A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience

Judith F. Daar
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by

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Introduction

On June 25, 1990, as the United States Supreme Court handed down its first “right to die” decision,1 a family crisis was developing in a Minneapolis hospital for which the newly proclaimed high court principles would prove obsolete. In the summer of 1990, Helga Wanglie, aged

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I wish to thank my colleagues who attended a faculty colloquium focusing on a draft of this Article: Deborah Forman, Howard Foss, Mary Ellen Gale, Richard Gruner, Patricia Leary, Bill Phelps, Cindy Raisch, Peter Reich, Reginald Robinson, and David Welkowitz. Their comments and insights were invaluable in helping shape a much-improved version of this Article. I also want to thank Eric Daar for his critique and continued support of my work. Finally, I want to give special thanks to my research assistant Laura Schulte. Her capability and enthusiasm were a constant source of support for me during the research and drafting stages of this project.

1. Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261 (1990) (Rehnquist, C.J.). Cruzan focused on the request of the parents of Nancy Cruzan, a young woman in a persistent vegetative state, to withdraw their daughter’s feeding tube after it became apparent she had virtually no chance of recovering her cognitive faculties. Writing for the majority, Chief Justice Rehnquist acknowledged that the questions presented by the case were ones of first impression for the Court. He wrote: “This is the first case in which we have been squarely presented with the issue of whether the United States Constitution grants what is in common parlance referred to as a ‘right to die.’” Id. at 277. In answering this question, Justice Rehnquist acknowledged prior high court decisions that held a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment, including nutrition and hydration. Id. at 278-80. But as to the rights of incompetent patients, such as Nancy Cruzan, the Court deferred to the Cruzans’ home state policy that requires clear and convincing evidence of what the patient’s wishes would be when a guardian seeks to discontinue life-sustaining treatment. Id. at 284.

eighty-five, was diagnosed to be in a persistent vegetative state, unable to breathe or eat on her own. Mrs. Wanglie’s biological existence was maintained by mechanical support; a respirator sustained her breathing and a tube supplied her nutrition. In the ensuing months, Mrs. Wanglie’s physicians came to believe that because of her extraordinarily poor prognosis, the aggressive care she was receiving was of no medical benefit to her and should be discontinued. Specifically, the health care team responsible for Mrs. Wanglie’s care felt that continued use of the respirator and other forms of life-sustaining treatment was “inappropriate medical treatment” that was “no longer serving the patient’s personal medical interest.”

Mrs. Wanglie’s family, particularly Oliver Wanglie, her husband of 53 years, vehemently disagreed with the hospital’s recommendation that care be terminated. In fact, the Wanglie family insisted all treatment be continued. Numerous conferences were held to resolve this fundamen-

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3. For a discussion of the characteristics, diagnosis, and prognosis of patients in persistent vegetative state (PVS), see Ronald E. Cranford, The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight), HASTINGS CENTER REP., Feb.-Mar. 1988, at 27, 28 (describing patients in PVS as “completely . . . [and] permanently unconscious”).

4. Mrs. Wanglie’s lapse into permanent unconsciousness began on December 14, 1989, when she slipped on a rug in her home and fractured her hip. While recuperating from her hip fracture in January 1990, Mrs. Wanglie developed respiratory failure and was placed on a respirator. Over the next several months numerous attempts were made to wean her from the respirator, all proving unsuccessful. On May 23, 1990, Helga Wanglie suffered a cardiopulmonary arrest that caused a lack of oxygen to her brain, rendering her permanently unconscious. Ronald E. Cranford, Helga Wanglie’s Ventilator, HASTINGS CENTER REP., July-Aug. 1991, at 23 [hereinafter Helga Wanglie’s Ventilator]. Over the next several months, Mrs. Wanglie was evaluated by several neurology and pulmonary medical specialists who concurred in the diagnosis of persistent vegetative state and permanent respirator dependence. Id.


6. Helga Wanglie’s Ventilator, supra note 4, at 23.

7. In addition to constant respirator support, Mrs. Wanglie was treated with antibiotics for recurrent pneumonia, artificially fed, and treated for electrolyte and fluid imbalance. Id. at 23.

8. This language was used in a letter to Oliver Wanglie, Helga Wanglie’s husband, from the medical director of the Hennepin County Medical Center (the facility in which Mrs. Wanglie was being treated). Id.

9. Id.

10. Mrs. Wanglie’s immediate family consisted of her husband Oliver, a son, and a daughter. Id. In an interview in January 1991, Mrs. Wanglie’s daughter Ruth was quoted as saying: “Mother . . . said that if anything happened to her, she wouldn’t want her life prematurely shortened if she wasn’t able to take care of herself.” B.D. Colen, Fight Over Life: Against Family Wishes, A Minnesota Hospital May Go To Court In An Effort To End Measures Keeping A Woman Alive By Artificial Means, NEWSDAY (Nassau ed.), Jan. 29, 1991, at 63. Oliver Wanglie describes himself and his wife as “pro-lifers.” Id. He argues that “only God
tal impasse between the hospital staff and the Wanglie family, but by the end of 1990 it became clear no resolution was forthcoming. Thus, in what was heralded as the first case of its kind, on February 8, 1991, a physician affiliated with the Hennepin County Medical Center filed a petition in a Minnesota trial court asking that a conservator be appointed for Mrs. Wanglie to “make appropriate recommendations to the court to determine what is in the best interest of the patient.” Although the case was widely perceived as one in which the hospital was seeking permission from the court to terminate life-sustaining treatment over the objections of a patient’s family, the petition merely asked the court to decide who should direct the course of Helga Wanglie’s medical care—her husband Oliver Wanglie or someone else.

Following a four-day emotionally charged trial, the court rendered its decision on July 1, 1991. Judge Patricia L. Belois found clear and convincing evidence that Oliver Wanglie was the best person to be the guardian for his wife. She stressed Mr. Wanglie was in the best position “to investigate and act upon Helga Wanglie’s conscientious, religious and moral beliefs.” Judge Belois acknowledged the dispute can take life and that doctors should not play God.”

1. Id. at 23.
3. Petition Filed Today For Appointment of General Conservator for Patient At Hennepin County Medical Center, PR NEWSWIRED, Feb. 8, 1991. “The petition... was filed by Steven H. Miles, a gerontologist who served as an ethical consultant to Mrs. Wanglie’s physicians at the Hennepin County Medical Center.” Capron, supra note 5, at 26.
4. Dr. Miles’s petition did not, as was widely reported, seek permission to terminate Mrs. Wanglie’s care. See, e.g., Life In The Balance, N.Y. TIMES, Jan. 13, 1991, § 4, at 7 (reporting “a hospital is preparing to ask the courts for permission to let a patient die against the wishes of the next of kin”). In fact, the petition requested only that an independent third party be appointed to decide whether continued treatment for Mrs. Wanglie was appropriate. Dr. Miles argued Mrs. Wanglie’s current guardian, her husband, “is not competent to be Helga Wanglie’s conservator with regard to making decisions about her shelter, medical care, and religious requirements.” In re Wanglie, at 11. On May 2, 1991, Mr. Wanglie filed an Amended Petition for Appointment of a Guardian (Person and Estate) asking the court to appoint him Conservator of the Person of his wife. Id. at 1.
5. The trial court framed the question presented by the petition as follows: “The Court is asked whether it is in the best interest of an elderly woman who is comatose, gravely ill, and ventilator-dependent to have decisions about her medical care made by her husband of 53 years or by a stranger.” In re Wanglie, at 11.
6. Trial was held in the District Court, Probate Court Division, Fourth Judicial District for the County of Hennepin, State of Minnesota from May 28, 1991 through May 31, 1991. Id. at 1.
7. Id.
8. Id. at 13.
9. Id. In what can be seen as an ironic ending to the Wanglie family saga, Helga Wan-
between Mr. Wanglie and the hospital over Mrs. Wanglie's treatment, but noted, "Except with regard to the issue of removing the ventilator, [Mr. Wanglie] has thoughtfully agreed with the treating physicians about every major decision in his wife's care." 20

Judge Belois's holding gave Helga Wanglie the right to demand, 21 and perhaps implicitly the right to receive, intensive medical treatment that at least some physicians felt was medically inappropriate. Thus, if Cruzan is properly pegged as a case about the "right to die," Wanglie surely stands as a contrasting, yet complimentary case about the "right to live." On a factual level, Cruzan stands in contrast to Wanglie in that Cruzan's family sought to withdraw life-sustaining treatment, while the Wanglie family sought to continue treatment in the face of physician objection. Given this contrast, at first blush it may appear that the principles that emerged from the Cruzans' battle for the right to die could not accommodate the dilemma faced by the Wanglies in their quest for continuation of life. But a closer look reveals the complimentary nature of these two situations: In both cases the rights asserted by the patients' families were met with resistance and ultimate opposition from the health care providers caring for the incompetent patients. In the end, both courts looked favorably on the principle of patient self-determination 22 and held that, given a sufficient level of evidence, patients or their surrogates have the right to direct the patients' medical care even in the face of physician opposition.

While Cruzan can rightly be heralded as a case simultaneously enhancing patients' rights and suppressing physician paternalism, 23 Wanglie defies similar characterization. While Wanglie can be seen as another case advancing patient self-determination, it is perhaps more properly deemed a case about patient paternalism. 24 The Wanglie deci-

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21. Mrs. Wanglie's demands for treatment were made on her behalf by her family who acted as surrogate decision makers. See Helga Wanglie's Ventilator, supra note 4, at 23.
22. See infra text accompanying notes 84-96 for a discussion of the doctrine of patient self-determination.
23. Arguably, this proposition is correct only with respect to competent patients. After all, the majority opinion in Cruzan draws a distinct line between the rights of competent and incompetent patients, since these rights relate to the state's ability to interfere with the patient's medical decision making. For a discussion of the state's interest in medical decision making as articulated in Cruzan, see John A. Robertson, Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients, 25 GA. L. REV. 1139 (1991).
24. Here I use the term "patient paternalism" to suggest a scenario in which patients exercise their will over that of their caretakers. By definition, paternalism may not be an
sion seems to suggest that patients have the right to regulate the conduct of their physicians, even when a doctor's medical, moral, or ethical judgment would dictate a different course. The doctors caring for Helga Wanglie were forced to continue care that, in their professional judgment, was inappropriate because it provided no medical benefit to the patient. Yet the court seemed comfortable compelling the physicians to compromise their own professional integrity for the sake of patient autonomy.

The notion that a physician brings to the bedside his or her own professional conscience is one that has received only bare recognition from courts and policy makers who confront clashes between patients and their doctors. Yet a physician's professional conscience, derived from personal and professional experiences, plays a vital role in the way in which a doctor interacts with his or her patients. At the very least, ignoring the moral, ethical, and professional make-up of the physician can only serve to chill communications between doctors and patients. That is, stripped of their ability to advocate based on their own belief system, doctors may begin to perceive themselves as "medical vending machines" whose only role is to dispense medical treatments. This image of a physician as a mere purveyor of medical "goods" belies the notion that an essential element of the doctor-patient relationship is open communication about treatment options.

The concept of a physician's professional conscience implies that the doctor is an independent moral agent with the capacity and the right to express his or her objections to patient choices, whether those objections derive from medical, moral, or ethical foundations. It is important to note that expressions of professional conscience will not always translate into sanctioning a course of treatment preferred by the physician. Physi-

entirely accurate term to describe a situation in which a patient's preferences prevail over the medical judgment of the physician. Paternalism implies an authority supplying the needs or regulating the conduct of those under its control. See Webster's Ninth New Collegiate Dictionary 862 (9th ed. 1984). While a patient may not be an authority in the sense that the physician is subordinate to the patient in the doctor/patient relationship, certainly the court in Wanglie approved of the patient's right to control the conduct of the physician. This, I argue, is patient paternalism.

25. See Lawrence J. Nelson & Robert M. Nelson, Ethics and the provision of futile, harmful, or burdensome treatment to children, 20 Critical Care Med. 427 (1992) (charging physicians who merely follow their patient's decisions without discussing their clinical judgment and ethical wisdom are practicing "vending machine" medicine). Other possible harmful consequences of ignoring or even substantially downplaying the physician's professional conscience include forcing doctors to refrain from offering treatments to patients during an acute medical episode for fear of never being able to recommend withdrawal of treatment, and discouraging students from entering the medical field because they envision a lack of autonomy in their role as clinicians.
cian conduct will continue to be governed by established standards of care. Assertion of a physician’s professional conscience will not mean that a doctor can offer a quality and degree of medical care that is below accepted standards; it simply means that a physician will be accorded the right to choose whether to initiate or continue a course of treatment that offends some deeply held personal beliefs.

This Article examines the role a physician’s professional conscience plays in the jurisprudence of medical decision making. Medical science and technology offers us an increasing array of therapeutics and apparatuses that can effectively sustain biologic existence, but which often cannot work cures or even reprieves from underlying illnesses. Thus, physicians perceive the application of these advances as medically futile or inappropriate in some cases. At the same time, the jurisprudence of patient autonomy has advanced to the point where many patients feel comfortable, even empowered, in seeking whatever treatments are available, often disregarding cost, prognosis, and ultimately the advice of their physician. Thus begins the so-called “clash at the bedside.”

Part I of this Article focuses on the issue of medically futile treatment, a phenomenon that I believe has ushered the doctor-patient clash at the bedside to the forefront of bioethics. When doctors and patients disagree over the wisdom and value of providing life-sustaining treatment, questions arise about how the concept of benefit should be defined, evaluated, and weighed in the hospital setting. The concept of benefit thus plays a critical role in understanding the notion of medically futile treatment. Part I analyzes the concept of benefit as it relates to medical treatment and medical futility. Subpart A of Part I describes a few of the cases that have raised the issue of medical futility publicly. Subpart B focuses on the definitions of medical futility provided by physicians and policy makers, concluding that there is a general lack of consensus in defining what constitutes medically futile treatment. Without consensus, the debate about medical futility shifts away from problems of definition toward questions about a physician’s duty to provide treatment he or she believes will provide no medical benefit to the patient. Subpart C addresses these questions.

Part II examines the patient’s right to demand medical treatment and the physician’s duty to deliver such treatment. Subpart A explores this latter concept in the context of the common law’s purported concern with upholding the ethical integrity of the medical profession. By exploring the underpinnings and development of this common-law interest, one can see the emergence of a physician’s professional conscience as a component of the jurisprudence of medical decision making. Subpart B ex
plains the role a physician’s professional conscience plays in cases involving patient abandonment, transfer, and refusal to provide continued care. What emerges from this case survey is a clear need for a more uniform approach to the clash at the bedside. That is, courts and hospitals alike seem ill-equipped and inconsistent in their response to a physician’s assertion of professional conscience.

Part III of this Article explores legislative responses to a physician’s assertion of professional conscience. In contrast to the courts’ somewhat scattered approach to clashes of conscience at the bedside, law makers in numerous states have carved out specific instances in which a doctor may refuse to participate in certain medical procedures on moral or ethical grounds. Subpart A addresses the most striking example of this legislative safe harbor—the performance of abortions. A majority of states permit a doctor to opt out of participating in the procedure on the ground that it offends his or her conscience. What these abortion refusal statutes demonstrate is that our society is sensitive to the fact that doctors are not mere technicians who, because of their special training, must use their skills whenever asked. Instead, society accords physicians a right to moral autonomy in selected clinical settings. Given the existence of legislation recognizing and respecting a physician’s professional conscience in certain instances, Subpart B of Part III argues that our jurisprudence should offer greater protection for physician autonomy in a wider clinical setting.

Part IV proposes a model for systematically handling conflicts between doctors and patients over the provision of certain medical treatment. Adapted from a model currently in place to resolve conflicts between attorneys and their clients, the proposed model in this Article attempts to uphold the principles of patient autonomy and self-determination, while at the same time respecting a physician’s professional conscience. Subpart B proposes that hospitals create treatment evaluation boards (TEBs) to hear and resolve disputes between doctors and patients within the confines of the hospital, obviating the need for judicial intervention. This Article contemplates that if doctors are given an open arena to air concerns about patients’ choices, the doctor-patient relationship will ultimately be enhanced.

In sum, this Article argues that in a world in which patients perceive an abundance of medical technology at their disposal, physicians should not be forced to choose between what they think is in the best interest of the patient and what the patient demands. Mutual and equal respect for patient and physician autonomy will facilitate dialogue and resolve the clash at the bedside.
I. Medical Futility: Challenging the Underpinnings of Patient Autonomy

A. The Case of Helga Wanglie: Focusing the Debate on a Patient's Right to Futile Care

The issue of a physician's duty to comply with a patient's treatment wishes likely arises in virtually every health care institution on a regular basis. After all, it is inconceivable that Helga Wanglie's family was unique in their quest for continued treatment of their comatose mother. But is Helga Wanglie representative of patients who, of their own accord or through their families, seek treatment their physicians deem of no medical benefit? Perhaps one would envision the prototype of such a patient to be, like Mrs. Wanglie, an octogenarian from a religious background, who is an integral member of a close family. These

26. Throughout this Article, the term "patient" means a decision maker about medical treatment, and is intended to include surrogate decision makers who are making medical decisions on behalf of incompetent patients. The proposals contained herein are equally applicable when a patient or his or her surrogate demands treatment the physician finds inappropriate. This assertion, of course, assumes the surrogate is the appropriate spokesperson for the patient and is either expressing views previously expressed by the patient or acting in the patient's best interest.

Whether a surrogate is truly acting as the patient would act must be of concern to every physician who looks to someone other than the patient to discern treatment preferences. This Article's arguments and proposals are premised on the assumption that the physicians and institutions involved in a patient-physician conflict have already crossed the surrogate approval threshold and believe the surrogate decision maker is acting as the patient would. If physicians believe otherwise, then their dispute with surrogates would focus on the decision maker, rather than the decision itself. While the appropriateness of particular surrogate decision makers is an important consideration in the area of medical decision making for incompetent patients, it is beyond the scope of this Article. For a more complete discussion of this issue, see John Hardwig, The Problem of Proxies with Interests of Their Own: Toward a Better Theory of Proxy Decisions, 1992 UTAH L. REV. 803.

27. Dr. Steven Miles, the physician and ethics consultant who filed the petition for appointment of an independent conservator for Mrs. Wanglie, reports that her physicians suggested that life-sustaining treatment be withdrawn "since it was not benefiting the patient." Steven H. Miles, Informed Demand for "Non-Beneficial" Medical Treatment, 325 NEW ENG. J. MED. 512, 513 (1991) [hereinafter Miles, Informed Demand]. Dr. Miles later elaborates on this point, explaining that Mrs. Wanglie was at the end of her life and "the respirator was 'non-beneficial,' in that it could not heal her lungs, palliate her suffering, or enable this unconscious and permanently respirator-dependent woman to experience the benefit of the life afforded by respirator support." Id. Thus, it appears Dr. Miles's concept of medical benefit encompasses more than mere extension of biologic existence. For a more complete discussion of the concept of medical benefit, see infra text accompanying notes 51-64.

28. At the time of her death, Helga Wanglie was 86 years old. See In re Wanglie, at 8.

29. Judge Belois described Mrs. Wanglie as follows: "[She] is a devout Lutheran and a dedicated churchwoman who served her congregation for many years as a Sunday school teacher." See id. at 2.

30. Family closeness defies formal definition and any such characterization is best left to those for whom the term is relevant. In the case of Helga Wanglie, it is interesting to note her
characteristics conjure up the image of someone who has reached the end of their predicted lifespan—someone for whom death would be an anticipated, inevitable reality, but who holds on to the hope that medicine can prolong a waning life.

In fact, the faces of patients and families who have battled with physicians for care deemed to be nonbeneficial are as diverse from that of Helga Wanglie as they are from each other. If anything, Helga Wanglie represents one point along a broad spectrum of patient characteristics. Although it is not possible to fully describe the breadth of this spectrum because few families reveal their conflicts to a court or to the media, those cases that have aired in the public domain demonstrate how widespread the conflict between patient and physician is becoming.

For instance, patients who seek continued care in the face of physician objection are not always elderly. In 1988, Murray Pollack, a Washington, D.C. physician, went to court seeking authority to withdraw life-sustaining treatment from a severely brain-damaged two month old boy. Like the petitioning physician in Wanglie, this doctor asked the court to appoint an independent guardian for the child in place of his mother, who demanded that her son be given what the physician considered futile treatment. In that case, the court declined to appoint an independent guardian for the child.

Three years later, this same physician confronted the case of Baby Rena, an eighteen-month-old child dying of AIDS. In this case, Dr. Pollack tried unsuccessfully to convince Rena’s foster parents that continued use of the respirator was wrong because “[i]t was making the child suffer.” Although the case was never brought to court, it was the subject of several hospital ethics committee meetings in which the foster parents

doughter Ruth, age 48, had always lived in her parents’ home. Also, both daughter Ruth and husband Oliver report having had conversations with Mrs. Wanglie about what she would want “if anything happened to her.” Colen, supra note 10, at 63.
31. See Benjamin Weiser, A Question of Letting Go; Child’s Trauma Drives Doctors to Reexamine Ethical Role, WASH. POST, July 14, 1991, at A1.
32. Id. At the time Dr. Pollack was interviewed for the Washington Post article, he reported that the boy “remains in a coma, breathing through a respirator at a long-term care facility.” Id. at A18. He also remarked, “It was the wrong decision for everyone.” Id.
33. Id. at A1. The article describes Rena as a victim of AIDS and heart disease who was hospitalized in the intensive care unit in January 1991. She could breathe only with the help of a respirator and was in so much pain that she was constantly sedated. The author reports, “When nurses performed even the simplest procedure, such as weighing her, her blood pressure shot up and tears streamed down her face. But a tube in her throat made it impossible for her to utter a sound.” Id.
and the physicians met to air their opposing views. In the end, Baby Rena died despite continued aggressive care.

The case of Baby L further exemplifies the conflict that arises when physicians and parents clash over medical intervention doctors say provides no benefit for an infant patient. Baby L was a two-year-old girl who was blind, deaf, and quadriplegic. She received her nutrition through a gastrostomy tube and required occasional mechanical ventilation (use of a respirator) for recurrent pneumonia. Her treating physicians felt that due to her extensive neurologic deficits, she could experience only pain, such that further medical intervention was not in the best interest of the patient. Therefore, they sought the mother's permission to withhold use of the respirator should the infant experience further breathing problems. The mother refused to consent, and instead went to court to resolve the conflict.

Another recent incident moves along the spectrum of patient types from infant to adolescent. In October 1991 an Atlanta Superior Court judge was asked to decide the fate of a thirteen-year-old girl suffering from an irreversible, degenerative neurological disorder. After five months of intensive treatment, physicians argued that their "life-sustaining efforts [were] becoming so painful as to be abusive." The hospital sought the court's permission to discontinue treatment for the patient, referred to as "Jane Doe," over the objection of her father.

35. Weiser, supra note 34, at A1.
36. A gastrostomy tube is a tube placed into a new opening to the stomach. STEDMAN’S MED. DICTIONARY 578 (illustrated 5th unabr. lawyers' ed. 1982).
37. John J. Paris et al., Physicians’ Refusal of Requested Treatment: The Case of Baby L, 322 NEW ENG. J. MED. 1012 (1990). The doctors also reported the court (no details as to the jurisdiction of the court are given) appointed a guardian ad litem for the child. The guardian ad litem asked a pediatric neurologist from another institution to assess the patient’s condition and make recommendations about care. Eventually, the pediatric neurologist agreed to take over the patient’s case, so Baby L was transferred to her care. Two years after the court action, Baby L was reported to be alive, requiring intensive home nursing care. Id. at 1013.
38. Id.
39. Id.
40. Id.
41. See Ronald Smothers, Atlanta Court Bars Efforts to End Life Support for Stricken Girl, 13 N.Y. TIMES, Oct. 18, 1991, at A10 [hereinafter Smothers, Atlanta Court Bars Efforts].
The court denied the hospital’s request, holding that “it is up to the parents of Jane Doe to decide when, for how long and at what cost to their child to extend her life and the manner of her death, even if it may be prolonged as a result.”

The case of Jane Doe stands in contrast to that of Helga Wanglie, not only because of the difference in the ages and life experiences of the two patients, but also because of the families’ role in reaching a decision contrary to physician recommendations. In *Wanglie*, it appears the family decision makers were united in their request for continued care. In the case of Jane Doe, her mother and father disagreed over what was in their daughter’s best interest; her mother reluctantly agreed to authorize removal of life support, while her father flatly rejected any cutback in treatment. Faced with this conflict between the two parent decision makers, the court opted for continued treatment until the conflict could be resolved.

Finally, Helga Wanglie can be contrasted with fifty-six-year-old Joseph Finelli, who suffered severe brain damage following a heart transplant operation in 1988. Unlike Mrs. Wanglie, Mr. Finelli did not require a respirator to breathe. He did, however, require constant care, including feeding and administration of immune-suppressing medication to prevent rejection of his transplanted heart. Mr. Finelli remained hospitalized for three years after his transplant, at which time the hospital petitioned a Suffolk County Probate Court in Massachusetts to appoint a guardian to determine the most appropriate placement for the patient. The court appointed an independent guardian who, after a six-month investigation, recommended Mr. Finelli be taken off the medication that prevented his body from rejecting his heart. Without his med-

44. *Id.* The presiding Fulton County Superior Court judge, Leah Sears-Collins, also ordered the State Attorney General to appeal her ruling to the state supreme court “so that the case could carry legal precedent in the state.” *Id.* William M. Droze, an Assistant Attorney General, filed a notice of appeal on October 18, 1991. See Ronald Smothers, *Ailing Girl at Center of Fight Over Life Dies*, N.Y. TIMES, October 26, 1991, § 1, at 6. Jane Doe died of cardiac arrest on October 25, 1991. *Id.*

45. Specifically, Judge Sears-Collins said “if either parent, in the exercise of his or her rights with regard to the welfare of Jane Doe, makes the decision to continue Jane Doe’s life, as the father has in this case, that decision must be respected.” See Smothers, *Atlanta Court Bars Efforts*, supra note 44.


47. At the time the action was filed, Mr. Finelli was a full-time resident of the Brigham and Women’s Hospital, the petitioner in his case. His family took him home every day, but returned him to the hospital at night since he required round-the-clock attention. *Id.*

lication, Mr. Finelli would die in short order. The court refused to rule on the guardian's treatment withdrawal recommendation. Instead, the court ordered the hospital to pay the salary of a home care worker, enabling Mr. Finelli to leave the hospital.

The case of Joseph Finelli stands as a reminder that life-sustaining treatment does not always come in the form of invasive machinery such as respirators and feeding tubes, nor does its administration have to be a source of constant pain for the dying patient. But whatever the modality—be it the respirators ventilating Helga Wanglie and Baby Rena, the gastrostomy tube feeding Baby L, or the drugs keeping Joseph Finelli alive—medical treatment that serves only to maintain rudimentary biologic function has generated dispute and debate among health care professionals. This debate focuses on the duty of a physician to prescribe medical treatment he or she believes to be of no medical benefit to the patient. Many physicians have referred to nonbeneficial treatment as "futile" and have asserted their right to unilaterally withhold or withdraw such therapy even in the face of patient opposition. Before exploring the parameters of a physician's duty to provide such treatment, it is important to more clearly define medically futile treatment.

B. The Definition of Medically Futile Treatment: Elusive At Best

The concept of medically futile treatment can be viewed simultaneously as having ancient roots and as a modern concept emerging only in the last several decades. One author suggests that medical practice has proscribed futile therapy from its beginnings, as evidenced by the Hippocratic tradition obliging physicians not to treat incurable diseases.

The more recent focus on the concept of medical futility can be attributed in

49. The court-appointed guardian, Betty Dew, is an attorney and a former nurse. Although her initial charge from the court was merely to determine an appropriate placement for Mr. Finelli, since he no longer required treatment in an acute care hospital, she said her recommendations were in the best interest of the patient. She stated: "I felt that the idea of Mr. Finelli being incapacitated the way he is would have been totally unacceptable to him... It was my judgment that he would not have wanted to live the way he is now." Id.

50. Alexander Reid, Judge Orders Hospital to Pay for Brain-Injured Man's Home Care Aide, BOSTON GLOBE, July 18, 1991, at 33. Judge Edward S. Ginsberg said he would restrict his decision to whether Mr. Finelli should be discharged from the hospital and to where he should be discharged. Id.

51. See Darrel W. Amundsen, The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots—What the Hippocratic Corpus Does Not Say, HASTINGS CENTER REP., Aug. 1978, at 23, 25 (stating that the Hippocratic Corpus defines a role of medicine as refusing to treat those who are "overmastered by their diseases," because "in such cases medicine is powerless").
large part to the development of cardiopulmonary resuscitation (CPR) in 1960.52

While CPR was originally developed for victims of sudden cardiac or respiratory arrest, its use has gradually increased to the point where it is presently used on any patient in the hospital who has a cardiac arrest, regardless of their underlying illness.53 The elevation of CPR to a routine hospital practice has engendered numerous studies on its efficacy, focusing particularly on survival rates of patients who receive CPR.54 When studies consistently showed that less than fifteen percent of patients who received CPR survived to leave the hospital, physicians began to question whether they were obligated to administer, or even offer, this therapy to patients they felt would surely not survive a cardiac arrest.55 Thus began a debate about the provision of perceived futile medical treatment that has since reached well beyond CPR to the limits of medical technologies.

To date, numerous physicians and ethicists have entered the debate about medical futility, but only a few have attempted to define the concept. For the most part, definitions of medical futility revolve around the goal of medical therapy and the benefit a particular patient can gain from that therapy. For example, one group of medical ethicists argues that "[m]edical intervention can be called futile . . . if the results are temporary and fleeting and will not improve the patient's condition."56 Others suggest futile treatment is that which has no reasonable expectation of benefit.57 Still others have described it as "treatment that prolongs the process of dying but offers no realistic chance of improvement."58

52. See W.B. Kouwenhoven et al., Closed-Chest Cardiac Massage, 173 JAMA 1064 (1960).
53. See Leslie J. Blackhall, Must We Always Use CPR?, 317 NEW ENG. J. MED. 1281 (1987). CPR, or any medical treatment for that matter, is not administered to patients who request not to receive such treatment. An order to withhold CPR is often referred to as a "do-not-resuscitate" (DNR) order. Id. at 1282.
54. See, e.g., S.E. Bedell et al., Survival After Cardiopulmonary Resuscitation in the Hospital, 309 NEW ENG. J. MED. 569 (1983); Mark L. DeBard, Cardiopulmonary Resuscitation: Analysis of Six Years’ Experience and Review of the Literature, 10 ANNALS EMERGENCY MED. 408 (1981); Arnold L. Johnson et al., Results of Cardiac Resuscitation in 552 Patients, 20 AM. J. CARDIOLOGY 831 (1967); R.C. Peatfield et al., Survival After Cardiac Arrest in Hospital, 1 LANCET 1223 (1977). For a discussion of the development of CPR as a standard of care for cardiac arrest, see Blackhall, supra note 53, at 1282.
55. See id.
The foregoing definitions of futile treatment, which focus on the rather amorphous relationship between treatment and benefit, have been criticized for not offering the clinician an objective measure for determining when medical treatment is futile. In an effort to objectify the concept of medical futility, one group of medical ethicists proposed a quantitative approach to its definition. Dr. Lawrence Schneiderman and his colleagues define medical futility as "any effort to achieve a result that is possible but that reasoning or experience suggests is highly improbable and that cannot be systematically produced." They further refine this quantitative approach by suggesting that "when physicians conclude (either through personal experience, experiences shared with colleagues, or consideration of reported empiric data) that in the last 100 cases, a medical treatment has been useless, they should regard that treatment as futile." Dr. Schneiderman defines "useless" as therapy that achieves a desired result in less than one percent of cases.

Any single definition of medical futility, be it qualitative (focusing on the nature of individual benefit) or quantitative (focusing on the degree of overall success), can be criticized for failing to include some component of individual patient goals. For example, while one patient may refuse CPR because she is informed of the low likelihood that she will ever leave the hospital, another patient may request that he be resuscitated just for the chance that he might be alive to see the arrival of a close relative, or his next birthday, or another sunrise. What is all too obvious to physicians is that patients differ in their goals for treatment, in their assessment of treatment benefit, and in their perception about quality of life.

Without some deference to individual patient goals, no definition of futility will ever be suitable for universal application. Thus, the question that should arise from cases like Wanglie is not whether a particular treatment meets some definition of medical futility. The question should be whether, given the likelihood of a beneficial result, coupled with the

60. Id.
61. Id. at 952. Dr. Schneiderman and his colleagues are not the only ones to define medical futility in terms of chances for success. See, e.g., J.D. Lantos et al., Survival After Cardiopulmonary Resuscitation in Babies of Very Low Birth Weight, 318 NEW ENG. J. MED. 91 (1988) (invoking notion of futility when survival is no greater than 7%); Donald J. Murphy et al., Outcomes of Cardiopulmonary Resuscitation in the Elderly, 111 ANNALS INTERNAL MED. 199 (1989) (suggesting that CPR is futile when patient survival following therapy is no greater than 2%).
62. Id. at 952. Dr. Schneiderman and his colleagues are not the only ones to define medical futility in terms of chances for success. See, e.g., J.D. Lantos et al., Survival After Cardiopulmonary Resuscitation in Babies of Very Low Birth Weight, 318 NEW ENG. J. MED. 91 (1988) (invoking notion of futility when survival is no greater than 7%); Donald J. Murphy et al., Outcomes of Cardiopulmonary Resuscitation in the Elderly, 111 ANNALS INTERNAL MED. 199 (1989) (suggesting that CPR is futile when patient survival following therapy is no greater than 2%).
63. Beneficial result must include any result the patient considers beneficial to him or her.
patient’s treatment goals, a physician has a duty to provide treatment. The answer to this question will depend on how much deference is given to a patient’s perception of benefit in relation to medical treatment.

For example, if we say that treatment can never be futile so long as the patient perceives it to provide some benefit, then in certain instances physicians will be under a duty to provide treatment that exceeds current thresholds of care. Instead, medical futility may be better defined by discerning the likelihood that a particular treatment will produce the benefit sought by the patient. If treatment will not produce a benefit sought by the patient, it can be considered futile. Even if this definition is workable in the health care setting, questions remain as to the physician’s duty to render futile care.

C. Physician Perception of the Duty to Render Futile Care

While Wanglie is characterized as a case about medical futility, the question presented to the trial judge in Wanglie was, on its face, a question about who could best represent the interests of the incompetent patient. As framed, the issue was not the more troubling question of whether physicians have a duty to prescribe treatment they believe provides no medical benefit. Yet despite the seeming clarity and simplicity of the question before the court, the petition filed in Wanglie was

In the case of surrogate decision makers, beneficial result should include any result the surrogates consider beneficial to the patient.

Drs. Tom Tomlinson and Howard Brody point out several instances in which patient perception of benefit is inaccurate and thus the physician should not allow the patient to demand treatment. For example, a patient who demands antibiotics for a simple cold, Tomlinson and Brody argue, will derive no physiological benefit from such treatment. Tom Tomlinson & Howard Brody, Futility and the Ethics of Resuscitation, 264 JAMA 1276, 1277 (1990). Moreover, even if the patient believes that the drugs will help psychologically by having a placebo effect, the patient should have no right to demand this treatment.

I agree that there are certain instances in which a patient simply cannot demand that a physician provide treatment. For example, a patient experiencing leg soreness cannot demand amputation just to rid himself of the pain if the surgery is contraindicated. But I tend to define this example and others like it as falling outside the standard of care so as to constitute medical malpractice. This Article is not intended to address those situations, but rather instances when a patient’s demand for treatment is within the standard of care but outside the scope of the physician’s professional conscience.

See, for example, Daniel Callahan, Medical Futility, Medical Necessity: The-Problem-Without-A-Name, HASTINGS CENTER REP., July-Aug. 1991, at 30, in which the author states that the Helga Wanglie case has brought the meaning of medical futility into prominence.


67. The trial court recognized the possibility that, given the media attention swirling around the case, some could be misled about exactly what the court was deciding. Perhaps in an effort to clarify the procedural posture of the case, the court stated at the outset of its Memorandum decision: “The Court is asked whether it is in the best interest of an elderly woman who is comatose, gravely ill, and ventilator-dependent to have decisions about her
designed to confront, albeit indirectly, the question of a physician's duty to provide nonbeneficial care. Dr. Steven Miles, who petitioned the court on behalf of the medical staff caring for Mrs. Wanglie, later described the case as raising two important questions: "Is respirator support of Helga Wanglie beneficial to her? If not, are medical staff obliged to provide it because of the strong preferences of her family?"68

The court in Wanglie did not begin to address these questions, nor was any judicial light shed on similar questions raised by the cases of Baby L, Jane Doe, or Joseph Finelli. But the absence of judicial analysis in this area of medical ethics should not be mistaken for a total absence of thoughtful analysis of questions that are certain to engender much debate given the tension between the rapid development of medical technologies and the escalating cost of health care.69 In the face of these ever-present medical and fiscal realities, physicians have begun to debate their responsibility to disclose and provide medical treatment options they deem futile. As one might expect, physicians' views on this subject are varied.

To begin, physicians often approach the question of medical futility at the pretreatment stage, that is, debating whether there is a duty to offer a treatment that provides no medical benefit.70 If medical literature

medical care made by her husband of 53 years or by a stranger." Id. at 13. To further forestall misinterpretation about the ramifications of its holding, the court made clear that

[n]o court order to continue or stop any medical treatment for Helga Wanglie has been made or requested at this time. Whether such a request will be made, or such an order is proper, or this Court would make such an order, and whether Oliver Wanglie would execute such an order are speculative matters not now before the Court.

Id. at 15.


70. The issue of pretreatment decision making was not presented in Wanglie because the respirator therapy was well underway when the ethical dilemma surrounding Mrs. Wanglie's care arose. Importantly, in no account of the Wanglie case does anyone suggest that the respirator should not have been offered to Mrs. Wanglie in the first place. The Wanglie dilemma demonstrates how fluid judgments about medical futility can be. While no one felt offering the respirator following cardiopulmonary arrest was futile, the medical staff generally agreed that
can serve as a gauge of physician sentiment, it appears that a majority of physicians subscribe to the view that they are under no obligation to offer futile therapy. The American Medical Association Council on Ethical and Judicial Affairs agrees. In a recent pronouncement of guidelines for the appropriate use of do-not-resuscitate orders, the AMA stated: “A physician is not ethically obligated to make a specific diagnostic or therapeutic procedure available to a patient, even on specific request, if the use of such a procedure would be futile.”

The AMA policy statement is careful to point out that, given the diversity of physician and patient values, judgments of futility are subject to a wide variety of interpretations. The AMA concludes that judgments of futility are appropriate so long as the patient determines what is or is not beneficial according to his or her personal values and priorities. Once that judgment is made, the AMA concludes that treatment would be considered futile if it could not be expected to achieve the goals expressed by the informed patient, and therefore could be withheld even if requested by the patient. Thus, the AMA, as well as many individual physicians, seems to take the position that doctors may make a final and

after several months, maintaining Mrs. Wanglie on the respirator was medically inappropriate.

The situation in *Wanglie* raises the question of whether a physician has a duty to continue treatment once it has proved ineffective. At least one court has said no to this question. In *Barber v. Superior Court*, 195 Cal. Rptr. 484, 491 (Cal. Ct. App. 1983), the California court stated: “Although there may be a duty to provide life-sustaining machinery in the immediate aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel.” The court went on to admit it could not offer precise guidelines about what constitutes futile treatment, urging such decisions are essentially medical ones to be made on a case-by-case basis. *Id.*

71. *See*, e.g., Blackhall, supra note 53, at 1284 (stating that in cases in which CPR is of no benefit, it should not be offered to patients); Donald J. Murphy & David B. Matchar, *Life-Sustaining Therapy; A Model for Appropriate Use*, 264 JAMA 2103 (1990) (stating that if therapy is either medically or economically inappropriate, it should not be automatically offered); Schneiderman, supra note 59, at 949 (stating that treatment that fails to improve the person as a whole is futile and may be withheld by physicians); Tomlinson & Brady, supra note 64, at 1278-79 (stating that physicians must be able to restrict alternatives offered to patients for sake of physician integrity and patient autonomy). Additionally, a leading treatise on clinical medical ethics states bluntly: “There is no moral obligation to perform useless or futile actions.” *Jonsen*, supra note 56, at 27.


73. *Id.*

74. *Id.*

75. *Id.* The particular treatment the AMA refers to in these guidelines is CPR, but the language used throughout the discussion is broad and does not appear to be limited to CPR. For example, the AMA urges physicians to talk with patients about their objectives and then “convey to the patient whether CPR or other medical treatments are likely to be effective in helping to achieve those goals.” *Id.* (emphasis added).
unilateral decision to withhold treatment when they deem it futile, by whatever definition of the term they have adopted.

Not all physicians agree with this position. Some argue that unilateral decision making by physicians, in any context, violates principles of patient autonomy that have come to dominate the patient-physician relationship. One physician, for example, argues that a unilateral decision to withhold CPR is highly paternalistic and involves value judgments that can only be made by the patient.\textsuperscript{76} In a similar vein, another group of physicians has said "patient preferences about the goals of therapy are an essential component of the clinical determination of futility."\textsuperscript{77} While this position may seem to comport with that taken by the AMA, this group goes on to say that when the patient and physician disagree about whether treatment is futile, the patient may demand, and presumably receive, therapy that the physician believes will not be beneficial.\textsuperscript{78}

Thus, physicians' views about what constitutes futile medical therapy range from treatment that will not prevent proximate death, to treatment that holds a quantifiably low probability of physiologic benefit, to therapy that a patient believes will not achieve his or her treatment goals. Given that perceptions of medical futility range from a purely objective medical judgment\textsuperscript{79} to a highly subjective individual judgment that may look well beyond medical ramifications, it seems the medical community is not likely to reach a consensus on how the concept should be defined. Definitions, however, serve only to alert physicians to the existence of a particular class of treatment. The more important question is: Once a physician makes a determination that treatment is futile in a particular case, how should that physician respond when faced with the patient who demands that futile therapy? Should a physician be compelled, either by a court or by statute, to provide care when in so doing, the physician may be violating his or her own personal or professional judgment about how medicine should be practiced? In short, should doctors be compelled to act against their professional conscience?

The answer to this difficult question can emerge only after a review of judicial and legislative responses to assertions of physician autonomy. If courts and law makers believe that a physician has a right to professional self-determination, then any solution to a dilemma over the provi-

\textsuperscript{77} John D. Lantos et al., \textit{The Illusion of Futility in Clinical Practice}, 87 AM. J. MED. 81, 83 (1989).
\textsuperscript{78} \textit{Id.}
\textsuperscript{79} Arguably, no medical judgment is ever purely objective. A physician's clinical judgment may be shaped by a host of factors including the patient's age, family support, compliance with past prescribed therapies, or even ability to pay for costly therapy.
sion of medically futile treatment must be one that balances the desires of the physician and the patient. Where that balance is struck depends a great deal on what role our legal institutions believe a physician’s professional conscience should play in the world of medical decision making.

II. Physician Autonomy: Looking Toward a Doctor’s Professional Conscience

In the mid-1970s, patients and their families began going to court to uphold their right of self-determination in medical decision making. In virtually all of these cases, courts were asked to uphold the right of a patient to refuse medical treatment. Many of these decisions upheld this right in published opinions that extolled the importance of patient autonomy in making decisions about medical treatment. Until recently, physician response to the burgeoning principle of patient autonomy has been dutiful compliance; at least in the judicial setting, doctors have displayed little or no evidence of disagreement with the notion of patient self-determination. But for the first time, in Wanglie, physicians brought to the judicial arena concerns about the entrenchment of patient autonomy that seem to leave no room for moral or medical judgments by the physician.

Dr. Steven Miles, the petitioner and ethical consultant in the Wanglie case, describes the frustration and internal conflict experienced by several members of the health care team caring for Mrs. Wanglie: “The nurses were feeling trapped by an endless treatment plan that obliged them to provide treatment they did not believe was appropriate or could benefit a dying patient.” Dr. Miles also relates that the physician attending Mrs. Wanglie, a devout Catholic, did much soul-searching, including reading the Vatican Declaration on Euthanasia, and concluded that he was not willing to continue to prescribe the respirator. Yet despite these strong sentiments, at no point in the trial court opinion did the court address what role, if any, a health care provider’s judgment—moral, medical, or otherwise—might play in a decision about patient care. Instead, the court’s holding reiterates the well-settled principle of patient autonomy and disregards whatever professional conscience the physician may bring to the bedside.

80. See infra text accompanying notes 84-96 for a discussion of the beginnings of the patient self-determination movement.
81. The courts have not held for the patient in every case in which the issue of patient self-determination is raised. For a discussion of the history of the law surrounding the right to refuse treatment, including a discussion of cases in which courts have refused to uphold a patient’s wishes, see Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 270-78 (1990).
82. Miles, Issues, supra note 68, at 62.
83. Id.
While concern for a physician compromising his or her own concept of professional integrity may seem to have no place in the world of patient autonomy, in fact both courts and legislatures have historically regarded a physician’s comfort with his or her actions as a high priority. As this section demonstrates, respect for professional integrity, defined individually by physicians, need not be submerged under the rubric of patient autonomy. Instead, patient and physician autonomy can be balanced by a system that accommodates both sets of values.

A. The Integrity of the Medical Profession as an Evolving Common-Law Concept

In *In re Quinlan*,84 a case heralded for setting the foundation of a patient’s right to refuse treatment,85 the New Jersey Supreme Court struggled to accommodate the divergent wishes of the parents of a severely brain damaged young woman and her attending physicians. While the dispute focused on continued use of a respirator, at the heart of the court’s decision is a discussion about control and compromise—control over medical decision making and compromise of individual and professional integrity in surrendering that control.86 In the end, the court gave control over treatment decisions to the patient and her family, but it was not unmindful of the toll that delegation might have on the conscience and professional integrity of the physicians involved.

The physicians caring for young Karen Quinlan argued that withdrawal of her respirator would offend “prevailing medical standards.”87 But the Quinlan court recognized that not all physicians caring for patients like Karen, perhaps not even all of Karen’s physicians, felt comfortable adhering to a perceived standard that offended their sense of what was morally, ethically, or medically the best course to take for their gravely ill patients. The court articulated this dissonance between a physician’s moral medical judgment and the current standard of care as follows: “[T]here must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients.”88

86. *Quinlan*, 355 A.2d at 671.
87. *Id.* at 664.
88. *Id.* at 668.
In the end, the court offered its holding as a way of ameliorating the professional problems at issue in the case by permitting physicians to withdraw life-sustaining treatment at the patient's or family's request. But more importantly, the court drew attention to the importance of the moral and ethical integrity of individual physicians confronting patients with whose treatment requests they profoundly disagree.

This notion that a physician's conscience is relevant to the jurisprudence of medical decision making was more formally delineated by the Supreme Judicial Court of Massachusetts in 1977. In *Superintendent of Belchertown v. Saikewicz,* the court relied on the right of privacy and the right of informed consent to authorize the withholding of chemotherapy from a profoundly retarded sixty-seven-year-old man suffering from leukemia. In so holding, the court explained that in any judicial decision involving termination of medical care, a court may weigh four countervailing state interests against the individual's request. These state interests are: "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession." In explaining this last state interest, the *Saikewicz* court picked up on the discussion begun in *Quinlan* regarding dissonance between a physician's own medical judgment and the prevailing standard of care, and said that in this case, no such dissonance existed because "[r]ecognition of the right to refuse treatment in appropriate circumstances is consistent with existing medical mores." In essence, the court told the physicians involved in the *Saikewicz* case, as well as the medical profession in general, that their professional integrity would not be compromised should they honor a patient's wishes to decline treatment because they would simply be following what was evolving into the prevailing medical standard.

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90. *Id.* at 425.
91. *Id.* at 426.
92. This same position was taken by the court in *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986). In *Brophy,* the wife of a patient in a persistent vegetative state wanted to remove a gastrostomy tube that supplied her husband's nutrition and hydration. The Massachusetts high court, following its own framework set out in *Saikewicz,* took note of the need to balance individual concerns against potentially overriding state interests. *Id.* at 635. The court held that removing Mr. Brophy's gastrostomy tube would not violate the integrity of the medical profession because such a practice "is consistent with the view of sound medical practice taken by the representative bodies of the American Medical Association, the Massachusetts Medical Society, and that of many ethicists and physicians." *Id.* at 638 (footnotes omitted). The *Brophy* court thus affirmed that a physician's professional integrity is linked to a generalized standard of care rather than to his or her own moral and ethical values.
Thus, the Saikewicz court sidestepped the more troubling question of what a physician is to do when his or her own medical mores dictate a different clinical outcome than that which the patient seeks, or that which prevailing medical standards dictate. In essence, this is the quandary in which the physicians caring for Helga Wanglie found themselves: an internal tug-of-war between what prevailing medical standards require (continued aggressive care per the family's request) and conflicting medical judgment, comprised in part of individual mores, about what was in the best interest of the patient.

The benefit of hindsight makes clear that the Wanglie dilemma grew from seeds planted in Saikewicz and other cases in which the courts were asked to balance patient and physician autonomy. But instead of offering guidance about how to resolve what proved to be an inevitable dilemma, the Saikewicz court simply acknowledged that doctors do have a professional conscience that impacts on their medical decision making. But on balance, the court said, "It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on the patient." 93

Following Saikewicz, courts confronted with right-to-refuse-treatment cases often referred to the four state interests set out by the Massachusetts court, including the interest in maintaining the ethical integrity of the medical profession. 94 But no court ever found this interest compelling enough to override a patient's request, or even suggested that doctor and patient autonomy could be viewed in parity. Instead, courts generally found the patient's interest in medical self-determination so compelling as to preclude a thorough balancing of individual and state interests. 95

93. 370 N.E.2d at 427.

94. See, e.g., In re Conroy, 486 A.2d 1209 (N.J. 1985) (noting the right to decline medical treatment may, in some cases, yield to countervailing societal interests, and citing the four interests set out in Saikewicz); accord Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1980); In re Spring, 405 N.E.2d 115 (Mass. 1980); In re Torres, 357 N.W.2d 332 (Minn. 1984); In re Colyer, 660 P.2d 738 (Wash. 1983). It is interesting to note that these courts considered the state's interests relevant to the right to decline medical treatment, whether that right was based on common-law doctrine (including the right to self-determination and informed consent) or on constitutional theory (the right to privacy, based on state or federal constitutional provisions or both). In either instance, these courts declared that the right to decline treatment was not absolute and must be considered in light of possible countervailing state interests. See, e.g., Conroy, 486 A.2d at 1223.

95. For example, in Conroy, the New Jersey Supreme Court considered whether a nasogastric feeding tube could be removed from an 84-year-old incompetent nursing home resident suffering from irreversible mental and physical ailments. In its discussion of the potential state interests that would weigh against a patient's request for such action, the court said, "On
Perhaps the strongest evidence of the low priority accorded the physician’s professional conscience by courts can be seen in *Cruzan*. In *Cruzan*, the Court highlighted the *Saikewicz* court’s enunciation of the four countervailing state interests that may be considered in treatment refusal cases. The Court concluded that only one, the protection and preservation of human life, was of import.96 Thus, it appears judicial regard for, or even consideration of, a physician’s moral and ethical concerns surrounding treatment decisions will be absent so long as the patient requests treatment (or lack thereof) that comports with an enunciated or evolving standard of medical practice.

**B. The Common Law’s Response to Assertions of Professional Conscience**

When courts are called upon to resolve a clash at the bedside, they inevitably must choose between honoring the values of the patient and those of the doctor.97 To date, in most instances courts have deferred to patients’ values by honoring their treatment requests.98 But this is not to say that courts have ignored the plight of physicians who express fundamental disagreement with a patient’s wishes. In fact, courts generally express empathy and concern for doctors and hospitals that, by virtue of

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96. The Court in *Cruzan* focused on the state’s interest in preserving life to the exclusion of the other three state interests outlined in *Saikewicz*. In the end, the Court held that a state “may legitimately seek to safeguard the personal element of th[e] choice [between life and death] through the imposition of heightened evidentiary requirements.” 497 U.S. at 281.

97. While values are an integral part of decision making in any context, they are paramount in reaching medical treatment decisions. Arguably, the values the patient and physician bring to the bedside are not similarly constituted. A patient’s values may be comprised of religious, sociologic, economic, and psychologic influences as well as a myriad of other considerations. The values a physician brings to the bedside may be similarly derived, but will also likely be based on experiences and training in the medical field. For a discussion of the role personal values play in a physician’s decision making, see SAMUEL GOROVITZ, DOCTORS’ DILEMMAS: MORAL CONFLICT AND MEDICAL CARE 98-111 (1982).

98. There have been numerous articles written about the rights of patients to refuse medical care. Recent additions include Thomas A. Eaton & Edward J. Larson, *Experimenting With The “Right to Die” In The Laboratory of the States*, 25 GA. L. REV. 1253 (1991); Michael R. Flick, *The Due Process of Dying*, 79 CAL. L. REV. 1121 (1991); Robertson, *supra* note 23. Perhaps the best summary of the law in this area comes from the Court’s opinion in *Cruzan*, in which Chief Justice Rehnquist reviews the constitutional, statutory, and common-law underpinnings of the right to refuse treatment. In so doing, he points out that not all courts have upheld treatment withdrawal requests by patients and their families. Citing *In re O’Connor*, 531 N.E.2d 607, 613-15 (N.Y. 1988), Chief Justice Rehnquist observes that the Court of Appeals of New York, “over the objection of the patient’s family members, granted an order to insert a feeding tube into a 77-year-old [incompetent] woman . . . . The [New York] court held that the record lacked the requisite clear and convincing evidence of the patient’s expressed intent to withhold life-sustaining treatment.” *Cruzan*, 497 U.S. at 274-75.
judicial order, find themselves as stumbling blocks to their patient’s desired outcome. In those instances in which a doctor refuses to continue treating a patient or declines to withdraw treatment, courts have struggled to accommodate the values of both doctor and patient.

(1) The Physician’s Right to Abandon a Patient Who Desires Continued Treatment

In all likelihood, every doctor has encountered a “difficult” patient—one who is noncompliant or uncooperative, or whose behavior exceeds the doctor’s level of tolerance. When such a mismatch occurs, a doctor may attempt to dismiss the patient, abdicating further responsibility for the patient’s care. While this may seem a callous response, the law permits a physician to abandon a patient so long as that physician provides due notice and an ample opportunity for the patient “to secure the presence of other medical attendance.”

This common-law principle permitting physician abandonment was tested to the limit in Payton v. Weaver. In that case, a physician specializing in kidney problems, Dr. John C. Weaver, attempted over the course of nearly four years to dismiss Brenda Payton, a patient described as exhibiting “‘persistent uncooperative and antisocial behavior . . . including the use of barbiturates and other illicit drugs.’” Dr. Weaver began treating Ms. Payton in 1975, but after three years of “‘persistent refusal to adhere to reasonable constraints of hemodialysis,’” he informed her by letter dated December 12, 1978 that he would no longer permit her to receive dialysis at the hospital with which he was affiliated. After this warning, Dr. Weaver continued to treat Ms. Payton on an emergency basis, although he sent repeated letters asserting that he no longer wished to treat her on a long-term basis. With his written notifications of dismissal, he included a list of dialysis providers in the

99. Payton v. Weaver, 182 Cal. Rptr. 225, 229 (Cal. Ct. App. 1982) (quoting Lathrope v. Flood, 63 P. 1007, 1008, rev’d on other grounds, 67 P. 683 (Cal. 1902). Accord Miller v. Greater Southeast Community Hosp., 508 A.2d 927, 929 (D.C. Ct. App. 1986) (holding that supplying noncritical patient with a list of substitute physicians to replace attending physician is reasonable means of severing professional relationship); Lyons v. Grether, 239 S.E.2d 103, 106 (Va. 1977) (holding physician has right to withdraw from case, provided patient is given reasonable opportunity to acquire needed services from another physician). To clarify, this policy generally applies when a medically stable patient desires continued care, but the physician is unwilling to provide care to that patient. As the court in Payton points out, such a policy may not apply when the patient is in need of emergency care. See 182 Cal. Rptr. at 229-30.

100. 182 Cal. Rptr. at 229.

101. Id. at 227 (quoting letter from Dr. Weaver to Mrs. Payton).

102. Id.
area and volunteered to help her find alternative care. Ms. Payton responded by filing a petition for mandate to compel Dr. Weaver to provide her with outpatient dialysis services.\textsuperscript{103} 

At trial, the court denied Ms. Payton's petition, holding she had no legal right to compel medical services from Dr. Weaver. But at the same time the trial court imposed a temporary order requiring the doctor to provide treatment to Ms. Payton on a regular basis pending appeal.\textsuperscript{104} On appeal, the California Court of Appeal upheld the trial court's finding that Dr. Weaver acted reasonably, and commended him for behaving "according to the highest standards of the medical profession."\textsuperscript{105} The court also empathized with both the physician's dilemma and the patient's crisis, saying the case "challenge[d] the ability of the law, and society, to cope effectively and sensitively with fundamental problems of human existence."\textsuperscript{106} 

Ultimately, the court upheld the trial court's finding that Dr. Weaver had no long-term duty to care for the plaintiff. The court emphasized that "there exists no basis in law or in equity to saddle [Dr. Weaver] with a continuing sole obligation for Brenda's welfare."\textsuperscript{107} After suggesting several alternatives that could assist the plaintiff, including involuntary or voluntary conservatorship, the court released Dr. Weaver from further responsibility, despite a last minute plea from Ms. Payton's attorneys to order the doctor to provide dialysis "'until he can, by use of his resources, arrange for an orderly transfer to another physician.'"\textsuperscript{108} The court refused this request.\textsuperscript{109} 

What seems most compelling about Payton \textit{v.} Weaver is not what the court did, but rather what the court refused to do. Faced with what it perceived to be a no-win situation, the court anguished over which party should be made to suffer, the doctor or the patient. In the end, the court

\begin{itemize}
\item \textsuperscript{103} Id.
\item \textsuperscript{104} Id. at 228-29. Ms. Payton also named as defendants two hospitals that refused to treat her in late 1978 after she received the letter of dismissal from Dr. Weaver. The trial court did not order these hospitals to accept the plaintiff as a patient because she was not in need of emergency treatment. The court cited to the California Health and Safety Code section 1317, which provides in relevant part: "Emergency services and care shall be provided to any person requesting such services or care, or for whom such services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department . . . ." Id. at 229.
\item \textsuperscript{105} Id.
\item \textsuperscript{106} Id. at 226.
\item \textsuperscript{107} Id.
\item \textsuperscript{108} Id. at 231 n.4.
\item \textsuperscript{109} Id.
\end{itemize}
felt the doctor had acted in the utmost good faith and absolved him of any further involvement with this difficult patient. One wonders what harm, or more aptly what additional harm, would have befallen Dr. Weaver had he been ordered to facilitate the transfer of his former patient to another physician. Surely a physician is in a better position than a patient, particularly an ailing patient, to access information about the existence and qualifications of other physicians. This assumption may be especially true when the search is for a doctor in the same area of expertise as the treating physician.

Admittedly, a system that relies on doctors to, in effect, "sell" a difficult patient to another doctor, is problematic, but at least such a system shows respect for both the physician and the patient. An order that a physician or hospital facilitate the transfer of a dismissed patient assures that the patient will not be abandoned without vital medical care, while at the same time according deference to the physician's professional conscience. Given the choice between continuing to treat a patient with whose treatment choices a physician fundamentally disagrees, and facilitating the transfer of that patient, it seems likely the physician would choose the latter option. Presumably, an action against one's conscience is more burdensome than any actions toward facilitation of a patient's transfer.

While the facts in Payton v. Weaver may suggest that courts are unwilling to engage physicians in a search for their replacements, this unwillingness is apparently limited to situations in which a patient seeks continued care. In cases in which patients request withdrawal of treatment, primarily life-sustaining treatment, and encounter an unwilling doctor or hospital, courts have almost universally ordered the health care provider to either accede to the patient’s wishes or facilitate the transfer of the patient to another provider who is willing to comply with the patient's request.

(2) The Physician’s Duty to Transfer a Patient Desiring Treatment Withdrawal

While the law permits a physician to abandon, with proper notice, a patient who seeks nonemergency care, it is more imposing on doctors

110. See infra text accompanying notes 124-131 for a discussion of the problems with court orders to transfer care of patients whose doctors refuse to honor their treatment requests.

111. The issue of a physician’s duty to treat those in need of emergency care is an interesting one, but also beyond the scope of this Article. For a good discussion of the legal duty to provide emergency care, see Karen H. Rothenberg, Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care, 26 HOUS. L. REV. 21 (1989).
who refuse to comply with a patient’s wishes to terminate treatment. When a court decides that a patient’s right to self-determination includes the right to demand that treatment be discontinued, it must also decide how to best achieve this desired outcome. Essentially a court has two choices in these situations: It can order the doctor or treating health care facility to transfer the patient to another facility that is willing to uphold the patient’s request, or it can order the doctor to comply with the patient’s request, and thus put aside his or her moral, ethical or professional objections to terminating treatment. Both options have been exercised by the courts, and both are problematic.

a. Court Orders To Transfer a Patient for Termination of Treatment

The fact that a patient has the right to refuse continued medical treatment does not give rise to a concomitant physician duty to discontinue care upon request. This principle is illustrated by Conservatorship of Morrison v. Abramovice, a case in which the daughter of a ninety-year-old woman in a persistent vegetative state sought removal of a nasogastric feeding tube from her mother. The hospital physicians refused the daughter’s request due to what the court called “personal moral objections.” In tackling this case, the court first held that a patient, as well as a patient’s surrogate decision maker, has the right to reject a physician’s recommendation. In this case, that meant Mrs. Morrison’s daughter could lawfully authorize removal of the tube.

The next question the court faced was whether a patient or surrogate can require a physician to comply with a treatment request against the physician’s personal moral objections. The court answered this question by holding:

The prevailing viewpoint among medical ethicists appears to be that a physician has the right to refuse on personal moral grounds to follow a conservator’s direction to withhold life-sustaining treatment, but must be willing to transfer the patient to another physician who will follow the conservator’s direction.

113. Id. at 534. The court’s summary of the facts of the case states only that the patient’s daughter, who was also appointed as her conservator, requested removal of the feeding tube, and the hospital refused her request. At trial, both the hospital medical director and the attending physician testified they had personal objections to removing the patient’s feeding tube. Based on this testimony, the court framed the issue in the case as follows: “Can a conservator require physicians to remove a nasogastric tube against their personal moral objections?” Id.
114. Id. at 533-34.
115. Id. at 534 (citing JONSEN, supra note 56, at 104). The court also supported this proposition with the ethical principles and guidelines developed by a joint committee of the Los Angeles County Medical and Bar Associations that provide: “A physician has the right to refuse to participate in continuing or foregoing life-sustaining treatment. In exercising this
This solution to transfer the patient is one that seems to meet the needs of both the patient and the physician and has been adopted in a variety of cases. For example, in *Brophy v. New England Sinai Hospital*, after finding that the patient’s surrogate had the right to authorize treatment withdrawal, the court made clear that this right did not justify compelling medical professionals to take active measures that were contrary to their view of the ethical duty owed their patients. The *Brophy* court ordered the hospital to assist the patient’s guardian in transferring the patient to a suitable facility. Mr. Brophy was transferred to another hospital where feeding was discontinued. He died eight days later.

It seems courts believe this transfer approach is fair and just, as do several medical ethics panels. For example, the American Medical Association, in a recent pronouncement about the care of patients in a persistent vegetative state, stated such patients or their surrogates have the right to demand that treatment be withheld or withdrawn. The AMA acknowledged that situations may arise in which a physician is personally opposed to participating in the requested discontinuance of care. In right, however, the physician must transfer the care of the patient to another qualified physician.”

Committee on Biomedical Ethics of Los Angeles County Medical Association & Los Angeles County Bar Association, Guidelines for Forgoing Life-Sustaining Treatment for Adult Patients, 2 (1986)). The joint committee revised these guidelines in 1990. The section regarding a physician’s right to refuse treatment states:

> Should the patient or patient’s surrogate choose a course of action that would violate the ethical or religious beliefs of the physician, the physician may generally decline to participate in that course of action, where another physician who is willing to be guided by the patient’s wishes will accept care of the patient. In so doing, however, the physician declining to participate must cooperate in transfer of the care of the patient to a new physician.

Committee on Biomedical Ethics of Los Angeles County Medical Association & Los Angeles County Bar Associations, Guidelines for Forgoing Life-Sustaining Treatment for Adult Patients, 4-5 (1990). In its revised 1990 guidelines, the joint committee seems to remove some of the burden of transferring the patient from the attending physician. Instead of requiring the declining physician to transfer the patient to another qualified physician, the committee now urges the withdrawing physician to simply “cooperate” in the transfer to a new physician. Perhaps this revision reflects the committee’s appreciation of the difficulty physicians and hospitals face when trying to transfer a patient based on an assertion of professional conscience. For a discussion of the realities of such transfers, see infra text accompanying notes 124-131.

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117. *Id.* at 639.
118. *Id.* at 639-40.
those cases, the AMA states that "the physician should transfer the patient to a physician who is willing to carry out the decision."121 Interestingly, the AMA does not state this same instruction with respect to a patient’s request for continued care that the physician opposes. In fact, the AMA does not address what a physician should do in this situation. It does, however, assert early in its policy statement that "caretakers have no legal duty to prolong life when treatment will not restore consciousness or produce other medically definable benefits."122

Perhaps the AMA’s silence in guiding physicians opposed to continuing treatment, coupled with its assertion that doctors have no legal duty to continue medically futile care, is a recognition that the transfer solution is the best one current medicolegal jurisprudence offers to physicians who face patient opposition at either end of the treatment continuum. That is, even if one accepts the proposition that a doctor has no legal duty to render futile care, the entrenched principle that a physician may not abandon a patient without providing appropriate backup remains.123 Thus, even if no duty to render care exists, a doctor would breach his or her duty not to abandon a patient if he or she both refused to provide care and refused to transfer the patient to another physician.

What the AMA policy seems to recognize is that a physician may refuse to provide what he or she feels is futile medical care, so long as the patient is transferred to another physician who either disagrees about the characterization of treatment or who is otherwise willing to provide care. Given judicial as well as private endorsement of patient transfer, a preliminary if not primary inquiry should explore whether such transfer is a viable option for most physicians and hospitals. If the ability to transfer a patient to another treating physician is more of an aspiration than a reality, then it is time for courts and policy makers to reevaluate their position on the clash at the bedside.

b. The Realities of Patient Transfer

Court orders and policies that call for a physician to facilitate the transfer of a patient to another provider carry the theoretical benefit of accommodating two conflicting interests, those of the patient and the physician. This benefit could be said to inure both in cases in which a patient seeks continued or additional care, and in cases in which patients request treatment withdrawal. But what are the realities of such transfer mandates? The medical staff caring for Helga Wanglie attempted to

121. Id. at 429. In reaching this recommendation, the AMA cites Brophy.
122. Id. at 426.
123. See supra text accompanying note 99.
transfer her to another facility after providing what it considered to be inappropriate care for many months. Despite intensive efforts to effectuate her transfer and generous insurance for her care, no provider would accept Mrs. Wanglie.124

A similar fate befell William Bartling, a seventy-year-old man suffering from chronic respiratory failure, in his quest to have his respirator disconnected.125 When Mr. Bartling asked that his life-sustaining breathing machine be removed, the hospital refused on the grounds that it was a “Christian, pro-life oriented hospital, the majority of whose doctors would view disconnecting a life-support system ... as inconsistent with the healing orientation of physicians.”126 Instead of simply dismissing Mr. Bartling’s request, the hospital attempted to strike a compromise between their position and that of the patient by trying to locate another hospital that would accept Mr. Bartling as a patient.127 This effort was unsuccessful, and Mr. Bartling died in the same hospital tethered to a respirator.128

The cases of Helga Wanglie and William Bartling are likely representative of a host of instances in which hospitals and individual physicians have attempted to transfer patients who they perceive to be “ethical hot potatoes.”129 Once so classified, the reality of these patients’ transfer becomes a near impossibility.

124. See Steven H. Miles, Interpersonal Issues in the Wanglie Case, 2 KENNEDY INSTITUTE OF ETHICS J. 61 (1992). In his personal description of the Wanglie case, Dr. Miles recounts that the Wanglie family believed the hospital, on the Wanglie family’s demand, had a duty to provide whatever care the insurer would pay for, and therefore refused the hospital’s offers to transfer Mrs. Wanglie. Id. at 69 n.1. The hospitals made such offers in August 1990, November 1990 and January 1991. Id. In March 1991, a week before the original trial date, the family asked for time to transfer her. Over the next five weeks, the hospital worked with members of the right-to-life community to identify a provider. Dr. Miles reports that no provider would accept Mrs. Wanglie as a patient. Id. at 69 n.1.


126. Id. at 225.

127. Id. at 225 n.7.

128. See id. at 221. Although the court does not explicitly say Mr. Bartling died while connected to the respirator, it does report he passed away the afternoon before the Court of Appeal hearing on the Bartling’s petition challenging the denial of their request for an injunction ordering the hospital to disconnect the respirator. The Court of Appeal held that the court below erred in denying injunctive relief. Id. at 227.

129. This term is borrowed from George J. Annas, supra note 119. In his article, Professor Annas argues hospitals are corporations incapable of having either “moral” or “ethical objections” to actions. He argues physicians derive their authority to practice medicine from the state (in the form of licensing), and their patients (in the form of consent) and therefore have no independent “right” to treat patients. Id. at 21. Thus, he seems to suggest neither hospitals nor physicians have the right to object to patient choices on the grounds of professional conscience, and their actions must be guided strictly by principles of patient self-determination. It seems to me that doctors, as independent moral agents, have both the capacity
At least some courts are aware of the difficulty of transferring patients whose treatment wishes contravene those of their health care providers. In *Conservatorship of Morrison*, the court acknowledged this difficulty when it held that "no physician should be forced to act against his or her personal moral beliefs if the patient can be transferred to the care of another physician who will follow the [patient's] direction." Since transfer of the patient did not appear to be a problem in the *Morrison* case, the court did not need to reach the difficult question of how to handle a case in which no provider can be found that will follow the patient's direction to withdraw treatment. In those cases, courts have generally sympathized with the patient's plight and ordered physician compliance.

c. Court Orders to Comply with Patient Wishes for Withdrawal of Treatment

Several courts facing the likelihood of a futile hunt for patient placement have opted instead to order providers to comply with the patient's wishes. For example, in *In re Jobes*, the husband of Nancy Jobes, a nursing home patient in a persistent vegetative state, sought a court order authorizing the withdrawal of a jejunostomy tube, which provided Nancy with nutrition and hydration. The facility had refused the husband's request on "moral grounds." The trial court held that Mr. Jobes could authorize removal of the tube, but the nursing home was entitled to refuse to participate in the withdrawal and could keep Mrs. Jobes connected to the tube until she was transferred out of the facility.

and the right to express their own moral and ethical objections to patient choices, as do institutions through their enunciated policies and guidelines. Instead of downplaying or ignoring the professional conscience of the health care provider, we should recognize its existence and acknowledge the important role it plays in the clinical setting. Only in this way can doctors and patients work toward resolving their conflicting choices of conscience.

130. 253 Cal. Rptr. at 534 (emphasis added).
131. The hospital that cared for Mrs. Morrison, Laguna Honda Hospital, is a public facility. Its administrators told Mrs. Childs, Mrs. Morrison's daughter, that it would transfer her mother at government expense to any suitable facility that would accede to her wishes. *Id.* Shortly after the court of appeal decided the case, Mrs. Morrison was transferred to a private hospital where her feeding tube was withdrawn. She died a few days later. Telephone Interview with John R. Weinstein, counsel for Louise Childs (Sept. 18, 1992).
133. A jejunostomy is defined as an "operative establishment of an opening from the abdominal wall into the jejunum." *Stedman's Med. Dictionary* 736 (illustrated 5th unabr. lawyers' ed. 1982). The jejunum is the portion of small intestine between the duodenum and the ileum. *Id.* Thus, a jejunostomy tube is a tube placed directly into the jejunum.
134. 529 A.2d at 437.
135. *Id.* "[T]he [trial] court found that Mr. Jobes had proved by clear and convincing
The New Jersey Supreme Court reversed the portion of the trial court's opinion allowing the nursing home to refuse to participate in the withdrawal of treatment. In so doing, the court highlighted the difficulty involved in securing another facility to carry out the patient's request. It noted, "The evidence indicates that at this point it would be extremely difficult, perhaps impossible, to find another facility that would accept Mrs. Jobes as a patient." The court therefore held that to allow the nursing home to discharge Mrs. Jobes if her family does not consent to continued artificial feeding would frustrate the patient's right of self-determination. In the end, the court ordered the nursing home to participate in the withdrawal of Mrs. Jobes's feeding tube and, simultaneously, to provide for her comfort and dignity.

In Jobes, the court was keenly aware that it had to choose between patient autonomy and physician autonomy, and that whatever decision it made would impinge on the rights of the nonprevailing party. In fact, the court acknowledged "that our decision will be burdensome for some of the nursing home personnel." Nevertheless, the court concluded, "In view of the immense hardship that would fall on Mrs. Jobes evidence that his wife was in a persistent vegetative state with no prospect of improvement, and that, if competent, she would not want to be sustained by the [jejunostomy] tube under her present circumstances." The New Jersey Supreme Court upheld the judgment of the trial court on slightly different grounds. It found although there was some "trustworthy" evidence that Mrs. Jobes would have wanted the feeding tube withdrawn, it was not sufficiently "clear and convincing." The court then adopted the "substituted judgment" approach that allows surrogate decision makers, such as a patient's family member, close friend, or court-appointed guardian, to make a substituted medical judgment for the patient based on the patient's prior expressed values. For a more in-depth discussion of the substituted judgment approach adopted by the Jobes court, see id. at 444-47.

Physician autonomy, as used here, can also include the ability of the health care facility to assert and enforce its policy toward withdrawal of artificial feeding. The Jobes court indicated that it was balancing the right of the patient's family to exercise Mrs. Jobes's right to self-determination against the nursing home's right to assert a policy that precludes withdrawal of feeding tubes. In this case, the court found that the facility had not informed Mrs. Jobes's family about its policy until May 1985 when they requested that the tube be withdrawn. Under these circumstances, said the court, Mrs. Jobes and her family were entitled to rely on the nursing home's willingness to defer to their choices among courses of medical treatment, presumably including the choice to discontinue feeding. Later, in dicta, the court said that it was not deciding a case in which a nursing home gave notice of its policy not to participate in the withdrawal or withholding of artificial feeding at the time of the patient's admission. The court simply said, "we do not hold that such a policy is never enforceable," leaving open the possibility that a facility could, under certain circumstances, lawfully refuse to participate in a patient's decision to forgo treatment.
and her family if she were forced out of the nursing home, we are compelled to impose on [the nursing home personnel] for her continued care.”

The court in Jobes was not the first and probably will not be the last to conclude patient autonomy must override a physician’s or an institution’s professional conscience, even when such a conclusion places a burden on the health care workers forced to participate in a treatment plan they find offensive. Given the difficult reality of doctor-assisted patient transfer and the impropriety of patient abandonment, courts may believe compelling a health care worker to honor a patient’s treatment wishes is, on balance, the least harmful alternative. After all, a court may reason, ordering a physician to render treatment is nothing more than requiring that the physician fulfill the professional duties he or she has committed to undertake. Alternatively, ordering a physician to participate in the withdrawal of treatment may be viewed as a natural extension of the principle of patient autonomy. Such orders may also be viewed as a necessity because physicians are uniquely qualified to provide for the comfort and dignity of patients who chose to forgo life-sustaining treatment.

Whatever the rationale, it seems that leaving courts, hospitals or doctors with an all-or-nothing remedy—i.e., comply or transfer—does not satisfy the goals of patient or physician autonomy. Forcing a dying patient to leave a setting that has become familiar, if not comforting, seems nonsensical at best; such a change would likely be emotionally and psychologically devastating to patients and their families. On the

142. Id.
143. For example, in Gray v. Romeo, 697 F. Supp. 580, 583 (D.R.I. 1988), the court upheld the right of an unconscious patient’s husband to authorize removal of his wife's feeding tube over the “adamant opposition” of the health care personnel caring for her. In addition, the court ordered the medical center to accede to the patient’s request (as made through her husband) “if [she] cannot be promptly transferred to a health care facility that will respect her wishes.” Id. at 591; see also In re Requena, 517 A.2d 869, 870 (N.J. Super. Ct. App. Div. 1986) (ordering hospital to comply with patient’s informed decision to withdraw treatment even though it presented an alternative hospital 17 miles away that was willing to acquiesce in patient’s decision).
144. See supra text accompanying notes 124-131.
145. Of course, this reasoning fails if one believes a physician is under no duty to furnish treatment that provides no medical benefit to the patient. See supra text accompanying notes 51-64 for a discussion of definitions of beneficial treatment.
146. Physicians are uniquely qualified because they are able to prescribe pain medications that can ease the dying process. This statement was not intended to ignore or downplay the essential role nurses and other health care workers play in aiding patients and their families through this terribly painful experience.
147. In In re Requena, a woman sought to compel a hospital to comply with her request for treatment withdrawal. The hospital refused and offered to transfer the patient to a nearby
other hand, forcing doctors to comply with a patient's wishes they find morally, ethically, religiously, or professionally offensive is an equally unsatisfactory result. Any solution to this dilemma must attempt to accommodate the competing interests of doctors and patients. A solution should strive to keep patients at the site where they have received care, but not force doctors to act against their professional conscience.

III. Statutory Schemes Upholding a Physician’s Right to Self-Determination

While courts seem unable or perhaps unwilling to weigh an individual physician’s concerns about the moral and ethical implications of accommodating a patient’s right to self-determination, legislatures in a variety of states have sought to protect a physician’s right to self-determination in certain situations. Specifically, legislatures appear sensitive to a physician’s desire to exercise moral choice in two instances. First, many states accord doctors, as well as other health care personnel, the right to refuse to participate in an abortion. Second, a few recently enacted statutes provide that a physician shall not be required to render medical treatment that the physician determines is medically or ethically inappropriate. By exploring these two statutory schemes, one senses that concomitant accommodation of patient and physician autonomy can be a reality.

A. A Physician’s Right to Refuse to Participate in Abortion

The vast majority of states in this country have enacted legislation permitting physicians to refuse to participate in an abortion. Typi-
cally, these statutes provide that no person shall be required to perform or participate in medical procedures that result in the termination of a pregnancy. They further provide that a person's refusal to participate in an abortion shall not be the basis for civil liability or other recriminatory action. In most states, the laws do not require physicians or other health care workers to provide any reason for refusing to participate in an abortion. The statutes simply state that a person may refuse to participate in an abortion, implying no explanation is necessary.

Federal law also recognizes the right of federally funded health care workers to decline to participate in an abortion if doing so would be contrary to their religious beliefs or moral convictions. See 42 U.S.C. § 300a-7(b) (1988).

For example, the Delaware Medical Practices Act provides:

No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy; and the refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person, nor a basis for any disciplinary or other recriminatory action against him.

This statute, as well as a majority of those cited in note 149, supra, also contain language that permits a hospital to refuse to participate in an abortion. In fact, the only states that do not explicitly permit hospitals to refuse to participate in an abortion are Louisiana and South Dakota. In Kentucky, Oklahoma, Utah, Washington, and Wyoming, the institutional right to refuse is expressly limited to private hospitals. See Ky. Rev. Stat. Ann. § 311.800(3) (Baldwin 1991); Okla. Stat. tit. 63, § 1-741(A) (1992); Utah Code Ann. § 76-7-306(2) (1992) (exempts private or denominational hospitals or both); Wash. Rev. Code Ann. § 9.02 (Initiative Measure No. 120) (1992); Wyo. Stat. § 35-6-105 (1992).

These statutes stand in contrast to the common law, discussed supra in the text accompanying notes 132-146, which generally requires that a physician who refuses to perform a patient's treatment requests must transfer the patient to another doctor who will abide by the patient's wishes. In no state does the abortion refusal law require or even suggest that an objecting physician transfer the patient to another physician or facility. At most, the statute may require that the physician notify the patient of his or her objection. See Ill. Rev. Stat. ch. 38, para. 81-33(13) (1991) (providing patient shall be promptly notified if her request for abortion is denied).
In contrast, a few states require doctors' refusals to participate in an abortion to be founded on some moral or religious ground. By imposing these rationale parameters, as amorphous as they are, these states appear to be trying to protect patients against arbitrary refusals to treat. Perhaps the state legislators worried that an unwanted pregnancy could raise questions in the physician's mind about the patient's morality, causing the physician to refuse to abort the fetus in an effort to impose his or her own judgments about the patient's lifestyle.

Whatever the reason for requiring physicians to provide a particular basis for opting out of performing an abortion, the evidentiary threshold for proving a moral or religious objection is so minimal as to be nonexistent. The statutes do not require the physician to provide any evidence of a religious affiliation; they merely state a doctor shall not be required to perform an abortion if he or she objects on moral or religious grounds. Consequently, it seems that most states allow physicians to exercise their professional conscience in dealing with these patients.

By analogy, it seems that our jurisprudence should accept a physician's assertion of professional conscience in settings other than abortion. If the law permits a physician to opt out of treating a pregnant patient

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152. See, e.g., ARIZ. REV. STAT. ANN. § 36-2151 (1991) (objection shall be on moral or religious grounds); CAL. HEALTH & SAFETY CODE § 25955(a) (Deering 1992) (person must indicate moral, ethical, or religious basis for refusal); COLO. REV. STAT. ANN. § 18-6-104 (West 1991) (moral or religious grounds); GA. CODE ANN. § 16-21-142 (1991) (same); ILL. ANN. STAT. ch. 38, para. 81-33(13) (1991) (no physician shall be required against his or her conscience); MASS. GEN. LAWS ANN. ch. 112, § 121 (Law. Co-op. 1992) (moral or religious objections); MONT. CODE ANN. § 50-20-111(2) (1992) (same); NEV. REV. STAT. ANN. 75(1) (Michie 1991) (moral, ethical, or religious basis for objection); VA. CODE ANN. § 18-2-75 (Michie 1991) (personal, ethical, moral, or religious grounds); WIS. STAT. ANN. § 140-42(1) (West 1990) (moral or religious grounds).

The foregoing state statutes also require a physician's objection to participating in an abortion to be stated in writing. Two other states, Idaho and South Carolina, also require that a physician's refusal to participate in an abortion be in writing, but do not require a physician to give a specific reason for his or her refusal. In both states, the statutory language provides written notice that a physician objects to performing an abortion "will suffice without specification of the reason therefor." See IDAHO CODE § 18-612 (1991); S.C. CODE ANN. § 44-41-50(a) (Law. Co-op.1990).

153. For example, a physician seeing a pregnant unwed teenager seeking her fourth abortion in two years could decide the only way the young girl will learn to practice birth control would be to "suffer the consequences" of the failure to use contraceptives. In that case, the physician's refusal to perform the abortion would not be grounded on his or her own moral or religious beliefs, but rather on a judgment about the morality of the patient.

154. In Illinois, the notion of a professional conscience is written into the abortion statute. Section 81-33(13) of the Abortion Law of 1975 provides: "No physician, hospital, ambulatory surgical center, nor employee thereof, shall be required against his or its conscience declared in writing to perform, permit or participate in any abortion . . . ." ILL. REV. STAT. ch. 38, para. 81-33(13) (1991).
seeking an abortion for moral, religious, or in most cases no stated reason, why shouldn't that same right exist when the patient is in a persistent vegetative state seeking ventilator support?

On the surface, the answer to this question might be that in one instance a physician is objecting to ending a potential life, while in the other a physician is objecting to providing for or maintaining an existing life, a concept far more objectionable. At the heart of both situations, however, is a doctor who is disinclined to carry out the wishes of the patient because of some deeply held personal convictions. These convictions are likely as strong and heartfelt when dealing with a terminally ill patient as they are in the abortion setting. To the extent the law acknowledges and respects these convictions in one medical setting, it should likewise accommodate them in others. Legislative efforts to expand a physician's right to refuse to provide treatment are underway, but the gap between protections afforded in the abortion setting and those provided in other medical settings remains wide.

B. Legislative Efforts to Protect a Physician's Professional Conscience Outside the Abortion Setting

In 1976, when the New Jersey Supreme Court handed down its decision in *In re Quinlan*,155 setting forth the common law basis for a patient's right to refuse treatment, state legislators in California were also debating the complexity of this issue. What emerged from this debate was the California Natural Death Act, the nation's first statute giving terminally ill patients the right to refuse life-sustaining treatment.156 Since that time, virtually every state has enacted legislation designed to address the needs of patients and their surrogates who seek removal of life-sustaining treatment.157 As in the case of courts that grapple with patients' rights issues, legislative attention to the concerns of the treating physician has been slight, but perceptible.

Legislative schemes for upholding a patient's right to refuse treatment come in essentially three forms: (1) "living will" or "natural death" laws which establish a written method for people to specify their own wishes about the use of artificial life support; (2) "health care agent" or "durable power of attorney for health care" laws which allow individ-

157. *See Society for the Right to Die, Refusal of Treatment Legislation* (1991). According to this 50-state survey, the only states that do not have legislation dealing specifically with medical decision making are Nebraska and Pennsylvania. *Id.*
uals to appoint someone to make decisions about the use of life-sustaining treatment for them; and (3) "surrogate decision-making" provisions which delineate the individuals who are empowered to make decisions on behalf of an incompetent patient who has not executed any document. In addition to spelling out a patient's right to direct his or her own care, many of these statutes also provide guidance in the event the health care provider does not want to honor a patient or surrogate's instruction. For example, the Oregon Directive to Physicians Act provides that a physician who refuses to comply with a terminally ill patient's request for withdrawal of life-sustaining treatment shall "[m]ake a reasonable effort to locate a physician or medical facility that will give effect to a qualified patient's directive and shall have a duty to transfer the qualified patient to that physician or facility." This transfer solution is the typical legislative approach to the problem of physician refusal to comply with patient wishes.

Like the abortion refusal laws, the treatment refusal laws do not require a physician to state a specific reason for declining to follow a patient's wishes. Unlike the abortion laws, however, patients' rights statutes do not explicitly permit physicians to refuse patient requests. At most, they sometimes provide that a doctor will not be held criminally or civilly liable for failing to follow a patient's written directive. Instead, unlike abortion refusal laws, treatment refusal statutes do not give physicians a statutory right to exercise their professional conscience. Instead, they provide a patient with the statutory right to demand treatment withdrawal while imposing on a physician the statutory duty to find another physician willing to follow the patient's wishes.

One notable characteristic of most treatment refusal laws is that they only address the situation of a patient who wishes to decline treat-

158. Id. at 1.
160. See, e.g., Colorado Medical Treatment Decision Act, COLO. REV. STAT. § 15-18-113 (1990) (attending physician who refuses to comply with declaration shall transfer patient to another physician who is willing to comply); Texas Natural Death Act, TEX. REV. CIV. STAT. ANN. § 672.016 (1990) (physician who refuses to comply with patient wishes shall make "reasonable effort" to transfer patient).
161. See, for example, Nevada Withholding or Withdrawal of Life-Sustaining Procedures Act, NEV. REV. STAT. § 449.640 (1991), providing: "No hospital or other medical facility, physician, or person working under the direction of a physician is subject to criminal or civil liability for failure to follow the directions of the patient to withhold or withdraw life-sustaining procedures." Colorado takes a different approach to physician refusal, providing: "Refusal of an attending physician to comply with a declaration and failure to transfer the care of the declarant to another physician shall constitute unprofessional conduct as defined in section 12-36-117, C.R.S." Colorado Medical Treatment Decision Act, COLO. REV. STAT. § 15-18-113(5) (1990).
ment. What about a patient, like Helga Wanglie, who demands continued care in the face of physician objection? Natural death and living will statutes do not tell a physician that he or she may refuse to treat a patient, only that he or she may not decline to discontinue treatment of a patient. Does this statutory silence mean that physicians have no protected right to refuse to provide what they consider inappropriate or futile care to a patient? If so, is this issue something our state legislatures should be concerned about?

At least one state has enacted legislation which recognizes that a physician has a professional conscience that can be offended by certain treatment requests. The Virginia legislature recently amended its Natural Death Act,\(^{162}\) which sets out patients' rights to make decisions about their health care, including the right to make an advance directive authorizing withdrawal or withholding of life-sustaining treatment under certain circumstances. As amended in April 1992, the Virginia law provides: "Nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate."\(^{163}\) The statute does not define "medically or ethically inappropriate treatment," but it does state that if a physician's treatment determination is contrary to that of the patient, "the physician shall make a reasonable effort to transfer the patient to another physician."\(^{164}\)

Thus, like the abortion refusal statutes, this change in at least one state's law\(^{165}\) acknowledges that a physician may object to a patient's treatment choices purely on ethical grounds and protects the physician in asserting that objection. In an instance of doctor-patient disagreement, the patient is likewise protected from abandonment by requiring the physician to transfer the patient to another qualified doctor. This statutory acknowledgement of a physician's professional conscience represents an important step toward providing greater physician autonomy and greater patient protection. If physicians know they are protected in the choices

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164. Id.
165. Legislators in California attempted to institute a similar change in that state's law. On February 25, 1991, a group of Assembly Members introduced A.B. 705 that would have extended the law regarding refusal to participate in abortion to any medical procedure. The bill provided in part: "No employer or other person shall require a physician . . . to directly participate in any medical procedure if the [physician] has filed a written statement with the employer or the hospital, facility or clinic indicating a moral, ethical, or religious basis for refusal to participate in the medical procedure." The bill was passed by the California Assembly and was referred to the California Senate on June 18, 1991. No further action has been taken on the bill.
they make vis-à-vis their patients, they are more likely to be open and forthcoming with their patients when making those choices.166

The dilemma of patient transfer remains problematic even in an atmosphere of tolerance toward a physician's moral and ethical assertions. As many cases demonstrate,167 it is often difficult if not impossible for a physician to transfer a patient with whom the doctor has clashed over treatment choices. Since it appears that our jurisprudence, and perhaps our collective societal conscience, is unwilling to advocate abandonment of patients who seek medically futile care, our focus should be on how to best effectuate patient transfer. Our current ad hoc method is not working. A better approach may be to develop a systematic response to individual cases, much like the system used by attorneys who wish to withdraw from representation of a particular client.

IV. A Systematic Approach to Patient Transfer: Adapting the American Bar Association’s Approach to Lawyer Withdrawal

A. Standards Governing Lawyer Withdrawal from Client Representation

The relationship between a doctor and a patient is unique, but not one without some analogy to other professions. Attorneys, like physicians, are trained to advise and serve their clients to the best of their ability. Lawyers have confidential relationships with clients who look to their counsel, in many instances, for assistance in confronting major life events such as divorce, bankruptcy, and even death.168 Like physicians,

166. If doctors believe that if they begin a therapy, such as ventilator support on an acutely ill patients, they will be bound to continue the treatment even if that treatment becomes what they consider to be “medically and ethically inappropriate,” then doctors are less likely to offer that therapy in the first instance. Alternatively, if doctors know that after treatment has begun, they have the option of declining to continue providing treatment once they consider it to be futile, they will be more likely to disclose and apply that treatment option to patients.

This same argument was recently advanced in an article by Lance Stell, a professor of philosophy. Professor Stell proposes hospitals adopt institutional standards for withholding or withdrawing futile treatment, even when the family demands continued care. He suggests such standards should require prompt, clear communication with the patient or surrogate, because

[n]ot to do this invites suspicion and cynicism and erodes medical integrity. In the absence of a standard, physicians who feel compelled to comply with medically unjustified demands for full measures may practice strategic concealment of their decisions or deliver half-measures in selected cases.


167. See supra text accompanying notes 124-131.

168. Lawyers help clients deal with death in a variety of ways, including drafting wills and
attorneys do not always agree with the course of action clients wish to take. In these instances, attorneys, like their medical counterparts, face the dilemma of whether or not to continue representing a client whose views or requests are in conflict with their professional consciences.

The American Bar Association, which governs the conduct of attorneys through its Model Rules of Professional Conduct,\(^{169}\) offers guidance to attorneys who wish to withdraw from representing a client. Model Rule 1.16 discusses the circumstances under which a lawyer may withdraw, providing in relevant part:

[A] lawyer may withdraw from representing a client if withdrawal can be accomplished without material adverse effect on the interests of the client, or if:

\[
\begin{align*}
&\ldots \\
&(3) \text{the client insists upon pursuing an objective that the lawyer considers repugnant or imprudent; [or]} \\
&\ldots \\
&(6) \text{other good cause for withdrawal exists.}^{170}
\end{align*}
\]

One noteworthy aspect of this rule is that it attempts to balance the interests of the client and the lawyer. The rule provides that a lawyer may withdraw from representing a client for any reason at any time so long as the client's interests are not adversely affected (thus the client is protected). However, a lawyer may withdraw, even if the client's interests will be adversely affected, if the lawyer considers the client's objective repugnant or imprudent, or for other "good cause." Thus, the lawyer is protected from having to represent a client with whom he or she fundamentally disagrees.

What this rule arguably represents is acknowledgement of and respect for the lawyer's professional conscience. The ABA seems to understand that in instances when an attorney and client reach an irreconcilable impasse as to how to proceed, continued representation is not in the client's or the lawyer's best interest. This sentiment is also reflected in Model Rule 1.7, pertaining to conflict of interest. This rule states that "[a] lawyer shall not represent a client if the representation of that client may be materially limited by the lawyer's . . . own inter-

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169. The ABA is a private organization that has no power to impose rules on lawyers directly. Instead, the ABA indirectly regulates the conduct of lawyers through the promulgation of the Model Rules of Professional Conduct. The Rules were adopted by the ABA House of Delegates on August 2, 1983, and have since been adopted by 34 states and incorporated into law in significant portion by six others. See Stephen Gillers, Regulation of Lawyers: Problems of Law and Ethics 3-4 (1992).

The Model Rules do not specifically define a lawyer’s “own interest,” thus allowing for a broad, perhaps individualistic, interpretation of such an interest. Allowing a lawyer to decide when his or her interests conflict with those of the client and to withdraw from representing that client for “good cause” is a way of permitting a lawyer to act as an autonomous moral agent in the practice of law.

The ABA has not been the only body to recognize the concept of lawyer autonomy. In Jones v. Barnes, the United States Supreme Court addressed the issue of whether an indigent defendant has a constitutional right to compel appointed counsel to raise any nonfrivolous point on appeal if counsel, as a matter of professional judgment, decides not to present those points. Holding that the defendant does not have such a right, the Court stressed the need for counsel to present the client’s case “in accord with counsel's professional evaluation.” The Court recognized that decisions about legal strategy should include lawyer and client input, but held that at some point an attorney must be allowed to exercise his or her professional judgement even if it is contrary to a client’s wishes.

While the Court in Jones did not address the issue of a lawyer’s withdrawal from representing a client, it did take a position on the importance of lawyer autonomy in the attorney-client relationship. The Court recognized a client “has the ultimate authority to make certain fundamental decisions regarding the case,” but held this right must be balanced against the attorney’s right to exercise “professional judgment” when proceeding in a manner disfavored by the client. This conflict scenario is not altogether different from that posed by Wanglie and other cases in which the physician disagrees with “certain fundamental decisions” made by the patient. In both instances the professional is forced to choose between the wishes of those they are trained to assist and their

171. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.7(b) (1989). The Rule also states that lawyers may undertake representation in such an instance if they reasonably believe the representation will not be adversely affected and the client consents after consultation.

172. The comments following Model Rule 1.7 give examples of a lawyer's own interest that might conflict with those of the client. The comments refer primarily to pecuniary interests that could conflict with the client's interests, such as referring clients to an enterprise in which the lawyer has an undisclosed interest. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.7 cmt. (1989).


174. Id. at 751.

175. Id.

176. Id. Here the Court was referring to a criminal defendant who was represented by appointed counsel. The principles announced in the opinion can arguably be extended to apply to any situation in which a client asks the lawyer to press a claim or strategy the attorney believes should not be pursued.
own professional conscience. In both instances lawyers and doctors have generally been permitted, either through statutes, codes of conduct, or court decisions, to decline services to those with whom they have clashed. 177

What is different between the clash experienced by doctors at the bedside and attorneys in the courtroom is the degree of supervision and assistance the professional receives when he or she makes the difficult decision to dismiss a patient or client. By comparing a physician treating a patient to an attorney representing a client in litigation, one can observe the different positions each professional finds themselves vis-à-vis the institutional setting in which they work. For doctors, a decision to transfer a patient is made in an institutional vacuum; no structure exists to facilitate or even guide the physician as to how to proceed. 178 As a result, in many cases no transfer is effected, or perhaps worse, no transfer is attempted because the physician fears overwhelming obstacles to its attainment.

In contrast, when an attorney representing a client before a tribunal decides to withdraw from that case, the lawyer must petition the court for permission to withdraw. 179 This procedure alerts the court that a

177. As noted supra in the text accompanying notes 132-148, doctors are not always permitted to transfer a patient when they disagree with the patient's treatment plan. Attorneys are likewise bound to continue representing their clients in certain situations. Specifically, Model Rule 1.6(c) provides: "When ordered to do so by a tribunal, a lawyer shall continue representation notwithstanding good cause for terminating the representation." Model Rules of Professional Conduct Rule 1.6(c) (1983). When courts are confronted with a request by an attorney to withdraw from a case that is pending before a tribunal, they must "'balance the need for the orderly administration of justice with the fact that an irreconcilable conflict exists between counsel and the [client].'" See Boudreau v. Carlisle, 549 So. 2d 1073, 1074 (Fla. Dist. Ct. App. 1989) (denying counsel's motion to withdraw less than one month before trial was to begin) (citations omitted). Because courts must be concerned with the orderly administration of justice, in many instances they will order an attorney to continue to represent a client in an ongoing case unless the court believes "'that the attorney-client relationship has . . . deteriorated to a point where counsel can no longer give effective aid in the fair presentation of a defense.'" Id. at 1075 (citation omitted).

178. For example, in the case of Mrs. Wanglie, Dr. Miles describes, with notable frustration, the efforts the medical center undertook to deal with the clash between the family and the treating physicians:

The medical staff had exhausted every means possible to address the dispute and avoid court, including: counseling, offering to transfer the patient to other providers, and providing months of inappropriate intensive care so that the family could come to terms with the irreversibility of the patient's condition.

Miles, Interpersonal Issues, supra note 68, at 63. This story indicates the medical center had no formal mechanism in place to address the clash that arose.

179. The rules governing attorney withdrawal and substitution of counsel are contained in local court rules. For example, Local Rule 2.8.2.1 of the United States District Court for the Central District of California, entitled Substitution of Attorney, provides as follows:

Motion for Withdrawal. An attorney may not withdraw as counsel except by leave
problem has developed in the attorney-client relationship. The court is forced to learn about the conflict and make a decision about whether the client will be better served by continued representation or by a new lawyer who must become familiar with the case in a short period of time. Bringing the court into the conflict allows for an independent assessment of the needs and interests of both lawyer and client.

While attorney withdrawal is never easy for the client who must secure other counsel, at least it can be accomplished in a routine, predictable, institutionalized setting. Establishing a more routine, systematic method of accomplishing physician withdrawal should provide doctors with greater opportunity to exercise their professional conscience. If physicians had access to a system that allowed them to air their views about a patient's treatment preferences, the overall doctor-patient relationship could be improved by enhanced communication and external support.

B. Establishing In-Hospital and Local Boards to Facilitate Patient Transfer

Hospitals, like courts, are institutions with the capacity to inaugurate reform that will enhance the institutional environment. As suggested above, one such reform should be to institute a formal mechanism for hearing and responding to fundamental disagreements between patients and physicians over the course of treatment. Arguably such a

of court. An application for leave to withdraw must be made upon written notice given reasonably in advance to the client and to all other parties who have appeared in the action.

The rules also address the situations under which a court may deny an attorney's motion for withdrawal. Local Rule 2.8.2.4 provides: "Unless good cause is shown and the ends of justice require, no substitution or relief of attorney will be approved that will cause delay in prosecution of the case to completion." C.D. CAL. R. 2.8.2.4.

180. The Model Rules of Professional Conduct address the responsibilities of an attorney who has withdrawn from representing a client. Model Rule 1.16(d) provides:

Upon termination of representation, a lawyer shall take steps to the extent reasonably practicable to protect a client's interests, such as giving reasonable notice to the client, allowing time for employment of other counsel, surrendering papers and property to which the client is entitled and refunding any advance payment of fee that has not been earned.

MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.16(d) (1983). This rule does not require an attorney to assist the client in securing another lawyer. In this sense, the rule resembles the common law governing physician abandonment of a patient, which likewise does not require a doctor to assist a patient in locating another physician if the patient is medically stable. See supra text accompanying notes 99-110. If a patient is not medically stable, a court will often instruct the withdrawing physician to assist in transferring the patient to another physician. See supra text accompanying notes 112-119.

181. It seems practical to limit the jurisdiction of such a group, as defined infra in the text accompanying notes 183-185, to "fundamental disagreements." Frivolous, day-to-day conflicts should not be heard by this forum. Instead, the forum should be designed to resolve
mechanism already exists in most hospitals in the form of ethics committees. However, as recent literature suggests, institutional bioethics committees are not uniform in composition, mission, or authority. Moreover, the type of committee contemplated herein would be more specialized and better equipped to respond quickly to physicians who find themselves facing a dilemma of conscience.

In order to provide a forum for physicians to exercise their professional conscience, hospitals should create treatment evaluation boards (TEBs). The purpose of these boards should be threefold: First, to create a forum for physicians to discuss specific disagreements with the course of treatment their patients have requested. Second, to deliberate as to how to meet the needs of the patient and the physician under the circumstances. Third, to facilitate, if necessary, the transfer of the patient either to another physician in the same hospital or to another facility. This third function stands out as the most important role of the TEB because it removes the burden of transfer from patients and physicians and places it on the institution.

Ideally, a TEB should be composed of two members from the full-time medical staff, one member who represents the hospital administration (this member should serve as chair of the board), and one member

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183. This second purpose, as phrased herein, is intentionally vague and optimistic in that it assumes that some resolution can be reached. In many cases resolution will not be easily achieved, if it can be achieved at all. For example, the family of a patient in a persistent vegetative state may demand continued aggressive care in the form of code-blue status, ventilator support, and artificial administration of food and fluids. The physician may believe "comfort care" such as hydration and pain relief is the only reasonable course of treatment. That same family might demand that the treating physician remain on the case because the family has grown to trust that doctor, in spite of their fundamental disagreement with the physician's recommendations. For this case and others like it, hospitals may want to enact more specific guidelines as to the resolution of disputes between doctors and patients. For example, hospitals could adopt policies that disclose to the patient that they will not offer treatment they consider medically futile. See Stell, supra note 166 (proposing a model hospital policy for withholding and withdrawing treatment on grounds of medical futility). Or hospitals may want to make a general statement that they will not compel a physician to act against his or her moral, ethical, or religious beliefs. See Edmund G. Howe, Caveats Regarding Slippery Slopes and Physicians' Moral Conscience, 3 J. CLINICAL ETHICS 251 (1992).

184. Patient transfer cannot and should not be achieved without some involvement of the patient and the physician. However, since hospitals have better resources to facilitate patient transfer, the bulk of responsibility should be shifted to the hospital.
who is a hospital social worker. This composition provides representation from the hospital departments most affected by a clash at the bedside. This four-member team should be appointed for a term of at least two years, with new appointments to occur on a rotating basis to ensure continuity of knowledge and experience. In addition, for each case presented to the board, the chair should appoint one member of the medical staff who has expertise in the particular disease or injury from which the patient suffers. The four-member TEB should meet initially to set up procedures for hearing and handling disputes. Thereafter, the full board should meet only when called upon by a physician.185

The notion of a hospital board constituted to resolve individual patient problems is not novel. Many hospitals have created “prognosis boards,” comprised of physicians who are asked to review an attending physician’s diagnosis of permanent unconsciousness for purposes of withdrawing treatment.186 The purpose of the prognosis board is to ensure the hospital has made an independent evaluation of the patient’s condition before authorizing withdrawal of treatment. Similarly, TEBs would insure an independent assessment of the situation by those who are knowledgeable about the medical crisis at issue. Additionally, these boards would serve the unique purpose of resolving individual physician dilemmas as they relate to patient care.

The institutional usefulness and benefit of the TEBs could be enhanced by modeling these boards in part after judicial tribunals that adjudicate criminal cases involving indigent defendants. Specifically, the aspect of the legal system that should be adapted to meet the needs of a physician and patient at odds over medical treatment is the procedure for appointment of counsel in criminal cases. When the law dictates, courts are required to adopt procedures for appointment of counsel in criminal cases for indigent defendants.187 These procedures are used internally by

185. In general, the TEB as proposed herein could not be accessed unilaterally by the patient. Instead, the patient would have to access the board through his or her physician (provided the doctor agrees to invoke the board). The reason for this dichotomy is that in general it is far easier for a patient to dismiss a physician than it is for a doctor to dismiss a patient. It is a problem for patients, however, to find another physician to take over their care. For this reason, the TEB bylaws should include some mechanism for patients to unilaterally access the board when they are seeking a substitute physician.

186. See Persistent Vegetative State, supra note 120, at 429.

187. The constitutional provision guaranteeing criminal defendants access to counsel is the Sixth Amendment to the U.S. Constitution, which provides in relevant part: "In all criminal prosecutions, the accused shall enjoy the right to . . . have the assistance of counsel for his defence." U.S. CONST. amend. VI. While a full discussion of the constitutional basis for the right to counsel in criminal cases is beyond the scope of this Article, the procedures courts have adopted to assure defendants adequate representation are worth examining for possible adaptation in the medical setting.
the court to ensure that each accused is adequately represented in the
criminal justice system.

For example, California Rule of Court 76.5 outlines the procedures
California Courts of Appeal are to follow when providing representation
for indigent appellants. The rule states: "The procedures shall require
each attorney to complete a questionnaire showing the date of admission
to the bar and the attorney's qualifications and experience."\(^{188}\) Once the
court receives the completed questionnaire, the court is directed to "evaluate
the attorney's qualifications to represent appellants in criminal
cases, and then place the attorney's name on one or more lists to receive
appointments to cases for which he or she is qualified."\(^{189}\) By keeping
and maintaining\(^{190}\) these lists, courts work to provide continual access to
representation for those clients they oversee.

Hospitals should look to this judicial model when setting up treat-
ment evaluation boards. The TEB should be charged with adopting pro-
cedures for the appointment of an alternative physician when the treating
physician requests the patient be transferred from his or her care. The
boards could require all physicians who are members of the medical staff
to complete a questionnaire disclosing their area of practice, their years
of experience, and their interest in having their name placed on a list of
doctors willing to accept patients transferred from other physicians.\(^{191}\)
The questionnaire would have to be designed to elicit information about
the doctor's professional conscience: what goals does the physician have
for terminally-ill patients; how comfortable does the physician feel ren-
dering treatment that provides no objective medical benefit; is the physi-
cian willing to withdraw or withhold life-sustaining treatment and if so,
under what circumstances. Granted, the complete accuracy of a ques-
tionnaire in reflecting this personal information could be questioned, but
at least the TEB would have some basic information about the pool of
physicians from which it could select a substitute caretaker.

There may be instances in which the TEB would be unable to locate
a substitute physician on the medical staff of the treating hospital.\(^{192}\) In

\(^{188}\) CAL. R. CT. 76.5(a).

\(^{189}\) CAL. R. CT. 76.5(b).

\(^{190}\) The courts are required to review and evaluate the performance of appointed counsel
to determine whether the attorney's name should remain on the appointment list, be placed on
a different list, or be deleted. CAL. R. CT. 76.5(c).

\(^{191}\) Alternatively, this information could be solicited from physicians when they apply for
medical staff privileges at an institution.

\(^{192}\) Ideally, the TEB should strive to locate an alternate physician from the same institu-
tion to minimize the time for transfer as well as the inconvenience to the patient and family.
There may be instances when the patient wishes to be transferred outside the institution, and
those instances, the TEB should search for an alternate physician at a different institution. To facilitate this search, each hospital TEB should submit to the local medical association its list of physicians willing to accept transfer patients. The medical association should act as a clearinghouse for the master list of possible appointees, thus facilitating transfer from one institution to another. With a centralized record keeper, information that is currently obtained only through individual, ad hoc searches could be made readily available as the need for such important information arises.

In sum, a system that gives physicians the opportunity to voice their professional conscience would create a better environment for doctors and patients alike. Treating doctors who clash with their patients similar to lawyers who seek to dismiss their clients means creating an overseeing body that can independently assess the needs of the patient as well as the physician. A hospital-based committee, such as the TEBs suggested herein, could serve as this overseer by hearing fundamental disputes between doctors and patients and making decisions about the future of those relationships. Moreover, equipping TEBs with the ability to assist in transferring a patient when necessary would drastically reduce the stress felt by doctors, patients, and their families when they fundamentally disagree about the course of treatment.

V. Conclusion

The plight of Helga Wanglie, a woman whose family tested the limits of medically appropriate treatment, brought attention to an issue that has been in the background of bioethical jurisprudence for many years. Wanglie focused attention on the issue of physician autonomy in the context of patient decision making. That case challenged the court, as well as our society, to consider whether a physician has an obligation to provide medical treatment he or she believes is inappropriate. While the Wanglie court may have successfully sidestepped that particular issue, it was unable to quell the mounting concern over a physician's ability to exercise his or her professional conscience in the clinical setting.

The concept of a physician’s professional conscience will become increasingly relevant as the cost of health care rises to the point where our demands for care greatly outweigh our ability to pay for such care. As cost becomes an increasingly important factor in the way medicine is practiced, patients may be forced to rely more on their physician's judg-
ment as to what treatment is medically appropriate.\textsuperscript{193} To downplay the role a physician's professional conscience plays in medical decision making, as both courts and policy makers traditionally have done, does not advance patient autonomy; instead, it causes doctors to be more conservative and withholding in the range of options they offer their patients.

If patient autonomy is to have meaning, recognition must also be given to a physician's moral autonomy. This Article suggests that when patients clash with their physicians over treatment choices, the principle of patient autonomy does not automatically require that the physician be forced to comply. Providing doctors with a forum in which to express their concerns and with the ability to transfer patients when necessary would enable physicians to practice medicine in a way that comports with their professional conscience. The exercise of a physician's professional conscience could go a long way toward resolving the clash at the bedside.

\textsuperscript{193} In our current health care system, physicians, as well as administrators and insurers, are already well accustomed to making decisions about the reasonableness and appropriateness of medical treatment with respect to cost. This Article has intentionally focused on issues outside of the economics of health care delivery. However, as our nation grows increasingly unable to provide economical care to its citizens, judgments about medical appropriateness will be linked directly to the cost of treatment.