

DEATH: A NEW LEGAL PERSPECTIVE

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I. INTRODUCTION

It is disturbing that so much of the debate surrounding the medical and legal definition of death is driven by a need to preserve medical resources and procure organs rather than by an honest scientific and philosophical inquiry about the meaning of life and death.¹ This Article argues that the focus should be on finding a precise definition of death and how to determine it with certainty, not how to reduce medical costs and increase the organ supply for transplantation. The issue usually debated by policymakers and healthcare ethicists is not death, but rather whether society can find a way to justify abandoning one set of dying patients to save another.² A liberal abandonment policy, however, entails ethically dangerous consequences such as using people as merely a means to an end, violating basic principles of informed consent, and disregarding patients' wishes about end of life care. Further complicating the situation, these debates are taking place in an atmosphere of public mistrust, and many of the policies being implemented add to, rather than ease, the public's sense that it is being deceived about the organ procurement process.³

Keeping the public in the dark about the realities of how organ donation affects end of life care is dishonest and manipulative, and such practices are in part responsible for the growing public mistrust of the healthcare profession in general and the organ procurement system in particular.⁴ With proper education and fully-informed consent, more individuals would

1. Robert M. Veatch, *The Evolution of Death and Dying Controversies*, 39 THE HASTINGS CTR. REP. 16, 18 (2009) ("Innumerable variations on the definition of death incorporate philosophical and religious positions, many of which are not obviously wrong.").

2. John A. Robertson, *The Dead Donor Rule*, 29 THE HASTINGS CTR. REP. 6, 6 (1999).

3. R. D. Truog, *Is It Time to Abandon Brain Death?*, 27 THE HASTINGS CTR. REP. 29, 35 (1997).

4. Susan E. Morgan et al., *In Their Own Words: The Reasons Why People Will (Not) Sign an Organ Donor Card*, 23 HEALTH COMM. 23, 25 (2008).

choose to donate their organs than would otherwise do so without such education, even if doing so meant abandoning preconceived notions of death or proper end of life care. It is unknown whether this assessment is accurate, but the current approach of encouraging donation without accurately informing the public about how donation affects end of life care risks a public backlash against the whole organ procurement process.⁵ This Article's solution is untried in the context of organ donation, but not unique; it models the already well-developed legal approach for dealing with similarly controversial decisions governing the refusal and withdrawal of treatment.⁶

This Article lays bare what is at stake in the modern dispute over the definition of death and argues that it is time to reconsider the legal definition of death as it has developed over the last fifty years. Certainty should take precedence over expediency, and individuals should be empowered to include organ donation in their end of life care plans based on their own personal beliefs. In short, as a matter of public policy, no patient should be declared dead until after all integrated circulatory and brain functions have ceased; but individuals should be allowed to decide for themselves, or through their surrogates, whether to donate organs based on their own concept of death and thus, if they so desire, before the official criteria for determining death are met.

A general note for this Article: the common nomenclature of "brain death" and "circulatory death" is confusing. The modifiers "brain" and "circulatory" are generally used to indicate how death was determined, not to indicate that only part of the person is dead.⁷ Yet, a central theme of this Article is the discomfort many people feel with the exclusive use of either neurological or circulatory criteria to determine death of the person as a

5. Considering the possible ramifications of closer consideration of declaring patients dead by cardiac standards and transplanting their hearts into other patients as in seen in Mark M. Boucek et al., *Pediatric Heart Transplantation after Declaration of Cardiocirculatory Death*, 359 N. ENG. J. MED. 709, 709-14 (2008), <http://www.nejm.org/doi/pdf/10.1056/NEJMoa0800660>; Arthur J. Matas et al., *Morbidity and Mortality After Living Kidney Donation, 1999-2001: Survey of United States Transplant Centers*, 3 AM. J. OF TRANSPLANTATION 830, 833 (2003).

6. See *infra* Part II; see generally *Defining Death: Medical, Legal, and Ethical Issues in the Determination of Death*, PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 1 (1981), http://bioethics.georgetown.edu/pcbe/reports/past_commissions/defining_death.pdf [hereinafter PRESIDENT'S COMM'N].

7. PRESIDENT'S COMM'N, *supra* note 6, at 3.

whole, and the use of such modifiers only contributes to the confusion beleaguering the definition of death.

II. WHY THE DEFINITION OF DEATH BECAME AN ISSUE

In the not too distant past, the transition from life to death in the hospital setting was more gradual, but also more definite than it is today.⁸ As hope waned, so did the efforts to bring about recovery.⁹ When medical interventions ceased, mourning began.¹⁰ Only those with the most emotional investment vigilantly searched for signs of life. Eventually the motionless patient became grey and stiff and even the most hopeful could not deny that death had occurred.¹¹ In the last century, however, dramatic advancements in medicine have brought with them a desire for a more precise definition of death.¹²

A. From Death of the Whole Organism to Death as Organ Failure

Black's Law Dictionary lists a pre-twelfth century definition of death that is concise and hard to dispute: "The ending of life; the cessation of all vital functions and signs."¹³ It is a definition that does not significantly differ from that given by the President's Council on Bioethics in its 2008 white paper on the definition of death,¹⁴ which concludes in relevant part that

8. *Id.* at 21.

9. *Id.*

10. *Id.*

11. *Id.* ("Until the past few decades, comatose patients fairly rapidly either improved or died. If no other complication supervened and the patient did not improve, death followed from starvation and dehydration within days; pneumonia, apnea, or effects of the original disease typically brought on death even more quickly. Before such techniques as intravenous hydration, nasogastric feeding, bladder catheterization and respirators, no patient continued for long in deep coma.").

12. *Id.*

13. BLACK'S LAW DICTIONARY 458 (9th ed. 2009).

14. THE PRESIDENT'S COUNCIL ON BIOETHICS, CONTROVERSIES IN THE DETERMINATION OF DEATH: A WHITE PAPER BY THE PRESIDENT'S COUNCIL ON BIOETHICS, 1, 1 (2008), http://www.thenewatlantis.com/docLib/20091130_determination_of_death.pdf [hereinafter PRESIDENT'S COUNCIL].

death is the absence of a “self-preserving commerce with the world.”¹⁵ Compare these approaches to defining death of the whole organism to the legal standards developed in the 1970s and 1980s that identify the loss of a single function or organ with the determination of death.¹⁶

Even as recently as 1968, death was legally defined as “[t]he cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc.”¹⁷ The definition remains holistic, but also mentions the criteria used for determining death, namely the cessation of vital functions.¹⁸

Since 1968, the definition of death has radically changed. Now, Black’s Law Dictionary still gives the pre-twelfth century definition, but also provides a definition for brain death: “[t]he bodily condition of showing no response to external stimuli, no spontaneous movements, no breathing, no reflexes, and a flat reading (usually for a full day) on a machine that measures the brain’s electrical activity.”¹⁹ With the advent of new medical technologies, we have parsed “death” into subcategories, such as brain death and cardiopulmonary death, which consequently has caused us to rethink how to determine when an organism’s life has ended. Where once “death” sufficed as an all-encompassing term, now a collection of terms exist—for brain death: whole or total brain death, total brain failure, coma depassee, irreversible coma, brain arrest, and total brain infarction (death of tissue due to lack of blood supply); and for circulatory death: heart death, heart/lung death, cardiorespiratory death, and cardiopulmonary death.²⁰

Unlike the definitions of the pre-1970s and the recent President’s Council, which considered death to be a holistic bodily event, the standards developed from the 1970s to the 1990s targeted the cessation of specific organ functions to justify removing the person from life support, or

15. *Id.* at 62.

16. PRESIDENT’S COMM’N, *supra* note 6, at 62 (summarizing KAN. STAT. ANN. §77-202 (1971)).

17. BLACK’S LAW DICTIONARY, *supra* note 13.

18. PRESIDENT’S COMM’N, *supra* note 6, at 5 (“Traditionally, the cessation of heartbeat and of breathing were regarded by the lay and medical communities alike as the definitive signs of death.”).

19. BLACK’S LAW DICTIONARY, *supra* note 13.

20. PRESIDENT’S COMM’N, *supra* note 6, at 21.

procuring organs before they become unusable.²¹ There is no doubt that the process of death is a continuum from the failure of individual organs to total system failure and then even to the breaking down of cellular processes. Yet the issue is not the inevitability of the process (if it is clear that the patient is in fact dying), but finding the point of no-return. The Nobel prize-winning surgeon Joseph Murray knew he did not have to wait for a potential donor to turn grey and stiff before harvesting the kidneys he needed for transplant, and Murray's team received organs from patients that were declared dead under the standard of the time, namely fifteen to twenty minutes after the cessation of circulatory functions.²² Much has changed with how we determine death (as evidenced by the methods described herein) since Dr. Murray did his trail-blazing transplants, but one issue still remains: there is a difference between dead beyond a reasonable doubt and the point at which death becomes inevitable based on our knowledge of the statistical likelihood of recovery. In dispute is which of these two sometimes quite variable points in time should be used as the threshold for organ recovery.

The exact moment of death is elusive, but for legal reasons surgeons are legitimately hesitant to take organs from patients who have not officially been declared dead.²³ A tension exists between the need for certainty and the need to procure organs early enough that they are still viable for transplantation. These tensions are complicated by the fact that in the last century medicine has improved dramatically in its ability to save lives

21. Stuart J Youngner & Robert M Arnold, *Philosophical Debates About the Definition of Death: Who Cares?*, 26 J. OF MED. & PHIL. 527, 533 (2001), <http://www.psy.vanderbilt.edu/courses/hon182/whocares.pdf> ("Brain death served two useful purposes in 1968. First, it allowed physicians to turn off respirators without fear of legal consequences"); "When the Harvard Committee put forward its new 'definition' of death in 1968, mechanical ventilators had just come into widespread use but our society had no clinical, psychological, or legal experience with turning them off. Physicians and hospitals were worried about the legal consequences of doing so." *Id.* at 534.

22. See generally, Thomas Brante & Margareta Hallberg, *Brain or Heart? The Controversy over the Concept of Death*, 21 SOC. STUD. OF SCI. 389, 389-413 (1991) (discussing the pre-transplant era, the standard for death was once considered to be "when heart beat and breathing has stopped for about 15-20 minutes, death has occurred - a so-called 'heart death.'"); THOMAS FLINT, JR., *EMERGENCY TREATMENT AND MANAGEMENT* 334 (3d ed. 1964) (instructing that emergency personnel should continue resuscitative efforts for an hour unless obviously futile (e.g. the person is decapitated) or doing so will put the person providing emergency services in danger).

23. See Youngner & Arnold, *supra* note 21.

previously thought to be hopeless cases.²⁴ For example, before the ventilator was invented in the 1900s, an inability to breathe meant death, and certain classes of comatose patients were destined to die within days if not hours or even minutes because the technology to sustain them did not exist.²⁵ Medical advancements made it possible to hope for recovery in increasingly unlikely situations and to parse the dying from the dead with ever greater precision.²⁶ The line between hope and despair easily becomes blurred for patients' families and medical staff, particularly when giving up on one patient may mean life for others.²⁷ Medicine and the law now find themselves at a cross-road: Does society continue encouraging that everything be done to save every life, no matter how slight the chances of recovery? Or is society ready to give up on certain classes of patients in order to save others with a more realistic chance of survival? The issues of 1) how we define death and 2) who we determine should decide the point at which we give up on one patient for the sake of others are critical to how humanity sees itself and the future of medicine.

B. Medical Advances and the Costs of Postponing Death

Medical science has marched towards an ever-increasing ability to postpone death.²⁸ The advent of artificial ventilation around 1900²⁹ and subsequent improvements in its design began to blur the line between life

24. PRESIDENT'S COMM'N, *supra* note 6, at 21.

25. *Id.* at 15-17.

26. *Id.* at 17-18.

27. Wayne Shelton, *Respect for Donor Autonomy and the Dead Donor Rule*, 3 AM. J. OF BIOETHICS 20, 20 (2003).

28. Even the stethoscope fundamentally renovated the means for determining death. It was one of the earliest technologies that could be used to look more closely at a body to observe signs of life. The stethoscope was invented in France in 1816 by René-Théophile-Hyacinthe Laennec at the Necker-Enfants Malades Hospital in Paris. See generally RENE-THEOPHILE-HYACINTHE LAENNEC, DE L'AUSCULTATION MÉDIATE OU TRAITÉ DU DIAGNOSTIC DES MALADIES DES POUMON ET DU COEUR: FONDÉ PRINCIPALEMENT SUR CE NOUVEAU MOYEN D'EXPLORATION (Brosson & Chaudé 1819).

29. L.A. Geddes, *The History of Artificial Respiration*, 26 INST. OF ELECTRICAL AND ELECTRONICS ENGINEERS ENGINEERING IN MED. & BIOLOGY MAG. 38, 39 (2007); Michael J. Cawley, *Mechanical Ventilation: A Tutorial for Pharmacists*, 27 PHARMACOTHERAPY 250, 251 (2007).

and death. The Iron Lung, widely used in the United States during the 1950s, kept alive polio patients whose brains were still fully functional, but whose bodies had otherwise forsaken them.³⁰ Soon, however, ventilators were also being used to keep patients alive who had lost brain function in the hope that given time the brain would recover.³¹ The question arose of how to deal with patients who had irreversibly lost their ability to interact with the world – patients who were kept alive by machines that supported their circulatory functions but did nothing to help them regain consciousness.³² People wondered whether keeping such patients alive by mechanical means was a wise use of medical resources, whether it was undignified or cruel, and, whether given the organ shortage, we should find a way to allow such patients to become donors while their organs were still viable for transplantation.³³

There was no organ shortage to speak of before the 1970s because organ transplantation was in its infancy. In 1954, Dr. Joseph Murray successfully transplanted a kidney from one identical twin brother into another. However, not until more than two decades later did life-saving transplants become a realistic option due to the development and improvement of immunosuppressant drugs.³⁴ In particular, the discovery of cyclosporine in 1978³⁵ greatly increased the survival rate of transplant recipients and made the expanded use of cadaver organs feasible. The procurement of cadaver

30. It is interesting to note the change in dynamics: patients using iron lungs or ventilators to compensate for broken bodies were undoubtedly alive, and though their lungs have failed, their hearts and brains remained intact. If there were a disease today where muscular degeneration could progress to the heart and lung muscles but stop there, would we put such a person on a heart/lung bypass machine or would we declare them dead? James H. Maxwell, *The Iron Lung: Halfway Technology or Necessary Step?*, 64 THE MILLBANK Q. 3, 3 (1986).

31. PRESIDENT'S COMM'N, *supra* note 6, at 21-22.

32. *Id.*

33. There is no breathing without a central nervous system (CNS), but the heart can beat without any signals at all from the CNS. See FREDERICK MARTINI & EDWIN BARTHOLOMEW, *ESSENTIALS OF ANATOMY AND PHYSIOLOGY* 338 (1997) (discussing heartbeat). See also *id.* at 424 (discussing the brain's role in breathing).

34. Peter L. Abt et al., *Donation After Cardiac Death in the US: History and Use*, 203 J. AM. COLL. SURGEONS 208, 208 (2006).

35. *Id.*

organs, however, was complicated by the need to do so with limited delay.³⁶ The longer the donor was dead, or rather the longer organs were without an oxygenated blood supply, the less likely it was that retrieved organs would be viable for transplant.³⁷ As the science and practice of transplantation and organ preservation techniques improved, the demand for organs surged.³⁸ As the demand for organs increased, so did the push to clarify the definition of death to allow for expeditious organ retrieval.

Laws developed to deal with three interrelated issues introduced by the advent of new ventilation and transplantation technologies: 1) how to deal with questions of human dignity and end of life choices in a pluralistic society; 2) how to deal with futile treatment and prevent the wasting of medical resources; and 3) how to maximize the supply of cadaver organs for transplant.³⁹ The law took two distinct approaches to dealing with these issues: 1) let patients decide for themselves at what point their life is no longer worth preserving; and 2) clarify the point after which there is no longer a social obligation to provide treatment and life-sustaining treatment can be stopped and/or organs can be harvested.⁴⁰ The first approach has the significant advantage that it helps preserve trust in the medical profession, while in hindsight the latter approach seems to have had the opposite effect.

III. HOW THE LAW EVOLVED TO DEAL WITH END OF LIFE ISSUES

Conflicting interests are at the heart of all legal action. Recent practices regarding end of life decisions raised several legal concerns.⁴¹ Healthcare

36. Robert Steinbrook, *Organ Donation after Cardiac Death*, 357 NEW ENG. J. MED. 209, 210 (2007), <http://content.nejm.org/cgi/reprint/357/3/209.pdf> ("If a patient does not die quickly enough to permit the recovery of organs, end-of-life care continues and any planned donation is canceled. At present, this may happen in up to 20% of cases.").

37. *Id.*

38. *Id.*

39. *In re Baby K*, 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 513 U.S. 825 (1994); UNIFORM ANATOMICAL GIFT ACT (2009), available at <http://www.anatomicalgiftact.org/DesktopDefault.aspx?tabindex=1&tabid=63>.

40. See, e.g., *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072 (La. Ct. App. 1998). For law increasing patient self determination, see Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.005 to 127.045 (2010); see *infra* notes 93, 97, and 98. For law describing the end of duty to treat, see UNIFORM ANATOMICAL GIFT ACT, *supra* note 39.

41. See Boucek, *supra* note 5, at 709-14.

costs were rising, and spending precious dollars on patients with no chance of recovery seemed to be a waste of money.⁴² Some argued for a right to life, others for a right to die.⁴³ Some argued that treatment was futile or that certain groups of patients should be considered dead, while others argued that such patients should not be abandoned.⁴⁴ Some urged that we find a way to harvest more organs more efficiently, while others argued that it was important to honor end of life wishes even if they interfered with organ donation.⁴⁵ The approaches described below involve two basic methods for solving such conflicts. The first creates a legal obligation to treat but gives patients and their proxies⁴⁶ the right to refuse treatment and shields medical professionals from liability if they heed such requests.⁴⁷ The second approach creates certain legal exceptions to the physician's obligation to treat, and authorizes medical professionals to override the wishes of patients

42. *U.S. Health Care Costs: Background Brief*, KAISER FAMILY FOUND. (Mar. 2010), http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358. Some of the data provided illustrates the staggering costs of health care spending in the United States, which:

[I]n 2008, accounted for 16.2% of the nation's Gross Domestic Product; this is among the highest of all industrialized countries. Total health care expenditures grew at an annual rate of 4.4 percent . . . , a slower rate than recent years, yet still outpacing inflation and the growth in national income.

Id.

43. See generally, Alexander M. Capron, *At Law: Death and the Court*, 27 HASTING CTR. REP. 25, 25-29 (1997).

44. PRESIDENT'S COMM'N, *supra* note 6, at 28.

45. D. Alan Shewmon et al., *The Use of Anencephalic Infants as Organ Sources: A Critique*, 261 JAMA 1773, 1775 (1989).

46. Like most courts, we will assume that when a patient's surrogate makes a decision, he or she is not exercising substituted judgment, but acting as the patient's agent, because the surrogate has unique knowledge as to what the patient would consider in the patient's own best interest. The one exception is that the substituted judgment standard is appropriate when the patient is a minor or an adult who never was competent to make healthcare decisions. To avoid cumbersome language in the text, please understand each reference to a patient's decision-making authority as implicitly including his or her surrogate decision-maker, whether that person's authority comes directly from the patient or by operation of law.

47. Omnibus Budget Reconciliation Act of 1990, H.R. 5835, 101st Cong. (1990).

or their proxies under certain circumstances (futility and brain death) without fear of liability.⁴⁸

A. First Approach: An Obligation to Treat and the Right to Self-Determination

It is difficult to engender trust in a policy driven definition of death in a pluralist society such as the United States, where cultural, religious, and philosophical notions of life and death differ broadly. In a situation where patients run the risk of being treated by medical professionals who do not share their moral perspective, it is the government's obligation to protect its citizens from both healthcare personnel who may disagree with a patient's perspective and shifting societal norms that may violate a patient's religious or moral beliefs. U.S. courts, and to some extent U.S. legislatures, realized in the early 1900s that the only way to preserve both trust and the pluralist nature of this country's moral fabric would be to establish a dual standard.⁴⁹ The government and medical profession would indiscriminately work to preserve life, and patients would have the right to decide for themselves when to change the goals of treatment or even stop treatment all together based on their own personal assessment of the meaning of life and death. There are some aberrant decisions,⁵⁰ but this dualist approach has been affirmed and reaffirmed repeatedly at all levels of government.

48. See *Bryan v. Rectors and Visitors of Univ. of Va.*, 95 F.3d 349 (4th Cir. 1996) (upholding the district court's grant of defendant's motion to dismiss the claim brought by Cindy Bryan, administratrix of the estate of Shirley Robertson, to hold the University of Virginia Medical Center liable for failing to provide stabilizing care as required by the Emergency Medical Treatment and Active Labor Act).

49. See discussion *supra* Part III.

50. See generally *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072, 1072 (La. Ct. App. 1998). The Louisiana Court of Appeals for the Second Circuit ruled that it was not a battery when a physician and hospital withdrew life-sustaining care from a thirty-one year-old quadriplegic comatose patient with end-stage renal failure over the express objection of the patient's family. The patient's treating physician stipulated that with continued ventilation and dialysis the patient could live another two years, but she would only have a one to five percent chance of ever regaining consciousness. The court acknowledged that questions of futility are subjective, but stressed that physicians have a right to decide when treatment is medically inappropriate and held that this particular case needed to be evaluated by a medical review panel under the state's Medical Malpractice Act to see if the physician's (and hospital's) action was outside the standard of care. *Id.*

The first prong of the dual standard - the medical profession's obligation to do its best to preserve each patient's life regardless of personal feelings about quality of life - helps engender trust in the profession but does nothing to prevent what may seem like a waste of scarce and expensive life-saving and life-preserving medical resources, and it does nothing to increase the organ supply. The second prong however, allows individuals to choose for themselves when to stop treatment that has little chance of improving their quality of life. The obvious advantage of this approach is that patients continue to trust healthcare professionals to do all they can to save a patient's life until the point where the patient himself, or through an advance directive or a proxy healthcare decision maker, requests that treatment be altered or stopped.⁵¹ The locus of this trust lies in the assurance that patients' decisions are respected, whether the decision is to continue, to alter, or to stop treatment. The added benefit of personal decisions to forego or withdraw treatment, is that fewer medical resources are spent on patients with a hopelessly diminished quality of life, and more organs of higher viability become available because the dying process, at least in some cases (e.g., removal from the ventilator and/or artificial heart), is controlled enough to allow for the careful timing of organ retrieval.⁵²

1. An Obligation to Treat

The physician's obligation to treat is deeply rooted in both medical and legal tradition.⁵³ First, there is the historic concept of obligations afforded by a physician's training. Second, there are the four principles dominating contemporary medical ethics.⁵⁴ Finally, there are duties imposed by professional associations and the legal system.⁵⁵

51. See Susan D. Goold, *Trust and the Ethics of Health Care Institutions*, 31 HASTINGS CTR. REP. 26, 27-28 (2001).

52. See Franklin G. Miller & Robert D. Truog, *Rethinking the Ethics of Vital Organ Donations*, 38 HASTINGS CTR. REP. 38, 45 (2008).

53. HIPPOCRATES, OF THE EPIDEMICS bk. I (Francis Adams trans., Internet Classics Archive) (c. 400 B.C.E.), available at <http://classics.mit.edu/Hippocrates/epidemics.1.i.html>.

54. TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS, PART II 99-287 (6th ed. 2009).

55. *Opinion 10.01: Fundamental Elements of the Patient-Physician Relationship*, AM. MED. ASS'N. (1993), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.shtml>.

The origin of physicians' obligations to their patients is usually traced to the Hippocratic school of medicine. Primarily, the maxim guiding physicians is found in the phrase *Primum non nocere*, "above all, do no harm."⁵⁶ This aphorism provides foundation for the principle of nonmaleficence, but the *Hippocratic Oath* itself provides a more express obligation to treat: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice."⁵⁷ Thus, a fiduciary duty to help patients in whatever way a physician's skills allow is evident even in some of the earliest tenants of the medical profession.

In contemporary medical ethics, physicians' obligations to their patients are fourfold: respect for autonomy, nonmaleficence, beneficence, and justice.⁵⁸ Each of these provides an interrelated component of the doctor-patient relationship; in sum, they provide a framework for the proper practice of medicine. Respect for the autonomous choices of patients upholds the ability of the patient to make informed "choices, and to take actions based on their personal values and beliefs."⁵⁹ The "principle of nonmaleficence imposes an obligation not to inflict harm on others."⁶⁰ While the extent to which this obligation should be followed is debatable,⁶¹

56. HIPPOCRATES, *supra* note 53 (in which physicians agree "to abstain from doing harm").

57. ANCIENT MEDICINE: SELECTED PAPERS OF LUDWIG EDELSTEIN 6 (Owsei Temkin & C Lillian Temkin eds., 1967); *see also* BIOMEDICAL ETHICS 71 (Thomas Mappes & David Degrazia eds., 2006).

58. *See* BEAUCHAMP & CHILDRESS, *supra* note 54, at 12-13.

59. *Id.* at 103.

60. *Id.* at 149.

61. Consider the case of the use of chemotherapy to inhibit the growth of and ultimately kill a tumor: the administration of such drugs markedly harms (in the limited sense) the patients. While the (intended) outcome of that specific course of action is in the best interest of halting the growth of the tumor, the action itself denies the prima facie obligation to "do no harm," because the drugs' effects on the patient's body are devastating. It is, therefore, the requisite task of the medical team in conjunction with the patient to deliberate over and decide upon in conjunction the best course of treatment for a specific medical need, using the four principles as guideposts rather than hard-and-fast rules. LOUIS LASAGNA, PHILOSOPHICAL MEDICAL ETHICS; ITS NATURE AND SIGNIFICANCE 43-46 (Stuart Spicker & Hugo Englehardt, Jr. ed., D. Reidel Publishing Co., 1975) (discussing "Do No Harm").

the obligation accords with the traditional roles assigned to physicians. The principle of beneficence requires that physicians provide a direct benefit to their patients while simultaneously balancing the benefits and risks to produce the best overall outcome.⁶² Finally, the principle of justice requires that “social benefits and social burdens be distributed in accordance with the demands of justice.”⁶³ Justice details, at least in part, the means by which resources that are paid for are allocated.⁶⁴

U.S. physicians’ obligations to their patients are grounded in adherence to these principles as expressed through the codes of conduct advanced by their governing professional associations. For example, the American Medical Association (AMA), speaking to the duty the physician owes the patient, states that:

The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.⁶⁵

This duty of nonabandonment clearly is intended to foster trust.

The physician’s obligation to treat was embodied in U.S. law through several developments. Since 1937, the law has required that physicians, after commencing treatment, continue treatment unless the physician gives “the patient sufficient notice” to “procure other medical attention if he desires.”⁶⁶ Furthermore, some courts have held that the locality rule (which recognizes limitations imposed on rural physicians because of a lack of

62. See BEAUCHAMP & CHILDRESS, *supra* note 54, at 197.

63. BIOMEDICAL ETHICS, *supra* note 57, at 27.

64. See generally NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* (Cambridge University Press 2008). The “Just Health” conception proposed by Norman Daniels is a theory that physicians should be concerned with the protection of the normal range of opportunity, and disparities in health should be mitigated to protect the normal range of opportunity afforded to the statistically “healthy” person. *Id.*

65. AM. MED. ASS’N, CEJA REPORT A-90: FUNDAMENTAL ELEMENTS OF THE PATIENT-PHYSICIAN RELATIONSHIP 1 (1990), http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_aa90.pdf; see also Timothy E. Quill & Christine K. Cassel, *Nonabandonment: A Central Obligation for Physicians*, 122 ANNALS OF INTERNAL MED. 368, 370 (1995).

66. *Ricks v. Budge*, 64 P.2d 208, 211 (Utah 1937).

specialized instrumentation or resources) does not relieve healthcare professionals of the obligation to refer their patients to other specialized providers when the first cannot or will not provide the required or requested treatment.⁶⁷ Also, the Americans with Disabilities Act (ADA) passed by Congress in 1990, and modified in 2008, requires physicians (as individuals operating services) to provide the disabled with the same opportunities afforded to the non-disabled.⁶⁸

Lastly, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals with emergency medical facilities examine all patients presenting to determine if an emergency exists, to either provide stabilizing treatment or transfer the patient to another hospital, and that specialty hospitals must accept cases requiring their specialty as capacity allows.⁶⁹ Specifically, the EMTALA calls for the following:

If any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists. [If so,] the hospital must provide either . . . further medical examination and such treatment as may be required to stabilize the medical condition, or . . . for transfer of the individual to another medical facility [and that] [a] participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, . . .) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.⁷⁰

Together, the ADA and EMTALA can be understood as requiring treatment for patients compromised by illness even if healthcare

67. See Jerald J. Director: *Malpractice: Physician's Failure to Advise Patient to Consult Specialist or One Qualified in a Method of Treatment Which Physician Is Not Qualified to Give*, 35 A.L.R.3d 349 (1971); see also Sylvia Law et al., *Notes: The Locality Rule and Quality of Care*, L. & AM. HEALTH CARE SYS. 845-47 (West Group Publishing 1999).

68. Americans with Disabilities Act Title III: Public Accommodations and Services Operated by Private Entities, 42 U.S.C. § 12186(b) (1990).

69. 42 U.S.C. § 1395dd (1986).

70. *Id.*

professionals feel there is no long-term benefit to such treatment. For example, in the case of *In re Baby K*, the Fourth Circuit Court of Appeals decided that emergency medical personnel could not refuse to provide emergency treatment for an infant over the mother's objection, even if the emergency team felt treating the anencephalic infant was futile and would only cause suffering and prolong the dying process.⁷¹

2. *The Right to Self-Determination*

The obligation to treat is a derivative of the right to consent or refuse treatment, not the other way around. Under common law, it was recognized early on that obtaining consent in emergency situations was impractical.⁷² Often the patient was not well enough to give consent and, in emergency situations, healthcare providers should concentrate on treatment, not getting consent. As a result, it became public policy to assume consent in emergency situations and protect healthcare providers from an accusation of battery if they treated a patient under such circumstances without first obtaining permission.⁷³ However, there were logical exceptions: What if the patient or the patient's family was expressly and coherently objecting to treatment despite the emergency? Or what if there was disagreement among medical staff over the urgency of treatment and whether there was time to obtain consent? The need for answers to these types of questions is what led to the development of a whole body of law that deals with patient self-determination and the right to refuse or demand the withdrawal of even life-saving or life-sustaining treatment.⁷⁴

a. Courts Uphold the Right to Refuse Treatment, Even Life-Saving or Life-Sustaining Treatment

In the United States, where the law strives to respect the pluralistic traditions of its citizenry, "dignity" and "quality of life" are concepts most

71. *In re Baby K*, 16 F.3d at 590; *but see Bryan*, 95 F.3d at 349 (discussing the limited duty to treat potentially futile case, overcoming the emergency, and its immediate aftermath).

72. See generally Comm. on Pediatric Emergency Med., *Consent for Emergency Medical Services for Children and Adolescents*, 111 PEDIATRICS 703, 703-706 (2003), <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;111/3/703.pdf>.

73. Kurt Hartman & Bryan Liang, *Exceptions to Informed Consent in Emergency Medicine*, 35 HOSP. PHYSICIAN 53, 56 (1999), http://www.turner-white.com/pdf/hp_mar99_emergmed.pdf.

74. Omnibus Budget Reconciliation Act of 1990, H.R. 5835, 101st Cong. (1990).

likely applied to broaden, not narrow, patient self-determination. In 1914, when the U.S. Supreme Court decided *Schloendorff v. Society of New York Hospital*, Justice Cardozo said, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."⁷⁵ Then in 1976, the U.S. Supreme Court denied *certiorari* in *In Re Quinlan, sub nom Garger v. New Jersey* and thereby let stand a New Jersey Supreme Court decision accepting the notion that the right to self-determination includes the right to have a surrogate decision-maker refuse even life-saving or life-sustaining treatment for a patient who cannot verbalize such a refusal on his or her own.⁷⁶ In *In Re Quinlan*, the New Jersey Supreme Court wrote:

If a putative decision by Karen [the patient] to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice.⁷⁷

Subsequently, in *Cruzan v. Director, Missouri Department of Health*, the U.S. Supreme Court acknowledged that there was a fundamental common law and probably also a constitutional right to make one's own healthcare decisions, including the right to refuse life-saving or life-sustaining treatment, but that states had a countervailing right, derived from their obligation to preserve life, to take appropriate measures to assure that there is sufficient evidence of a patient's wishes before a surrogate may act to withdraw life-sustaining treatment.⁷⁸ The Court did not specify what standard of proof was required, only that it was acceptable for states to set their own standards as to how much proof should be required. In this particular instance, it was decided that Missouri's decision to use an intermediate standard of proof, the "clear and convincing" standard, as opposed to the lesser "preponderance of the evidence" or more stringent "beyond a reasonable doubt" standard, was not an unconstitutional restriction on a patient's right to due process.⁷⁹ Consequently, state laws in effect today range from those that only require the surrogate to have some evidence of the patient's wishes to those that specifically require a valid

75. *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 126 (1914).

76. *In re Quinlan*, 355 A.2d 647, 673, 684 (1976), *cert. denied sub nom Garger v. New Jersey*, 429 U.S. 922 (1976).

77. *Id.* at 41.

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

79. *Id.*

advance directive that clearly identifies which types of life-sustaining treatment the patient would want to refuse and under what circumstances.⁸⁰

b. Advance Directive Laws

While cases like *In Re Quinlan* were working their way through the courts, many state legislatures, and eventually even the U.S. Congress, considered advance directive legislation.⁸¹ Judicial decisions regarding treatment refusal or withdrawal overwhelmingly focus on patients' rights, but advance directive legislation often serves multiple purposes.⁸² In addition to affirming a patient's right to refuse treatment, these laws also provided healthcare professionals with immunity from prosecution for following advance directives, and legislators who have ethical qualms about allowing the withdrawal of treatment were afforded an opportunity to control the circumstances under which the right can be exercised.⁸³

In 1976, California passed the first advance directive legislation in the country, the California Natural Death Act, which stated that "[t]he

80. For example, Nebraska law provides that an attorney may not remove patients from artificially administered hydration and nutrition unless:

[T]he principal is suffering from a terminal condition or is in a persistent vegetative state and the power of attorney for health care explicitly grants such authority to the attorney in fact or the intent of the principal to have life-sustaining procedures or artificially administered nutrition or hydration withheld or withdrawn under such circumstances is established by clear and convincing evidence.

NEB. REV. STAT. § 30-3418 (2010). Alternatively, South Dakota seems to utilize the "preponderance of evidence" standard, although not explicitly, for the making of substituted judgment decisions. South Dakota's healthcare decisions by agent statute states: "Whenever making any health care decision for the principal, the attorney-in-fact or agent shall consider[] the decision that the principal would have made if the principal then had decisional capacity, if known, and the decision that would be in the best interest of the principal." S.D. CODIFIED LAWS § 59-7-2.5 (2008). At this point there are no states that require the most stringent "beyond a reasonable doubt" standard to permit a healthcare proxy or advance directive to make decisions about the cessation of life-sustaining treatments, although arguably, some, like Nebraska and Alabama, seem to apply a "clear and convincing" standard that is strict enough to almost qualify as "beyond a reasonable doubt." ALA. CODE § 22-8A-11 (2009).

81. See, e.g., *California's Natural Death Act*, 128 W. J. MED. 322, 322-28 (1978), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1238103/pdf/westjmed00260-0066.pdf>.

82. *Id.* at 323.

83. *Id.*

terminally ill patient, in a prospective way, makes the decision,” and that “[t]hose most affected by the prospect of dying ought to determine how their final days are to be spent.”⁸⁴ The California legislation also specifically protected healthcare providers who in good faith followed a “Living Will” written under the Act.⁸⁵ But this legislation and the legislation passed by other states since, limit the right of patients to direct end of life healthcare decisions should they become incompetent. These limitations would not be judicially acceptable for competent patients, but in the interest of protecting potentially vulnerable incompetent patients the states have imposed various restrictions. For example, the first version of California’s advance directive law was only available to patients suffering from a terminal condition, and to be valid the Living Will could not be executed any earlier than two weeks after the patient received a prognosis that death was imminent.⁸⁶ Arkansas followed with almost identical legislation in 1977.⁸⁷ Most advance directive laws today are not so restrictive regarding the declarant’s prognosis at the time the directive is executed, but they are often restrictive in other respects.⁸⁸

84. *Id.*

85. *Id.*

86. Since 1976, the law in California has become less restrictive regarding who qualifies for relief under the statute. Before the California Natural Death Act was repealed and superseded by provisions of the California Probate Code, related to advance health care directives, it provided the following definitions: “‘Qualified patient’ means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient,” and “‘Terminal condition’ means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures, serve only to postpone the moment of death of the patient.” The Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-88 (repealed 1999) (The Natural Death Act in California is superseded by the provisions of the California Probate Code relating to advance healthcare directives.); see Bernard Lo & Robert Steinbrook, *Resuscitating Advance Directives*, 164 ARCH. INTERN MED. 1501, 1502 (2004); see also Med. Staff Conference, *supra* note 81.

87. ARK. CODE ANN. §§ 20-17-201 to 20-17-218 (2010).

88. *E.g.*, restrictions on the use of artificial nutrition and hydration to non-invasive forms without explicit request. *Id.* Many states, such as Colorado, include limitations of application of advance directive to exclude pregnancy. See COLO. REV. STAT. §§ 15-18-101 to 15-18-113 (2009). Similarly, a few states also include restrictions of the power of a proxy (restricting consent to abortion, sterilization, or psychosurgery). See D.C. CODE

With time, various kinds of durable power of attorney (DPA) for healthcare also became acceptable forms of advance directives. DPAs were a pre-existing legal convention that became more common as a means of appointing a proxy of one's choice instead of allowing a surrogate to be appointed by operation of law.⁸⁹ Most states currently have incorporated some form of DPA for health care, usually called a "healthcare proxy," into their advance directive legislation, but even in those states where no special healthcare power of attorney is available, the standard durable power of attorney used in other contexts is an option.⁹⁰

In 1990, Congress passed The Patient Self-Determination Act (PSDA) with the intent of encouraging reliance on advance directives.⁹¹ The PSDA requires that: (1) at the time of admission, patients be given a written summary of healthcare decision-making rights specific to the state and the facility's policies with respect to recognizing advance directives, (2) patients be asked if they have an advance directive and that their response be documented, (3) hospitals make an effort to educate staff and the community about advance directives, and (4) no discrimination based on whether or not a patient has an advance directive, and (5) providers educate themselves, their staff, and the community on issues concerning advance directives.⁹²

3. Physician Aid in Dying

Physician aid in dying tips the balance in favor of self-determination and allows physicians to aid patients in ending their lives. The practice is legal in Oregon, Washington, and Montana.⁹³ Physician aid in dying, or physician assisted suicide as it is sometimes called, is clearly more than just a case of

§§ 7-621-30 (2009); *see also* Health-Care Decisions Act, D.C. CODE §§ 21-2201 to 21-2213 (2009).

89. *Advance Directives*, NAT'L CANCER INST. (Mar. 7, 2000), <http://www.cancer.gov/cancertopics/factsheet/support/advance-directives>.

90. *E.g.*, The Natural Death Act, ALA. CODE §§ 22-8A-1 to 22-8A-14 (2010); The Health Care Decisions Act, ALASKA STAT. §§ 13.52.010 to 13.52.395 (2010).

91. Omnibus Budget Reconciliation Act of 1990, H.R. 5835, 101st Cong. (1990).

92. *Id.*

93. *See* Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.005 to 127.045 (2010); *see also* The Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.101 to 70.245.200 (2009), available at <http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245>; *see also* Baxter v. Mont., 224 P.3d 1211 (Mont. 2009).

treatment refusal because patients are authorized to request lethal medication, and physicians may assist by prescribing such medication without fear of prosecution.⁹⁴ Some say aid in dying is a clear violation of the obligation to treat.⁹⁵ Others argue that the obligation to treat includes the obligation to treat terminal patients (or those whose self-assessed quality of life falls below an acceptable threshold) by helping them through the dying process, including helping them hasten death if that is what they wish.⁹⁶ Aid in dying is an undeniable example of how the law, at least in the jurisdictions listed above, has found a way to preserve the general principle that all medical professionals are obligated to preserve life while simultaneously creating a safe harbor from liability for physicians who feel caring for their patients includes respecting a terminally ill patient's wish to end a life of pain and suffering or a life the patient no longer feels is worth preserving. The legalization of "aid in dying" indicates that even an extremely controversial practice can be accommodated without causing a legal breach of the general medical obligation to treat. A vital distinction to note is that "aid in dying" as practiced in Oregon and Washington State,⁹⁷ unlike the active euthanasia practiced in countries like the Netherlands, has effective safeguards in place to assure that the decision to end the patient's life rests squarely with the patient and never with his or her physician. The most significant safeguard is that patients must take the medication themselves. No one can assist in the administration of the lethal dose. Thus, these states allow individuals to make very controversial decisions for themselves, while preserving trust in the medical profession by having safeguards that protect the general public from even the perception that healthcare professionals could take the initiative in ending a patient's life.⁹⁸

94. *Id.*

95. See generally Elliot N. Dorff, *Assisted Suicide*, 13 J.L. & RELIG. 263, 263-88 (1998).

96. F. M. Kamm, *Ronald Dworkin on Abortion and Assisted Suicide*, 5 J. ETHICS 221, 239-40 (2001).

97. Montana is not included because, as of this writing, the practice of "aid in dying" is legal but not regulated. See *Baxter v. Mont.*, 224 P.3d 1211, 1211 (Mont. 2009) (holding that "physician aid in dying provided to terminally ill, mentally competent adult patient, was not against public policy for purposes of exception to consent defense.").

98. The Oregon law provides the following basic safeguards: 1) the patient must be an Oregon resident; 2) an adult of sound mind, demonstrated by a consultation with a psychiatrist if needed; 3) have a terminal medical diagnosis (less than six months to live), confirmed by a second physician; 4) make multiple requests, repeated by no less than fifteen in a days' time, and one must be in writing witnessed by a non-relative of the

4. Anatomical Gifts

Organ donation does not have a judicial history of preserving patient self-determination as is the situation for treatment refusal and withdrawal cases.⁹⁹ Under English common law, the disposal of corpses and organ donation at death was a matter of respecting the familial right of burial, not a patient's right to make end of life treatment decisions.¹⁰⁰ It is only in the last half-century that decisions about organ donation have become more patient-centered and less about burial.¹⁰¹ This shift has created a situation in which anatomical gifts are treated more like end of life care decisions than decisions about the disposition of corpses. Thus, instructions regarding anatomical gifts are now frequently included in, or along with, a patient's advance directive, as if such decisions were end of life treatment decisions, not wishes to be carried out after death.¹⁰²

The Uniform Anatomical Gift Act (UAGA), originally drafted in 1968 and revised in 1987 and 2006 suggests model legislative language for state laws governing anatomical gifts.¹⁰³ In the Prefatory Note of the Revised UAGA the National Conference of Commissioners for Uniform State Laws (NCCUSL) states that the Act "is promulgated . . . to address in part the critical organ shortage by providing additional ways for making organ, eye, and tissue donations."¹⁰⁴ Furthermore, the most recent update of the UAGA

patient requesting the medication; 5) have a physician inform the patient of all potential side-effects of the medication, including unintended effects and feasible alternatives; and 6) neither the physician, nor anyone other than the patient him/herself may administer the medication. *See* OR. REV. STAT. §§ 127.005 to 127.045 (2010).

99. *See generally* Hudson v. Children's Hosp., 177 S.W. 3d 232 (Tex. Crim. App. 2005).

100. *See* Lott v. N.Y., 225 N.Y.S.2d 434 (N.Y. App. Div.1962) ("The law is well settled that the surviving next of kin have a right to the immediate possession of a decedent's body for preservation and burial and that damages will be awarded against any person who unlawfully interferes with that right or improperly deals with the decedent's body.").

101. 1962 marks the beginning of cadaveric kidney transplantation. Transplant Network, HISTORY OF TRANSPLANTATION (Nov. 28, 2010), <http://thetransplantnetwork.com/faq/history-of-transplantation/>.

102. *See* CAL. PROB. CODE § 4701 (West 2010).

103. UNIFORM ANATOMICAL GIFT ACT, *supra* note 39.

104. *Id.* The Prefatory Note goes on to state:

adopts first person consent to specifically give physicians the authority to follow a patient's wishes with respect to organ donation over a family's objection. This most recent iteration protects physicians against civil suits from patients' families for respecting a patient's wishes, over a family's objection. The 1968 UAGA, which originally established the right to donate organs, eyes and tissues was adopted by all states,¹⁰⁵ though the 1987 version was only adopted by twenty-six states, with others creating non-uniform anatomical gift acts.¹⁰⁶ To date, forty-two states as well as the District of Columbia and the Virgin Islands have enacted the 2006 version of the UAGA, and two states are currently considering a bill to adopt the 2006 revisions.¹⁰⁷

B. Second Approach: Limiting Quality of Life Decisions

All of the developments in the courts and legislatures mentioned thus far have dealt with the scope of an individual's authority to make decisions regarding the care of his or her body during life and immediately following death. But, there is another, less individualistic, approach to preventing the waste of medical resources and increasing the organ supply. This second approach, which was being pursued simultaneously with the first, focused its efforts on redefining futility and death (as a matter of law and public policy) in such a way that, in the most extreme cases, treatment could be stopped without consideration for individual preferences.

Laws governing end of life decisions that focus on the obligation to treat and patient self-determination always try to achieve what is best for the patient, whether this includes preserving the patient's life at all costs, even against his or her will, or allowing patients and their proxies to make life and

First, the [act] is designed to encourage the making of anatomical gifts. Second, the [act] is designed to honor and respect the autonomy interest of individuals to make or not to make an anatomical gift of their body or parts. Third, the [act] preserves the current anatomical gift system founded upon altruism by requiring a positive affirmation of an intent to make a gift and prohibiting the sale and purchase of organs.

Id. at 2.

105. *Id.*

106. See UNIFORM ANATOMICAL GIFT ACT OF 1987, <http://www.law.upenn.edu/bll/archives/ulc/fnact99/uaga87.pdf>.

107. *Enactment Status Map*, NAT'L CONF. OF COMMISSIONERS ON UNIFORM STATE LAWS (Oct. 31, 2010), <http://www.anatomicalgiftact.org/DesktopDefault.aspx?tabindex=2&tabid=72>.

death decisions based on their own personal quality of life assessments. The central issue in the obligation to treat / patient self-determination area of law is always what is in the patient's interests, not cost containment or solving the organ shortage. Some argued, however, that this patient oriented approach was misguided and that more emphasis should be placed on the good of society as a whole.¹⁰⁸

The fierce battle waged over futility and the determination of death fundamentally boils down to a debate over who will decide how to allocate two types of life-sustaining medical resources for three types of patients: emergency services for patients not likely to recover or live long, life-sustaining treatments for those suffering from significant permanent loss of brain function, and life-saving organs for patients in need of an organ transplant.¹⁰⁹

Allocation approaches aim to legally shift certain kinds of end of life decisions away from patients and their proxies to the medical profession.¹¹⁰ One approach entails broadening the concept of medical futility to include decisions not to treat patients with extremely poor prognoses. Another approach includes redefining death so that hopeless cases can be declared dead and removed from life support without the patient's, or the patient's proxy's, consent. Most advocates of these approaches to cost containment and increasing organ supply understand that they limit patient autonomy, but argue that such limitations are justified in service of a greater good - that is, to save money and save lives.¹¹¹ Few, however, seem to acknowledge that these approaches could undermine public trust in the medical profession as a whole and the organ procurement system in particular.¹¹²

108. Sheri Fink, *Advisory Subcommittee to CDC Approves Ethics Guidance for Rationing Ventilators*, PROPUBLICA (Nov. 23, 2009), <http://www.propublica.org/feature/advisory-subcommittee-approves-ethics-guidance-rationing-ventilators-1123>.

109. Focus on these issues has only intensified over the years. *Id.* at 1.

110. *Id.*

111. See Boucek, *supra* note 5, at 709-14; see also Truog, *supra* note 3, at 674-75.

112. *But see* Boucek, *supra* note 5. The report recognizes that certain members of the transplant community and of the public at-large may object to reframing the determination of death on the ethical principle of nonmaleficence because, as they state, "if patients are not declared dead before organ procurement, then it seems there is no choice but to conclude that the patients are being killed by their doctors." Robert D. Truog, *Role of Brain Death and the Dead-Donor Rule in the Ethics of Organ Transplantation*, 31 CRITICAL CARE MED. 2391, 2395 (2003). This consideration brings to light the fact that the public's understanding of the facts about determinations of death

1. Expanding the Definition of Futility

From the 1970s to the early 1990s, a movement developed to leave determinations of “futility” to the medical community guided by the heuristic of determining whether the patient had a chance of returning to a meaningful quality of life.¹¹³ The notion of “absolute” medical futility was already a part of a legally recognized medical standard of care. Under the “absolute medical futility” standard, usually just referred to as “medical futility” but referred to here as “absolute medical futility” to distinguish it from later, more subjective, interpretations of the phrase, physicians were not expected to engage in procedures that had no chance of achieving the immediate goals for which that procedure was intended.¹¹⁴ But under the newer, broader and more subjective, definition of futility, physicians were allowed to consider not only the treatment’s ability to meet immediate goals, but also whether it would further longer term goals such as the recovery of consciousness or discharge from the hospital.¹¹⁵ It would be absolutely futile to perform resuscitative efforts on a corpse or to operate on the lungs of a patient whose heart is failing because such procedures would not realize their immediate intended medical goal of keeping the patient alive. A physician who refused to perform such procedures under the given circumstances would be excused from legal liability on the bases of absolute medical futility regardless of whether the patient or patient’s proxy felt such procedures should be performed.

The logical leap some philosophers and physicians began suggesting to courts and state legislatures in the ‘70s, ‘80s and early ‘90s, was that life-sustaining treatment for some patients is futile, not because the patient is dead (that would be absolute medical futility), but because the patient’s chances of returning to a meaningful quality of life was too low to warrant the expenditure of medical resources it would take to keep the patient

are confused, and thus may severely degrade the trust placed in the medical transplantation system. *Id.*

113. See *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072, 1075 (La. Ct. App. 1998).

114. *Id.* (“The physician has an obligation to present all medically acceptable treatment options for the patient or her surrogate to consider and either choose or reject; however, this does not compel a physician to provide interventions that in his view would be harmful, without effect or ‘medically inappropriate.’”).

115. See *Hudson v. Children’s Hosp.*, 177 S.W. 3d 232, 233 (Tex. Crim. App. 2005).

alive.¹¹⁶ The problem with this approach is that the medical intent of life-sustaining treatment is to sustain life, without reference to its quality. Life-sustaining treatment is not medically futile, at least not in the traditional absolute sense, if it realizes its goal of keeping the patient alive. Those advocating an expansion of the concept of futility are trying to give physicians authority to stop treatment on living patients based on so-called “futility” for reasons of cost containment when traditionally such decisions were reserved for patients and their proxies.

Understandably, this newer definition of futility causes confusion.¹¹⁷ Absolute medical futility details treatment options that will not achieve their short-term goals, for example, restart the heart or keep the blood circulating.¹¹⁸ The newer, more subjective form of futility details those aspects of treatment modalities that capture non-isolated medical issues about a patient.¹¹⁹ For example, treating a patient in persistent vegetative state (PVS) for years, with no signs of higher brain function, may be considered futile even from a medical standard of care perspective because, based on current medical understanding of PVS, the patient is never going to return to a meaningful quality of life. Resuscitation, if necessary, or the provision of nutrition and hydration for such a patient would not be medically futile in the absolute sense, but may be from a subjective standpoint.

Traditionally, subjective forms of futility determinations were reserved for patients and their proxies, but in a few instances, such determinations are now left up to physicians under current law.¹²⁰ Another important point about having physicians make subjective futility decisions is that it is very difficult in a pluralistic society to come up with a coherent medical standard for determining what is, and what is not, a potentially meaningful quality of

116. See generally Council on Ethical and Judicial Affairs, Am. Med. Ass’n, *Medical Futility in End-of-Life Care: Report of the Council of Ethical and Judicial Affairs*, 281 JAMA 937 (1999).

117. *Id.*

118. *Id.*

119. *Id.* at 938 (“Claims of medical futility inherently involve a value judgment. For example, 1 patient may consider the physical, emotional, practical, or financial burden of aggressive intervention not worth the purpose of prolonging seemingly meaningless life.”).

120. *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072, 1072 (La. Ct. App. 1998); TEX. STAT. ANN. § 166.052 (2003).

life.¹²¹ It is for these reasons that most courts still leave such decisions to patients and their surrogates, and not to healthcare professionals.

There are two notable exceptions where the law seems to have agreed to shift more subjective decisions regarding futility out of the realm of individual choice and into the realm of medical standards of care established by medical professionals. In *Causey v. St. Francis Medical Center*, the Louisiana Second Circuit Court of Appeals decided that, under state law, a medical panel, not the court, should decide whether a physician could determine when to withdraw life-sustaining care.¹²² Specifically, the physician wanted to withdraw life-sustaining care from a thirty-one year-old quadriplegic comatose patient with end-stage renal failure over the express objection of the patient's family.¹²³ The patient's treating physician stipulated that with continued ventilation and dialysis the patient could live another two years, but she would only have a one to five percent chance of ever regaining consciousness.¹²⁴ The court acknowledged that such questions of futility are subjective, but stressed that physicians have a right to decide when treatment is medically inappropriate and held that this particular case needed to be evaluated by a medical review panel under the state's Medical Malpractice Act to see if the physician's (and hospital's) action was outside the standard of care.¹²⁵ It is, thus, in this court's opinion, the physician's prerogative to determine whether a proposed intervention would be without medical effect or medically inappropriate. Furthermore, the state court of appeals opined that, when the decision to abort treatment because of medical futility is reached by a consensus of competent, specialized physicians and affirmed by the ethics panel, the decision becomes a standard practice of care that can be utilized as precedent.¹²⁶

121. Yitzchok A. Breitowitz, *The Brain Death Controversy in Jewish Law*, JEWISH LAW ARTICLES, <http://www.jlaw.com/Articles/brain.html> (last visited Nov. 30, 2010).

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

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.* ("The physician has an obligation to present all medically acceptable treatment options for the patient or her surrogate to consider and either choose or reject; however, this does not compel a physician to provide interventions that in his view would be harmful, without effect or 'medically inappropriate.'").

Another notable exception to patient self-determination is that portion of the Texas Advance Directive Act that transfers decision-making authority from individuals to the medical profession in certain circumstances.¹²⁷ The “futility” section of the state statute allows physicians to stop life-sustaining treatment on patients, even over a family’s objection, after giving the family ten days written notice to arrange to have the patient transferred to another facility.¹²⁸ Notably, this law does not take into consideration the patient’s personal preferences, but instead gives physicians (and their medical institutions) the right to stop treatment in order to prevent the wasting of scarce and expensive medical resources.¹²⁹ The validity of the Texas statute and the authority of medical professionals to unilaterally decide to stop treatment in “futile” cases was affirmed by the Texas Court of Appeals in *Hudson v. Children’s Hospital* where a family was demanding treatment for an infant with thanatophoric dysplasia and the patient’s treating physicians and the hospital (after giving the family the statutorily required time to transfer the patient) discontinued life-sustaining treatment.¹³⁰

2. Expanding the Definition of Death

Another notable shift away from patient-self determination is evident in efforts to expand the definition of death. The NCCUSL, for example, made no claims to any new philosophical insight or scientific discovery that lead to its broadening the definition of death.¹³¹ It was forthright in identifying its motives, among which are listed:

- 1) The UDDA [(Uniform Determination of Death Act)] will help assure the public that emergency equipment, such as respirators, will be available in crisis situations for patients whose lives can be saved.

127. TEX. STAT. ANN. § 166.052 (2003).

128. *Id.*

129. TEX. STAT. ANN. § 166.046(e) (2003). This law provides that a patient may request continued life-sustaining treatment, despite the determination of the attending physician that such treatment is inappropriate, and such treatment will be provided in preparation for the patient’s transfer to another facility. In such an event, the patient will be responsible for any costs incurred in the transfer process. *Id.*

130. *Hudson v. Children’s Hosp.*, 177 S.W. 3d 232, 232 (Tex. Crim. App. 2005).

131. *Why States Should Adopt the Uniform Determination of Death Act*, NAT’L CONFERENCE OF COMM’RS ON UNIFORM STATE LAWS, http://www.nccusl.org/Update/uniformact_why/uniformacts-why-udda.asp [hereinafter NAT’L CONFERENCE OF COMM’RS] (last visited Nov. 28, 2010).

2) A state's adoption of the UDDA aids the medical profession in saving lives. Brain death determinations are important for organ transplantation because, once death occurs, viable organs begin to deteriorate. Brain death determinations make fresh organs more available to those who need them.¹³²

Arguably, however, the transplant community (as explained further below) is trying to adopt a medical standard that construes death far more broadly than what was originally intended by the UDDA or the 1980-1983 President's Commission. Both were deliberating the issue at the same time the NCCUSL was considering replacing the Uniform Brain Death Act (UBDA) with the UDDA.¹³³ And both the NCCUSL and the President's Commission advocated for a whole organism definition of death, not the more recent position that circulatory criteria could be used as an alternative to brain death *even in situations where it is evident that brain death has not occurred*.¹³⁴

Efforts to redefine death began in the late 1960s and quickly proliferated.¹³⁵ In 1968, the Ad Hoc Committee of the Harvard Medical School, which was created to examine the definition of brain death, first drew serious attention to the option of creating a new legal definition of

132. *Id.*

133. See Maxine Harrington, *The Thin Flat Line: Redefining Who is Legally Dead in Organ Donation After Cardiac Death*, 86 DENV. U.L. REV. 335, 361 (2009).

134. NAT'L CONFERENCE OF COMM'RS, *supra* note 131. The NCCUSL states "[A]n attending physician often waits until a patient's heart fails to declare death even though death has, in fact, already occurred." (i.e. brain death has already occurred). *Id.* See PRESIDENT'S COMM'N *supra* note 6, at 58, (stating "[a]lthough absence of breathing and heartbeat may often have been spoken of as 'defining' death, review of history and of current medical and popular understanding makes clear that these were merely evidence for the disintegration of the organism as a whole."). See also Harrington, *supra* note 133. Professor Harrington agrees with our conclusion, stating:

The President's Commission also looked upon death as a unitary phenomenon. Consideration was given by the Commission to a statute that would contain only a definition of brain death but circulatory death was included as alternative criteria because 'the loss of spontaneous breathing and heartbeat are surrogates for the loss of brain functions.'

Id.

135. For one such attempt, see generally Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 JAMA 337, 337-40 (1968).

death.¹³⁶ The Ad Hoc Committee determined that patients in an “irreversible coma” should demonstrate unreceptivity and unresponsivity to all stimuli, no movements or breathing, and no reflexes.¹³⁷ Using different criteria, Kansas, in 1970, was the first state to pass legislation defining brain death.¹³⁸ The Kansas law required that “based on ordinary standards of medical practice, there is the absence of spontaneous brain functions.”¹³⁹ In 1972, Professor Capron and Dr. Kass proposed a substantially shorter definition of death intended to overcome the “two deaths” problem by making the two types of determinations mutually exclusive.¹⁴⁰ Only when “artificial means of support preclude” an ordinary determination of death should brain death be considered.¹⁴¹ In 1975, the Law and Medicine

136. *Id.*

137. *Id.*

138. PRESIDENT’S COMM’N, *supra* note 6, at 62 (citing KAN. STAT. ANN. §77-202 (Supp. 1971)).

139. *Id.* The Kansas statute, in relevant part, states:

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and, in this event, death will have occurred at the time these functions ceased; or a person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain functions; and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance won’t succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before artificial means of supporting respiratory and circulatory function are terminated and before any vital organ is removed for purposes of transplantation. These alternative definitions of death are to be utilized for all purposes in this state, including the trials of civil and criminal cases, any laws to the contrary notwithstanding.

Id.

140. PRESIDENT’S COMM’N, *supra* note 6, at 118.

141. *Id.* at 118 (“A person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has experienced an

Committee of the American Bar Association (ABA) drafted a Model Definition of Death Act that abandoned the cardiorespiratory determination of death altogether and stated: "For all legal purposes, a human body, with irreversible cessation of total brain function, according to usual and customary standards of medical practice, shall be considered dead."¹⁴² In 1978, the NCCUSL completed the UBDA based on the ABA suggestions.¹⁴³ The AMA, not fully satisfied with the ABA model, created its own Model Determination of Death statute in 1979.¹⁴⁴ The AMA Model Determination of Death statute offered legal protection to individuals who made end of life decisions based on the statute. And then in 1980, the NCCUSL revisited the issue, creating the Uniform Determination of Death Act, which, unlike the UBDA, included circulatory criteria as an acceptable alternative to the use of brain death criteria.¹⁴⁵

irreversible cessation of respiratory and circulatory functions, or . . . irreversible cessation of total brain functions. Death will have occurred . . . when the relevant functions ceased.").

142. PRESIDENT'S COMM'N, *supra* note 6, at 117.

143. UNIFORM BRAIN DEATH ACT, (1978). The Uniform Brain Death Act stipulates: "For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standards." *Id.*

144. UNIFORM DETERMINATION OF DEATH ACT (Aug. 1, 1980), *available at* <http://www.law.upenn.edu/bll/archives/ulc/fnact99/1980s/udda80.htm> (approved by the American Medical Association on Oct. 19, 1980 and the American Bar Association on Feb. 10, 1981). The Act states in relevant part:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, shall be considered dead. A determination of death shall be made in accordance with accepted medical standards A Physician or any other person authorized by law to determine death who makes such determination in accordance with [the aforementioned] is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts or the acts of others based on that determination. Any person who acts in good faith in reliance on a determination of death is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act If any provision of this Act is held by a court to be invalid such invalidity shall not affect the remaining provisions of the Act, and to this end the provisions of this Act are hereby declared to be severable.

Id.

145. *Id.* at 5.

The NCCUSL understood that in most settings, circulatory death and brain death are so closely linked that they are indistinguishable and that it was impractical in most situations to require more than proof of cessation of circulatory functions for a declaration of death.¹⁴⁶ It is clear in hindsight that the NCCUSL introduced brain function criteria specifically to allow the removal of brain-dead patients from life-support and to allow the harvesting of their organs, but did not anticipate (at least there is no indication in their published discussions), that circulatory criteria might someday be used to harvest organs even more expeditiously than brain criteria.¹⁴⁷

The 1968 Ad Hoc Committee of the Harvard Medical School, however, foresaw problems with a dual-pronged approach.¹⁴⁸ It clearly stated that reliance on circulatory criteria “for the definition of death can lead to controversy in obtaining organs for transplantation.”¹⁴⁹ However, nowhere in its discussion did the Ad Hoc Committee address the NCCUSL concern that always requiring the use of brain death criteria would be impractical. Also, Jerry Menikoff, the former director of the Office for Human Research Protections, believes there is no doubt that the UDDA was meant to point to one death phenomenon, not two.¹⁵⁰ Menikoff states, “cardiopulmonary criteria were being retained [in the UDDA] precisely because they gave clear results in the *easy* cases, where it was *quite evident* that brain function had ceased”¹⁵¹ Finally, the President’s Commission states, “the loss of spontaneous breathing and heartbeat are surrogates for the loss of brain function.”¹⁵²

146. *Id.*

147. *Id.* (“A state’s adoption of the UDDA aids the medical profession in saving lives. Brain death determinations are important for organ transplantation, because once death occurs, viable organs begin to deteriorate. Brain death determinations make fresh organs more available to those who need them.”).

148. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 JAMA 85, 85-88 (1968).

149. *Id.* (“The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients. Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.”).

150. Jerry Menikoff, *Doubts About Death: The Silence of the Institute of Medicine*, J. L., MED., & ETHICS 157, 160 (1999).

151. *Id.* at 164.

152. PRESIDENT’S COMM’N, *supra* note 6, at 37.

Because the two sets of criteria for determining death are so closely linked, we imagine that had the Ad Hoc Committee foreseen the current controversy, it might have proffered something like the Institute of Medicine (IOM) suggestion in its 1997 report, namely that non-heart-beating organ donation is ethically acceptable as long as there is clear evidence of irreversibility.¹⁵³ Although the Ad Hoc Committee would probably have added that in questionable cases, there should also be a sufficient waiting period after the end of circulatory functions to assure that brain death has occurred.

Revisions to the holistic approach to the definition of death have been controversial from the beginning, and over the years the debate has intensified rather than cooled.¹⁵⁴ Today, there still is no medical consensus as to how much time after the cessation of circulatory functions brain death occurs.¹⁵⁵ Furthermore, several circumstances (*e.g.*, immersion in cold

153. ROGER HERDMAN & JOHN T. POTTS, *NON-HEART-BEATING ORGAN TRANSPLANTATION: MEDICAL AND ETHICAL ISSUES IN PROCUREMENT* (1997).

154. PRESIDENT'S COUNCIL, *supra* note 14, at 1-2.

155. E-mail from James L. Bernat, Neurology Department, Dartmouth-Hitchcock Medical Center to Thomas Reher, (Mar. 17, 2010) (on file with author). Dr. Bernat postured that:

In most clinical settings in which the brain suffers anoxia (or hypoxia), it is accompanied by ischemia (lack of blood flow). The typical situation occurs during cardiopulmonary arrest when the brain is deprived of both blood flow and oxygen. We call that circumstance "hypoxic-ischemic" neuronal injury. When both occur together, it is hard to determine in retrospect how much neuronal injury resulted from hypoxia and how much from ischemia.

We know that during normal brain metabolic conditions, consciousness is lost after 10-20 seconds and irreversible neuronal damage begins after a few minutes. During hypothermia or treatment with central nervous system depressant medications that diminish neuronal metabolism - such as are used to induce coma therapeutically after a brain injury - the brain can tolerate loss of blood flow or oxygen for much longer periods because the neuronal metabolic demands are lessened. But no one knows the minimum duration of circulatory-respiratory arrest sufficient to produce "brain death" with destruction of essentially all neurons. Most neurologists think that it takes at least 20-30 minutes of complete cessation of circulation and oxygenation, assuming normal metabolic conditions.

The reason it is not known is there is no human model and studies on patients during cardiopulmonary arrest are complicated by the fact that a resuscitation is

water or similar sources of hypothermia, drug exposure, or metabolic or endocrine disorders) can make conventional techniques for determining death inaccurate.¹⁵⁶ While one would expect the advancement of medicine to provide more accurate means of determining death, the opposite seems to be the case. In recent years, both circulatory and brain criteria for determining death have become more, rather than less, controversial.¹⁵⁷

IV. THE PHILOSOPHICAL CRISIS

Every argument about the determination of death presumes the existence of a perspective on what constitutes a human life worth saving. The UDDA is vague on this point, perhaps intentionally so, but the fundamental underlying metaphysical question has significant social and legal ramifications that cannot be ignored.¹⁵⁸

A. Balancing Respect for Persons and Maximizing Healthcare Utility

There is much debate over how to improve the U.S. healthcare system, but there is little doubt that there is both a shortage of mechanical ventilators and organs for transplantation.¹⁵⁹ The ethos of always putting patients first has

underway with some degree of restoration of oxygenation and circulation, at least temporarily.

Id.

156. PRESIDENT'S COMM'N, *supra* note 6, at 154 ("There should be no suspicion that this state is due to depressant drugs. Primary hypothermia as a cause of coma should have been excluded. Metabolic and endocrine disturbances which can be responsible for or can contribute to coma should have been excluded.").

157. PRESIDENT'S COUNCIL, *supra* note 14, at 1-2; *see also* PRESIDENT'S COMM'N, *supra* note 6, at 3.

158. NATIONAL CONFERENCE OF COMM'NS, *supra* note 131.

159. Douglas B. White et al., *Who Should Receive Life Support During a Public Health Emergency? Using Ethical Principles to Improve Allocation Decisions*, 130 ANNALS OF INTERNAL MED. 132, 138 (2009); John L. Hick & Daniel T. O'Laughlin, *Concept of Operations for Triage of Mechanical Ventilation in an Epidemic*, 13 ACADEMIC EMERG'Y MED., 223, 224 (2006), http://depts.washington.edu/respcare/journal_club/articles/20071022/Mech%20vent%20Triage%20in%20Epidemic.pdf (stating that if patients expected to improve have to compete with PVS or brain dead patients without quality of life considerations, the shortage will worsen. The current number of patients waiting for organs is well over 100,000); *see generally* UNITED NETWORK FOR ORGAN SHARING, www.unos.org (last visited Nov. 28, 2010).

been curtailed by notions of public responsibility and a need to balance the interests of individual patients in need of expensive emergency care against the needs of others.¹⁶⁰ It is a difficult task to both show respect for the individual patient and balance social pressures to maximize the overall availability of health care. This ethical tension between respect for individual persons and overall public health reflects the age-old conflict between deontological and utilitarian approaches to ethics.

Deontology favors respecting patients as persons capable of making their own decisions.¹⁶¹ The obligation of physicians under this perspective requires that they think in terms of just the individual patient's best interest, not how the individual patient's interests may be superseded by general societal considerations. A deontological respect for persons is the justification for allowing advance directives to extend a person's autonomy beyond his or her capacity to decide.¹⁶² Deontological thought places a paramount value on self-governance.¹⁶³ Court cases and statutes that allow individuals the freedom to make their own healthcare decisions, even if the majority of the population believes such decisions are a mistake or against the public interest, are motivated by the deontological principle of respect for persons.¹⁶⁴ All the right-to-die cases, the Patient Self-Determination Act, and most of the legislation about advance directives fall into this category.¹⁶⁵

Alternatively, utilitarianism focuses on creating the greatest aggregate good.¹⁶⁶ Utilitarianism does not hesitate to balance the good of individual

160. Fink, *supra* note 108, at 1.

161. TOM L BEAUCHAMP & JAMES F CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 351 (5th ed. 2001) (“‘The principle of autonomy,’ [Kant] contends, is ‘the sole principle of morals,’ and autonomy alone gives people respect, value, and proper motivation. A person’s dignity—indeed, ‘sublimity’—comes from being morally autonomous.”).

162. *Id.* at 69 (“[A]s with respect for prior wishes of the now-deceased, we are, except in rare cases, *obligated to respect* the previously expressed autonomous wishes of the now severely nonautonomous person because of our *respect for the autonomy* of the person who made the decision.”) (emphasis added).

163. *Id.*

164. *Cruzan v. Director, Mo. Dep’t. of Health*, 497 U.S. 261, 268-69 (1990).

165. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388, *amended by* Patient Self-Determination Act of Dec. 1, 1991, Pub. L. No. 101-508, 104 Stat. 1388 (S) 4206, 1388 (1990). *See also* *Cruzan*, 497 U.S. at 261.

166. Julia Driver, *The History of Utilitarianism*, *STANFORD ENCYCLOPEDIA OF PHILOSOPHY* (Mar. 27, 2009), <http://plato.stanford.edu/entries/utilitarianism-history/>.

patients against the overall good to be gained by society.¹⁶⁷ When achieving the good of a particular individual carries too great a cost for society as a whole, principles of utility suggest that the individual should be denied the right to further that individual good.¹⁶⁸ Statutes that try to prevent the wasting of medical resources by denying certain categories of patients the right to those resources are a clear example of a utilitarian calculus.¹⁶⁹ Laws shifting futility determinations away from individuals to the medical profession and laws that redefine death to limit the use of scarce life-sustaining resources to those who have a chance of regaining consciousness are both examples of laws implemented to promote utilitarian principles.¹⁷⁰ Additionally, policies that clearly shift medical attention away from attempting to save the most seriously injured to harvesting organs are also motivated by a utilitarian approach to resource allocation.

It is useful to keep in mind these two major approaches to ethics and the tension between them when considering arguments for revising the definition of death.

B. The Metaphysics of Death

Answering what death is and why it matters is complicated by religious and cultural pluralism.¹⁷¹ For some, death signifies an end; others, a transition; still others, a return to the beginning.¹⁷² Further complicating the issue, death is fragmented by terms such as ‘legal death,’ ‘cardiorespiratory death,’ ‘brain death,’ ‘medical death,’ and more. Even if society settles on

167. *Id.*

168. BEAUCHAMP & CHILDRESS, *supra* note 161, at 347.

169. 42 U.S.C. § 1395dd (1986) (limiting the obligation to medical screening and care or transfer only in the case of “an emergency medical condition.”).

170. TEX. HEALTH & SAFETY CODE § 166.052 (2003).

171. H. TRISTRAM ENGELHARDT, JR., THE FOUNDATIONS OF BIOETHICS 26 (1986) (“Absent either a general conversion to one religion, or the existence of a generally imposed orthodoxy, one will need to search for common grounds to bind rational individuals in a peaceable community.”).

172. Some believe “[d]eath is life’s ending,” yet, the relationship between death and one’s existence is controversial. While atheists generally understand death as the annihilation of the self, many world religions (eg. Christianity, Islam, Buddhism) posit that there is persistence beyond bodily death. Stephen Luper, *Death*, STANFORD ENCYCLOPEDIA OF PHILOSOPHY (May 26, 2009), <http://plato.stanford.edu/entries/death/>.

