al., *Changes in Physicians' Attitudes Toward Telling the Cancer Patient*, 241 JAMA 879 (1979)).

[200] Novack, *supra* note 199, at 2984. Researchers have explored the use of physician deception in a variety of studies. For example, one study revealed that 20% of neurologists favored withholding anxiety-provoking information from adult patients with seizure disorders *and their families*. Another study found that physicians provided vague information about diagnosis and treatment to 39% of 1262 women with newly diagnosed breast cancer. *Id.* (emphasis added) (citations omitted). Courts have supported liberal non-disclosure by physicians who fear patient reaction. *See, e.g.*, Hook v. Rothstein, 316 S.E.2d 690, 694 (S.C. Ct. App. 1984) (physician's non-disclosure of risk of death due to experience and training that patient apprehension plays significant role in reactions to contrast media justified under therapeutic privilege).

Veatch observes that there are a number of ways physicians deceive patients using vague speech and non-disclosure: the truthful lie—physician tells the truth in very complete and scientific way, using jargon the patient cannot possibly understand; "we'll never know for sure"—the physician avoids telling the patient the severity of the situation, rationalizing that it is impossible to be 100% surė and that miracles do happen; and "you can't tell the patient everything"—the exact nature of the illness and prognosis is impossible for the physician to disclose or the patient to understand. VEATCH, *supra* note 197, at 177–79.

[201] *See, e.g.*, VEATCH, *supra* note 197, at 171 (anxiety from not knowing accurate diagnosis at least as great as knowing truth); Wanzer, *supra* note 45, at 957 (anxiety of unknown can be much more upsetting than dealing with grief of truth).

The patient who is not prepared for the potential aftermath of contraindicated resuscitation must experience some of the same trauma as any family member who is not prepared for the potential risks of a treatment or death of a loved one. By coincidence, I recently had separate conversations with my mother and a very dear friend about their feelings as teenagers at not having been told that a parent was dying until immediately before their parents' deaths. I am still struck by the almost identical expressions of resentment, betrayal and aftershock they still harbor at having been kept in the dark, of not having been able to prepare themselves and, in my mother's case, of having missed the opportunity to say goodbye. I can't help but wonder how their feelings compare to those of a patient who is similarly "protected" from preparing for the last days of life and prevented from determining how those last days will be spent. In *A Very Easy Death*, Simone de Beauvoir allows a poignant glimpse into her own struggles over whether to tell her mother she is dying and whether her mother, though not told of the gravity of her condition, does indeed know her fate. One wonders if the author's alternating perceptions that her mother "was aware of her sickness, but she accepted it patiently" and that the shock of learning she had cancer would have been too great for her to survive are more reflective of Madame de Beauvior's last days or her daughter's feelings as she watched her mother lay dying. SIMONE DE BEAUVIOUR, A VERY EASY DEATH (Patrick O'Brian trans. 1965).

Studies indicate that patients who are not terminally ill experience increased trauma when not prepared for the potential risks of a treatment which then occur:

> When a doctor deprives a patient of information with regard to risks that attend therapeutic intervention and the risks actually occur, the patient is beset by serious and unexpected psychological iatrogenic injury, in addition to the physical injury. Not only does the patient suffer needless trauma, but the patient is also profoundly troubled that medical therapy induced the trauma.

Twerski & Cohen, *supra* note 101, at 654. Widespread agreement exists that well-informed patients display a better ability to cope with adversity. *Id.* at 655 n.173. Twerski and Cohen argue that the failure of the informed consent doctrine to compensate for this trauma undervalues the importance of patient autonomy and fails to encourage information sharing. *Id.* at 648. *But* and that disclosure not only has few harmful effects, but may benefit the patient.[202]

> [P]ractically all patients, even disturbed ones, are better off knowing the truth. A decision not to tell the patient the truth because of fear of his or her emotional or psychological inability to handle such information is rarely if ever justified, and in such a case the burden of proof rests on the person who believes that the patient cannot cope with frank discussion.[203]

Physician non-disclosure engenders distrust of the medical profession as a whole,[204] which is counter-productive to the development of a patient-physician relationship most conducive to patient self-determination.[205] Exclusion from decision-making undermines the patient's trust in her physician and corrodes the very foundation of the patient-physician relationship. Every patient, but particularly one who is acutely ill, needs to be able to trust her physician. She needs the comfort and reassurance of knowing exactly what is going to happen to her and that she can believe her physician when he explains what she can expect. "A patient who is fully informed for reasoned decision-making brings personal willingness and acceptance to the ultimate decision,"[206] which is especially important in end-of-life decision-making. The physician who seeks not to upset his patient pursues an elusive goal; it is the unusual patient who will not become upset upon learning that she is terminally ill or that successful resuscitation is unlikely.

Overall, the ill-defined therapeutic privilege operates in too many instances as an escape hatch for the physician who wishes to avoid discussing end-of-life treatment issues with his patient because he remains skeptical about the concept of informed consent, continues to rely on the myths that patients cannot cope with news of poor prognoses, or is personally uncomfortable confronting patients for whom he can do no more than provide comfort care.[207] Physicians' use of the privilege to avoid having to obtain consent to a DNR order validates the fears of those who portend that the therapeutic privilege has a tremendous potential for abuse by the physicians who "may use

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see Edmund D. Pellegrino, *Is Truth Telling to the Patient a Cultural Artifact?*, 268 JAMA 1734 (1992) (suggests that truth telling and respect for autonomy as moral absolutes may be inappropriate with patients whose cultural values and concepts of autonomy incorporate delegations of authority for medical decision-making and expectations that the patient will be protected from news of impending death).

[202] Novack et al., *supra* note 199, at 2984.

[203] Wanzer, *supra* note 45, at 957. The law does not concur with the view that the physician has the burden of proof in this context. *See, e.g.*, Nishi v. Hartwell, 473 P.2d 116, 121 (Haw. 1970) (plaintiff must show under reasonable standard of medical practice doctors required to disclose); Aiken v. Clary, 396 S.W.2d 668, 675 (Mo. 1965) (patient must offer expert testimony as to disclosures reasonable medical practitioner would have made); Hook v. Rothstein, 316 S.E.2d 690, 703 (S.C. Ct. App. 1984) (plaintiff must prove by expert testimony that reasonable physician would have disclosed risks).

[204] *See, e.g.*, VEATCH, *supra* note 197, at 173.

[205] *Id.* at 172.

[206] Twerski & Cohen, *supra* note 101, at 655. Twerski and Cohen believe that the limitations imposed by illness make physician honesty particularly important: "[m]ost people are painfully aware that illness deprives them of enormous freedom and that their options are limited. However, when someone unilaterally takes away even the few choices left to them, bitterness and anger follow." *Id.* at 658.

[207] *See generally* APPELBAUM ET AL., *supra* note 90, at 72–73.

it to promote their own values or notions about what constitutes an acceptable quality of life, which may be quite different from those of the patient."[208]

2. *The Futility Exception*

No court has confronted the specific question of whether a patient can demand the continuation of treatment deemed futile by her physician.[209] Two early "right-to-die" decisions assumed that futility was a medical determination but did not entirely discount patient wishes in the withdrawal decision. The first case, *In re Dinnerstein,*[210] dealt with the legality of a DNR order consented to by the patient's family without prior court approval[211] for a terminally ill woman who was incompetent and had a life expectancy of no more than one year.[212] The court found that any attempt to resuscitate Mrs. Dinnerstein, even if successful, would do nothing to cure or relieve her illnesses.[213] The court then opined that this type of decision did not even fall within the realm of a competent patient's choice when resuscitation was not life-saving or death-prolonging.[214] The court characterized a decision about useless treatment as a "question *peculiarly within the competence of the medical profession* of what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient's history and condition and the wishes of her family."[215]

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[208] Youngner, *supra* note 7, at 28–29.

[209] The two cases involving what some would classify as futile treatment issues did not provide legal guidance. In *In interest of* Baby L, 576 A.2d 1142 (Pa. Super. 1990), the mother of a profoundly retarded child initiated court action as a result of ongoing disagreement between the mother, who requested that everything be done for her child, and hospital personnel, who felt that it was in the child's best interests to discontinue further medical intervention. John J. Paris et al., *Physicians' Refusal of Requested Treatment—The Case of* Baby L, 322 NEW ENG. J. MED. 1012, 1012–13 (1990). The case was dismissed when the consultant retained by the mother's attorney agreed to assume responsibility for the child's care. *Id.* at 1013.

In *In re* Wanglie, No. PX–91–283 (Probate Ct. Div. Minn. June 28, 1991), the physician of an 86 year-old woman in a persistent vegetative state sought the appointment of a conservator to make Mrs. Wanglie's medical decisions. This action was taken in response to her husband's refusal to consent to withdrawal of the respirator. *Id.* at 3–4. Although the family initially indicated that Mrs. Wanglie had never discussed her preferences about life-sustaining treatment, her husband testified that his wife "had consistently said she wanted respirator support for such a condition." Steven H. Miles, *Informed Demand for "Non-Beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512, 513 (1991). The probate court appointed Mr. Wanglie as conservator, finding that the hospital failed to establish that Mr. Wanglie was incompetent to serve as his wife's conservator, but proved only that Mr. Wanglie would not accept the physician's recommendations to remove his wife's ventilator. *Wanglie*, slip op. at 6. Three days later, Mrs. Wanglie died, after nineteen months on the respirator.

In *In re* Jane Doe, 418 S.E.2d 3 (Ga. 1992), a hospital sought a declaratory judgment to resolve a conflict between the parents of a minor child for whom the child's pysicians had recommended a DNR order and deescalation of other life-sustaining treatment. *Id.* at 4. Because both parents opposed deescalation of treatment at the time of the hearing, the appeal did not present and the Georgia Supreme Court did not reach the question of "medical abuse." *Id.* at 7.

[210] 380 N.E.2d 134 (Mass. App. Ct. 1978).

[211] *Id.* at 136.

[212] *Id.* at 135.

[213] *Id.* at 139. The potential of successful resuscitation (however success would be defined—a few hours, days, weeks or months) would lead some to conclude that CPR is not futile treatment and, therefore, not eligible for unilateral physician decision-making under any set of circumstances.

[214] *Id.*

[215] *Id.*

In the second case, *Barber v. Superior Court of California*,[216] the court agreed that end-of-life medical decisions belonged within the scope of the physician's role, but seemed to place higher priority on patient wishes:

> If the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. Of course the difficult determinations ... [are] who should have the power to make that decision and who should have the authority to direct termination of treatment. ... *[T]his determination is essentially a medical one .... Of course the patient's interests and desires are the key ingredients of the decision-making process.*[217]

The courts in these cases discussed futile or useless treatment in situations in which the physicians and families desired to withdraw treatment. Neither of these courts contemplated the situation where the physician would seek to remove treatment which a patient or patient's family believed held further benefit. Thus, these courts' allocation of decision-making authority to the physician where treatment is futile should not guide future courts confronted with patient or family requests to continue treatment which the physician does not recommend. Because the physician does not base the futility determination exclusively on objective medical criteria, the law should enable the patient to retain ultimate authority to decide whether futile treatment should be withheld or withdrawn.[218]

The assessment of futility invokes individualized conceptions of the benefits of risk-taking about which the physician and patient might not agree.[219] Because the benefits weighed by the patient implicate her personal values and goals about therapy, patient preferences "are an essential component of the clinical determination of futility."[220] Thus, termination of futile treatment without patient involvement isolates at least three inherent conflicts in the patient-physician relationship: (a) the scope of medical authority versus patient self-determination, (b) the boundary between medical judgment and patient values in end-of-life decision-making; and (c) futility versus resource allocation.

a. Patient Self-Determination Versus Physician Authority

The concept of self-determination and requirements of informed consent are ideals of recent origin that contrast starkly with the centuries-old conception of the patient-physician relationship as one in which the physician's

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[216] 195 Cal. Rptr. 484 (Dist. Ct. App. 1983).

[217] *Barber*, 195 Cal. Rptr. at 491–92 (quoting from Dennis Horan, *Euthanasia and Brain Death: Ethical and Legal Considerations*, 315 ANNALS N.Y. ACAD. SCIENCE 363, 367 (1978) (citations omitted) (emphasis added)).

[218] Scofield notes that the futility exception is merely a repackaging of the already rejected argument that no consent is needed for a DNR order. Scofield, *supra* note 9, at 30.

[219] Youngner makes the point that "[r]isk takers might see a 3% chance as worth taking, while others might give more weight to the 97% chance of failure." Youngner, *supra* note 81, at 2095. *See also* Twerski & Cohen, *supra* note 101, at 628–40 (discussing the many mistakes, illogical tendencies, and subconscious influences involved in patient decision-making which make patient treatment decisions unpredictable).

[220] Lantos et al., *supra* note 77, at 83. Veatch and Spicer argue that "'care that produces an effect, but one believed to be of no benefit,' should not be referred to as futile on *medical* grounds. It might be religiously futile, philosophically futile or personally futile." Veatch & Spicer, *supra* note 62, at 16–17.

role was to make all decisions which the patient was to obey without question.[221] Although the doctrine of informed consent expresses ideals intended to reject this ancient philosophy, neither the law[222] nor the medical profession has dealt satisfactorily with the issue of allocating authority in instances where a conflict exists between the values of the patient and physician.[223] Due to continued disagreement about what situations, if any, sufficiently justify the physician's interference with his patient's autonomy[224] or self-determination, the physician's dominant role continues to typify a model of medical paternalism.[225] The writings of physician proponents of patient self-determination evidence a continued paternalistic physician-patient relationship by describing the relationship as one requiring physician decision-making after consultation with the patient or family[226] rather than patient decision-making after consultation with her physician. For example, Evans and Brody explain the goals of the DNR order in terms of physician decision-making in which the physician is encouraged to "consult" with the patient or incompetent patient's family.[227] Although Evans and Brody agree with the goal of promoting patient self-determination and soliciting patient "input" in resuscitation considerations,[228] they apparently view the final decision-making authority as resting with the physician.[229]

Still wedded to medical paternalism, some physicians maintain that their duty to act in the patient's best interests requires that they retain a substantial level of decision-making authority:

> There is nothing more crucial to a physician's professional role than the making of [life-death] decisions. His responsibility for the welfare of his

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[221] *See, e.g.*, VEATCH, *supra* note 197, at 175 (describing the traditional role of the physician as analogous to a priest or parent); Shultz, *supra* note 120, at 221 (under traditional view of doctor-patient relationship, patient needed only to make one decision—to place herself in the doctor's care, "thereby delegating all subsequent authority to the doctor").

[222] Many state formulations of the doctrine of informed consent continue to grant extreme deference to the better judgment of the doctor. The realities of the patient-physician encounter more clearly reflect the extent to which the ideals of self-determination and shared decision-making in the patient-physician relationship remain theoretical or continue to be disputed by medical professionals.

[223] Shultz, *supra* note 120, at 275. Shultz observes that "[t]he medical profession holds relatively strong ethical and disciplinary ideals proscribing conflicts of interest, but its norms about deference to patient autonomy in instances of conflict of judgment or value are seriously underdeveloped." *Id.* Professor Weisbard explains the absence of norms to mediate the conflict between patient autonomy and the physician's authority as "not a failure of legal technique but a failure of will, rooted in deep-seated ambivalence among both legal and medical professionals toward the reallocation of decisionmaking authority in the professional-patient relationship." Alan J. Weisbard, *Informed Consent: The Law's Uneasy Compromise with Ethical Theory*, 65 NEB. L. REV. 749, 752 (1986).

[224] Recall that moral philosophy requires that interference with a patient's autonomy has to be justified by a competing moral principle that outweighs the principle of respect for autonomy. *See supra* notes 124–26 and accompanying text.

[225] Allen Buchanan, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling* Saikewicz-*type Cases*, 5 AM. J. L. & MED. 97, 101 (1979).

[226] *Id.*

[227] Evans & Brody, *supra* note 25, at 2236.

[228] *Id.* at 2238.

[229] *Id. Cf.* Steven S. Spencer, *"Code" or "No Code": A Nonlegal Opinion*, 300 NEW ENG. J. MED. 138, 139 (1979) ("In cases in which the physician has firmly decided that a 'no code' order is the proper course, it usually works out better for him to *explain* to family members why resuscitation will not be attempted than to *ask* them whether or not they want it attempted.") (emphasis added).

> patients often requires that he deal with technical medical issues which are of vital importance to his patients but which they [and their families] are unable to comprehend fully, if at all, and which they must therefore delegate to him. Unless he is willing to assume this decisionmaking role in the patients' [or family's] behalf he is not really doing his job.[230]

Several commentators attribute the continuing debate about "Who Decides" to the simultaneous but conflicting commitment in Anglo-American law to the vision of human beings as autonomous persons and to the values of paternalism.[231] One physician-lawyer contends that the ability of the state to override patient choices in certain circumstances evidences that patient autonomy is not absolute[232] and that physicians should therefore be "ad hoc paternalists."[233] This contention ignores the constitutional basis of the state's action and the procedural due process accorded to the patient before any such state override occurs.[234] Thus, it is incongruous to conclude that because a judge may weigh certain state interests against a patient's exercise of her right to self-determination that a physician may act similarly.[235]

Medical paternalists also argue that illness naturally makes the patient psychologically dependent on the physician, who in turn has a responsibility to accept the patient's delegation of authority to act in her best interests. Katz rejects this as a legitimate rationale for paternalism, by attributing patient dependency to the phenomenon of transference, where for a limited time, the patient sees the physician as a "parent" and the physician perceives the patient as a "child" who wants the physician to assume complete authority.[236] Katz concludes that the physician should focus instead on the patient's "still-considerable powers of understanding and choice"[237] rather than assuming

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[230] Arnold S. Relman, *The* Saikewicz *Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233, 237 (1978). Relman claims that the "traditional responsibilities of the physician demand that he make judgments to treat, or not to treat, which in effect will determine whether, and for how long, and in what condition, the patient is likely to live or die." *Id.* at 236. Buchanan criticizes Relman's view, stating that this "model takes as paradigmatic the case in which the physician alone is able to understand what is in the patient's best interest." Buchanan, *supra* note 225, at 101.

[231] *See, e.g.*, Katz, *supra* note 99, at 139; Meisel, *supra* note 99, at 418. Flick argues that the imperative of patient autonomy is itself paternalistic by deciding for patients that autonomy is best for them. Flick, *supra* note 1, at 1132.

[232] Flick, *supra* note 1, at 1133.

[233] *Id.* at 1150. Flick contends that such *ad hoc* paternalism would not be grounded on physicians' desire to tip the balance of power in their favor, but on an ethic of care—the need to protect patients from their mistakes. *Id.* at 1150. The justification for such *ad hoc* paternalism presumably rests on the principle of beneficence—that physicians ought not to inflict harm or should prevent harm. *See generally* FADEN & BEAUCHAMP, *supra* note 89, at 9–14.

[234] *See generally* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1330–33 (2d ed. 1988).

[235] *See* Rhoden, *supra* note 122, at 430 (arguing that courts should require physicians to seek judicial guidance before overriding family refusals of treatment).

[236] KATZ, *supra* note 46, at 143–46.

[237] Rhoden, *supra* note 122, at 428. Katz argues that physicians' exercise of authority results from countertransference which is manifested in "the need to appear authoritative, the importance of hiding uncertainties from patients, the need to view patients as incompetent to participate in decision making, and the belief that patients' welfare depends on patients' trusting doctors' capacities to know what is in patients' best interests." KATZ, *supra* note 46, at 150. Katz also contends that physicians have a responsibility to manage the patient's transference by acknowledging their limitations and medicine's limitations and to try to correct unreasonable patient expectations. *Id.* at 147.

complete or substantial decision-making authority from a patient weakened by pain, fear, and uncertainty.[238]

Medical paternalism creates an impossible conflict between the ethical principles that the physician act in the patient's best interest (beneficence) and that the physician not impinge upon a patient's right to consent to or refuse treatment (respect for autonomy).[239] A physician's assertion of authority to act in the patient's best interest in the face of contrary patient preferences assumes that a physician's medical training endows him with the ability to identify and assess patient values, thereby preventing a patient's exercise of her autonomy when she makes choices which cannot be objectively or scientifically validated.[240] Studies indicating that health care providers cannot accurately predict whether their patients desire DNR orders[241] further validate the conclusion that physicians have neither the skill nor knowledge to exercise authority over value-based patient treatment decisions.

Finally, physicians argue against vesting ultimate decision-making authority in the patient because a patient's choice of futile treatment undermines the *physician's* autonomy or moral principles.[242] Because the conflict between physician and patient autonomy implicates whether the patient will live or die, the patient's autonomy must supersede.[243] Two commentators have observed that to conclude otherwise the

> clinician would have to argue that the patient would be dramatically better off dead, even though the patient cannot be hurt in any but a metaphorical or symbolic way by being treated; and that the clinician's conscience is so intensely violated that it is better off that another die than that the violation occur.[244]

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[238] Physicians' relinquishment of power requires that patients overcome their fear and dependency to act autonomously by making their own decisions. *See, e.g.*, Jones, *supra* note 38, at 425. In response to critics of the *Silent World of Doctor and Patient*, Katz noted that his focus on physicians' obligations to ensure joint decision-making, with insufficient attention to patient obligations to assume responsibility for their health care decisions, was a mistake. Jay Katz, *Physician-Patient Encounters "On a Darkling Plain,"* 9 W. NEW ENG. L. REV. 207, 208 (1987).

[239] Buchanan, *supra* note 225, at 108. *See also* FADEN & BEAUCHAMP, *supra* note 89, at 13 (stating that the "problem of whether to override the decisions of patients in order to benefit them or prevent harm is one dimension of the problem of medical paternalism, in which a parent-like decision by a professional overrides an autonomous decision of a patient.").

[240] I hesitate to call any informed, thought-out choice foolish or unwise. What would be a disastrous decision for 99% of us may for some reason be the best alternative for the remaining 1%. Faden and Beauchamp observe that promotion of patient autonomy can be justified from beneficence because decisional autonomy has psychological benefits which may positively impact patient health or recovery. FADEN & BEAUCHAMP, *supra* note 89, at 14. In addition, an assumption that predominantly white male physicians of a narrow social and economic strata can determine what is in the best interests of all others ignores and denigrates those who maintain other values and priorities as a result of their very individualized situations and experiences rooted in their gender, race, class, creed, and sexual orientation.

[241] *See supra* note 40 and accompanying text.

[242] *See* Brett & McCullough, *supra* note 69, at 1349. Veatch and Spicer refer to this as "the argument from violation of professional conscience." Veatch & Spicer, *supra* note 62, at 24.

[243] *See* Veatch & Spicer, *supra* note 62, at 25. Veatch and Spicer reach the same conclusion on the bases of the duty of fidelity to promises and the monopoly privileges of licensure. *Id.* at 27–28.

[244] *Id.* at 25.

The medical profession's failure to justify satisfactorily physicians' claims of superior ability to determine their patients' best interests[245] and the supremacy of this determination over patient self-determination lead to the conclusions that the physicians' claims are illegitimate and patient self-determination must prevail. Fostering patient autonomy should be the preeminent concern about the CPR actual consent/DNR presumed consent model. A new exception to informed consent in futile cases "will swallow the rule at a time when physicians are still reluctant to speak with patients about resuscitation."[246]

b. The Line Between Medical Judgment and Patient Values

The question of what decisions belong exclusively to the physician as medical judgments and what decisions belong solely to the patient as value judgments which implicate self-determination lies at the heart of the quest by physicians for a futility exception to DNR orders.[247] Most patients' desires to

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[245] Buchanan argues that if physicians have a duty to do what is in the patient's best interest and patients do not know what is in their best interest, as many physicians suggest, then the requirement that physicians act in the patient's best interests requires that the physician violates the principle of informed consent. Buchanan, *supra* note 225, at 108. Katz concurs, stating that "[t]he idea that doctors know what is in their patients' interest and therefore can act on their behalf without inquiry is so patently untrue that one can only marvel at the fervor with which the notion has been defended." KATZ, *supra* note 46, at 98.

[246] Miller, *supra* note 27, at 251. Miller fears that physicians will use the futility exception as an "escape hatch" to avoid conversations with patients. *Id.*

Scofield objects to an exception to informed consent which further vests physicians in a position of increased authority for which they are totally unaccountable. He argues that forcing the physician to share with patients the basis of his or her determination that CPR is not worthwhile will foster self-scrutiny and force the physician to clarify the basis upon which the recommendation is being made. Scofield, *supra* note 9, at 31.

Scofield also fears a slippery slope:

> If physicians are given the authority to enter DNR orders unilaterally when they believe resuscitation would be futile, nothing prevents their using the same reasoning to enter DNT (do-not-treat), DNH (do-not-hospitalize), or any other order denying treatment unilaterally when they believe it would be futile—whether "futile" means not medically effective, not cost effective, or not worth it for this patient. The futility exception sets limits to everything and everyone except the medical profession's autonomy.

Id. at 34.

[247] Commentators have recently begun to argue that even brain-death implicates both medical judgment and patient values. Brain-death has almost universally been recognized as a legally appropriate standard for determining the point of death. *See, e.g.*, Strachan v. John F. Kennedy Memorial Hosp., 538 A.2d 346 (N.J. 1988) (brain death appropriate for inclusion in legal definition of death); *In re* Jones, 433 N.Y.S.2d 984 (Sup. Ct. 1980) (brain death as medically defined meets legal requirement for death); *In re* Bowman, 617 P.2d 731 (Wash. 1980) (brain death standard appropriate legal standard for death, which should be determined pursuant to appropriate medical criteria). *See also* ALA. CODE § 22-31-1 (1991); ALASKA STAT. § 09.65.120 (1991); CAL. HEALTH & SAFETY CODE § 7181 (Deering 1992); FLA. STAT. ch. 382.009 (1991); IOWA CODE § 702.8 (1991); LA. REV. STAT. ANN. § 9:111 (West 1992); MONT. CODE ANN. § 50-22-101 (1992); N.C. GEN. STAT. § 90-320 (1991); OKLA. STAT. tit. 63, § 3123 (1991); TEX. HEALTH & SAFETY CODE ANN. § 671.001 (West 1992); VA. CODE ANN. § 54.1-2972 (Michie 1992); W. VA. CODE § 16-10-1 (1992).

However, some argue that it may be appropriate to continue treatment for a patient for whom a determination of death by brain death criteria violates the patient's religious or cultural beliefs. *See* Fred Rosner, *Definition of Death in Jewish Law*, N.Y. J. MED. 973, 975-76 (June 1983) (Jewish legal definition establishes death when spontaneous respiration ceases; minority would also require cessation of heart beat); Robert D. Truog & James C. Fackler, *It Is Reasonable to Reject the Diagnosis of Brain Death*, 3 J. CLINICAL ETHICS 80 (1992) (Jewish, Japanese and Native American cultural traditions reject neurological grounds for diagnosing share end-of-life treatment with their physicians blurs any line which may exist between medical judgments and patient values.[248] Despite the impracticability of line-drawing in this context, physicians' desires to make unilateral futility decisions coupled with the legal problems arising from patient-physician disagreement necessitate further discussion of where ultimate decision-making power and the boundary between medical judgment and patient values rests.

Paul Ramsey has argued that physicians define too broadly the realm of medical judgment and has called for the medical profession to adopt a stricter construction of medical judgments instead of assuming "responsibility for the full range of human moral considerations."[249] Thus, Ramsey advised that the medical imperative must be distinguished from the moral imperative in dealing with the dying.[250] Professor Katz seems to agree with Ramsey: *how* to render treatment, says Katz, is a question for the physician; *whether* to undergo treatment is a decision for the patient.[251]

Futility proponents, on the other hand, reserve for physicians the authority to assess the reasonableness of a patient's choice or assertion of values. Specifically, Tomlinson and Brody argue that physician authority to implement a DNR order without patient consent or in the face of explicit patient non-consent is necessary and appropriate when the patient's demand for CPR is unreasonable.[252] They believe, however, that the physician should inform the patient of his decision not to resuscitate as a means of "investigating or securing the patient's best interest."[253] They allow that the physician might acquiesce to a patient demand for futile resuscitation out of concern for the patient's psychological welfare,[254] but emphasize that respect for patient autonomy does not *require* this compromise by the physician.

Two legal commentators who have addressed patient consent to futile treatment have adopted positions similar to that of Tomlinson and Brody.

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death). *See also* 1991 N.J. LAWS 90 (5) (brain death criteria shall not be used when it would violate religious beliefs of moral convictions of patient); Charlotte K. Goldberg, *Choosing Life After Death: Respecting Religious Beliefs and Moral Convictions in Near Death Decisions*, 39 SYRACUSE L. REV. 1197, 1197 *passim* (individual's moral convictions or religious beliefs that treatment should continue beyond societal definition of death should be respected); *Brain Death and the Termination of Life Support: Case and Analysis*, 3 J. CLINICAL ETHICS 78 (1992). *But cf.* Gallups v. Cotter, 534 So. 2d 585 (Ala. 1988) (parents have no cause of action against physicians who withdraw treatment from brain-dead child despite parents' alleged objection to termination of such treatment). A decision to continue treatment in such a situation is reflective of Ramsey's comment that "a doctor may and sometimes should allow his medical judgment to defer to a patient's estimate of the higher importance of the worth and the relations for which his life was lived." PAUL RAMSEY, THE PATIENT AS PERSON: EXPLORATIONS IN MEDICAL ETHICS 137 (1970).

[248] *See supra* notes 39–40 and accompanying text (studies indicating patients' desires to share resuscitative treatment decisions with their physicians).

[249] RAMSEY, *supra* note 247, at 123.

[250] *Id.* at 124. Jay Katz seems to concur by his observation that "doctors' value judgments" are often obscured by their homogeonizing all values under the single rubric of medical judgment. KATZ, *supra* note 46, at 96.

[251] KATZ, *supra* note 46, at 98.

[252] Tomlinson and Brody use as their referent a "*social* judgment of 'reasonableness,' not an individual one, because it does not suspend judgment about what ends are worth pursuing. Social judgments about the range of rational conceptions of the good set the boundaries within which individual, instrumental rationality can competently operate." Tomlinson & Brody, *supra* note 65, at 1279.

[253] *Id.*

[254] *Id.*

George Annas, who raised the issue in 1982, almost eight years before physicians began arguing strenuously for a futility exception, suggested that cases exist where the patient's condition is hopeless and the DNR decision is basically a medical one which should be made by the attending physician.[255] Although Annas initially stated that the role of the family is irrelevant, by analogizing a "hopeless prognosis" to a pronouncement of death, he later indicated that he "would want" a competent patient's consent to the DNR order.[256] He then reiterated, however, that even if the patient did not consent, "at some point even the patient's demand for CPR becomes a demand for 'mistreatment' with which the physician need not comply."[257]

Carol Ann Mooney has also considered the futility issue, and states that the decision not to resuscitate is not exclusively medical, but also is a moral, ethical, and religious one,[258] which therefore removes it from the exclusive realm of medical expertise. Although Mooney speculates that in the future society may reach a consensus that at some point further treatment offers no benefit and can be withheld without patient consent, she emphatically concludes that "little consensus exists; therefore self-determination rules."[259] However, Mooney then retreats from this position, asserting that "situations may arise where even the patient's wishes are insufficient to change the physician's judgment not to resuscitate"[260] in which case "the physician may enter the order without her patient's concurrence."[261]

In my opinion, Annas and Mooney accord insufficient weight to patient self-determination. A patient's right to demand futile treatment implicates the same legal rights as those at issue in "right-to-die" cases and consequently should be governed by that jurisprudence. If society accepts or courts decide to recognize a futility exception to informed consent, they should adopt the most narrow definition of medical futility identified by Youngner;[262] those situations in which a physician can say with absolute certainty that CPR will not reestablish spontaneous heartbeat or will not postpone death for even a few

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[255] Annas, *supra* note 58, at 30. *See also* Conny Davinroy Beatty, Comment, *Case of No Consent: The DNR Order as a Medical Decision*, 31 ST. LOUIS U. L.J. 699, 706 (1987) (if CPR would be ineffective, informed consent to DNR order is "senseless").

[256] Annas, *supra* note 58, at 30–31. *See also* Spencer, *supra* note 229, at 139 (commenting that when a physician has decided a "no code" order is appropriate, he should *explain* why resuscitation is not going to be attempted, rather than *ask* family members whether they wish resuscitation attempts).

[257] Annas, *supra* note 58, at 30.

[258] Mooney, *supra* note 9, at 1078.

[259] *Id.* at 1078 n.334.

[260] *Id.* at 1079.

[261] *Id.* I agree with Professor Mooney's initial proposition that medical and societal consensus may be reached at some future time that non-beneficial CPR may be withheld without patient consent. I do not believe, however, that the medical community has presented sufficient evidence about and agreement on the precise circumstances in which CPR is physiologically non-beneficial. Neither has the medical community obtained societal support for a shift in CPR treatment to provide for unconsented withholding of CPR. Although no patients with metastatic cancer who received CPR have been shown to survive until hospital discharge, a determination that CPR is non-beneficial for these patients ignores the potential value to the patient of the additional time lived after CPR and has not been discussed publicly so that patients understand that hospitals will no longer automatically perform CPR in every circumstance. In addition, even if physicians do not offer CPR to all patients, circumstances may remain in which physicians should honor a patient request for non-beneficial CPR. I believe that all of these goals can be best pursued by shifting to the conventional informed consent paradigm.

[262] *See supra* note 82 and accompanying text.

minutes. In actuality, this narrow definition of futility encompasses merely a few patients. In all other cases, an evaluation of whether CPR is worthwhile involves value judgments, a cost-benefit analysis, or assessments of risk-taking, all of which fall outside the realm of medical judgment into the realm of patient self-determination. Irrespective of what the physician believes about the probable success of CPR for a particular patient, self-determination demands that the competent patient retain the sole right to weigh the risks and benefits associated with CPR in determining whether she desires to be resuscitated.

In many instances, a physician becomes part of his patient's life for the first time when she enters the hospital. The physician in a teaching hospital may be one of a number of residents and fellows caring for the patient or, as the attending physician who supervises the residents, see the patient only a few short times. Thus, although the physician may make every attempt to ascertain the bases of his patient's decisions, he is essentially caring for a stranger. The physician who decides to override his patient's decision for CPR because he believes his patient's decision is unreasonable is frequently operating devoid of any knowledge of his patient's values, experiences, hopes and fears. Indeed, he has little or no basis for knowing that what seems unreasonable and wasteful to him may, for his patient, make perfect sense "in the big scheme of things."[263]

Patients who demand futile CPR fall within one or more of the following four categories: (i) those who are unwilling to accept their prognosis and impending death; (ii) those whose religion, ethics or values demand that they pursue every potential treatment; (iii) those who desire to remain alive to witness a life event such as the marriage of a child or the celebration of a major holiday; and (iv) those who appear to their caretakers to be idiosyncratic or unreasonable. The physician's primary concern for the dying patient who demands futile CPR because she refuses to acknowledge her impending death should be her psychological well-being. The patient's right to be the ultimate decision-maker[264] about her treatment cannot disappear simply because she is extremely ill or dying, even if her illness impairs optimal psychological functioning.[265] Katz advises that

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[263] Allowing physicians' decisions to supersede patient determinations also ignores the value of the information exclusively available to the patient, such as her familial, financial and emotional concerns. *See* Theodore J. Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices*, 1976 WIS. L. REV. 124–34. Physicians' desire to overrule patient requests for continued treatment which the physician deems "medically useless" may result in part from the phenomenon of the medical profession described by Ian Kennedy to view the patient not as a complex human being, but as a specific disease. IAN KENNEDY, THE UNMASKING OF MEDICINE 1–25 (1981).

[264] *See generally* Shultz, *supra* note 120.

[265] KATZ, *supra* note 46, at 154. Pursuant to the exceptions to informed consent, a physician is not required to obtain consent to treatment from a patient whom the physician determines is incompetent. *See generally* APPELBAUM ET AL., *supra* note 90, at 81–83. Although legal standards for incompetency are unclear, it is generally understood that a patient who lacks the ability to "understand the nature and consequences of authorizing treatment" cannot give a valid consent. ROZOVSKY, *supra* note 120, at 21. In this context, I am using impaired psychological functioning to refer to the patient's denial of her impending death. Such impairment would not generally constitute incapacity for treatment decision-making and should not be used by physicians as a basis to overrule the patient's decision under the incompetency exception to the doctrine of informed consent. *See* Lane v. Candura, 376 N.E.2d 1232, 1235–36 (Mass. App. Ct. 1978) (irrationality of medical decision does not make patient legally incompetent to make decision).

> in the evaluation of patients' ultimate choices, considerations of human beings' psychological limitations should not lead to overruling patients' decisions. Although this may mean bowing at times to "foolish" choices, they must be honored to protect the process of thinking about choices which would become compromised if the threat of having patients' choices vetoed whenever they appear foolish hangs over their heads.[266]

If the physician discovers that the patient is merely denying impending death or requesting continued treatment out of an inability to decide, the physician should obtain counselling for and suggest to the patient that an appropriate decision would be to discontinue useless treatment. Ultimately, in the case of continued physician disagreement, physician and patient should either go their separate ways or the physician should agree to provide care within the limits imposed by the patient. [267]

The patient's right to make health-care decisions for herself on the basis of her religious, ethical, or moral beliefs is generally supported by the doctrine of informed consent.[268] Patient requests for futile CPR based on religious or ethical grounds most acutely implicate the underlying concept of informed consent—self-determination. Vesting in the physician the power to arbitrate what constitutes reasonable patient decisions and rationales which deserve respect grants physicians authority never previously accorded by a court or legislature, and establishes as superior the physician's values, culture, beliefs and decision-making process.

Despite commentators' most ardent support for the futility exception when the patient's demands for futile CPR seem baseless and irrational,[269] the patient's unique experiences and perspectives, which are frequently unknown to her physician, require that the physician comply with even the apparently irrational choices of the competent patient. For example, an uninsured Latino's belief that his physician would not have suggested a DNR order if he had insurance or an African-American AIDS patient's belief that his white physician's recommendation of a DNR order perpetuates racial genocide may not be known to the physician or, if known, may be deemed irrational. Physicians fail to recognize that what they perceive to be "irrational" patient

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[266] KATZ, *supra* note 46, at 154.

[267] *Id.* at 163; TASK FORCE, *supra* note 13, at 10.

[268] The most obvious line of cases exemplifying courts' support of health care decision-making grounded on religious beliefs is the Jehovah's Witness blood transfusion cases. The cases in which courts have required pregnant women to accept medical treatment in contravention of their religious beliefs constitute a notable exception to courts' support of treatment refusals on religious grounds. *See, e.g.*, Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981) (ordering woman to have caesarean section and blood transfusions despite religious beliefs to the contrary); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 201 A.2d 537 (N.J.), *cert. denied*, 377 U.S. 985 (1964) (ordering pregnant Jehovah's Witness to receive blood transfusions to save woman's and fetus' lives); Crouse-Irving Memorial Hosp. v. Paddock, 485 N.Y.S.2d 443 (Sup. Ct. 1985) (ordered transfusions over religious objections of pregnant Jehovah's Witness because right to religious beliefs must yield to state's interests, as *parens patriae*, in protecting child's welfare); *In re* Jamaica Hosp., 491 N.Y.S.2d 898 (Sup. Ct. 1985) (ordered transfusions for pregnant Jehovah's Witness because state's interest in pre-viable fetus outweighed patient's right to refuse on religious grounds). *But see* Taft v. Taft, 446 N.E.2d 395 (Mass. 1983) (vacated order which required born-again Christian to submit to operation for benefit of fetus).

[269] *See, e.g.*, Beatty, *supra* note 255, at 709 ("The informed consent doctrine should be employed in a manner that encourages rational decisionmaking .... '[a] demand for futile treatment is irrational'").

choices may be an expression of "different value preferences about the importance of longevity, quality of life, bodily invasions, or the risks a patient is willing to take for the purposes of greater well-being."[270]

No legal precedent exists to support a physician's unilateral substitution of his judgment for a competent patient's decision. In fact, the New Jersey Supreme Court has stated that if the "right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole"[271] and that medical choices should be free from "societal standards of reasonableness or normalcy."[272] Utilizing this standard, virtually every court has upheld a competent patient's treatment choice with which her physician disagrees, even when that choice would result in death. Certainly, a court would support and affirm a patient decision to continue treatment that constitutes not only an exercise of patient self-determination but also coincides with the state interest in preservation of life.[273]

The vesting of decision-making authority becomes a more difficult issue when an incompetent patient has not discussed end-of-life treatment decisions with her physician and has not provided any advance directives.[274] Although state standards for surrogate decision-making for an incompetent patient vary,[275] all states accord significant weight to patient values. Courts and

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[270] KATZ, *supra* note 46, at 118.

[271] *In re* Conroy, 486 A.2d 1209, 1225 (N.J. 1985). *See also*, Lane v. Candura, 376 N.E.2d 1232, 1236) (Miss. App. Ct. 1978) (law protects right to accept or reject treatment, whether decision is wise or unwise).

[272] *In re* Peter, 529 A.2d 419, 423 (N.J. 1987).

[273] State right-to-die decisions have agreed that "the most significant of the asserted State interests is that of the preservation of human life." Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977).

[274] The publicity surrounding the various "right-to-die" cases over the last several years has spawned enumerable state legislative responses to the problem of determining incompetent patients' preferences about withdrawal of death-prolonging treatment. Such legislation provides for a variety of "advance directives," including living wills, which enable a patient to set forth treatment preferences in certain limited circumstances; durable powers of attorney, which allow a patient to appoint an agent to make her health care decisions in the event of incompetency; and health care agent proxy laws, which also allow a person to appoint an agent to make health care decisions, with or without prior instruction. For a more detailed overview of the legislative activity in this area, see generally HANDLING YOUR FIRST HEALTH CARE PROXY, LIVING WILL AND DURABLE POWER OF ATTORNEY (Practising Law Institute 1992) [hereinafter HANDLING YOUR FIRST HEALTH CARE PROXY]; REFUSAL OF TREATMENT LEGISLATION (Soc'y for the Right to Die ed., 1991).

[275] *See* Veatch & Spicer, *supra* note 62, at 22. The states are split as to whether decisions for an incompetent patient should be made according to a best interests or substituted judgment standard. Substituted judgment permits the decision-maker to choose medical care according to his or her perception of the patient's attitude toward death-prolonging treatment. Some states require clear and convincing evidence of a patient's wishes. *See, e.g.*, Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 283–84 (1990); *In re* Estate of Longeway, 549 N.E.2d 292, 299–300 (Ill. 1989); Mack v. Mack, 618 A.2d 744 (Md. Ct. App. 1993); *In re* Gardner, 534 A.2d 947, 952 (Me. 1987); *In re* Jobes, 529 A.2d 434, 443 (N.J. 1987); *In re* Storar, 420 N.E.2d 64, 72 (N.Y. 1981); *In re* Westchester County Medical Ctr. *ex rel.* O'Connor v. Hall, 531 N.E.2d 607, 613–15 (N.Y. 1988); Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809, 815 (Ohio Misc. 1980). Other jurisdictions allow for substituted judgment with less stringent evidentiary requirements. *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580, 587–88 (D.R.I. 1988); Brophy v. New Eng. Sinai Hosp., Inc., 497 N.E.2d 626, 633–34 (Mass. 1986).

The substituted judgment standard, as applied in Massachusetts, has come under criticism for allowing decisions to be made based on the hypothetical wishes of a patient who legislators defer to family members or other persons designated by the patient[276] as the most reliable sources to determine the patient's values or the patient's best interests.

Preference for family as surrogate decision-makers does not foreclose the possibility that a patient's family will request futile treatment for an incompetent patient that is neither in the patient's best interest nor a reflection of the patient's values.[277] In such a case, the physician does not have the power to independently override the family's decision but may and should seek the appointment of a guardian[278] who will make decisions for the patient pursuant to appropriate medical, ethical and legal criteria.[279] In right-to-die cases, judges have not and should not defer to family solely by virtue of their relation to the patient; judges have merely created a rebuttable presumption that family

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was never competent and who never considered nor made a statement concerning medical treatment. *See, e.g.*, Care and Protection of Beth, 587 N.E.2d 1377, 1381 (Mass. 1992) (applied substituted judgment standard for a young child); *In re* Doe, 583 N.E.2d 1263, 1268 (Mass. 1992) (applied substituted judgment standard for 33-year-old retarded woman, but recognized that substituted judgment as used for a never-competent person is indeed a legal fiction); Custody of a Minor, 434 N.E.2d 601, 608 (Mass. 1982) (applied substituted judgment for a terminally ill abandoned newborn); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 430–32 (Mass. 1977) (applied substituted judgment for mentally retarded man).

The best interests standard allows the decision-maker to choose treatment based on his or her own perception of the best course of action for the patient. Some states indicate that although substituted judgment should be used when the patient's desires are known, the best interests standard is acceptable when the patient never expressed her preferences. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 221–22, 741 P.2d 674, 688–89 (1987) (because no reliable evidence of a patient's wishes, best interests standard is appropriate); *In re* Grant, 747 P.2d 445, 456–57 (Wash. 1987) (patient's guardian must attempt first to determine what decision the patient would have made; if no choice can be ascertained, a best interests standard may be applied).

[276] *See infra* note 280.

[277] Ramsey attempts to explain why families request treatment which is neither in the patient's best interests or a reflection of the patient's previously expressed desires:

> Out of their guilt, members of the family are likely—at long last—to require that everything possible be done for the hopelessly ill and the dying loved one. This may mean the prolongation of dying or the continuation of extraordinary life-sustaining measures beyond reasonable moral justification. ... This means that the physician must exercise the authority he has acquired as a physician and as a man in relation to the relatives and take the lead in suggesting what should be done. In doing this, the doctor acts more as a man than as a medical expert, acknowledging the preeminence of the human relations in which he with these and all other men stand. For this reason, the medical imperative and the moral imperative or permission are, while distinguishable, not separable in the person or in the vocation of the man who is a physician.

RAMSEY, *supra* note 247, at 143. *See also In re* Jobes, 529 A.2d 434, 447 (N.J. 1987) ("[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient").

[278] Mooney observes that

> A court likely will resolve disputes when the family is "acting in a manner which is clearly not in the best interests of the patient." Such resolution is more probable when the family demands a medically inappropriate DNR order than when the family opposes a DNR order. In the latter case, hospitals appear to acquiesce to the family's request to attempt resuscitation.

Mooney, *supra* note 9, at 1048–49 (citations omitted).

[279] It is not the purpose of this Article to engage in the debate about the proper standard for decision-making on behalf of incompetent patients. My only point is that physicians may seek alternative decision-makers where a family is not complying with whatever standard has been adopted in the state in which the physician practices.

members are the best qualified to act as surrogate decision-makers.[280] This same standard should apply when the family is inappropriately requesting to continue futile treatment.[281]

In sum, the rare case of patient or family demands for futile CPR which physicians believe are unreasonable and idiosyncratic do not support the application of a futility exception which could be applied to a broad spectrum of patients.[282] In addition, it is inappropriate to even consider the creation of an exception to the doctrine of informed consent which would legitimize physician usurpation of patient autonomy when poor physician communication continues to be a substantial reason for patient misunderstanding about resuscitation. The recognition of a futility exception would have the primary effect of relieving physicians of the admittedly difficult, but necessary, responsibility of discussing death and dying with their patients.[283] Rather than providing physicians an excuse to avoid discussing end-of-life treatment, the law should encourage physicians to be more aggressive about discussing CPR with patients as early as possible.[284]

c. Futility Versus Resource Allocation

One of the reasons physicians support a futility exception is that resuscitation wastes scarce health care resources.[285] This rationale, as a motivating factor for the futility exception, presents two problems. First, it confuses the issues of futility and resource allocation. Second, there exists no public consensus as of yet as to whether or how health care resource reallocation should occur; therefore a physician has neither the authority nor the guidance to determine that a patient should not receive "futile" treatment which the physician decides is not cost-beneficial.

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[280] *See* Brophy v. New Eng. Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); *In re* Peter, 529 A.2d 419 (N.J. 1987). "The proper presumption ... is that the family of an incompetent patient, in consultation with the physician, is to make decisions concerning initiation and continuation of treatment, unless there exists a clear and reliable prior expression of the patient's preferences when he or she was competent (for example, a bona fide 'living will')". Buchanan, *supra* note 225, at 110–11. *But see Cruzan,* 497 U.S. at 284 (a state is not constitutionally required to repose substitute judgement with anyone but the patient herself). "[T]here is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent." *Id.* at 286.

[281] I agree with Dr. Angell who asserts that providers should challenge family decisions only when they appear to violate the patient's best interests. Marcia Angell, *The Case of Helga Wanglie: A New Kind of "Right to Die" Case,* 325 NEW ENG. J. MED. 511 (1991).

[282] Scofield, *supra* note 9, at 32.

[283] *Id.* at 33.

[284] *See* Wanzer et al., *supra* note 45, at 956; Youngner, *supra* note 7, at 29.

[285] *See, e.g.*, Murphy, *supra* note 9, at 2098. *See also* Beatty, *supra* note 255, at 715 (urging elimination of consent requirement when CPR is futile in part due to cost of resuscitation). Patients who receive CPR tend to be the highest cost to hospitals (one-fourth considered high outliers; $741/day) while the DNR patients are the second highest (one-third considered high outliers; $510/day) as compared to a control group (10% considered high outliers; $383/day) Stolman et al., *supra* note 9, at 1854. Outliers consist of cases in which the length or cost of care greatly exceeds the norms assigned to the case by Medicare, but for which Medicare will pay a part of the additional costs. *See* BARRY R. FURROW ET AL., HEALTH LAW 729 (2d ed. 1991).

There is great danger in confusing the issues of physiologically futile treatment and allocation of scarce health care resources.[286] The need for reallocation of health care resources may be an appropriate reason for society to consider whether it is willing to pay for futile treatment for a dying patient[287] but it is not a criterion by which a physician may independently determine that particular treatments for a dying patient are futile:

> Although care that is futile is also not "costworthy," care that is not costworthy relative to other uses of medical resources may still offer benefits to the patients and so not be futile. Public trust in physicians' loyalties to patients can be maintained, and deception of patients avoided, only if the public dialogue distinguishes carefully between treatment judged to be futile and treatment judged not costworthy.[288]

At least one physician commentator contends that a social consensus exists that allows physicians to withdraw care from patients for whom it is no longer cost-beneficial.[289] In *In re Wanglie*, the physicians argued that the family was unreasonably demanding continued treatment for an incompetent patient.[290] One of the physicians involved in the case recommends that the physician must consider resource allocation in deciding whether to accede to patient requests for treatment:

> After the conclusion was reached that the respirator was not benefiting the patient, the decision to seek a review of the duty to provide it was based on an ethic of "stewardship." Even though the insurer played no part in this case, physicians' discretion to prescribe requires responsible handling of requests for inappropriate treatment. Physicians exercise this stewardship by counseling against or denying such treatment or by submitting such requests to external review. This stewardship is not aimed at protecting the assets of insurance companies but rests on fairness to people who have pooled their resources to insure their collective access to appropriate health care.[291]

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[286] *Cf.* Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L. REV. 1809, 1818 (1992) ("One of the primary issues involved in defining necessary care is the extent to which the societal interest in conserving costs should be taken into account.").

[287] *See* Veatch & Spicer, *supra* note 62, at 28–31. That intensive care may now account for 15% of the gross national product makes futile treatment a serious economic concern. Truog, *supra* note 247, at 80. Veatch and Spicer note, however, "that not all care that is inefficient in cost-benefit terms is morally expendable." Veatch & Spicer, *supra* note 62, at 29. Because the principle of justice requires benefit to the least well off, "an equitable limit on care will permit some care to be provided for the least well off patients even if that care is not the most cost-beneficial." *Id.* at 29–30.

[288] Tomlinson & Brody, *supra* note 65, at 1280.

[289] Miles, *supra* note 209, at 514.

[290] *In re* Wanglie, No. PX-91-283 (Probate Ct. Div. Minn. June 28, 1991). Maintaining Mrs. Wanglie in a persistent vegetative state for sixteen months cost in excess of $700,000, $200,000 of which was paid by Medicare, with the balance covered by private insurance. Miles, *supra* note 209, at 513. The physicians' position that Mrs. Wanglie's respirator be removed was not based on a futility determination, since the respirator sustained her life. Paul T. Menzel, *Some Ethical Costs of Rationing*, 20 LAW, MED. & HEALTH CARE 57, 59 (1992); Miles, *supra* note 209, at 513. Menzel opines that Wanglie's physicians should have portrayed her case not as one in which further care had no benefit to the patient but as "a permissible case of rationing out care that is too expensive for its benefits." Menzel, *supra*, at 59.

[291] Miles, *supra* note 209, at 514. *Cf.* Norman G. Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED. 1573, 1574 (1984) (physicians not entitled to discontinue treatment on basis

Society has not yet reached a consensus that a physician may refuse to honor patient requests for treatment for which the physician believes the costs outweigh the medical benefits.[292] No regulatory agency, legislature[293] or court,[294] the ultimate purveyors of the social conscience recognized in our

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of cost considerations, and should not attempt resource conservation by relying on probabilities of success or failure to decide about patient's care).

[292] Murphy argues for a rather broad application of a futility exception for DNR decisions in the long term setting as a solution to resource allocation in the context of resuscitation, but recognizes that consensus has not yet occurred:

> Should all LTC patients be entitled to CPR so that we can avoid the extremely rare case of an elderly patient dying before death is inevitable? And, further, should society provide the substantial resources needed to prevent such a case? If CPR is viewed as a life-prolonging therapy with certain indications (similar to organ transplantation), rather than an emotion-laden, technological attempt to do "everything possible," the answer may be no. Once society recognizes the futility of CPR in the LTC setting, it is likely that society will not be so willing to provide those resources (training, technology, professional time, etc.) necessary to prevent the extremely rare case ...

Murphy, *supra* note 9, at 2100.

[293] Oregon's Medicaid reform proposal is probably the single exception. Aimed at the seemingly divergent goals of cost-containment and universal coverage, The Oregon Medical Demonstration Project proposes a controversial rationing approach to providing health care services to the poor. *See generally* Marilyn Moon & John Holahan, *Can States Take the Lead in Health Care Reform?* 268 JAMA 1588, 1589 (1992). The Oregon plan envisions expanding Medicaid coverage to an additional 120,000 of the state's working poor by limiting its coverage to pre-prioritized "condition-treatment pairs." Neil R. Pierce, *AmBush May Chill Health Care Reform*, THE HOUSTON CHRONICLE, August 10, 1992, at A14. *See also* Elliott S. Fisher et al., *Prioritizing Oregon's Hospital Resources: An Example Based on Variations in Discretionary Medical Utilization*, 267 JAMA 1925, 1925 (1992). Implementation of the Oregon statute was contingent upon a federal waiver sanctioning the restriction of Medicaid services for current recipients, and the expansion of the program to include the additional 120,000 recipients currently not eligible for Medicaid. Moon & Holahan, *supra*, at 1589. The Bush Administration denied Oregon's application for waiver in September of 1992 on the grounds that it violated the 1990 Americans with Disabilities Act. Pierce, *supra*.

[294] The caselaw which forms our right to die jurisprudence has for the most part rejected financial considerations as a basis upon which termination of end-of-life treatment decisions may be made, reasoning that financial concerns may inappropriately influence a surrogate's decisions on behalf of an incompetent patient. *See, e.g., In re* Doe, 583 N.E.2d 1263, 1269 n.15 (Mass. 1992) ("The cost of care in human or financial terms is irrelevant to the substituted judgment analysis"). Courts frequently look at the financial effects on surrogate decision-makers of a patient's continuing treatment as one of the benchmarks to ensure that the surrogates are not acting contrary to the incompetent patient's best interests. *See, e.g., In re* Browning 568 So. 2d 4, 18 (Fla. 1990) (dissent); *In re* Longeway, 549 N.E.2d 292, 300–01 (Ill. 1989); *In re* Spring, 405 N.E.2d 115, 122 (Mass. 1980); *In re* Colyer 660 P.2d 738, 747 (Wash. 1983). *But see In re* Grant, 747 P.2d 445, 455 (Wash. 1987) ("The prolongation of the existence of this vegetative state for possibly years to come by artificially placing liquids and nutrients into this body to the emotional and economic destruction of the survivors is a monstrous assault to the family concerned that we will not countenance.").

Very few courts discuss the public policy implications of maintaining terminally or irreversibly ill patients on life support systems for prolonged periods of time. Justice Blackmar raised this issue in his dissent in *Cruzan*: "The absolutist position is also infirm because the state does not stand prepared to finance the preservation of life, without regard to the cost, in very many cases. ... Many people die because of the unavailability of heroic medical treatment." Cruzan v. Harmon, 760 S.W.2d 408, 429 (Mo. 1988) (en banc) (dissent). "An absolutist would undoubtedly be offended by an inquiry as to whether the state, by prolonging Nancy's life at its own expense, is disabling itself from pending needed treatment to others who do not have such dire prognosis." *Id.* 429 n.4.

Professor Fleck further elucidated Justice Blackmar's point:

> [I]t is prima facie unjust that the state of Missouri would spend close to one million dollars in Medicaid funds to keep Nancy Cruzan alive for nearly eight

democratic society,[295] has expressed a consensus[296] that physicians may determine or how they should determine[297] that costly treatments should not be offered to patients for whom they will provide only marginal benefits. The fiduciary nature of the patient-physician relationship requires that the physician, as an exclusive agent of the patient, place the patient's interests above all others, including societal concerns about conserving health care resources.[298]

Policy makers, not individual physicians, should establish guidelines to contain health care costs.[299] The physician should participate in these public

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> years in a persistent vegetative state while providing access to Medicaid for only forty percent of those below the poverty level in Missouri.

Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach,* 140 U. PA. L. REV. 1597, 1611 (1992) (citations omitted).

[295] One commentator explains: "Courts, together with legislatures, act as the vehicle of societal expression about the values which should guide the decision about whether likely benefits are significant enough to provide services, and the amount of resources that should be expended on an individual." Hirshfeld, *supra* note 286, at 1835–36.

[296] Consensus building through the legislative process enables various disciplines and segments of society to have a voice. Presumably, a legislative hearing considering rationing of health care would hear patient organizations representing the many segments of society who would be affected as well as physicians, medical ethicists, lawyers, and third party payors. One commentator notes that an advantage of explicit rationing by a central authority is that it "can make more scientifically sophisticated choices than individual professionals who proceed on the basis of a fragmentary command of scientific evidence and who are strongly influenced by their personal clinical experience." David Mechanic, *Professional Judgment and the Rationing of Medical Care,* 140 U. PA. L. REV. 1713, 1720 (1992).

Fleck cautions against legislative, judicial or administrative bodies as the *primary* mechanisms for rationing decisions, though he recognizes they will play a role. Fleck, *supra* note 294, at 1599. He believes that rationing protocols generated in the public sector lack moral legitimacy because "competing interest groups significantly shape the outcomes of the legislative process, and hence, the values of more powerful health interest groups would be reflected in any rationing protocols." *Id.* at 1620. *See also* Mechanic, *supra,* at 1746. Fleck argues that the only fair process is an "informed democratic consensus" of citizen groups which would develop rationing protocols which would be "public or explicit, rationally justifiable, autonomously imposed, and impartially generated and applied." Fleck, *supra* note 294, at 1621. *But see* Mechanic, *supra,* at 1722 (implicit rationing at the level of the individual physician within broad constraints set by central authority most realistic in meeting individual patient's needs).

[297] For a comparison of explicit versus implicit rationing, see Fleck, *supra* note 294, at 1612–17 and Mechanic, *supra* note 296, at 1722 *passim.*

[298] Specifically, as the patient's agent,

> the physician is obligated to the patient and no one else. He is not the agent of society, nor of the interests of medical science, nor of the patient's family, nor of his co-sufferers, or future sufferers from the same disease. The patient alone counts when he is under the physician's care.

Hans Jonas, *Philosophical Reflections on Experimenting with Human Subjects, in* CONTEMPORARY ISSUES IN BIOETHICS 417 (Tom L. Beauchamp & LeRoy Walters eds., 1978). *See* Hirshfeld, *supra* note 286, at 1838 (physician's obligations as fiduciary and to act in patient's best interests "prevent(s) the physician from paying excessive attention to the societal interest in conserving resources when caring for a patient"); Levinsky, *supra* note 291, at 1573 (physicians required to do everything to benefit patient without regard to costs or other societal considerations). Professor Fleck would reject any system which appoints physicians as "front-line rationers," for two reasons. First, empirical clinical research, the basis of physicians' expertise, does not yield the values by which rationing judgments must be made. Fleck, *supra* note 294, at 1619. Second, the role of the physician as rationing agent conflicts with the physician's role as "a loyal and uncompromised advocate of her patients' best medical interests". *Id.*

[299] Brett and McCullough explain the economic need to limit patient access to marginal treatments:

policy discussions and determinations to provide "the medical information necessary to form opinions about whether care should be provided in certain situations."[300] The physician's utilization of cost-containment guidelines would be legitimate[301] if agreed to by public consensus[302] as long as the patient was aware that these factors were operating within the patient-physician relationship.[303] In addition, some mechanism would be essential to protect against physician abuse.[304] Presently, none of these criteria can be met, therefore a physician's denial of CPR for cost reasons is inappropriate.

Although limitations on access to health care[305] require a more thoughtful discussion of how and to whom our health care resources should be

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> At least two economic reasons for hesitating to authorize certain procedures requested by patients can be postulated. First, the funding of medical care is increasingly a shared enterprise in which many persons ultimately pay—through taxes or insurance premiums—for excessive costs generated by a few. Popular consensus might find it unfair to fund procedures done only to provide reassurance. Second, the demand for some medical resources may exceed the supply, and certain interventions will not be available to all patients who request them. Ideally, the welfare of individual patients should be paramount in clinical decision making. Asking physicians to override "correct" medical decisions by ad hoc bedside determinations of their economic effects would erode the foundation of the physician-patient relationship. *Rather, economic guidelines for medical practice should be established, when necessary, at a public policy level, and both patients and physicians should be accountable.*

Brett & McCullough, *supra* note 69, at 1350 (emphasis added). *See also* David M. Eddy, *The Individual vs. Society: Resolving the Conflict*, 265 JAMA 2399 (1991).

[300] Hirshfeld, *supra* note 286, at 1818. Hirshfeld argues:

> that physicians should adhere to traditional patient-interest oriented ethical and legal standards when developing medical information and forming opinions about necessity. Other societal institutions, including legislators, regulatory agencies, and courts, may choose to override physician opinions about necessity and give greater weight to the societal interest in conserving costs. Given that these institutions have the ability to do so, and given that they are ultimately accountable to the populace in a representative democracy, it is appropriately their role to make such discussions and there is no reason for physicians to abandon their traditional role as the patient's advocate. If that role is abandoned, we lose something of incalculable value.

Id. at 1818–19.

[301] According to Fleck:

> [I]n the universal closed system that we envision with explicit health priorities and rationing protocols democratically endorsed, a physician can in good conscience implement those rationing protocols because the savings will be recaptured for higher priority health needs, and those protocols and priorities will have been endorsed by the patient before her.

Fleck, *supra* note 294, at 1626–27.

[302] Fleck argues that "any fair approach to health care rationing must be a product of patient choice, freely and rationally self-imposed." Fleck, *supra* note 294, at 1621. *See also* Menzel, *supra* note 290, at 57–58 (individual patient's consent to rationing scheme maintains respect for patients' own values and reconciles rationing with providers' fidelity to patients).

[303] *See generally* Frances H. Miller, *Denial of Health Care and Informed Consent in English and American Law*, 18 AM. J.L. & MED. 37 (1992) (arguing that duty of informed consent should require that physicians disclose to patients that potentially beneficial treatment is being denied for economic reasons).

[304] Buchanan contends "that the quality of physicians' moral decisions has suffered from the medical community's failure to provide an institutional framework in which principled decisions are criticized vigorously and in which obvious sources of bias or error are checked." Buchanan, *supra* note 225, at 107.

[305] Hirshfeld observes that controlling volume and intensity of health care services is probably the more difficult issue (as compared with controlling prices) in controlling cost increases. Hirshfeld, *supra* note 286, at 1819.

allocated, a societal consensus has not been reached that allows a physician to factor financial considerations into a medical recommendation[306] about resuscitation under either the DNR actual consent or conventional informed consent model, except when the patient identifies personal financial concerns. A futility exception to informed consent grounded on allocation of resource considerations unilaterally made by individual members of an exclusive segment of society[307] should not become part of the private patient-physician relationship until protections are established to guard against inappropriate physician bias.[308]

III. A PROPOSAL FOR INFORMED CONSENT TO CPR

The current policies and realities of CPR decision-making are indefensible from practical, medical, ethical and legal perspectives.[309] CPR presumed consent subjects many patients to medically inappropriate resuscitation to which they would not have consented if given the opportunity.[310] Because cardiac arrest can be anticipated for many hospital inpatients, no justification exists to continue treating all cardiac arrests as emergency conditions. Retention of the model of presumed consent to CPR

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[306] *But see* Mechanic, *supra* note 296, at 1729–30 (arguing that in reality, physicians' provision of care influenced by patient's ability to pay and insurance coverage).

[307] Professor Shultz argues that doctors, like any other group, are subject to intellectual or professional fashion and that their preferences as a group may differ from those of their patients. Shultz, *supra* note 120, at 273. *See also* Veatch & Spicer, *supra* note 62, at 15–16 (noting that the medical ethics debate of the 1990's over refusing patient requests for futile treatment has come a long way from the "era of Karen Quinlan" when physicians resisted patient and family attempts to discontinue treatment); *Id.* at 29.

[308] Mechanic notes that

> [a] core dilemma of such decisionmaking [implicit rationing] is the difficulty of distinguishing clinical judgments from normative assessments and the extent to which these issues become intermingled in an implicit rationing process. Physicians commonly project their own values onto their patients in making judgments about patient motivation. Thomas Halper, for example, offers numerous examples in which physicians made unwarranted assumptions of who would or would not benefit from treatment based on judgments of intelligence, involvement in gainful employments, and worthiness. Such judgments, however, are not explicit, but are deeply embedded in the processes of clinical decisionmaking and are thus not open to discussion or review.

Mechanic, *supra* note 296, at 1736.

Mechanic believes that the danger "is not so much that physicians consciously impose their values on patients who come from different life circumstances, but that their normative judgments are so taken for granted that they are no longer subject to circumspection." *Id.* at 1737. For a proposal to achieve physician accountability against "differential treatment according to socioeconomic status, race, gender, or other personal characteristics" in an implicit rationing system, see Mechanic, *supra* note 296, at 1748–52.

[309] The CPR presumed consent model typifies Flick's concern that choice in medical decision-making has given way to the objectification of the healing enterprise. For example, he argues that the disease makes the choice of treatment, thereby relieving patients and doctors of the responsibility of having to assess the possibilities of the alternatives. This applies to cardiac arrest which automatically results in the provision of CPR, with no opportunity for the patient to make a choice. Flick argues that patients and physicians become the victims of the bureaucratic policies which are the product of an objectified vision of medicine. Flick, *supra* note 1, at 1154–55.

[310] In the words of Bartholome, "we need to think of sick patients in hospitals or nursing homes as being 'at risk' of becoming the unwitting patients (victims?) of 'code blue teams.'" William G. Bartholome, *"Do Not Resuscitate" Orders: Accepting Responsibility,* 148 ARCHIVES INTERNAL MED. 2345, 2345 (1988).

denies the patient her right to control her health care decisions. Declassification of in-hospital cardiac arrest as an emergency and prohibiting physicians from relying on the various exceptions to the doctrine of informed consent to circumvent DNR actual consent would force the physician to assist his patient in assessing whether it is worthwhile to engage in the physical, emotional and financial struggle of prolonging her death by empowering her with the necessary information to make a knowledgeable decision about resuscitative treatment and her future health care.[311] The physician's obligation to assist his patient with her end-of-life decisions entails three responsibilities: first, to identify the patient's end-of-life goals, values and end-of-life treatment preferences while she is still competent;[312] second, to advise the patient of all options which will most likely accomplish her goals, including their probable effects and costs; and third, to faithfully adhere to whatever decisions she makes, irrespective of whether the physician agrees, and even after the patient becomes incompetent.

It is crucial that, whenever possible, the physician engage in this discussion while his patient is competent. The value of the information the physician receives from discussing end-of-life treatment with a still-competent patient greatly outweighs the utility of any information the physician gleans from an incompetent patient's advance directives.[313] Although the various forms of advance directives aid the incompetent patient's physician and family

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[311] Flick, *supra* note 1, at 1145 (respect for autonomy requires that competent patients make own decisions, even to forego therapy necessary for survival); Twerski & Cohen, *supra* note 101, at 651 (purpose of physician's duty to share information is to empower patient to participate in important decision-making processes about her own body).

[312] The physician must assume the responsibility for initiating this discussion. However, the patient has a concomitant responsibility to apprise her physician of her needs and desires:

> If patients do not tell their doctors how they are suffering and what they require, they cannot expect their needs will be met. No one can presuppose that doctors will know what is best for their patients, what information patients will need to make their choices, or what goals are the ones that shall determine their way.

Flick, *supra* note 1, at 1162. In *Canterbury v. Spence,* the court specifically acknowledged that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential." 464 F.2d 772, 781 (D.C. Cir. 1972).

[313] For an explanation of advance directives, see *supra* note 274. Advance directives may be inadequate to ensuring effectuation of a patient's health care wishes in a particular situation. Many physicians complain that abstract discussions or directives set forth in standardized living wills provide little, if any, guidance to families or treating physicians.

> Even if patients have expressed or suggested wishes or desires prior to their incapacity and their competence or capacity to have done so is not disputed, there is no clear way to apply such abstract wishes or desires to specific medical decisions required in particular settings of acute illness and threat of death.

Flick, *supra* note 1, at 1145–46. *See also* Emanuel, *supra* note 10, at 88; Lynn M. Peterson, *Advance Directives, Proxies, and the Practice of Surgery*, 163 AM. J. SURGERY 277, 277 (1992).

On the other hand, other commentators complain that advance directives that are too specific or narrow are equally useless because they so rarely address the particular problem with which the physician is confronted. *See, e.g.*, Allan S. Brett, *Limitations of Listing Specific Medical Interventions in Advance Directives*, 266 JAMA 825, 826–27 (1991). Consequently, some medical professionals advocate the use of a "Values History Form" in which patients answer general questions about their feelings regarding such issues as independence and control; pain, illness, dying and death; what causes the patient pleasure or sorrow; religious beliefs; how much they worry about finances. *See* HANDLING YOUR FIRST HEALTH CARE PROXY, *supra* note 274, at 415–31. *See generally* Rich, *supra* note 55.

in determining whether a patient would decline death-prolonging treatment,[314] most patients do not have advance directives[315] and even if they do, the advance directives do not replace the value of information the physician obtains from a discussion with competent patient about particular end-of-life treatments given a specific prognosis. Thus, health care providers should not rely on advance directives as a substitute for eliciting from the competent patient her preferences.

The patient's decision-making about end-of-life treatment, including CPR, necessarily includes consideration of the financial implications of a prolonged death.[316] Many individuals who hope to preserve their estates for their spouses and loved ones desire to avoid depletion of their assets by foregoing the prohibitive costs of advanced technology necessary for a prolonged life.[317] Health care providers must empower patients to decide whether the emotional,

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[314] In 1991, Congress responded to the "right-to-die" movement by enacting the Patient Self-Determination Act of 1991 (PSDA), which requires health care facilities receiving federal funds to (1) develop policies concerning advance directives; (2) provide patients with information about the facility's policies and state law regarding advance directives; (3) ask patients at the time of admission if they have advance directives and if so, include it in the medical record; and (4) educate their staff and community about advance directives. 42 U.S.C. § 1396(a)(w) (1992). Several medical commentators have correctly observed that the focus of the PSDA on procedural policies of hospital admitting offices would be better directed to improving the patient-physician discussion about end-of-life treatment. *See, e.g.*, Kevin M. McIntyre, *Shepherding the Patient's Right to Self-determination*, 152 ARCHIVES INTERNAL MED. 259, 259 (1992); Peterson, *supra* note 313; William B. Ventres & Steven S. Spencer, *Doctor-Patient Communication About Resuscitation: "Have You Signed an Advance Directive?"*, 33 J. FAM. PRAC. 21, 22–23 (1991).

[315] At least two problems exist with over-reliance by the physician or patient on an advance directive. First, few Americans have executed any kind of advance directive. *See, e.g.*, LaPuma et al., *Advance Directives on Admission: Clinical Implications and Analysis of the Patient Self-Determination Act of 1990*, 266 JAMA 402, 402 (1991) (between 4% and 17% of adults have an advance directive); S. Van McCrary & Jeffrey R. Botkin, *Hospital Policy on Advance Directives: Do Institutions Ask Patients About Living Wills?*, 262 JAMA 2411, 2411 (1989) (only 15% of people surveyed in 1988 had living wills); Donald J. Murphy, *Improving Advance Directives for Healthy Older People*, 38 J. AM. GERIATRICS SOC'Y 1251, 1253 (1990) (only a minority of elderly have living wills). Thus, physicians cannot assume the existence of a living will in lieu of discussing end-of-life treatments with their patients. Second, studies indicate that patients may not be able to rely on the hospital to get the advance directive in the medical record or on the patient's caretakers to remember its presence. *See, e.g.*, Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882, 884–85 (1991) (advance directive in nursing home chart successfully incorporated into hospital record for only 25 of 71 hospitalizations; if advance directive in chart, treatment inconsistent about 2.3 times more often than when directive absent).

[316] It is estimated that $109 billion was spent in 1990 on patients who would have declined death-prolonging treatment if they had been asked. Peter A. Singer & Frederick H. Lowy, *Commentary - Rationing Patient Preferences, and Cost of Care at the End of Life*, 152 ARCHIVES INTERNAL MED. 478, 479 (1992).

[317] In 1987 "per capita spending on health care was $745 for people under age 19, compared with $5360 for those ages 65 or over, and $9178 for people age 85 or over." Hirshfeld, *supra* note 286, at 1824 n.37 (citing HENRY J. AARON, SERIOUS AND UNSTABLE CONDITION: FINANCING AMERICA'S HEALTH CARE 42–3 (1991)). Studies indicate that "about 30% of the total Medicare expenditures are incurred by the 6% of enrollees in their last year of life." Hirshfeld, *supra* note 286, at 1824 n.37 (citing James Lubitz & Ronald Prihoda, *The Use and Costs of Medicare Services in the Last 2 Years of Life*, 1984 HEALTH CARE FIN. REV. 117, 117). About $184 billion was spent in 1990 on patients who died. Singer & Lowy, *supra* note 316, at 479. *But see* James R. Webster, Jr. & Celia Berdes, *Ethics and Economic Realities: Goals and Strategies for Care Toward the End of Life*, 150 ARCHIVES INTERNAL MED. 1795, 1795 (1990) (most major Medicare expenditures attributable to chronically ill and frail as opposed to moribund or terminal).

physical and economic costs warrant continued health care expenditures for continued medical interventions.

Physicians' failure to obtain informed consent to provide or withhold CPR is troublesome for a number of additional reasons. First, despite the admonitions of medical ethicists and policy makers against withholding other treatment when a DNR order is entered,[318] the DNR order does implicate treatment other than resuscitation in many health care facilities.[319] Indeed, some physicians argue that aggressive medical care is inconsistent with a DNR order.[320] As a result, presumed consent to CPR or the entry of a DNR order on a patient's chart may effectively constitute an order to use or withhold other forms of end-of-life treatment as well.[321]

Second, physicians' unilateral implementation of a futility exception to the doctrine of informed consent represents a policy decision with serious and far-reaching implications which have not been subjected to public discussion through any judicial, legislative or other democratic process.[322] In particular, a

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[318] "Any DNR policy should ensure that the order not to resuscitate has no implications for any other treatment decisions. Patients with DNR orders on their charts may still be quite appropriate candidates for all other vigorous care, including intensive care." PRESIDENT'S COMMISSION, *supra* note 7, at 251. *Accord* Murphy, *supra* note 9, at 2098; *1992 Guidelines for CPR*, *supra* note 2, at 2284, 2287.

[319] *See, e.g.*, Brennan, *supra* note 9, at 16 (DNR decision often affects level of care physician offers to hopelessly ill patient); Emanuel, *supra* note 10, at 87 (interpretations of DNR order "often incorrectly influence other medical decisions, such as triage for intensive care unit beds and other scarce medical facilities"); Murphy, *supra* note 315, at 1251–52 (DNR associated since inception with general limitations on care); Murphy, *supra* note 9, at 2098 (DNR order "may result in withholding of other forms of care and treatment."); Youngner, *supra* note 7, at 26–27 (DNR order creates confusion about what other care should be given or withheld).

[320] Tomlinson and Brody argue that "the same logic that supports the DNR order also supports the withholding or withdrawing of other life-prolonging measures, other things being equal." Tomlinson & Brody, *supra* note 9, at 44. However, Youngner contends that "aggressive care short of CPR may be entirely justified on medical grounds." Youngner, *supra* note 7, at 31. Youngner believes that a patient may still otherwise be viable as long as she does not arrest; her medical condition may be reversible, but "arrest would signal an irreversible deterioration that would result in death or [an] unacceptable quality of life .... *Id.* In addition, Youngner argues that other forms of life sustaining care may have the same medical implications as CPR but "different and often competing *nonmedical* values" which justify different treatment. *Id.*

[321] Some physicians are recommending the replacement of the term DNR with "no emergency CPR" or "NO ACLS" to emphasize and reiterate the policy that the DNR order is intended to address only resuscitation and not the provision of other care. *See* Murphy, *supra* note 315, at 1253; *1992 Guidelines for CPR*, *supra* note 2, at 2284.

[322] Absent judicial or legislative recognition of a futility exception to the doctrine of informed consent, or physicians educating the public or at least their own patients about the potential reliance on a futility exception in the DNR context, physicians' current reliance on the futility exception to initiate a DNR order without patient consent may constitute a breach of contract. As currently applied, the emergency provision of resuscitation on anyone who has a cardiac arrest in the hospital is a universally known policy which constitutes a promise to attempt to resuscitate, or in legal terms, an "offer" of that treatment which patients are presumed to "accept." This offer and acceptance form a contract which the physician breaches if he directs that the patient not be resuscitated without the patient's knowledge and consent. Consideration, the third element of an enforceable contract, can easily be found to exist under either the benefit/detriment or bargained for theory of exchange test. RESTATEMENT (SECOND) OF CONTRACTS § 71 (1981).

The physician must make a new bargain with the patient to vitiate his duty to resuscitate. As long as the presumption of consent to resuscitation remains or is understood by the public to be standard hospital policy, the patient and physician must specifically agree that the patient will not be resuscitated in the event of cardiac arrest. This can be accomplished in one of two ways: (1) by discharging the original agreement that the patient will be resuscitated and substituting it futility exception empowers individual physicians to independently implement solutions on a case-by-case basis to the unresolved social policy questions of rationing and utilization of end-of-life technologies. In addition, the scope of a new futility exception to informed consent must be broader than is currently acknowledged by its proponents; the futility exception cannot be principally limited to resuscitation but must apply generally to the doctrine of informed consent. Finally, experience with physician over-use of the therapeutic privilege augurs a similar fate for the futility exception.

A new perspective is needed in approaching resuscitation and other end-of-life treatment decisions.[323] The dual interests in patient self-determination and integrity of the practice of medicine can be better served by utilizing the conventional informed consent model for resuscitation decisions in the acute care inpatient setting.[324] Accordingly, hospitals should no longer presume consent to CPR for in-patients, but should resuscitate patients only with their prior informed consent.[325]

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with another or (2) by rescinding the original contract. The patient and physician create a substitute contract when they agree to a DNR order. The substitute contract discharges the physician's original duty to resuscitate the patient. RESTATEMENT (SECOND) OF CONTRACTS § 279 (1981); E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS § 4.24 (1990). The physician cannot be sued by the patient for failure to resuscitate. RESTATEMENT (SECOND) OF CONTRACTS § 279, cmt. a (1981).

Alternatively, the DNR order constitutes an "agreement of rescission" whereby the parties agree to discharge each other's remaining duties under an existing contract. RESTATEMENT (SECOND) OF CONTRACTS § 283(1); FARNSWORTH, *supra*, § 4.24. The consideration for this agreement is the patient's discharge of the physician's duty to resuscitate. *See* FARNSWORTH, *supra*, § 4.24. Thus, the patient and physician agree to the DNR order, thereby rescinding the prior agreement that the patient will be resuscitated and relieving the physician of his duty to resuscitate the patient.

[323] Bartholome, *supra* note 310, at 2345. "The data regarding the futility of CPR in most individuals who are sick enough to become hospitalized must somehow jar our complacency regarding the advisability of this unwritten policy. ... What is needed is a new perspective, a new way of thinking about DNR orders." *Id.*

[324] This proposal was made previously. *See* Dean M. Hashimoto, Note, *A Structural Analysis of the Physician-Patient Relationship in No-Code Decisionmaking*, 93 YALE L.J. 362 (1983).

This proposal is not intended to suggest that the conventional informed consent model does not need further refinement. "[E]vidence continues to suggest that the concept [of informed consent] has been poorly integrated into American medical practice, and that in many instances the needs and desires of patients are not being well met by current policies." Brody, *supra* note 38, at 5. Professor Shultz also argues that a new model of informed consent is needed:

> A patient should be able to avail herself of a doctor's services without depriving herself of the opportunity to control significant care choices. Patients should, of course, be free to delegate authority, but such delegation should not be required or presumed. Giving patients control over medical choices would delimit doctors' authority and their responsibility. At the same time, such control implies that new obligations would be placed on doctors to facilitate and defer to patients' choices. To effectuate such a relationship, the direct creation of an independent interest in medical choice would be preferable to the indirect vindication now derived through protection of other, related interests.

Shultz, *supra* note 120, at 276. *See also* Twerski & Cohen, *supra* note 101 (courts should shift focus from personal injury to process rights by identifying, valuing, and awarding more than nominal damages for breach of patients' decision rights independent of personal injuries, to enhance goals of patient autonomy). It is beyond the scope of this Article, however, to discuss the reform of informed consent.

[325] Consent would continue to be presumed for traditional emergent situations such as cardiac arrest in transit to or in the emergency room or immediately upon admission before the patient has had contact with the attending physician, unless it is definitively known from prior

The application of the conventional informed consent paradigm to CPR comports with medical data indicating that CPR provides the most benefit to a discrete population of patients for whom there is a possibility of meaningful survival. The mere elimination of the presumed consent to CPR would contribute to more accurate public perceptions about the success rates of CPR. As a result, a patient will have lower expectations of CPR and be more open minded to the possibility that she is not an appropriate candidate for resuscitation. The conventional informed consent procedure would compel physicians to raise resuscitation with patients and share realistic information about survival, thereby protecting patients from unwanted and inappropriate medical care. Hopefully, adoption of the conventional model would encourage physicians to raise the issue of CPR with patients in the context of a general discussion about end-of-life treatment and will facilitate the development of a comprehensive and appropriate treatment plan with which the patient, physician, and other caregivers can generally agree.

The conventional informed consent paradigm would not only promote more appropriate treatment choices but will also make physicians, patients and their families more comfortable in discussing CPR and other end-of-life treatment decisions. Rather than asking the patient or surrogate decision-maker whether she is willing to waive orders for resuscitation which apply generally to hospital inpatients, and thus be allowed to die if she arrests, the physician and patient should engage in discussion when the patient is admitted to the hospital about the various treatments available, including CPR, to mutually determine the most appropriate treatment plan given the patient's goals, values, diagnosis and prognosis.[326]

CONCLUSION

No one can adequately address and resolve the myriad of medical, ethical and legal issues that confront physicians counselling patients who must make end-of-life treatment decisions. Physicians' desires to reform hospital DNR policies to address the problems of medically inappropriate resuscitation are commendable; however, the creation of a futility exception to the doctrine of informed consent is an unacceptable solution. Implementation of a futility exception subordinates patients' ethical, religious, cultural and social values to physicians' medical judgments that CPR offers no medical benefit. Moreover, a policy that allows physicians to make unilateral futility determinations fails to protect patients from the unconscious biases that may underlie a physician's decision that his patient should not receive treatment and should be allowed to

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contact with the patient that the patient had requested not to be resuscitated after discussion with her physician.

[326] Adoption of conventional informed consent to CPR and discussion about CPR with patients upon admission to the hospital comports with the recently updated Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care which state:

> Often physicians discuss CPR only with patients whom they consider at risk for cardiopulmonary arrest. Typically the possibility of cardiopulmonary arrest becomes clear as a patient's condition worsens; at that point the patient often is no longer capable of making decisions, although often the patient was capable of doing so on admission to the hospital. ... For these reasons, physicians must consider taking the initiative in discussing CPR with all adults admitted for medical and surgical care or with their surrogates.

1992 Guidelines for CPR, *supra* note 2, at 2283.

die in the case of cardiac arrest. In addition, a futility exception to informed consent would not be limited to CPR decision-making and would therefore allow a physician to decide, independent of his patient, that she should not receive potentially lifesaving medical treatment.

Despite the difficulties in resolving such complex life and death issues, any policies implemented to deal with end-of-life treatment decision-making must promote mutual patient-physician interaction and must maintain patient self-determination as its ultimate goal. Consequently, neither hospital policy nor the law should recognize a futility exception to the doctrine of informed consent. Instead, hospitals should address the problems of medically inappropriate patient resuscitation and exclusion of patients from end-of-life decision-making by abandoning the CPR presumed consent/DNR actual consent model and applying the conventional model of informed consent to CPR decision-making. Adoption of the conventional model of informed consent would enable patients to receive the information necessary to make informed, intelligent resuscitation decisions and would protect patients' exercise of their right to self-determination. Strengthening rather than compromising the informed consent process is the best mechanism for physicians to fulfill their fiduciary responsibilities to their patients.