

Some Thoughts on Teaching Medical Futility to Law Students

Phebe Saunders Haugen
phebe.haugen@wmitchell.edu

Of the many ways legal education has changed since I was in law school, one of the more interesting has been an increasing emphasis on inter-disciplinary work and the availability of highly specialized courses that would have been unrecognizable to the traditional law student thirty years ago. These days, it seems many more students study law in order to do something else when they finish. Some of them take what they learn back to a family business or even to a medical practice. Others plan to practice law, but they arrive at school with a clear idea of a specialized area in which they want to work and an impatience to get past the basics and into the esoterica of that specialty. Health Law is one such area; Elder Law is another. Law schools today may have fifteen or twenty specialized course offerings that students are eager to take, including seminars with titles like *Regulation of Drugs, Biologics and Devices*; *Global Health and Human Rights*; and *Public Health and Bioterrorism*.

Even schools without such a varied Health Law curriculum at least have a course in Bioethics, and some of us who have taught such a course find that it is enormously popular, even among the students who have not made an early commitment to Health or Elder Law. Many tell me they take it because it is “something different,” raising issues they may not have seen in their other classes. They soon discover that even recognizable issues are approached differently in a law school Bioethics class. Informed consent, euthanasia, and surrogate decision-making at the end of life, for example, are all more or less familiar to law students from their Torts, Criminal Law, and Constitutional Law classes, but they quickly learn that the language of the law – particularly the language of rights – by which they may have analyzed these issues in other classes, is often strikingly inadequate in the real-world contexts of clinical bioethics. Yet, these are issues that many of our students will face with their clients and even in their own families. If these students are to be effective counselors in health or elder law practices in the future, they must be able to think about these problems in a quite different way than they’ve been taught to do in other law school courses. Many students find that it is quite liberating to put aside “thinking like lawyers” (whatever that may mean) for a time. They come to appreciate that the kind of expanded analysis that will help them better understand the issues in bioethics is exactly what can help them be better lawyers, that is, better counselors to clients with particular kinds of real problems to be solved.

This expanded, more contextual thinking is especially necessary when we talk about end-of-life care, and especially the problem of medical futility, the idea – to oversimplify – that some medical treatments in some contexts are inappropriate and need not be provided to patients, however much they or their families may want them. Consider this problem:

The husband and an adult daughter of an elderly, end-stage stroke patient want her to be maintained on the feeding tube that is presently providing her nutrition and hydration, and they want her to remain in “full code” status, so that all attempts would be made to resuscitate her in

the event of a cardiac arrest. Their religious beliefs tell them that life is sacred and should be preserved at all cost; only God should determine the moment of death. The patient's adult son believes that his mother has reached the end of a long life and should be allowed to die, which she will do soon if the feeding tube is removed. The patient has no advance directive, has never directly expressed her views on the matter or her preferences for her own care, and is no longer competent to discuss her wishes.

Here we have a situation that is fraught with difficulties, most of which the law has something to say about, but all of which must be examined with a more complicated set of evaluative tools than the law alone provides. Among the issues this case raises are those of patient autonomy, surrogate decision-making, and family dynamics; of religious values, the doctor-patient relationship, and professional integrity; of the appropriate use of medical resources, the limits of medicine, and the best methods for sorting out these conflicts. Does anyone really think that the law can solve all these problems?

In fact, the law might well provide these rather unsatisfactory responses to our dilemma:

- Patient autonomy is paramount. It is not lost when the patient becomes incompetent but may be exercised by another on her behalf. The husband is the presumptive surrogate decision-maker for his wife now that she is incapable of making her own decisions about her medical care.
- His wishes for continued aggressive care should be honored, as there is an abiding presumption that life should be sustained in the absence of evidence that the patient would wish otherwise for herself.
- A physician who wants to unilaterally withdraw a medical treatment over a family's objection has, at the moment, no clear statutory authority to do so (except perhaps in Texas), however well-founded the doctor's judgment that the treatment is medically inappropriate.

Additionally, a hospital attorney might well add that a lawsuit by the husband and the attendant negative publicity are risks the hospital is unwilling to take. If the husband cannot be persuaded to forgo these interventions for his wife, then they should be continued. If the physician is unwilling to continue them, then the patient should be transferred to one who is.

To be sure, even a purely legal analysis of these issues will be a deeper one than the preceding responses suggest, but students in bioethics are encouraged to think about all the aspects of the problem that the law does not resolve or might resolve badly. For instance, as Dr. Joanne Lynn says, "Families visit graves." They will carry away with them everything that was done for (and to) their patient and the way in which decisions were made, especially if there were conflicts among family members or with the doctors. Surely the worst thing that can be done to such a family is to default to the "legal" surrogate – even one designated in an advance directive – without doing whatever it takes to help the rest of the family come together about the patient's care. The vast majority of families will do so, with a little time and a little help. Most end-of-life decisions do not have to be made instantly. Taking some time to help the family absorb the medical reality is far better than playing any sort of legal trump card.

How and when doctors discuss the patient's care with her family is extremely important, as is a sensitive exploration with them of their reasons for wanting aggressive treatment continued when it can only prolong the patient's unconscious but inexorable decline towards death. An on-going discussion, begun early, of the patient's and family's goals for treatment can often prevent such conflicts from developing at all, especially if the physician is willing to be scrupulously honest about the patient's prognosis. Lawyers can help families and doctors have these all-important conversations, and students in Bioethics classes should begin learning how to encourage and facilitate such non-adversarial encounters. Sometimes, there will be sincere value differences that cannot be compromised. This family may be unlikely to see continued aggressive care as "futile" if it serves their religious values. The physician may be unlikely to see it as anything other than a misuse of valuable resources that cannot benefit the patient, and that compromises the doctor's professional and moral integrity. Arguments about whether the treatment can rightly be called "futile" are themselves likely futile. Still, no one should abandon the effort to bring them all together on a plan to which they can all agree.

Bioethics students learn that there are many sources of authority for physicians to refuse to provide medically inappropriate treatments, but the law is often not the best place to look for them. Even if a state legislature does enact a statute that permits physicians and hospitals to unilaterally withdraw treatments from patients who are "overmastered by their disease" (as Hippocrates would have said), is invoking such a law really the best way to deal with their distraught families? Increasingly, hospitals are taking a much better course. They are developing written policies that provide a clear, deliberate process for dealing with such conflicts – policies that give ample attention and respect to both families and doctors. Even if the end result of such a process permits the hospital to withdraw the treatment over the family's objection, a careful, well-defined, respectful way to get there can often make that last step unnecessary. Certainly, it leaves families more likely to feel that they were heard and respected.

We do students and their future clients a great service when we encourage them to think contextually and non-adversarially in these situations, and when we help them see that many problems their clients will bring them are not best resolved by a rigid appeal to legal rules. Lawyers can be of enormous help even in those cases where their counsel is away from a "legal" solution. Many of the conflicts about end-of-life medical care are best resolved by a clear-eyed recognition not only of the limits of medicine, but of the limits of the law, as well.

Phebe Saunders Haugen
Professor of Law
William Mitchell College of Law
875 Summit Ave.
St. Paul, MN 55105-3076

I have been at WMCL for the last 30 years, teaching a variety of courses – Criminal law, Torts, Contracts, among others. I've taught Bioethics for the last 18 or so years. I have been on 6 different health facility ethics committees over the last 20 years, and I currently serve on the committees of three area hospitals. My concentration both in teaching and writing is clinical bioethics, especially end-of-life care.]