

**The Quality of Mercy
and Common Dignity:
Safeguarding The Last Right**

a

University Lecture

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by

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For

**The Noble Lord Joel Joffe, CBE, humanist and humanitarian,
visionary and frontiersman—with gratitude and respect
for his courageous campaign to assure a humane,
dignified, and merciful approach to death for
all in the United Kingdom**

INTRODUCTION

It is a high honor and special privilege to be invited by Professor Aguilar to return to St. Andrews and present this lecture this afternoon. When I visited last Spring at Easter time as his guest, I was struck not only by the invigorating winds from the North Sea, the historic ruins of the Cathedral, the unparalleled scenic beauty of the terrain and the record of academic excellence which the University, itself, has sustained since its beginning in 1413. More contemporaneously, I am impressed, encouraged and refreshed by the consistently high level of scholarship and teaching that I have observed—and, never more so than at the Centre for the Study of Religion and Politics in St. Mary's College where the research and teaching is of the highest quality and on cutting edge issues confronting contemporary society—all undertaken, as such, within an atmosphere where both a commitment and a challenge “Ever to be the Best” validates the University motto.

Today, I speak as a non-denominational Christian and not as a spokesman for the University of my current academic affiliation. I see myself—in the words of Karl Rahner—as a “pilgrim.” Nothing more than a mortal man seeking my way “with difficulty through the darkness” and “failing again and again” yet nonetheless “bound in duty to my earthly task” of seeking a concrete prescription for shaping my life¹ strengthened, as such, by “God’s grace”² in

¹ KARL RAHNER, *THE CHRISTIAN OF THE FUTURE* at 75 (trans. W. J. O’Hara 1967).

² *Id.* at 73.

this quest.

The thesis of my lecture is simple—indeed, deceptively so, and holds that each of us under the principle of autonomy or self-determination, is entitled to exercise a right to a good or dignified death. This right is fortified by the standards of common decency and human dignity, mercy, and compassion;³ and it must be safeguarded by the state through applicable legislation, the courts through reasoned determinations and by the medical community. It is from the fundamental right to life, then, that the right to die with dignity is to be found.⁴

The right to die is, however, heavily constrained—as Lord Justice Stephen Sedley admonishes us to remember—by evolving circumstances or vectors of force that are humanitarian, social, medical, economic and ethical.⁵ Realism, however, must always be tempered with principle.⁶ The right to freedom in searching for the truth undergirding principle is also seen as a fundamental human right and includes the co-ordinate right to express and communicate varying opinions. This point was made eloquently by Pope John XXIII in his

³ MARGARET P. BATTIN, *ENDING LIFE: ETHICS AND THE WAY WE DIE* 8 (2005).

⁴ Rt. Hon. Lord Justice Stephen Sedley, Monograph, *Are Human Rights Universal and Does It Matter?*, (Holdsworth Club, Univ. Birmingham, 2005).

⁵ *Id.* at 11.

⁶ *Id.* at 14.

encyclical, *Pacem in Terris* (Peace on Earth) issued April 11, 1963.⁷

I.

SHAPING THE ISSUE

When medical treatment is deemed to be “futile,” it frees the physician from the moral, medical, and legal duty to provide such treatment.¹ While most reasonable persons agree with this proposition, much disagreement exists as to the definition of futile treatment and who decides whether a given treatment is futile.

The Council on Ethical and Judicial Affairs of the American Medical Association determined in June, 1994, that “physicians are not ethically obliged to deliver care that, in their professional judgment, will not have a reasonable chance of benefitting their patients. Patients should not be given treatments simply because they demand them. Denials of treatment should be justified by reliance on openly stated ethical principles and acceptable standard of care² . . . not on the concept of ‘futility’ which cannot be meaningfully defined.”³

This position can be seen as definitive or merely as a mechanism to validate the transfer of authority to make ethically charged decisions from patients to physicians.⁴ Is the doctrine of medical futility inexplicable as the AMA Council has determined, or can it provide a framework for principled medical decisions? I shall conclude, however, that this doctrine is, indeed, an invaluable construct for medical decision making.

⁷ Reprinted in *CATHOLIC SOCIAL THOUGHT: THE DOCUMENTARY HISTORY* at 143 (David J. O’Brien & Thomas A. Shannon, eds. 1998).

Physicians often make these end-of-life decisions without informing the patient or family. As a result, extraneous factors such as race, wealth, gender, and age of the patient, as well as judgments on the quality of the patient's life and concerns with cost containment, may cloud a physician's determination to withhold or withdraw treatment. A clear working definition of futility is needed to ensure that physicians not only inform patients and their families about the decision to withdraw or withhold treatment, but also to provide the patients, their families, and the courts with objective criteria against which they may judge the medical decision.⁵

In April, 2006, the charity—Help The Aged—released a survey of some 800 health workers in the United Kingdom which found a considerable number of the elderly are being denied a “good death” because of two major inadequacies: absence of “end of life” procedures and improper staff training. The respondents in this survey included nurses, NHS managers, physicians and consultants. Where end-of-life treatment protocols were in place, however, sixty percent of those questioned in the survey found those policies to be “ineffective” or only followed partly.⁶

More than two-thirds responding to the survey stated that in the care of elderly who were dying, conditions such as arthritis, sensory loss and depression were often overlooked. Over a third acknowledged that they “did not have time to spend comforting older dying patients because of the stress of their own jobs.” A majority of the respondents admitted that the care given to this group of patients was “worse than that given to younger dying people.” Finally, fifty-seven percent “said that they would benefit from more support or training in working with older patients.”⁷

The magnitude of this issue is seen even more vividly when it is realized that the number of Britons over 65 is expected to rise by 50% by the year 2030, to approximately 15 million people. When present staffing inadequacies for elder care are set within this statistical profile, and the increased tempo of hospital layoffs, closures of geriatric care and transfers to nursing homes continue, one sees the sad reality of the future writ large.⁸

The issue of futility sparks the most discussion when the patient is in a persistent vegetative state (“PVS”) and when the physician directs a do not resuscitate (“DNR”) order.⁹ A patient diagnosed as being in a PVS has no chance of regaining consciousness or returning to a sapient existence.¹⁰ Similarly, when a patient suffers from severe and irreversible dementia¹¹—meaning that he is unable to initiate any purposeful activity and only accepts nourishment and bodily care in a helpless, passive state—his condition could be classified as futile. The definitional scope of futility could also include treatment for those in a deep, irreversible coma for an extended period of time (*i.e.*, six months to a year), as well as those who are permanently vegetative.¹² The central point to any determination that medical treatment would be futile should be an understanding, if not a realization, that terminal illness should not be the sole and necessary criterion for withholding treatment. For example, many comatose or barely conscious patients are not terminally ill yet are in such an irrevocable state of mental and physical deterioration—with no realistic hope of a qualitative restoration of health—that they should be properly classified as outside the bounds of treatment.¹³

A DNR is ordered when a physician concludes that it is not worth the effort to effect cardiopulmonary resuscitation (“CPR”) in the event of cardiac or respiratory arrest. While the law does not prevent a physician from ordering a DNR, problems arise due to the absence of

clear guidelines for making the DNR decision and the fact that patients and their families are often unaware whether and why such a decision is made.¹⁴

II.

MEDICAL FUTILITY v. PATIENT AUTONOMY: A TRUE BATTLE?

The debate over medical futility has increased over the years with the expansion of patient autonomy. Thirty years ago, there was no need for this debate because technology had not given physicians the tools to provide many treatments that are available today and because few patients questioned their doctors' orders. As the role of the patient increases in choosing care, so does the debate surrounding futile care. It might be suggested that futility is the point at which to draw the line on the advancement of patient autonomy. This is not necessary, however, because the goals of patient autonomy and cessation of futile treatment are not inconsistent. Patient autonomy does not convey the right to demand futile treatment. In effect, offering or administering futile treatment undermines patient autonomy by raising false expectations of recovery.¹⁵

Patient autonomy includes the right to be a fully informed participant in every aspect of the medical decisionmaking process, as well as the right to refuse medically prescribed lifesaving treatment.¹⁶

In 1990, in a concurring opinion in the case of *Cruzan et ux. v. Dir. Missouri Dept. of Health et al.*, Justice Sandra Day O'Connor of the U.S. Supreme Court observed that the artificial delivery of food and water should be viewed properly as medical treatment and—as such—may be rejected under the principle of liberty found within the Due Process Clause of the

Constitution.¹⁷

English Law is unequivocal in allowing a competent person the right to refuse medical treatment altogether even though such a refusal results in death.¹⁸

Under the Mental Capacity Act of 2005, the law is clear: one is presumed competent unless there is evidentiary proof to the contrary.¹⁹ If this issue is litigated subsequently in the British courts, it is incumbent upon the physician or health care professional to show that, “on the balance of probabilities,” the patient lacks capacity. When one is declared incompetent under the Act, he is found “unable to make a decision for himself . . . because of an impairment of, or a disturbance in the functioning of, the mind or brain.”²⁰ Without receiving consent from a competent patient, no treatment can be provided.²¹

If a patient is determined to be incompetent, again, the Mental Capacity Act directs the course of action to be followed before treatment may be given.²² Time does not permit a detailed analysis of the four steps which must be undertaken in order to meet the requirements of the law.²³ In the absence of an effective advance directive refusing treatment,²⁴ suffice it to acknowledge here that treatment seen as such by the physician as in “the best interests” of the at-risk patient can be provided.²⁵ A relative of an incompetent adult cannot give consent on behalf of the patient. Indeed, it is the medical team which makes the ultimate decision.²⁶ If the patient is an incompetent child, anyone with parental responsibility for the child (generally the mother) can provide the necessary consent for treatment.²⁷

Abridgements of Autonomy

In America, patient rights of autonomy or self-determination are abridged, *not* when there

is a denial of opportunities to make *any* medical decision, but rather when there is a denial of an opportunity to make “a *rightful* medical decision.”²⁸ Patient autonomy does not give the patient the right to demand futile treatment because this is not a rightful medical decision. The patient does not have a right to the treatment because it has been determined that the treatment is not warranted for persons in his condition. The patient does not have a right to opt out of the class to which his medical condition relegates him.

Patient autonomy gives rise to a negative right rather than a positive right—for, the patient has a right to refuse a given treatment but *not* a corresponding right to demand a given treatment.²⁹ Once it has been determined what is futile, a patient’s autonomy is not invaded or sacrificed if the physician does not honor the request for such treatment because patients are simply not entitled to futile treatment. The physician, by virtue of his training and expertise, is given the right to determine what treatment alternatives are available to the patient. “No ethical principle or law has ever required physicians to offer or accede to demands for treatments that are futile.”³⁰ Even civil malpractice standards do not require a physician to render useless interventions. Moreover, a physician does not have a legal duty to act contrary to his conscience. Therefore, because patient autonomy does not give the patient the right to demand futile treatment, autonomy is not invaded when the physician withholds treatment on these grounds.³¹

On the contrary, withholding or withdrawing futile treatment furthers the goals of the patient autonomy movement because administering futile treatment, in fact, undermines patient autonomy. Offering treatments known medically to be futile, erode, if not destroy, the principles of autonomy of self-determination because use of such intervention invites a level of hope and raises false expectations of recovery. Indeed, “[s]uch offers send a mixed message, implying a

real choice when none exists.”³² Deception of this sort distorts the patient’s perspective and deprives him of the opportunity to make informed decisions. Thus, the doctrine of futility and patient autonomy share the same goals of giving the patient reasonable control over his treatment. A patient will have the right to refuse any treatment offered, but that right does not extend so far as to require the physician to yield to demands for treatments that are futile. By withholding futile treatment, the physician is showing respect for the patient by being honest about the chances of recovery and the futility of providing a given treatment.

Some may contend that a patient or his family has a greater right to demand that treatment be continued once the physician has begun such treatment. The mere fact that a physician has begun treatment, however, does not obligate the physician to continue to administer that treatment once it becomes apparent that the treatment is futile.³³ Patients and their families alike cannot successfully argue for the continuation of such treatment.³⁴ Even if a patient and his family could justify such a demand on a reliance theory, physicians would simply find other reasons for not administering the treatment in the first place.³⁵ This would frustrate, rather than further, the goals of patient autonomy because physicians would be depriving patients of treatment to which they are rightly entitled.

III.

THE DUTY *NOT* TO ADMINISTER FUTILE TREATMENT

Three reasons why physicians should have a duty *not* to provide futile treatment may be advanced.³⁶ It has been argued that if it were an option, rather than a duty, physicians could use the term “as a subterfuge for rationing, cost containment, or refusals to treat vulnerable

patients.”³⁷ If each physician was given the discretion to provide treatment deemed to be futile, patients with the means—either independent wealth or superior insurance—could bypass the doctrine of futility by merely changing physicians. This would drastically limit its effect by relegating it to a device for depriving treatment for those who cannot afford it.

It is next argued that since the public looks to the medical profession to set medical standards, making *ad hoc* assessments of futility by individual physicians rather than enforcing objective criteria developed by the medical profession would be an abdication of professional responsibility.³⁸ A substantial burden must be placed on the medical profession to take action in order to preserve its stature and credibility by mandating uniform treatment for all patients in a given condition.

Lastly, it is maintained that offering futile treatment exploits the public’s fear of death and exaggerates the results that medicine and science can achieve. This leads to false expectations and inevitable disappointment, which in turn, undermines the public’s confidence. While these arguments support the proposition that physicians should have an affirmative duty *not* to administer futile treatment, more compelling arguments can be found.

Scientific and Ethical Futility

In America, it is accepted generally that scientifically futile treatment need neither be offered nor provided a patient who requests it. Put directly, when the medical result expected by either the patient or his family cannot be achieved, it is termed scientifically futile.³⁹ For example, even if a request by a seriously ill cancer patient is made for use of laetrile drug therapy, it need not be honored by the attending physician—this, simply because this drug is

useless under this particular circumstance. Similarly, antibiotics need not be prescribed to a child with a viral illness—this, again, even though the child’s parents request it. The reason for this position is that, as a matter of science, the antibiotic will be ineffective in treating that illness. Finally, even though a patient with a cold may request a CAT scan, the physician may refuse to issue the order. Since there is no reason to believe that there will be any efficacious connection between what can be discovered on the scan and the appropriate treatment of the cold, the CAT scan is inconsequential or futile.⁴⁰

The question becomes more complicated when a patient’s request for treatment, though not scientifically futile, is—in the opinion of the health care provider—*ethically futile*. Treatment is deemed ethically futile if it will not serve the underlying interests of the patient.

One example will suffice. To keep a patient’s body aerated and nourished when that patient is in a persistent vegetative state, is thought by some providers to be ethically futile. Under these circumstances, these healthcare providers maintain that it is beyond the scope of medicine to sustain corporeal existence if nothing qualitatively can be achieved beyond that level of mere existence. And, if conditions arose where CPR became an option, these same conservative healthcare providers would deem it ethically futile to perform this procedure when the object of the intervention would be but to prolong the patient’s life by a few hours.⁴¹

When conflicts arise in cases of the nature that I have just posited, regarding the standards for determining ethical or even scientific futility, the best route to follow in order to keep issues out of the courts, is to refer such cases to Hospital Ethics Committees where non-binding recommendations can be made and which, in turn, can assure the certainty of fair, objective judgment that patients and their families need in critical end of life care.⁴²

Futility disputes are inevitably about optimizing end of life care.⁴³ The transition from curative to palliative measures requires good lines of communication between the clinician, patient, and family; and ethics committees can be a tool for effecting these lines. Ideally, this transition becomes simply the exchange of curative goals of care for comfort measures.⁴⁴ Simply stated, then, the shared goal is “to reach a mutual understanding about disease trajectory and what goals of care might be appropriate given the changing medical facts and patient/family preferences.”⁴⁵

Pain Management or Patient Preference

The argument that efforts should always be undertaken to eliminate pain or other symptoms of human suffering, rather than the person exhibiting them,⁴⁶ completely ignores the principle of autonomy or self-determination. Pain management, from a communitarian standpoint, may salve the conscience of the health care provider by forestalling, or perhaps, dispelling the need to even consider euthanasia—instead, allowing time to take its course passively. From the competent patient’s standpoint, however, pain management ignores his moral and legal right—acting for whatever purposes are clear to him—to end his life with a semblance of dignity.

While patient pain may be managed effectively today, what occurs when this is merely palliative and the disease that gave rise to the pain continues its malignant progression toward terminality? What if, as a consequence of the reduction in pain, an individual becomes exceedingly debilitated and his overall quality of functional existence becomes low or even worthless because of the consequent restrictions or reductions in lifestyle and the utter

dependence upon others for daily life assistance? Are individual patient preferences, recognized as futile by all reasonably objective medical standards, to be subsumed under a contrived medical mandate of sanctified purposefulness?⁴⁷ Whose values and preferences should be given priority—the individual patient’s or those of the medical community?

In a 1997 United States Supreme Court case, *Washington v. Glucksberg*, the Court held that a statutory prohibition in the state of Washington against “causing” or “aiding” a suicide does not offend the Fourteenth Amendment to the Federal Constitution either on its face or “as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.”⁴⁸

As significant as this holding is, the concurring opinion by Justice Sandra Day O’Connor has more direct relevance here. For, in this opinion, Justice O’Connor states—unequivocally—that “a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering (by palliative care), even to the point of causing unconsciousness and hastening death.”⁴⁹

In England, while it is recognized as unlawful for a physician to administer drugs to bring about a patient’s death—even if such action is prompted by the goal of relieving his suffering, it is also recognized that if—in accordance with proper medical practice—a physician prescribes drugs to relieve pain not to end life, no actionable offense will arise. Interestingly, in cases where high qualities of pain relieving drugs have been given with result death, there have been few prosecutions. And, in those prosecutions, it is rare for a conviction to be obtained.⁵⁰

A Middle Ground

Alexander McCall Smith has observed that while the British courts do countenance the “widely-accepted medical practice of drawing a line beyond which further prolongation of life merely add to the suffering of a patient,” they stop short of endorsing active euthanasia.⁵¹ Viewed by some critics as inconsistent and oftentimes even cruel, others view this posture as being attractive since it allows hastening of death in cases where the very palliative measures employed have the *incidental* effect of shortening a patient’s life.⁵² Accordingly, physicians are, indeed, allowed to limit suffering “even if they cannot bring it to an immediate end by causing a patient’s death.”⁵³

Physicians know fully what the outcome will be when diamorphine dosages are increased. Yet, they refuse to describe their actions—to both themselves and to others—as acts of killing. It has been suggested that this moral metaphor validates the very moral underpinning of helping rather than killing. As such, it is seen as a “valuable one to those whose duty it is to look after the terminally ill.”⁵⁴ The further argument is made that by validating the withholding of treatment seen as “unproductive” or futile, such actions in no sense detract from the moral force of the law on homicide.⁵⁵ For, the legal prohibition on killing is indeed preserved; but under certain end-state medical conditions, life may be ended by omission. Accordingly, this allows for a feeling of a “sustainable moral position.”⁵⁶ A position which, in turn, “gives something to those who feel discomfort over the unforgiving nature of strict anti-euthanasia laws while at the same time . . . satisfies many of those who feel that it would be a profound mistake, on consequentialist grounds if on no others, to allow consensual killing in these circumstances.”⁵⁷

Proportionality

The principle of proportionality is closely related to the principle of medical futility. Proportionality recognizes that overuse, as well as underuse, of medical treatment and advanced life extending technologies may create an unreasonable burden where the harm and suffering inflicted by such a modality of treatment may be disproportionate to any realistic benefit to be derived from it. When this happens, it is recognized that there is no obligation to provide specific treatment.

Proportionality is relatively easy to state and visualize as a cost-benefit theory where costs are balanced against benefits. In practice, however, seeking to quantify both factors in the balancing equation is quite difficult. It is generally thought that this principle can be actualized or structured with considerable less difficulty and more precision through the use of advanced medical directives. Sadly, experience has shown popular and widespread use of such directives to be wanting.

A Roman Catholic Construct

In 1957, His Holiness Pope Pius XII addressed the issue of care at the end of life and laid a foundation for Catholic teaching by stating that under certain circumstances—when, that is, treatments are deemed “extraordinary” and excessively burdensome—they may, licitly, be withdrawn.⁵⁸

Building upon this foundation, in 1980, the Sacred Congregation for The Doctrine of the Faith issued its Declaration on Euthanasia which provides a useful construct for the Catholic Christian. In discussing the terms, “proportionate” and “disproportionate” in the context of

medical treatment, the Congregation declares “. . . it will be possible to make a correct judgment as to means by studying the type of treatment to be used, its degree of complexity and comparing these elements with the result that can be expected taking into account the state of the sick person and his or her physician and moral resources.”⁵⁹ Dr. Edmund D. Pellegrino, Chairman of the President’s Council on Bioethics, and a pre-eminent Catholic ethicist, suggests a “disproportionate” means would, in fact, be a futile means.⁶⁰

IV.

AN ETHICAL CONSTRUCT FOR DECISIONMAKING

When does treatment become futile? Stated otherwise, when does the futility of existence become so obvious that sustaining it becomes useless or, indeed, of no socio-legal, philosophical, ethical, or religious “value”?

The concepts of ordinary versus extraordinary lifesaving treatment must be recognized as highly relative or situational—not only as to time and locale, but also in their application to individual cases. Indeed, both of these concepts have the ultimate effect of serving as value judgments which determine whether a given modality of treatment poses an undue hardship on the patient or provides positive hope for a direct and positive benefit. Accordingly, if a particular mode of either medical or surgical intervention imposes either too great a burden on the patient, or offers no reasonable hope of beneficial recovery, such treatment could be classified as extraordinary, and thus, nonobligatory. This determination is essentially a quality of life statement; in reaching it, either knowingly or unknowingly, a substituted judgment is made that if the proxy decisionmaker were in a similar situation to the patient, he would (or would not)

wish to survive in such a state of impairment. Alternatively, a best interests standard could be utilized with the central question being: What course of action is in the patient's best interests?⁶¹

The basic ethical goals of man should be to respect, safeguard, and advance individual autonomy, seek equity and justice in dealing with one another, and undertake beneficent actions which minimize human suffering and seek to actualize the social utility of the purposes of life. From a Judeo-Christian perspective, the meaning of life is tied to two inextricable components of love: love of God and love of neighbor—for it is through love of others that God is, in turn, recognized and loved.⁶² Under this interpretation, the very meaning of life is to be found in human relationships and the qualities of respect, concern, compassion, and justice that support these associations or relationships.⁶³

Social Justice

Under the theory of social justice, each individual is recognized as having an equal opportunity to maximize his potential. A point may be reached, however, where maintenance of an individual defies the very concepts of humanitarianism and justice. Accordingly, when an individual's medical condition reaches a level where it represents a complete negation of those qualities associated with being a human and maintaining a "relational-potential"⁶⁴ with others, the best and most reasonably prudent decision regarding treatment would be that it not be undertaken or that it be withdrawn and only palliative care be administered.⁶⁵ When maintenance of life means the prolongation of pain, with little or no chance of a real or sustainable level of qualitative recovery, there is no opportunity to grasp or seek the overall meaning of life or "relational-potential," or to seek "growth in love of God and neighbor"

through continued human relationships. At this point, such actions should be recognized as being futile and cease.⁶⁶

In attempting to structure an ethical construct for decisionmaking in critical at-risk cases, a balancing test should be utilized that weighs the gravity of the harm in allowing lifesaving actions versus the utility of the benefits stemming from the actions. Accordingly, the gravity of the harm would be assessed in terms of not only social and economic costs that might induce serious financial hardships to all members of the primary or afflicted interest group (*e.g.*, the family), but the religious, philosophical and ethical “costs” (or compromises) as well. The utility of the benefits would be measured in terms of an evaluation of the positive consequences that flow to the threatened individual and to society. In truth, then, this balancing test seeks to arrive at a cost-effective decision through a cost-benefit analysis.⁶⁷

In order to strengthen and add substance to the balancing test, a number of specific factors may be considered or utilized. Indeed, the late Dr. Joseph Fletcher, an Anglican priest, posited a number of such factors that he termed, alternatively, as qualities or indicators of humanhood.⁶⁸ The central most factor to be considered in any balancing equation is whether the at-risk patient has a functioning cerebral cortex—for without it one is “nonexistent and an object rather than subject. Minimal intelligence combines with rationality to build self-awareness and self-control, as well as an ability to be emotive and intuitive. Other factors of importance include: time consciousness, a sense of futurity tied to a theological assertion, a sense of the past, the ability to display curiosity instead of indifference, changeability, a capability to relate to others, compassion or an ability to express concern for others, an ability to communicate, the ability to be idiomorphous or distinctive, and the ability to assert control in life-directing

situations and not display utter helplessness.⁶⁹

Taken together, the Fletcher indicators present a test of humanhood which is shaped by the exigencies of each situation. As such, these factors are shaped or even controlled by a situational ethic which flexibly adapts to each individual problem instead of being directed uniformly by a rigid and unyielding *a priori* ethical standard. Driven by a case-by-case methodology, the boundaries of the situation ethic are incapable of absolute determination. Yet, the basic norm used in decisionmaking will be love, human compassion, common dignity or simply mercy.⁷⁰ Some of the indicators of humanhood may have greater or lesser significance depending upon the diagnosis and prognosis of each case and the balance sought to be struck. For example, some patients and their families might well make trade-offs, desiring to place greater value and emphasis on self-control over a sense of the past and an ability to be emotive and intuitive. Other patients and families may value an ability to communicate over compassion and the ability to express concern for others. In employing the reasonableness standard as the lynchpin in any ultimate medical decision regarding the continuation of medical treatment or the recognition that such would be medically futile, two primary questions under the ethical construct for decisionmaking will be proposed here: (1) Whether the medically at-risk individual possesses a real likelihood of sustaining a “relational-potential” with others?; and (2) Whether the present or proposed course of medical treatment not only minimizes suffering, but also seeks to maximize the potential utility of a life that functions at qualitative levels of cognition?⁷¹

V.

A PARLIAMENTARY EFFORT AT PROBLEM-SOLVING:

THE JOFFE PROPOSAL

On May 12, 2006, the House of Lords—after a seven hour debate filled with high drama and more emotion than reasoned discourse (and thus reminiscent of the U.S. Senate)—voted 148/100 to postpone further consideration of the Assisted Dying for the Terminally Ill Bill which had the effect of rejecting the measure altogether.⁷²

Proposed by Lord Joel Joffe, a cross-bencher, the government asserted its complete neutrality on the vexatious nature of the proposed legislation.⁷³ This Bill, which was patterned closely after a comparable one enacted into legislation in the state of Oregon⁷⁴ in 1994, was designed essentially to “find a solution to the unbearable suffering of patients whose needs cannot be met by palliative care.”⁷⁵

A pervasive concern among religious leaders was that, if enacted into law, a new duty to die would be imposed upon the terminally ill, and, more broadly, the law would place the elderly, lonely, sick or distressed—under real or imagined pressure—to ask for an early death.⁷⁶ Indeed, the Archbishop of Canterbury, Dr. Rowan Williams, Cardinal Cormac Murphy-O'Connor and the Chief Rabbi, Sir Jonathan Sacks, of the United Hebrew of The Commonwealth united in opposition to Lord Joffe's proposal.⁷⁷ And, for the moment, at least, the religious lobby appeared to win, tactically, with the bill's defeat—even though Lord Joffe has promised to introduce another (replacement) bill in the future.⁷⁸

Of course, the Joffe proposal—in no way whatsoever—can be taken as an attempt to degrade the sacredness of life. In a very real way, it validates that sacredness or sanctity by

allowing a competent, terminally ill individual, exercising his right of personal autonomy or self-determination, to determine whether his life has a qualitative relevance *to him*. In reality, the very goal of Lord Joffe's bill was to guarantee a level of common dignity and respect for the terminally ill. It simply did not deal with "killing"—but, rather, only with the choice to commit suicide in medical cases deemed medically futile or, in other words, terminal.⁷⁹

A number of peers re-enforced, quite eloquently these very points. In debate, Baroness Warnock stressed the fear that Lord Joffe's bill would widen the euthanasia movement was not a rational fear for, the bill excludes, specifically, euthanasia as grounds for assistance of the terminally ill.⁸⁰ Instead of moving to the top of a "slippery slope," the bill merely allows a small category of people who wish to end their lives—determined, medically, to be terminal or futile—prematurely. Inasmuch as they do not believe their actions to be "morally wrong," why, then, "should they be governed by moral and ethical principles of the clergy and medical profession" asked the Baroness? Put simply, they "should not be compelled to live against their will."⁸¹

Lord May of Oxford underscored Baroness Warnock's views, by stressing the Joffe Bill is limited in application to an individual "*in extremis*."⁸² He made the point, as well, that assisted dying and palliative care are not alternatives, but rather separate (albeit interrelated) issues. Indeed, the bill requires the distressed patient to be informed of alternatives to assisted dying and, specifically, palliative care. The patient's own physician must ensure that a specialist in palliative care has seen the patient and, furthermore, explained the benefits of it. Both, in turn, must then be satisfied that the patient's request is voluntary and given with informed consent.⁸³

It remained for Lord Goodhart to analyze the Joffe Bill clause by clause and both allay, and thereby dispute, the rationality of the emotional fears surrounding the proposed legislation.

Time does not allow an analysis of these points. Suffice it to note here, however, that the bill has strong safeguards. In addition to the one I just mentioned regarding informed patient alternatives to assisted dying, another of the fundamental strengths of the legislative proposal is the requirement that, before applicable, two confirming opinions—one by the patient’s own doctor and another from a consultant diagnostician—that the patient’s mental capacity is such that he can seek medical assistance in ending his terminal illness must be obtained. And, terminal illness is defined as a medical condition as “progressive, irreversible, and likely to lead to death within six months.”⁸⁴

The Care Not Killing Alliance’s pamphlet, “Assisted Suicide,” (issued in 2006) and distributed widely in some churches, recognizes society has a duty to alleviate suffering “but by killing the pain not by killing the patient.” The Alliance asserts the problem is that many patients do not have access to good palliative care; and, thus, the solution is to fund wider availability of palliative care—not eliminate those needing it. “The hospice movement has shown what can be done to ensure a dignified and peaceful death.”⁸⁵

While some physicians maintain improvements in hospice and palliative care now result in allowing even the most stricken patients to be helped effectively through their final days,⁸⁶ others maintain between 3% and 10% of the terminally ill cannot be helped by pain killers.⁸⁷ The question is thus framed: Why should an individual within this group be denied the freedom to die with carefully supervised assistance?⁸⁸

While, by a narrow vote in 2005, the British Medical Association adopted a neutral position on euthanasia and physician assisted suicide, in June 2006, that decision was overturned—this, as 65% of some physicians attending the BMA’s meeting in Belfast, Ireland,

voted against assisted dying.⁸⁹

Interestingly, a survey conducted by GFK Healthcare for Dignity in Dying, of 200 physicians found 30% of general practitioners would be willing, in principle, and if permitted by law, to write a prescription to assist a patient to die if their suffering could not be relieved by palliative care.⁹⁰

A poll taken by the organization, Death with Dignity, May 13, 2006, showed $\frac{3}{4}$'s of 1,770 respondents drawn from the general public favored (with appropriate safeguards) assisted dying.⁹¹

Even more persuasive and, indeed, compelling are the results of the British National Center for Social Research released this January.⁹² On the issue of euthanasia, with a statistical sample population of some 2,176 respondents, the survey discovered 4 out of 5 and 80%⁹³ of those responding held to the opinion that a physician should be allowed to hasten the death of those who are in a painful, terminal condition and who are going to die.⁹⁴ The same cannot be said, however, when one is not terminally ill; for, here, slightly less than half of respondents to the survey support assisted dying.⁹⁵

This report on social attitudes shows, rather conclusively, that public views are more stable and informed than some parliamentarians, and especially Lord Mackay of Clashfern, thought them to be when the House of Lords Select Committee on the Assisted Dying for The Terminally Ill Bill (Lord Joffe's Bill) of 2005 issued its report.⁹⁶ Indeed, the results of this aspect of the survey show that the public opinion now is quite similar to what it was some ten years ago.⁹⁷

The editors of the survey conclude that “the disjuncture between the current law on assisted dying and majority public opinion . . . seems unlikely to disappear.”⁹⁸ Finding a reasonable “solution” or compromise to continuing efforts to legislate in this area will be problematic.⁹⁹

Should the fear of a “slippery slope” toward public approval of active euthanasia¹⁰⁰ be allowed to trump a standard of common dignity and mercy at the end-stage-of life for the terminally ill?

In truth, “the slippery slope is the human condition.” And, thus, “we are already on it and unable to escape.”¹⁰¹ “It is our destiny to struggle along in life, upwards or downwards, with very uncertain footing. There is no safe plateau of moral security; we are constantly faced with painful dilemmas . . . (with the goal of human moral effort) but to keep seeing and drawing the line, and struggling to stay above it.”¹⁰²

VI.

THE EIGHTH AMENDMENT AND CRUEL AND UNUSUAL

PUNISHMENT: A MEDICO-LEGAL REVISION

The Historical Development

The Eighth Amendment to the United States Constitution prohibits cruel and unusual punishment being administered to prisoners.¹⁰³ This prohibition originated in the Magna Carta, was carried through in the English Declaration of Rights of 1688, and was later adopted as part of the Bill of Rights of the United States Constitution.¹⁰⁴ While the Eighth Amendment has been used only in the context of criminal incarceration, it has contemporary and expanded relevance

to the issue of determining whether providing medically futile treatment results in cruel and unusual punishment to a patient.

Contemporary Medico Legal Applications

Several factors dictate that administering futile treatment is “cruel and unusual” within society’s evolving standards of decency. If a physician treats a patient when the physician knows that such treatment is futile, the physician implies that there is a possibility, if not a likelihood, that such treatment will be effective. In this case, the physician is knowingly deceiving the patient by offering the patient and his family false expectations of recovery. This deception clearly violates the principle of self-determination and autonomy for the patient himself.

The primary obligation of health care providers is: “Do no harm.”¹⁰⁵ Thus, physicians must minimize or prevent mental and physical suffering because this is harmful to patients. Physicians must endeavor to demonstrate levels of compassion which counter an all too pervasive indifference within the medical profession to allow terminally ill patients to die lingering deaths—a manner which defies the minimally civilized goal of allowing all individuals to die with humaneness and dignity. What real value is there to pain management if death is imminent and the added days of life provided are of inferior quality?¹⁰⁶

Administering futile treatment ignores this primary obligation of a health care provider by exposing the patient to additional risks of that treatment. If a physician prescribed a course of treatment knowing that it was futile, he would be needlessly exposing the patient to additional risks associated with the treatment such as infection or adverse reactions. Even if the futile

treatment did not adversely affect the patient, the mere exposure to the risk is cruel. Moreover, some interventions, such as CPR, inflict severe physical trauma. Administering CPR when, as seen, there is no medically reasonable chance that the patient will recover from the underlying illness amounts to physical torture.¹⁰⁷ Physicians should be under a duty not to administer futile treatment because, by doing so, they are inflicting “cruel and unusual punishment” on patients and their families.

It is similarly “cruel and unusual punishment” to sustain patients who exist in a PVS. This is equivalent to giving a life sentence to an innocent person. The remedy for persons in a PVS, however, is not an executive pardon, but rather a death sentence (*i.e.*, the withdrawal of treatment that merely maintains the unconscious nonsapient condition). When a person is diagnosed as being in a PVS, there is an agreement among physicians that such a condition is not “living” and that preservation of “life” in that state is not a proper goal for medicine. This is supported by the “traditional and modern view that . . . expert physician[s] should not prescribe therapies which cannot restore health to a dying person,”¹⁰⁸ and that all medical decisionmaking should have as its goal the benefit of the human person. Clearly, physicians have no duty to preserve mere biological “existence” *per se*.¹⁰⁹

The Katrina Tragedy: A Case on Point

In the aftermath of Hurricane Katrina in Louisiana, on July 19, 2006, the Attorney General of the State ordered charges of “Mercy Killing” filed against a physician and two nurses in New Orleans who injected four patients with a combination of morphine and midazolam. As many as 14 bodies showed indications that a lethal dose of drugs had been administered. In

combination, these drugs are administered routinely to relieve pain or anxiety.¹¹⁰

The patients who died, ranging from 61 to 90 years of age, were literally stranded on the seventh floor of Memorial Medical Center in a long term care unit. In all, some 250 patients were unable to leave the hospital because of high flood waters. The four patients at the center of the controversy were among 24 who died on the seventh floor. Because of their chronic medical needs, the seventh floor patients were non-ambulatory and in need of supportive care. None were considered in imminent danger of dying, however, prior to the onset of the hurricane.¹¹¹ Inside the hospital, itself, the temperature rose to 100 degrees, there was no electricity and no waste disposal system. In a word, the hospital was in a crisis, and none of the patients had asked for assistance in euthanizing themselves.¹¹²

The stranded patients were *triaged* or rated according to their potential for survival.¹¹³ “Red” was the color used to denote critical care; “Black” meant moribund with only comfort care administered. The salvageable were, over time, put on helicopters and transferred to a local airport where the airport personnel re-evaluated them again before routing them to other health care facilities outside of New Orleans. Some of these patients rated red and needing critical care, were classified as moribund or black and not given heroic treatments. Different levels of care were given according to the availability of medical resources at specific locations.¹¹⁴

Should the physician and her two nurses been seen as murderers or, as humane physicians acting in a manner justified medically under the circumstances? Is this not a direct case on point for application of the principle of ethical futility? I would suggest that instead of being vilified as criminals, the physician and her nurses acted with humaneness, compassion and mercy in sedating their moribund patients trapped on the seventh floor of Memorial Hospital.

VII.

CONCLUSION

Dying is, “[b]y and large, a messy business.”¹¹⁵ It is both “ugly and dirty” in a world that is intolerant of such qualities.¹¹⁶ Perhaps the only true dignity found within the occurrence of death is a full appreciation of the life that precedes it.¹¹⁷

The management of death can surely be both more humane and more efficient when the principle of medical utility is harmonized with patient autonomy. By defining medical utility as the maximization of the welfare of patients in need of treatment, it is clear that criteria are essential in determining, in a fair and equitable manner, who will receive and benefit from an initial use or continuation of scarce medical resources, and conversely, who will not.

Utilitarianism, then, in choosing which course of action to follow will evaluate those actions which produce the greatest benefit for the greatest number of individuals. Social utility is used as an integral part of the balancing equation. Herein lies the problem: How can the needs and prognosis of a particular patient be balanced against the needs of society? Stated otherwise, how can physicians serve two masters, society and patients, in determining the type and amount of medical care?

The principle of medical futility, delineated and tested in the manner proposed here, can serve as a catalyst for public action, acceptance, or both. Furthermore, medical futility can serve as the dominant vector of force in validating the very essence of utility, and thus, resolve the inherent conflict between patient needs and greater societal goals. The fact that there is a pressing national need for a clear, objective, and practical definition of futility is without doubt. Yet, the reality of the situation dictates that regardless of the definition settled upon, a debate

between and among the medical professionals and social policy makers will inevitably arise. The public, because of its inherent lack of sophistication in this area, will depend upon both groups to educate them and win their acceptance. To fail in this mission means, simply, an increase in suits for medical malpractice by uninformed patients and their families or proxy decisionmakers.

Once defined criteria for medical futility are accepted by health care providers and the public which they serve, this restructured principle affords the ideal construct for determining the utilitarian balance between patient and majoritarian preferences, wants, or needs. It achieves this by institutionalizing a balancing point that distinguishes the medical actions agreed upon as useful, reasonable, or promotive of restorative quality under particular circumstances with various patient profiles, and those actions not beneficial to patients or economically feasible for society to undertake. In a real way, then, these criteria act as a socio-legal-ethical-medico-economic *triage*, providing various medical and surgical interventions not regarded as *reasonable* for use by certain patients with profiles which show that there is no assurance of a sustained level of qualitative rehabilitation or salvageability.¹¹⁸

Stated otherwise, again, Dr. Pellegrino suggests that the primary goal in dealing with cases of futility is achieving for the patient a level of “total good.” This, in turn, then, is realized when a carefully calibrated balance is struck between three criteria: effectiveness, benefit and burden reached, co-operatively, within an “alliance” between the treating physician, the patient or his surrogate decisionmaker.¹¹⁹

For Dr. Pellegrino, futility is not an isolated, empirical yes/no test. Rather, each judgment of futility takes all aspects of a patient’s total life experience into account—physical,

mental, spiritual preferences and life goals. As such, each judgment “demands prudential assessments for a particular person in a particular experience of illness and within a particular metaphysical and theological context.”¹²⁰

Physicians must always be leery of being forced to practice “irrational medicine”—all demanded by the patient, as such, who expects “everything be done” even though treatments may be judged futile by his physician.¹²¹ Indeed, to attempt to demand or to order treatment when a medical condition is diagnosed as futile “violates the first principle of traditional medical ethics—beneficence” which mandates that actions taken by a physician always be for the patient’s good.¹²²

Upon the acceptance or adoption of guidelines for determining futility, a three-tiered decisional structure has been proposed as a mechanism for determining whether a given treatment for a given patient falls within the scope of these guidelines. Accordingly, the treating physician would be given the primary responsibility for making the decision to withdraw or withhold treatment on the grounds of futility. Although he would be under a duty not to prescribe treatment deemed futile by him, he would be obliged to inform the patient, and if necessary, the family of this decision and its rationale. This would provide the patient and family a basis for an “appeal” to the hospital ethics committee, if such course were elected.¹²³ Any further appeal from an adverse finding by the committee would be to the courts, where a limited review of the reasonableness of the decision to withdraw or withhold treatment would be undertaken.

Absent both a redefinition of death to include a PVS and anencephaly and a failure to achieve a broad consensus to establish criteria for treatment based upon the extent and duration

of neurologic damage, perhaps a less contentious approach to the effort of redefining the principle of medical futility would be the acceptance of a presumption that those permanently existing in a vegetative state would not want to be kept alive for an indefinite period of time. Accepting this presumption would, in turn, allow a standard of care to be established that would include routinely a cessation of treatment after a reasonable time. Although the standard of reasonableness would vary with medical circumstances or situations, it would be tied with sufficient clarity to a recognition of irreversibility. Consistent with this new medico-legal presumption would be a shift in the burden to those wishing maintenance of a vegetative state to show that they are acting in accordance with what they know from clear and convincing evidence to be the wishes of the patient himself.¹²⁴

Since administering futile medical treatment is tantamount to inflicting cruel and unusual punishment on the patient and an abridgement of his rights of self-determination, it is incumbent upon physicians to recognize that they should accept the imposition of an affirmative legal, professional, moral, and ethical duty *not* to prescribe a modality of treatment that falls clearly within the scope of being considered futile, freakish, and tortious. The utilitarian value of a revalidated and operative principle of futility is all too apparent. Let it be used in a reasonable and compassionate manner to end the cruel punishment of terminal and hopeless cases of “human” existence and, at the same time, hopefully, give rise to an ethic of palliative care and less to a relentless pursuit of technologies that extend futility to the point of indecency and inhumaneness.¹²⁵

Of the eight beatitudes which mark the opening of the Sermon on the Mount by Jesus, the fifth one admonishes us to remember that the merciful are blessed, for they shall obtain mercy.¹²⁶

And, Shakespeare reminds us, through Portia, in the Merchant of Venice, that “The quality of mercy is not strain’d, it droppeth as the gentle rain from the heaven upon the place beneath. It is twice blest: It blesseth him that gives and him that takes . . . It is an attribute to God himself; And earthly power doth then show likest God’s, When mercy seasons justice.”¹²⁷

ENDNOTES

1. Lawrence J. Schneiderman & Nancy Jecker, *Futility in Practice*, 153 ARCH. INTERN. MED. 437, 440 (1993) (stating that “overwhelming agreement has been reached in the medical community that physicians are not required to provide futile treatment”).

A physician has no duty to continue treatment, once it has proved to be ineffective. 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. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1017-18 (1983).

“[I]f a treatment is clearly futile . . . there is no obligation to provide the treatment.” Nancy S. Jecker & Lawrence J. Schneiderman, *Medical Futility: The Duty Not to Treat*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 151, 156 [hereinafter *Medical Futility*] (quoting THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 19 (1987)).

2. Council on Ethical and Judicial Affairs, American Medical Association, Current Opinion, 2.03, CODE OF MEDICAL ETHICS (1994).

3. *Id.*, Opinion 2.035 (“Futility”).

4. BARRY R. FURROW, THOMAS L. GREANEY, SAUNDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *BIOETHICS: HEALTH CARE LAW AND ETHICS* (5th ed. 2004) at 310.

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5. See George P. Smith, II, *Utility and The Principles of Medical Futility: Safeguarding Autonomy and The Prohibition Against Cruel and Unusual Punishment*, 12 J. CONTEMP. HEALTH L. & POL'Y. 1 (1995).
 6. THE TIMES, April 12, 2006, at 25 (unauthored byline, *Care for Dying Found Inadequate*).
 7. *Id.*

See generally ROGER S. MAGNUSON, ANGELS OF DEATH: EXPLORING THE EUTHANASIA UNDERGROUND (2002).
 8. Damian Thompson, *Welcome to Britain's New Dying Room*, THE DAILY TELEGRAPH, May 20, 2006, at 18.
 9. Robert D. Truog, et al., *Sounding Board: The Problems with Futility*, 326 NEW ENG. J. MED. 1560 (1992).
 10. See Marcia Angell, *The Case of Helga Wanglie: A New Kind of 'Right to Die' Case*, 325 NEW ENG. J. MED. 511, 512 (1991).
 11. Sidney H. Wanzer, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 958 (1984).
 12. See DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY, 181 (1988).
 13. Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 442-43 (1988).

14. See Marni J. Bonnin *et al.*, *District Criteria for Termination of Resuscitation in the Out-of-Hospital Setting*, 270 JAMA 1457 (1993).

15. See Kathleen Boozang, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 ARIZ. L. REV. 23 (1993).

16. Lawrence J. Schneiderman *et al.*, *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 949 (1990).

It has been suggested that the ethical principle of autonomy should be re-shaped and thus redefined as the principle of relational authority. Accordingly, a variety of relationships a patient experiences and obligations he assumes would be factored into health care decisions.

Communitarian ideals would, thus, direct ultimate actions rather than individualistic concepts.

HERRING, *infra* note 18 at 125–130.

17. 497 U.S. 261 at 288, 289 (1990).

18. JONATHAN HERRING, *MEDICAL LAW AND ETHICS* 421, 482 (2006).

See also JOHN KEOWN, *EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGISLATION* 58 *passim* (2002).

19. HERRING, *id.* at 89.

20. *Id.*

21. *Id.* at 108.

22. *Id.* at 109.

23. *Id.*

24. *Id.*

25. *Id.* at 87.

26. *Id.*

27. *Id.* at 88.

28. Nancy S. Jecker & Robert A. Pearlman, *Medical Futility: Who Decides?*, 152 ARCHIVES INTERNAL MED. 1140, 1142 (1992).

29. See Lance K. Stell, *Stopping Treatment on the Grounds of Futility: A Role for Institutional Policy*, 11 ST. LOUIS U. PUB. L. REV. 481, 484 (1992).

30. *Supra* note 16 at 950.

31. See generally Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47 (1993).

32. Stuart J. Younger, *Futility in Context*, 264 JAMA 1295 (1990).

33. *Supra* note 16 at 950.

34. *Id.* at 953.

35. *Supra* note 20 at 487-88.

36. Nancy S. Jecker & Lawrence J. Schneiderman, *Medical Futility*, *supra* note 1 at 155 (1987).

37. *Id.* at 155.

38. *Id.*

39. *Supra* note 3 at 309.

40. *Id.*

41. *Id.*, at 311.

When used in patients dying of some underlying fatal disease or when the heart muscle is, itself, damaged seriously, cardiopulmonary resuscitation is of dubious, or little—if any—value at all. Edmund D. Pellegrino, *Decision at The End of Life: The Use and Abuse of The Concept of Futility* in THE DIGNITY OF THE DYING PERSON, Juan De Dios Vial Correa & Elio Sgreccia eds. (2000) (Proceedings of the Fifth Assembly of The Pontifical Academy of Life, Feb. 1999).

42. See George P. Smith, II, *The Ethics of Ethics Committees*, 6 J. CONTEMP. HEALTH L. & POL'Y 157 (1990).

43. JOSEPH J. FINS, A PALLIATIVE ETHIC OF CARE 85 (2006).

44. *Id.*, at 86.

45. *Id.*

46. See Margaret A. Somerville, *The Song of Death: The Lyrics of Euthanasia*, 9 J. CONTEMP. HEALTH L. & POL'Y 1, 74 (1993).

47. See HELGA KUHSE, *THE SANCTITY-OF-LIFE DOCTRINE IN MEDICINE* (1987).

48. *Washington v. Glucksberg*, 521 U.S. 702 (1997).

In a companion case, *Vacco v. Quill*, a New York state prohibition on assisting suicide was found not violative of the Equal Protection Clause of the 14th Amendment, 531 U.S. 793 (1997).

49. O'Connor at 736, 737.

50. HERRING, *supra* note 18 at 426, 427. See also ch. 8 for an expanded analysis.

51. Alexander McCall Smith, *Euthanasia: The Strengths of The Middle Ground*, 7 MED. L. REV. 195, 206 (1999).

52. *Id.*

53. *Id.*

54. *Id.* at 207.

55. *Id.*

56. *Id.*

57. *Id.*

58. Pellegrino, *supra* note 41 at 219.

59. *Id.* at 229.

60. *Id.*

61. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS at 171-73 (3d ed. 1989).

62. Richard McCormick, *To Save or Let Die: The Dilemma of Modern Medicine*, in HOW BRAVE A NEW WORLD? 346 (Richard McCormick ed. 1981).

63. *Id.*

64. *Id.* at 347.

65. *See* GEORGE P. SMITH, II, FINAL CHOICES: AUTONOMY IN HEALTH CARE DECISIONS ch. 4 (1989).

66. *Supra* note 62 at 347.

67. George P. Smith, II, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis*, 63 NEB. L. REV. 709, 734 (1984).

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68. Joseph Fletcher, *Indicators of Humanhood: A Tentative Profile of Man*, HASTINGS CENTER RPT., Nov. 1972 at 1.
69. *Id.* at 1-3.
70. MARGARET P. BATTIN, *ENDING LIFE: ETHICS AND THE WAY WE DIE* 8 (2005).
71. *Supra* note 67 at 734-35.
72. Astrid Zweymert, *British Parliament Blocks Assisted Suicide Law*, <http://go.reuters.com/newsArticle.jhtml?type=healthNews&storyID=12190846&src=r...> (accessed May 16, 2006).
73. *See generally* *Interview: Jaspar Gerard meets Lord Joffe*, THE SUNDAY TIMES, May 14, 2006, at 4/5.
74. The Oregon Death with Dignity Act, ORE. REV. STAT. §127.800—897 (2003).
75. Rosa Prince, *Assisted Suicide Bill is Killed Off: Should We Get the Right to Have Ourselves Killed?*, http://www.mirror.co.uk/news/topstories/tm_objectid=17072287&method=full&siteid... (accessed May 16, 2006).
76. Ruth Gledhill, *Religious Leaders Fear Right to Die Law Would Turn into Duty to Die*, THE TIMES, May 12, 2006, at 16.
77. *Id.*

78. Minette Marrin, *An Acceptable Way to Arrange our Death*, <http://www.timesonline.co.uk/article/0,,2088-2179494,00.html> (accessed May 16, 2006).

79. *Id.*

80. Lords Hansard, column 1221, <http://www.publications.parliament.uk/pa/ld199900/ldhansrd/pdvn/lds06/text/60512-2...> (accessed May 12, 2006).

81. *Id.*

82. *Id.*, column 1278.

83. *Id.*, Lord Goodhart, column 1205 *passim* (discussing clauses 2—6 of the Joffe Bill).

84. *Id.*

85. Care Not Killing Alliance, “Assisted Suicide” (2006).

86. *Doctors Change Euthanasia Stance*, BBC NEWS, <http://news.bbc.co.uk/2/hi/health/5123974.stm> (accessed June 30, 2006).

87. Marrin, *supra* note 78.

88. *Id.*

89. *Supra* note 86.

90. *Id.*

91. Astrid Zeveynert, *Assisted Dying Bill Blocked in London*, <http://www.tiscali.co.uk/news/newswire.php/news/reuters> (accessed May 15, 2006).

92. BRITISH SOCIAL ATTITUDES: THE 23rd REPORT—*Perspectives on a Changing Society* (A. Park, J. Curtie, *et al.*, eds.) (2007).

93. *Id.*, ch. 2 at 39.

94. *Id.* at 50.

95. *Id.*, at 39, 50.

96. *Id.* at 36.

97. *Id.* at 50.

98. *Id.*

99. *Id.*

100. This point was stressed, among others, by The Lord Bishop of St. Alban's. *See* Lords Hansard, May 12, 2006, column 1210 *passim*.

Lord Taverne, (column 1225) and Baroness Barker (column 1281) also expressed concern over what they considered an overly aggressive campaign by churches and church leaders to “distort” the evidence and thereby defeat the Joffe Bill.

101. *Supra* note 78.

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102. *Id.*
103. U.S. Const. amend VIII.
104. Michael C. Friedman, *Cruel and Unusual Punishment in the Provision of Prison Care: Challenging the Indifference Standard*, 45 VAND. L. REV. 921, 925 (1992).
105. John L. Paris *et al.*, *Physicians' Refusal of Requested Treatment: The Case of Baby L.*, 322 NEW ENG. J. MED. 1012, 1014 (1990).
106. *See generally* George P. Smith, II, *Reviving the Swan, Extending the Curse of Methuselah or Adhering to the Kevorkian Ethic?*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 49 (1993).
107. *See* George P. Smith, II, *Euphemistic Codes and Tell-Tale Hearts: Humane Assistance in End-of-Life Cases*, 10 HEALTH MATRIX J. LAW-MED. 175 (2000).
108. Steven H. Miles, *Medical Futility*, 20 L. MED. & HEALTH CARE 310, 311 (1992).
109. *Supra* note 26 at 489.
110. Peter Whoriskey & Catherine Skipp, *3 Arrested in New Orleans Hospital Deaths*, WASH. POST, July 19, 2006, at A3.
111. Tyler J. Curiel, *Murder or Mercy: Hurricane Katrina and The Need for Disaster Training*, 355 N. ENG. J. MED. 2067 (Nov. 16, 2006).
112. *Id.* at 2068.

113. George P. Smith, II, *Triage: Endgame Realities*, 1 J. CONTEMP. HEALTH L. & POL'Y 143 (1985).

114. *Supra* note 110.

115. SHERWIN B. NULLAND, HOW WE DIE: REFLECTIONS ON LIFE'S FINAL CHAPTER 142 (1994).

116. *Id.* at 255.

117. *Id.* at 242.

118. *See generally* George P. Smith, II, *Triage: Endgame Realities*, 1 J. CONTEMP. HEALTH L. & POL'Y 143 (1985).

119. Pellegrino, *supra* note 41 at 227.

120. *Id.* at 240.

121. *Id.* at 235.

But see Pam Belluck, *Even as Doctors Say Enough, Families Fight to Prolong Life*, N.Y. TIMES, Mar. 27, 2005, at A1.

122. Pellegrino, *supra* note 41 at 227.

123. George P. Smith, II, *All's Well that Ends Well: Toward a Policy of Assisted Rational*

Suicide or Merely Enlightened Self-Determination, 22 U.C. DAVIS L. REV. 275, 415 (1989).

124. Marcia Angell, *After Quinlan: The Dilemma of the Persistent Vegetative State*, 330 NEW ENG. J. MED. 1534, 1535 (1994).

125. Nancy S. Jecker & Lawrence J. Schneiderman, *Is Dying Young Worse Than Dying Old?*, 34 THE GERONTOLOGIST 66, 71 (1994).

126. Matt. 5:6; Matt. 6:2–4.

See also Mary Hinkle, *Learning What Righteousness Means: Hosea 6:6 and The Ethic of Mercy in Matthew's Gospel*, 8 WORD & WORLD 355 (1998).

127. William Shakespeare, *The Merchant of Venice*, Act IV, scene 1.