# Toward a Pragmatic Model of Judicial Decisionmaking: Why Tort Law Provides a Better Framework than Constitutional Law for Deciding the Issue of Medical Futility

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If I were hospitalized with a bad case of the flu, I could not rightfully demand that my attending physician prescribe antibiotics. Antibiotics are not an effective treatment for the flu because the flu is viral, not bacterial, and antibiotics are effective only against bacterial infections.[1] Even in the nomenclature of doctors and lawyers, the point is a simple one: physicians have no obligation to provide treatment deemed to be "medically futile."[2] In determining whether a specific treatment is medically futile, physicians ask whether providing the treatment would benefit the suffering patient.[3] The above example is a simple one because the treatment that I am demanding would not be effective against the flu and would, therefore, be of no benefit to me.

The question of whether a treatment is medically futile is most often a purely clinical one of the sort that generates little controversy.[4] In the above example, my physician's special competence unquestionably includes the ability to determine which medicines should be prescribed and which withheld. Determinations of this sort are based on clear treatment goals (e.g., recovery from the flu) and fairly certain results (e.g., antibiotics will not aid recovery from the flu).

The same cannot be said for the kind of medical futility with which this Comment is concerned. Indeed, as we move further from

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1. *See* Daniel R. Mordarski, Comment, *Medical Futility: Has Ending Life Support Become the Next "Pro-Choice/Right to Life" Debate?*, 41 CLEV. ST. L. REV. 751, 755 (1993).

2. *See* Robert M. Taylor & John D. Lantos, *The Politics of Medical Futility*, 11 ISSUES L. & MED. 3, 4 (1995).

3. *See* Mordarski, *supra* note 1, at 755-56.

4. *See id.* at 755.

the flu scenario, the term "medical futility" acquires a nebulous new meaning that is divorced in all but name from the clinical definition just discussed. The following hypothetical recreates the essential facts of *In re Wanglie*,[5] the first case of medical futility to reach the courts.

Imagine that I am a longtime cigarette smoker of advanced years and, as a result, I am unable to breathe without a respirator. To make matters worse, I have suffered a stroke and am in a comatose condition that my physician calls a permanent "vegetative state."[6] Neurologists at the hospital where I am being treated have informed my physician that I am unlikely to ever regain consciousness, much less live a normal life. My brain damage is severe, but it is unknown whether I have any thoughts or dreams in my mechanized slumber. Always wary of legal documents, I left no written expression of whether I would prefer to live or die under circumstances like these.[7] Indeed, I found the topic a touchy one, and my family and friends do not recall my ever having expressed an opinion one way or the other. Only one thing is certain: I will be able to live many more years with the aid of a respirator.

Now suppose that my physician wants to terminate the respirator treatment because she believes that the mere preservation of my physical existence is nonbeneficial and, therefore, such treatment is medically futile. In her opinion, the respirator is just as futile for treating a permanent vegetative state as antibiotics are for treating the flu. Does the fact that my life depends on its continued use preclude her from declaring it a futile treatment?

Before we answer this question, or examine the process of answering, let us indulge in the recitation of a few more facts. My physician has another patient in need of a respirator for survival. Predictably, my respirator is the only one currently available in this under-funded facility. The other patient's likelihood of recovery is far greater than mine. Moreover, he is younger and his brain damage is less severe. Although comatose, he exhibits signs of awareness such as darting eyes, suggestive of a dream state, and tears and twitches upon

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5. No. PX-91-283 (P. Ct., Hennepin County, Minn. 1991), *reprinted in* 7 ISSUES L. & MED. 369 (1991).

6. A vegetative state is characterized by exclusively reflexive, involuntary, or unconscious functioning in the "manner of vegetable life." STEDMAN'S MEDICAL DICTIONARY 1692 (25th ed. 1990).

7. "Nearly every state has enacted statutes authorizing the use of living wills and advanced directives to allow patients to refuse life sustaining treatment." Neal F. Splaine, Comment, *The Incompetent Individual's Right to Refuse Life-Sustaining Medical Treatment: Legislating, Not Litigating, A Profoundly Private Decision*, 27 SUFFOLK U. L. REV. 905, 926-28 (1993).

hearing the voices of his family. He will likely regain consciousness. I, on the other hand, am dead to all stimuli save the tubes to which I am vitally connected. Keeping my body alive costs thousands of dollars each day,[8] but, for religious reasons, my family insists that the treatment continue.

Things were much easier when I had the flu. While the futility question faced there was a purely clinical one for which there was a clear answer, the present example raises complex economic and moral questions that are considerably less straightforward. In its most stark formulation, the issue in the present example is whether patients in my condition should be kept alive with costly cutting-edge technology when doing so substantially reduces the resources available for more promising and widely accepted treatments.[9] It is impossible to determine whether a life-sustaining treatment can be considered in any sense nonbeneficial without at least a partial answer to the moral, ethical, and economic questions involved.[10] Because there is no common law or statutory authority on these questions, the physician in the hypothetical above is left to her own devices in deciding whether my respirator treatment is futile or beneficial and, hence, whether she has the duty to make this treatment available.

Recognizing that courts will eventually have to confront the issue of medical futility,[11] this Comment argues that there is no principled basis for omitting these difficult questions from a legal analysis of the issue and that courts should therefore decide the issue in a manner that honestly confronts them. Specifically, the argument advanced here is that courts confronted with cases of medical futility should decide the issue under principles of tort law, rather than under principles of constitutional law. The crux of this argument is that tort principles provide an open-ended analytical framework conducive to considering troublesome questions like those raised by the respirator scenario, while constitutional principles provide a framework that is conducive to avoiding those questions.

This argument is presented in three parts. Part I provides a general overview of medical futility. Part II describes two opposing

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8. *See* Robert J. Dzielak, *Physicians Lose the Tug of War to Pull the Plug: The Debate About Continued Futile Medical Care*, 28 J. MARSHALL L. REV. 733, 760 (1995).

9. *Cf.* Mark A. Bonanno, *The Case of Baby K: Exploring the Concept of Medical Futility*, 4 ANNALS HEALTH L. 151, 172 (1995) ("The issues are dying and who should control the decision of how and when death will occur.").

10. *Cf.* Taylor & Lantos, *supra* note 2, at 10. ("[T]he illusion that futility and rationing are entirely distinct can no longer be maintained.").

11. Bonanno, *supra* note 9, at 160.

methods of deciding cases—formalism and pragmatism—and shows why the issue of medical futility should be approached pragmatically. Finally, Part III argues that tort law provides a pragmatic model of decisionmaking better suited to deciding issues of medical futility than the formalistic model often used in constitutional decisions of similarly volatile issues.

## I. MEDICAL FUTILITY

The background material presented below is divided into four subparts. Subpart A explains the four ways in which the concept of medical futility is used in contemporary health care, paying particular attention to the type of futility at issue in the respirator scenario. Subpart B discusses how the four concepts of medical futility evolved in response to recent economic incentives to limit life-sustaining treatments. Subpart C reviews the debate over the use of medical futility as a rationale for terminating or withholding treatment in cases such as the respirator scenario. Finally, subpart D discusses the unsettled legal status of this difficult and multi-faceted issue.

### *A. The Contemporary Concept of Medical Futility*

The term "medical futility" has several acceptable synonyms but no real definition. It refers generally to a "physician's conclusion that a therapy will be of no value to the patient and should not be prescribed."[12] As a limitation on the physician's duty to a patient, the notion that a physician has no duty to provide futile treatment is grounded in settled principles of negligence law.[13] Despite its familiar foundation, however, the concept of medical futility has never been explicitly relied upon in judicial decisions[14] or defined by statute.[15]

This lack of authority leaves physicians free to define what constitutes futile treatment on a case-by-case basis.[16] As a result, the concept of medical futility has a confusing array of meanings derived from varied clinical contexts. Despite this definitional confusion, it is

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12. Mordarski, *supra* note 1, at 755 (quoting Steven H. Miles, Medical Futility 1 (Jan. 11, 1992) (unpublished manuscript, on file with the *Cleveland State Law Review*)).

13. *See* Bonanno, *supra* note 9, at 166. This observation is based on the fact that the physician's duty of care is governed by the standard of reasonableness and the principle that truly futile care is per se unreasonable.

14. As shown in Part I, subpart D, the two leading cases of medical futility strain to avoid the merits of the issue. *See* Dzielak, *supra* note 8, at 755.

15. Bonanno, *supra* note 9, at 158 (noting the absence of statutory guidelines on medical futility "other than state-level 'do not resuscitate order' or 'advance medical directive' legislation").

16. *Id.*

clear that, as a means of limiting expenditures, medical futility is becoming increasingly important in contemporary health care.[17] The discussion below identifies four distinct applications of the concept of medical futility.

### 1. Physiological Futility

A treatment is physiologically futile when it "is clearly futile in achieving its physiological objective and so offers no physical benefit to the patient."[18] In the flu scenario, for example, my physician refused to prescribe antibiotics because doing so would not aid my recovery from the flu. As a rationale for withholding treatment, physiological futility is less troublesome than the "nonbeneficial treatment" rationale invoked in the respirator scenario.[19] Unlike this more extreme version of medical futility, physiological futility raises purely medical questions informed by clear treatment goals.[20]

### 2. Nonbeneficial Futility

The current debate owes most of its fervor to the frequent use of medical futility as a rationale for withholding or terminating life-sustaining treatments that are considered "nonbeneficial."[21] Although this version of medical futility recognizes that life-sustaining treatment may provide important physical benefits, it justifies withholding such treatment on the ground that the treatment is "nonbeneficial" in a holistic sense.[22] Consider the following example:

> A patient in a permanent vegetative state (PVS) who has renal failure will receive physiological benefit from dialysis treatments. However, these dialysis treatments will be non-beneficial to the patient as a person since the treatment will serve only to keep the biological organism alive and not ameliorate the cause of the PVS, nor enable him to regain consciousness.[23]

This is essentially the same argument advanced by my physician in the respirator scenario. Its validity depends on the troublesome question of whether life-sustaining treatment can ever be considered non-

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17. *See id.* at 158-60.

18. Mordarski, *supra* note 1, at 755 (quoting R.D. Truog et al., *The Problem with Futility*, 326 N. ENG. J. MED. 1560 (1992)).

19. *See id.* at 755-56.

20. *See id.*

21. *See id.* at 758.

22. *Id.*

23. *Id.* at 755-56 (citations omitted).

beneficial when the patient or the patient's family has expressed the contrary opinion.

A common objection to this type of futility is that it disguises value judgments about quality of life in the language of medical certainties.[24] The nonbeneficial treatment rationale is often used by physicians to write "do not resuscitate" (DNR) orders, withholding CPR from patients who are unlikely to live long enough to be discharged from the hospital.[25] In those cases, the conclusion that CPR is a nonbeneficial treatment is based on the fact that it buys the patient very little time. This kind of reasoning is problematic because it ignores more qualitative concerns: time acquired by virtue of CPR gives patients the chance to say good-bye to family and friends, to settle financial matters, or merely to live a little longer.[26] Even the shortest periods of added life may be of significant value to some patients.

### 3. Cost-Benefit Futility

Medical futility is used in a third sense to describe treatments that "are very unlikely to produce a desired physiologic or personal benefit."[27] Consider the example of a brain scan used to rule out the marginal possibility of brain cancer in a patient who suffers from tension headaches.[28] The use of a brain scan in this type of case is said to constitute futile treatment because the probability that the patient actually has cancer is extremely low.[29] Precisely how low this probability must be to justify withholding treatment, however, is arguably more a question of policy than medicine.

### 4. Cost-Probative Futility

The fourth clinical use of medical futility refers to nonvalidated treatments that show substantial promise.[30] This type of futility differs from the others because decisions to withhold nonvalidated treatments are made by third-party insurance carriers instead of physicians.[31] Even treatments deemed beneficial by physicians can

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24. *Id.* at 758-59.
25. *Id.* at 759-60.
26. *Id.*
27. *Id.* at 756 (quoting Steven H. Miles, Medical Futility 2 (Jan. 11, 1992) (unpublished manuscript, on file with the *Cleveland State Law Review*)).
28. *Id.*
29. *Id.*
30. *Id.*
31. *Id.* at 757.

be withheld under this version of futility.[32] This withholding is justified because of the additional expenses incurred with respect to nonvalidated treatments. These expenses exist because such treatments have not been thoroughly tested or have proven to be largely unsuccessful.[33] Insurance carriers will, therefore, refuse to pay for these nonvalidated treatments.[34] Decisions to withhold treatments under this rationale reflect purely financial, as opposed to medical, considerations.

### *B. From Humble Beginnings: The Conceptual Evolution of Medical Futility*

The concept of medical futility did not always cover so much ground. Before a case like the respirator scenario was even conceivable, the term "medical futility" was used innocuously to describe "an area requiring further research."[35] The discussion in subpart 1 below describes the process by which this rather inane concept grew into the expansive forms of futility just discussed. Subpart 2 explains the financial incentives that encouraged this growth.

#### 1. The Conceptual Expansion of Medical Futility

The four disparate forms of medical futility discussed above originated in the 1980s with the publication of several articles that documented the general ineffectiveness of CPR in specific patient groups.[36] In 1983, physician-commentator Dr. Susanna E. Bedell concluded that the low rate of "survival-to-discharge" for these groups reflected the serious limitations of CPR.[37] This line of argument was taken to its next logical step in 1987, when it was finally concluded that "[o]ffering CPR to [these patient groups] represented bad faith because doing so implied a potential for benefit when there was none."[38] This argument is the genesis of the current "nonbeneficial" concept of medical futility discussed above.[39]

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32. *Id.*
33. *Id.*
34. *Id.*
35. Taylor & Lantos, *supra* note 2, at 5.
36. *Id.*
37. *Id.* (citing Susanna E. Bedell et al., *Survival After Cardiopulmonary Resuscitation in the Hospital*, 309 NEW ENG. J. MED. 569, 575 (1983)).
38. *Id.* at 6 (quoting Leslie J. Blackhall, *Must We Always Use CPR?*, 317 NEW ENG. J. MED. 1281, 1284 (1987)).
39. *Id.*

Unlike the original use of the term that merely described the need for further research, the more expansive view of medical futility distilled from Dr. Leslie J. Blackhall's work provides actual justification for terminating or withholding any treatment so long as its burdens are deemed to outweigh its benefits.[40] The groundbreaking stature of this new concept of futility is apparent from the fact that, just ten years before the publication of Blackhall's work on CPR, the medical community had uniformly opposed the termination of life-sustaining treatments in all circumstances.[41] Under the pressure of changing financial realities, however, physicians were quick to adopt the new futility rationale.[42] Marching to the beat of Blackhall's drum, physicians began identifying situations in which "unilateral, physician-initiated treatment limitation policies" could be justified on futility grounds.[43]

Today, medical futility is often invoked to justify the termination and withholding of life-sustaining treatments when the burdens (i.e., the cost of treatment) are deemed to far outweigh the benefits (i.e., the resulting quality of life).[44]

### 2. From Cost-Based Reimbursement to Managed Care: The Economic Incentive for Expanding the Concept of Medical Futility

Hard financial realities encouraged the conceptual expansion of medical futility and are directly responsible for the increasingly important role the new concept plays in treatment limitation policies.[45] Shielded from the financial consequences of unlimited treatment expenditures by a system of cost-based reimbursement, physicians involved in the right-to-die litigation of the late 1970s asserted that the duty of care physicians owe to their patients required them to take whatever steps were necessary to preserve the lives of their patients.[46]

The transformation of health care financing from cost-based reimbursement to managed care, however, provided for the first time an economic incentive sufficient to overcome deeply rooted hesitations about limiting the use of life-sustaining treatments.[47] Although

40. *Id.* at 9.
41. *Id.* at 6-7.
42. *Id.*
43. *Id.* at 6.
44. *Id.* at 9.
45. *Id.* at 7.
46. *Id.* at 6.
47. *Id.* at 7.

health care costs had been rising faster than the rate of inflation for decades, the traditional "fee-for-service" payment system continued to reward providers for those increasing costs well into the 1980s.[48] The stark reality of limited resources became harder to ignore as the nation moved toward "prospective payment" systems, which shifted substantial costs from third-party insurance carriers to health care providers.[49] This changing economic landscape provided the necessary incentive to begin seriously discussing the possibility of rationing life-sustaining technology in accordance with cost-benefit criteria.

### C. *Opposing Views on Medical Futility: A Review of the Current Debate*

The debate over medical futility is about whether physicians should be required to honor the wishes of patients and family members regarding the use of life-sustaining treatment, even when doing so would offend the physician's professional judgment that providing such treatment is futile. The central policy arguments advanced in the debate over medical futility are reviewed below.

#### 1. Arguments Against the Use of Medical Futility as a Justification for Restricting the Use of Life-Sustaining Treatments

While the term "medical futility" suggests a scientific question (i.e., a medical question) with clear and certain results (i.e., futility), the foregoing discussion has shown that neither connotation is accurate. In referring to justifications for restricting the use of life-sustaining treatments, it would perhaps be more accurate to use a different term.[50] In cases where physicians seek to terminate or withhold life-sustaining treatments, some argue that the question is really more moral and economic than medical, and our attempts to answer it are too interwoven with "questions of values" to be properly characterized as determinations of "futility."[51]

Use of the term "medical futility" as a synonym for "economically inappropriate," it is argued, signals a dangerous expansion of the concept that threatens to damage physician integrity and subvert "attempts to develop ethically defensible systems for allocating scarce medical resources."[52] Even among commentators who acknowledge

48. *Id.*
49. *Id.*
50. *See id.* at 10.
51. Mordarski, *supra* note 1, at 758-59.
52. *See* Taylor & Lantos, *supra* note 2, at 12.

a need for "some kind of rationing" in cases like the respirator scenario, serious questions exist about the propriety of using the nebulous "beneficial treatment" standard as the touchstone for life-and-death treatment decisions.[53] Treating these difficult policy decisions as purely medical decisions is, for some critics, a subterfuge meant to disguise "the inevitable tragic choices that result from limited resources."[54]

2. Arguments in Support of Using Medical Futility as a Justification for Restricting the Use of Life-Sustaining Treatments

Proponents of "economically inappropriate" and "nonbeneficial" futility are far more concerned with the health care crisis that gave rise to the concept of medical futility than with definitional difficulties pointed out in the law reviews. While occasionally acknowledging that a more precise definition is desirable,[55] proponents of the new medical futility defend these admittedly "somewhat fuzzy"[56] formulations by referring to such realities as increased life expectancy and increasingly frequent calls for universal coverage.[57] The concept of medical futility provides, in their view, a necessary means of limiting the most extreme expenditures according to a neutral assessment of benefits and burdens.[58]

The chief proponent of medical futility, Dr. Steven Miles, is the physician who recommended termination of the ventilator treatment in *In re Wanglie*, the case upon which the respirator scenario is based. In making this recommendation, Dr. Miles believed that an "ethic of 'stewardship'" required him to balance the treatment's benefits to Mrs. Wanglie with its burdens to other members of the insurance pool.[59] Dr. Miles is critical of those who complain disparagingly about the subjectivity inherent in distinguishing the "beneficial" from the "nonbeneficial," arguing that

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53. *See, e.g., id.* at 10-12.

54. *Id.* at 11-12.

55. *See* Dzielak, *supra* note 8, at 760.

56. Steven Miles, *Futility and Medical Professionalism*, 25 SETON HALL L. REV. 873, 881 (1995).

57. Taylor & Lantos, *supra* note 2, at 10 ("It is inevitable, though rarely acknowledged, that some form of rationing will ultimately be necessary if we are to be able to afford universal health care.").

58. *See* Miles, *supra* note 56, at 880 (arguing that "a discretionary and prudential clinical authority to use medical futility is likely to be a social policy that on balance protects individuals from the arbitrary exercise of power").

59. Steven H. Miles, *Informed Demand for "Non-beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512, 514 (1991) [hereinafter Miles, *Informed Demand*].

> [i]t is an elite, academic sophistry (not practical, serious, civic, moral reflection) to equate years of respirator support for an anencephalic baby, cryogenic suspension of a person with untreatable pancreas cancer, or years of intensive care for an eighty-seven year old permanently unconscious, respirator dependent woman with the decisions about ordinary access to penicillin, vaccinations, or appendectomies, which are routinely used and widely recognized as beneficial.[60]

A "common sense of the purpose and good of health care" provides, according to Dr. Miles, a non-arbitrary basis for distinction, which critics are wrong to dismiss as overly subjective.[61]

Judges and legislatures are anything but eager to pit this utilitarian perspective against the more idealistic one voiced by opponents. Indeed, society as a whole appears reluctant to address the difficult questions raised by cases like the respirator scenario. Thus, it is not surprising that the law in this area is wholly unclear.

### *D. The Legal Status of Medical Futility: An Open Question*

In cases involving the withdrawal of life-sustaining treatments, no court has ever specifically decided whether physicians may unilaterally determine that a life-sustaining treatment is futile and, hence, outside the scope of the physician's duty to render reasonable care. Despite an abundance of seemingly relevant authority, the issue of medical futility has no precedent.

While the respirator scenario inevitably brings to mind right-to-die cases, the legal principles articulated there have little relevance to the issue of medical futility.[62] Ironically, the same is true of *In re Wanglie*[63] and *In re Baby K*,[64] two cases in which the issue of medical futility actually came before a court. In examining these two cases, the discussion below focuses on how each court strained to avoid confronting the futility issue.

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60. Miles, *supra* note 56, at 880.

61. *See id.*

62. The issue in right-to-die cases is the exact opposite of the issue in cases of medical futility. While the right to die requires physicians not to preserve a patient's life where he or she refuses treatment, cases of medical futility raise the issue of whether physicians should be required to provide life-sustaining treatment if the patient or patient's family insist that this be done. *See, e.g.*, Mordarski, *supra* note 1, at 761.

63. No. PX-91-283 (P. Ct., Hennepin County, Minn. 1991) *reprinted in* 7 ISSUES L. & MED. 369 (1991).

64. 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

### 1. *In re Wanglie*

*In re Wanglie (Wanglie)* is the 1990 seminal case of medical futility on which the respirator scenario is based. Although the case sparked a national debate over physician-initiated treatment limitations, the dispute was resolved in probate, so consideration of the futility issue was unnecessary.[65]

In *Wanglie*, health care providers at Minnesota General Hospital sought to terminate life-sustaining treatment for an elderly woman whose family demanded its continuation.[66] The patient, Mrs. Helga Wanglie, had suffered severe oxygen deprivation as a result of a heart attack, but remained physically alive in a permanent vegetative state.[67] Dr. Steven Miles, one of Mrs. Wanglie's physicians at the time, argued that providing life-sustaining treatment was futile because she had what was believed to be a negligible chance of recovery.[68] Mrs. Wanglie's family insisted that treatment continue on grounds of religious faith and a desire to "hope for the best."[69]

The hospital devised a two-step process to settle its conflict with the Wanglie family. First, it petitioned the Minnesota Probate Court to appoint an independent guardian charged with determining the propriety of continued treatment for Mrs. Wanglie.[70] Second, it agreed with the Wanglie family that if the guardian decided against continued treatment, a hearing would be held to determine whether the hospital had a legal duty to provide continued treatment.[71]

This last step proved unnecessary, however, because the probate court appointed Mrs. Wanglie's husband as guardian.[72] Disregarding contrary provisions of Minnesota law,[73] the court justified its appointment of Mr. Wanglie, stating that he was the one most qualified to

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65. Mordarski, *supra* note 1, at 763-64 (citing Ronald E. Cranford, *Helga Wanglie's Ventilator*, HASTINGS CENTER REP., July-Aug. 1991, at 23).

66. *Id.*

67. *Id.*

68. Miles, *Informed Demand*, *supra* note 59, at 513.

69. Ronald E. Cranford, *Helga Wanglie's Ventilator*, HASTINGS CENTER REP., July-Aug. 1991, at 23.

70. Mordarski, *supra* note 1, at 764.

71. *Id.*

72. *Id.*

73. Dzielak, *supra* note 8, at 752. Dzielak argues that, by appointing Mr. Wanglie as guardian, the court disregarded Minnesota's guardianship statute, Minn. Stat. § 144.651 (12) (Supp. 1989), which recognizes "that continued medical treatment does not always serve a patient's best interests." Dzielak, *supra* note 8, at 752 (quoting *In re* Torres, 357 N.W.2d 332, 339 (Minn. 1984)).

determine and protect his wife's best interests.[74] In that capacity, Mr. Wanglie demanded that his wife receive continued treatment.[75] Having resolved the dispute in probate, it was unnecessary for the *Wanglie* court to address the competing contentions of the parties about medical futility.

### 2. *In re Baby K*

In *In re Baby K (Baby K)*, the mother of an infant born with anencephally[76] demanded that the hospital provide mechanical ventilation when her baby had difficulty breathing.[77] The hospital argued that such treatment "would serve no therapeutic or palliative purpose" for Baby K, who, because of her condition, possessed no cognitive ability and was unable to see, hear, or feel pain.[78] Indeed, it was expected from the beginning that Baby K would die before the conclusion of the dispute.[79]

Because of its disagreement with Baby K's mother, the hospital tried to find another treatment facility that would accept Baby K.[80] However, when it became clear that no area facility was willing to assume such a costly treatment obligation, the hospital filed an action to determine whether it had a duty to provide emergency medical treatment that the hospital considered medically and ethically inappropriate.[81]

Like the *Wanglie* court, the court in *Baby K* never had to address the substantive question of medical futility. Applying a widely criticized construction of the Emergency Medical Treatment and Active Labor Act (EMTALA), the court reasoned that the hospital had to provide a ventilator because the breathing difficulty experienced by Baby K was an emergency medical condition under the statute.[82]

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74. Miles, *Informed Demand*, *supra* note 59, at 513.

75. *Id.*

76. In the words of the court:

> Anencephally is a congenital defect in which the brain stem is present but the cerebral cortex is rudimentary or absent. There is no treatment that will cure, correct, or ameliorate anencephally. Baby K is permanently unconscious and cannot hear or see. Lacking a cerebral function, Baby K does not feel pain.

*In re* Baby K, 832 F. Supp. 1022, 1025 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir.), *cert., denied*, 115 S. Ct. 91 (1994).

77. *Id.*

78. *Id.*

79. *Id.*

80. *See* Bonanno, *supra* note 9, at 164.

81. *Id.* at 161 (The hospital sought a declaratory judgment as to its duty to render medical care to Baby K.).

82. *In re* Baby K, 16 F.3d at 596.

The decision in *Baby K* is often faulted for ignoring legislative intent to limit the scope of the EMTALA to cases in which patients are denied emergency room treatment for lack of adequate insurance coverage or personal resources.[83] In this case, the hospital did not seek to deny treatment because Baby K lacked funds, but because her life expectancy was only a few days and the hospital believed that no available treatment could increase her quality of life.[84]

## II. HOW JUDGES DECIDE CASES

Despite their inevitable inaccuracies, stereotypes provide a helpful frame of reference for distinguishing between formalism and pragmatism, the two opposing methods of judicial decisionmaking discussed below. In American jurisprudence, the Formalist is perhaps best symbolized by the archetypal black-robed judge who carefully balances the scales of justice by "blinding" himself to nontextual, nondoctrinal policy concerns that are best left to the legislature. The Pragmatist, though less amenable to symbolization, can be thought of as the tweed-suited intellectual whose schooling in modern philosophy has convinced him or her that law and public policy cannot honestly be separated. Although these opposing images of the American judge reflect differences of opinion regarding the proper role of the courts, they also reflect more abstract differences concerning the limitations of logical reasoning.

In examining these disparate approaches, the discussion below provides the theoretical foundation necessary to show how tort law provides a better basis than constitutional law for deciding the issue of medical futility. This discussion has three subparts. Subpart A examines legal formalism, a method of judicial decisionmaking defined by its use of syllogistic reasoning. Subpart B examines legal pragmatism, an alternative to formalism which, as shown by example, differs from formalism by relying explicitly on inductive reasoning and policy analysis. Finally, subpart C explores the limits of legal formalism with respect to particular types of cases. This discussion is relied upon in Part III to show how using constitutional law to decide issues such as medical futility facilitates and encourages formalistic decisionmaking that avoids difficult social issues, while the use of tort law, by contrast,

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83. *See, e.g.*, Bonanno, *supra* note 9, at 167; Dzielak, *supra* note 8, at 756-57; *In re* Baby K, 16 F.3d at 598 (Sprouse, J., dissenting).

84. *See, e.g.*, Bonanno, *supra* note 9, at 167; Dzielak, *supra* note 8, at 756-57; *In re* Baby K, 16 F.3d at 598 (Sprouse, J., dissenting).

encourages and facilitates pragmatic decisionmaking and, ultimately, useful decisions that discuss the true bases for opinions.

### A. *Legal Formalism*

Legal formalism is defined, for purposes of this Comment, as the use of syllogistic reasoning in judicial decisionmaking.[85] The following discussion reviews the basic rules of syllogistic reasoning and provides an example of its use in judicial decisionmaking.

#### 1. Syllogistic Reasoning

As a form of deduction, syllogistic reasoning "draws out the implications of knowledge we already possess."[86] A syllogism has two premises (stated as "categorical sentences") and a conclusion.[87] By convention, the first premise, called the "major premise," contains the predicate of the conclusion, while the second premise, called the "minor premise," contains the subject of the conclusion.[88]

It is important to distinguish truth from validity. A syllogism is valid if the conclusion flows from the premises.[89] The validity of a syllogism, however, does not guarantee the truth of its conclusion. The conclusion of a valid syllogism is true only if, in addition, each premise is true.[90] In a valid syllogism, the truth of the two premises guarantees the truth of the conclusion.[91] Consider the following example:

P1 No Marxist advocates private property.
P2 All conservatives advocate private property.
C No conservative is a Marxist.[92]

This syllogism is valid because the conclusion flows from the premises. However, its validity does not guarantee the truth of its premises. What its validity does guarantee is that the truth of the conclusion cannot be denied if the truth of each premise is accepted.[93] Unlike

85. Richard A. Posner, *The Jurisprudence of Skepticism*, 86 MICH. L. REV. 827, 831 (1988).
86. DAVID KELLEY, THE ART OF REASONING WITH SYMBOLIC LOGIC 167 (1990).
87. *Id.*
88. *Id.* at 194.
89. Posner, *supra* note 85, at 833.
90. *Id.*
91. KELLEY, *supra* note 86, at 198.
92. *Id.* at 195.
93. "A valid argument can have false premises and/or a false conclusion. And an argument whose premises and conclusion are all true can nevertheless be invalid. The relationship between validity and truth is that a valid syllogism cannot have true premises and a false conclusion." *Id.*

"truth," which is determined with reference to "facts we already know," validity depends solely upon the "internal coherence of the argument" (i.e., the logical relevance of the premises to the conclusion).[94] The persuasive power of a valid syllogism is the fact that if the premises are true, the conclusion must necessarily be true as well.[95]

### 2. Legal Formalism Applied

Syllogistic arguments in law utilize the structure just outlined. The major premise in a legal syllogism contains the operative legal rule (e.g., "No contract is enforceable without consideration."), while the minor premise contains the application of that rule (e.g., "The contract in suit has no consideration.").[96]

Imagine a dispute involving a motion to dismiss for failure to state a claim, filed pursuant to Federal Rule of Civil Procedure (Fed. R. Civ. P.) 12(b)(6).[97] Assume that the defendant had previously filed a motion to dismiss for insufficient service of process and moves for a 12(b)(6) dismissal in her answer. In determining whether the defendant waived her 12(b)(6) claim by not raising it in her first motion, the judge would first look to Fed. R. Civ. P. 12(h)(2), which provides that motions to dismiss for failure to state a claim can be made "in any pleading permitted or ordered under Rule 7(a)." Turning, as directed, to Fed. R. Civ. P. 7(a), the judge would then discover that an answer is indeed an "ordered pleading."

Though a judicial opinion in this case would invariably lack the virtue of brevity, it would still look something like the following:

1. All motions to dismiss for failure to state a claim are permissible if permitted or ordered under Rule 7(a).
2. All answers are ordered pleadings under Rule 7(a).
3. Therefore, all answers are pleadings that may properly contain a motion to dismiss.[98]

The judge would therefore hold that the defendant may properly raise a 12(b)(6) motion in her answer.

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at 198.

94. *Id.* at 94.

95. *See* Posner, *supra* note 85, at 833.

96. *Id.* at 831.

97. This example is taken from JOSEPH W. GLANNON, CIVIL PROCEDURE: EXAMPLES AND EXPLANATIONS 281-84 (2d ed. 1992).

98. *See id.*

From a rhetorical perspective, this example highlights the graphic form of syllogistic reasoning.[99] The judge's holding seems indisputable because it appears in the first premise, which is a partial definition of the class of pleadings—those "ordered or permitted under Rule 7(a)"—in which a 12(b)(6) motion can be raised. Thus, we are convinced beyond doubt that any pleading taken from this class may, by definition, properly contain a motion to dismiss. Having established this, the second premise goes on to say, in effect, that all pleadings within this class have labels and that "answer" is one of those labels. As a result, when we remove our defendant's answer from this class, we know that it can properly contain a motion to dismiss: the only pleadings in this class bearing the label "answer" are those in which a 12(b)(6) motion can always be raised. The syllogistic structure of the opinion is assuring in that it leaves the impression that we are doing nothing more than "taking out what we put in."[100]

### *B. Legal Pragmatism*

The term "pragmatism," as used in this Comment, refers to the method of judicial decisionmaking advocated by the Practical Legal Studies (PLS) movement, the practitioners of which are hereinafter referred to as "Pragmatists." The following discussion reviews the jurisprudential philosophy of the PLS movement and provides an example of the pragmatic method of deciding cases.

#### 1. Practical Legal Studies

The PLS movement shares with its older cousin, Critical Legal Studies (CLS), certain core beliefs about the inherent limitations of using syllogistic reasoning to decide particular kinds of cases.[101] Like the CLS practitioners, or "Crits," Pragmatists reject "foundationalism"—legal theories that "posit one critical value and deduce 'right' answers to all cases from it"—as a legitimate method of legal reasoning.[102] Unlike the Crits, however, Pragmatists resist the conclusion that legal reasoning is, therefore, an indeterminate and angst-ridden

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99. Posner, *supra* note 85, at 830-31. The discussion in this paragraph borrows from Posner's graphic account of the persuasive power of syllogistic reasoning.

100. *Id.* at 831.

101. DANIEL A. FARBER ET AL., CONSTITUTIONAL LAW: THEMES FOR THE CONSTITUTION'S THIRD CENTURY 125 (1993).

102. *Id.*

process inseparable from mere politics.[103] Instead, Pragmatists argue that

> the complex "web of beliefs" in the legal interpretive community, if approached with an open mind and a sensitivity to the situation under litigation, provide both a constraining influence (lessening the fear of tyranny by the judiciary) and a way to liberate us from a tyranny by the majority.[104]

No longer searching for "the right answer" promised by foundationalist theories, Pragmatists look instead for the "best answer available."[105]

The PLS approach to judicial decisionmaking contradicts the formalist conception of legal reasoning as a distinct, policy-neutral form of deductive reasoning.[106] It represents an "eclectic—but by no means unfamiliar—methodolog[y]," which Pragmatists call "practical reason."[107] Included in this "grab bag" methodology are

> anecdote, introspection, imagination, common sense, intuition (due apparently to how the brain structures perceptions, so that, for example, we ascribe causal significance to acts without being able to observe - we never do observe - causality), empathy, imputation of motives, speaker's authority, metaphor, analogy, precedent, custom, memory, "induction" (the expectation of regularities, related both to intuition and analogy), [and] "experience."[108]

Such a broad litany of nonlegal concerns may appear too subjective to form the proper basis of judicial, as opposed to legislative, decision-making. Pragmatists argue, however, that this type of reasoning offers a "non-arbitrary" means of deciding cases[109] subject to the internal constraints of the common law method and to the external constraints imposed by prevailing ideologies.[110]

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103. *Id.*; *see also* Jay M. Feinman, *Practical Legal Studies and Critical Legal Studies*, 87 MICH. L. REV. 724, 725 (1988).

104. FARBER, *supra* note 101, at 125.

105. *Id.* at 126.

106. *See* Posner, *supra* note 85, at 838; *see also* Daniel A. Farber & Philip P. Frickey, *Practical Reason and the First Amendment*, 34 UCLA L. REV. 1615, 1646 (1987) (defining the fundamental characteristics of this approach as "a concern for history and context; a desire to avoid abstracting away the human component in judicial decisionmaking; an appreciation of the complexity of life; some faith in dialogue and deliberation; a tolerance for ambiguity, accommodation, and tentativeness, but a skepticism of rigid dichotomies; and an overall humility").

107. FARBER, *supra* note 101, at 126.

108. Posner, *supra* note 85, at 838.

109. FARBER, *supra* note 101, at 126-27.

110. *Id.* at 125; *see also* Posner, *supra* note 85, at 834-35.

While this methodology of practical reason contradicts the policy-neutral, formalistic approach used in the motion-to-dismiss case, Part III of this Comment will show that the formalistic approach erroneously and unreflectively presumes that all cases can be decided through syllogistic reasoning. Before taking up this point, however, it is helpful to consider the following historic example of pragmatic decisionmaking.

### 2. An Application of Legal Pragmatism

Consider the Supreme Court's landmark decision in *Brown v. Board of Education*.[111] Although few would quibble with the "correctness" of this decision, its ultimate justification lies not in constitutional text or doctrine, but in fundamental policy considerations that are outside the realm of legitimate foundationalist concerns.[112] After all, the language of the Equal Protection Clause is "not obviously incompatible with a system of segregated schools."[113] Nor, for that matter, did the Framers of the Fourteenth Amendment actually intend "to bring about true equality between whites and blacks."[114] Finding nothing in the constitutional text or history that required the holding in *Brown*, Judge Richard A. Posner argues that

> the ultimate justification for the *Brown* decision must be sought not in technical legal materials but in such political and ethical desiderata as improving the positions of blacks; adopting a principle of racial (and implicitly also religious and ethnic) equality to vindicate the ideals for which World War II had recently been fought; raising public consciousness about racial injustice; promoting social peace through racial harmony; eradicating an institution that was an embarrassment to America's foreign policy; reducing the social and political autonomy of the South ("completing the work of the Civil War"); finding a new institutional role for the Supreme Court to replace the discredited one of protecting economic liberty; breathing new life into the equal protection clause.[115]

That such factors played a role in the *Brown* decision seems too obvious to mention.

When cases are decided under foundational doctrines like the Equal Protection Clause, however, explicit consideration of policy

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111. 347 U.S. 483 (1954).
112. *See* FARBER, *supra* note 101, at 126.
113. RICHARD A. POSNER, THE PROBLEMS OF JURISPRUDENCE 303 (1990).
114. *Id.*
115. *Id.* at 304 (footnote omitted).

matters like these becomes inconsistent with the neutral act of doctrinal interpretation. However, because the Equal Protection Clause provides no explicit guidance on the issue of segregated schooling, an honest decision in *Brown* would have been impossible without reference to basic tenants of public policy.

### *C. How Views Collide: Easy vs. Hard Cases*

This Comment adopts the position of the PLS movement that there are two types of cases, "easy cases" and "hard cases," and that only the former are appropriately decided under the formalistic method.[116] The discussion below shows that cases of medical futility are "hard cases" and argues accordingly that the issue of medical futility should be decided pragmatically.

The distinction between "hard" and "easy" cases is critical to understanding the limitations of the formalistic method. An easy case is one where the applicable law is clear; a hard case, on the other hand, is one in which a number of rules could arguably be applied.[117] The motion-to-dismiss example discussed above is an easy case because the Federal Rules of Civil Procedure are unquestionably applicable. Conversely, *Wanglie* and *Baby K* are hard cases because any number of legal doctrines could conceivably be invoked to decide the issue of medical futility.[118]

Only clearly applicable rules can be "true" in the sense that the premises of a valid syllogism must be true.[119] If, for example, the judge in our motion-to-dismiss case could have chosen to apply a principle of estoppel to bar the defendant's motion, we would be uncertain that the decision in that case was anything more than the judge's personal, albeit quite defensible, policy preference. Because the major premise would be grounded in judicial discretion instead of

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116. *See* Posner, *supra* note 85, at 832-35. Although not employed by Posner, these terms are used here for convenient reference to distinctions made by Posner.

117. *Id.* at 833.

118. Because medical futility is an issue of first impression, courts could choose to resolve the issue under constitutional or tort law, or under an applicable statute. *See* Mordarski, *supra* note 1, at 765-77 (discussing a variety of potential tort and constitutional approaches available to courts confronted with the issue of medical futility); *see also* James A. Gardner, *The Ambiguity of Legal Dreams: A Communitarian Defense of Judicial Restraint*, 71 N.C. L. REV. 805, 808-27 (1993) (discussing the discretionary nature of the rationales invoked by courts in deciding whether to resolve issues under constitutional law and the philosophical and practical difficulties of these rationales). Innumerable opportunities for further discretion exist because each of these areas has its own doctrines (e.g., substantive due process, res ipsa loquitur, various maxims of statutory construction).

119. *See* Posner, *supra* note 85, at 833-34.

binding rules, we would be left with the impression that the formalistic structure of the opinion was something of a sham, leaving the real basis of the decision unstated. Thus, syllogistic reasoning is an intellectually honest basis of decision only in easy cases.[120]

In cases involving constitutional law, rules are largely the product of judicial imagination and, hence, cannot be true in the same way that Fed. R. Civ. P. 12(h)(2) is true in our motion-to-dismiss example.[121] The process of deciding which legal rules or interpretations of those rules to apply in hard cases, though not without articulable limits, is not a deductive one.[122] In deciding common law and constitutional issues, for example, judges "will often refuse to reexamine legal rules, but the reasons for their refusal need have nothing to do with logic; stare decisis is not a rule of logic."[123]

Similarly, where a legal rule is statutory, as opposed to judge-made, the interpretive process, which is often required to give effect to such rules, involves far more than simple deduction.[124] Antitrust law, for example, has changed dramatically in the past century despite only minor changes in the Sherman Act itself.[125] These new interpretations "can be given syllogistic form but [their] nature is not syllogistic, and attempts to make it appear so show merely that judges exaggerate the role of logic in legal reasoning."[126]

## III. ANALYSIS

As discussed in Part I of this Comment, the issue of medical futility is a complex and multi-faceted one with no clearly applicable precedent. The methods of formalistic and pragmatic decisionmaking, as outlined in Part II of this Comment, are relevant to show why

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120. *Id.*

> Some unwarranted invocations of logic may seem transparently and harmlessly rhetorical, as when a judge says that it would be "illogical" to read a statute requiring periodic safety inspections of motor vehicles to exclude jeeps. But it is not a completely harmless locution. Logic has nothing to do with the problem, and judges who do not realize this may fail to interpret rules properly. Although the dictionary defines a jeep as a motor vehicle, the issue for the judge is what the legislature meant, and dictionary meanings are just evidence of that meaning. The interpretive issue can be given syllogistic form but its nature is not syllogistic, and attempts to make it appear so show merely that judges exaggerate the role of logic in legal reasoning.

*Id.* at 832.

121. *Id.* at 833.

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.* at 835.

126. *Id.* at 832.

courts should decide the issue of medical futility under tort principles rather than under constitutional doctrine.

Subpart A, below, analyzes two leading constitutional rights cases to show how the doctrinal focus of constitutional law results in a formalistic approach that allows judges to easily ignore significant and ideologically troublesome questions. Subpart B argues that, in contrast to constitutional doctrine, the elements of common law tort provide a viable framework for pragmatically deciding the issue of medical futility.

### *A. Constitutional Formalism*

Constitutional decisions in socially volatile cases tend to be formalistic. As shown below, important policy questions in these types of cases are often treated as nonexistent because the foundational theories on which constitutional law is based make their consideration unnecessary. It is important to note, however, that constitutional law itself is not to blame. Rather, it is the syllogistic structure of the opinions in these cases that accounts for the ease with which judges can avoid such important policy questions.

The Supreme Court's reasoning in *Roe v. Wade*[127] and *Bowers v. Hardwick*[128] illustrate this phenomenon. Although the issues in these cases are markedly different than the issue of medical futility, two considerations make them relevant for present purposes. First, it is the structure of judicial reasoning in each case, not the factual aspect of the issues, that make these decisions formalistic. Because a constitutional approach to medical futility would likely rest on doctrines like substantive due process or the right to privacy, *Roe* and *Bowers* are the best cases at which to look in trying to envision a constitutional decision of the medical futility issue. Second, the issues in *Roe* and *Bowers* rival the level of controversy generated by the debate over medical futility: like sexuality and child bearing, death is an extremely private experience.

#### 1. *Roe v. Wade*

The Court in *Roe* invalidated as unconstitutional a statute criminalizing abortion at any stage of pregnancy except to save the life of the mother.[129] Absent from the Court's opinion, however, is any genuine consideration of whether a fetus is a "life" deserving of the

127. 410 U.S. 113 (1973).
128. 478 U.S. 186 (1986).
129. 410 U.S. at 154.

same constitutional protections as individuals already born. One need not disagree with the holding in *Roe* to see how its formalistic approach makes consideration of this most controversial question unnecessary. The Court's reasoning was as follows:

P1 All rights "implicit in the concept of ordered liberty" are protected rights to privacy under the Constitution.[130]

P2 A right to choose abortion of a nonviable fetus is a right "implicit in the concept of ordered liberty."[131]

C Therefore, a woman's right to an abortion is a constitutionally protected right to privacy.[132]

At first, this explication of the *Roe* opinion seems overly simplistic. Given the lengthy historical discussion of abortion presented by Justice Blackmun,[133] the decision in *Roe* would appear to rest on far more than a simple syllogism.

The decision in *Roe*, however, rests solely on the "ordered liberty" concept of due process announced in *Palko v. Connecticut*,[134] and thus makes the volatile question of whether a fetus is a life legally irrelevant.[135] While the application of the *Palko* rule is buttressed by careful examination of both ancient and contemporary views on abortion, the decision to restrict the constitutional meaning of "person" to include only postnatal human life lacks a clear foundation.[136] The

130. *Id.* at 152.

131. *Id.* at 154.

132. *Id.*

133. *Id.* at 129-47.

134. 302 U.S. 319 (1937).

135. This difficult ethical and scientific question—one that is a cornerstone of public debate over abortion—is unnecessary to confront under Justice Blackmun's historical approach to "ordered liberty" analysis because it focuses on the legal history of abortion, not the volatile questions of public debate. Justice Blackmun's historical approach is clear throughout the majority opinion, most notably when he reaches the conclusion that "at common law, at the time of the adoption of our Constitution, and throughout the major portion of the 19th century, abortion was viewed with less disfavor than under most [statutes in effect at the time *Roe* was decided]." *Roe*, 410 U.S. at 140. By observing how this approach made considerations of the most controversial dimensions of the abortion issue unnecessary, this Comment does not suggest this approach was necessarily the wrong one for the Court to follow. Instead, the focus here is solely on the implications of approaching medical futility in this manner. Unlike the abortion issue, medical futility is a new and seldom discussed issue, which no legislature has explicitly addressed. It is thus arguably more important with medical futility than with abortion that a judicial decision on the issue have the effect of opening our eyes.

136. In defining person to mean only postnatal life, the Court looked to how the word was used in § 1 of the Fourteenth Amendment; in the Due Process and Equal Protection Clauses; in the listing of qualifications to hold legislative office, art. I, § 2, cl. 2, and § 3, cl. 3; in the Apportionment Clause, art. 1, § 2, cl. 3; in the Migration and Importation provision, art. I, § 9,

Court's argument that this limited view is required by the various uses of the word "person" throughout the Constitution[137] is specious. In contrast to this narrow view, the opinion in *Brown v. Board of Education* employed a broad reading of the constitutional text that accounted for modern conceptions of equality,[138] even when those conceptions were perhaps at odds with the original intent of the Framers.[139] Thus, the strict approach taken by the *Roe* Court in defining "person" represents nothing more than the choice of one method of constitutional construction over another equally valid method.

Freed from the task of deciding when life begins by its application of the *Palko* rule, the Court was able to decide *Roe* according to the familiar pattern of other privacy rights cases,[140] the pattern represented by the above syllogism. Although the Court's decision to employ this method was not *required* by the Constitution, compared to a rule that narrowly defines person, the settled principle of "ordered liberty" on which the Court's decision rests is less discretionary. Regardless of how well settled this principle is, however, it cannot be syllogistically true in the same way that the premise "all answers are ordered pleadings under Rule 7(a)" was true in the motion-to-dismiss example in Part II. The Court in *Roe* was, after all, free to announce a new test to be used in deciding fundamental rights cases. The fact that "stare decisis" or other maxims of judicial policy can be used to support the continued application of the "ordered liberty" test makes it a defensible rule, but not a "true" one in the sense that Rule 7(a) is the true rule for judges to apply in deciding procedural disputes.

### 2. *Bowers v. Hardwick*

The issue in *Bowers v. Hardwick*[141] was whether a Georgia statute criminalizing sodomy violated the fundamental rights of homosexuals.[142] In a five-to-four decision, the Supreme Court held that the Georgia statute did not violate the fundamental rights of

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cl. 1; in the Emolument Clause, art. 1, § 9, cl. 8; and in several other provisions. *Roe*, 410 U.S. at 157.

137. *Id.* at 158.

138. *See supra* note 114 and accompanying text.

139. *See supra* note 111 and accompanying text.

140. *See, e.g.*, Griswold v. Connecticut, 381 U.S. 479, 484-85 (1965); Loving v. Virginia, 388 U.S. 1, 12 (1967); Skinner v. Oklahoma, 316 U.S. 535, 541-42 (1942).

141. 478 U.S. 186 (1986).

142. *Id.* at 187-88. The Georgia statute at issue was Ga. Code Ann. § 16-6-2 (1984).

homosexuals because the Constitution does not confer a fundamental right upon homosexuals to engage in sodomy.[143] The syllogism upon which the Court's holding rested was as follows:

P1 All rights protected under the Due Process Clause of the Constitution are rights so "implicit in the concept of ordered liberty" that "neither liberty or justice would exist if [those rights] were sacrificed."[144]

P2 A right to homosexual sodomy is not a right so "implicit in the concept of ordered liberty" such that "neither liberty or justice would exist" in its absence.[145]

C Therefore, the rights protected by the Due Process Clause do not include a right to homosexual sodomy.[146]

The major premise (P1)—the *Palko v. Connecticut* formulation of "ordered liberty"[147]—is the law of the case, and its validity is presumed. The fact-specific minor premise (P2), which appears to be a mere application of P1, is supported by the Court's discussion of this country's historical proscription against homosexual sodomy.[148]

The problem with this syllogism is not its logical validity (clearly, the premises require the conclusion), but rather the fact that its premises cannot be labeled true or false in any meaningful sense. Recall that in a valid syllogism, the truth of the premises guarantees the truth of the conclusion.[149] In the *Bowers* syllogism, therefore, the truth of P1 and P2 is required for the conclusion to be true. But who is to say whether the "ordered liberty" concept of due process is indeed the "true" one? While the obvious answer—the Supreme Court!—is right in a pejorative sense, it does nothing to explain the logical basis of the holding in *Bowers*. The rule that only rights implicit in the concept of ordered liberty are protected by due process cannot be true in the same way that the premises in a valid syllogism are true. If, as in *Bowers*, the legal rule expressed in the major premise—the *Palko* rule—is a mere application of stare decisis, the conclusion is not "true" in the sense that it is logically required by the premises. Instead, the conclusion is "true" only insofar as the judge's decision to adhere to

143. *Bowers*, 478 U.S. at 192-93.
144. *Id.* at 191-92.
145. *Id.*
146. *Id.* at 192.
147. *See supra* note 133 and accompanying text.
148. *See Bowers*, 478 U.S. at 192-93 (providing historical background of state sodomy laws).
149. *See supra* note 91 and accompanying text.

stare decisis is "correct." Such reasoning is illusory: the form promises a conclusion deduced from true premises, but the conclusion offered is instead merely a defensible exercise of judicial discretion.

Only by assuming that the "ordered liberty" test applies does the *Bowers* Court avoid addressing the difficult questions that non-judges would surely ask in deciding whether laws against homosexual practices are constitutional. Writing for the majority, Justice White pays lip service to general principles of judicial restraint,[150] but he does not explain the stringent application of these principles in light of their more relaxed role in other landmark decisions involving fundamental rights. While arguments about the limited role of the judiciary are not necessarily without merit, they do not make *Palko* "true" in the sense that the Federal Rules were true in the civil procedure case discussed earlier.

The Court's formalistic approach enabled it to ignore the socially divisive issues that come to mind in considering whether constitutional protections should be extended to include a right to engage in sexual relations with members of the same sex. These issues include obvious questions, such as whether recognizing a right to engage in homosexual activity would undermine traditional family structures or, on the other end of the ideological spectrum, whether such a right would in fact enhance these structures by reducing the ill effects of pervasive social stigma.[151] These policy questions are irrelevant under Justice White's formalistic approach, however, because the decision to apply a narrow, historically based reading of *Palko* effectively disposes of the case. The discretionary nature of this decision is apparent when we recall that in *Brown* the Court opted for a broader and less historically based reading of the Due Process Clause.[152]

The absence of demonstrably true premises in both *Bowers* and *Roe* is problematic not because logic is the only acceptable basis for the decision, but because *the structure of the decision purports to rest on logic*. Because it offers judges numerous doctrinal bases for avoiding tough decisions, the federal constitution is an easy thing to hide behind. Like the issues of abortion and homosexual sodomy, medical futility is not directly addressed in the Constitution. Neither does the Constitution *require* the "ordered liberty" concept of due process. Thus, any decision to make the difficult questions raised by the issue

150. *Bowers*, 478 U.S. at 191-92, 194-95.

151. *See, e.g.*, Beverly Balos, Book Review, 8 CONST. COMMENTARY 317, 319 (1991).

152. *See supra* note 114 and accompanying text.

legally irrelevant can reflect nothing more than a desire to avoid confronting them.

### B. *Pragmatism and the Elements of a Tort*

Judges have considerable discretion in choosing the legal doctrine to be used in deciding the issue of medical futility.[153] Three considerations support the argument that this discretion should be exercised in favor of deciding medical futility under common law tort principles. First, the elements of a tort—duty, breach, causation, and damage[154]—do more to encompass the kinds of difficult policy questions raised by the issue of medical futility than the confined discussion of history on which the opinions in *Roe* and *Bowers* purportedly rest.

Second, the discussion about duty of care that a tort approach would require is exactly the sort of discussion that is needed in the area of medical futility. As discussed in Part I, legislators and judges alike have avoided confronting this issue at the expense of certainty in a vital area of medical rights. A judicial decision on whether a physician has a duty to provide life-sustaining treatment in cases of medical futility if the treatment does not comport with the standards of reasonableness would invariably generate the discourse needed to trigger legislative response.

In contrast, constitutional pronouncements are not as effective in generating discourse because the process of constitutional interpretation is commonly viewed as something completely distinct from other policy-based decisions.[155] This sense of reverence for constitutional pronouncements often chills legislative action as to social issues entwined with constitutionally based decisions.

Similarly, it may seem less shocking to say that the Constitution does or does not support a right to medically futile treatment than to say whether or not such a right is reasonable. But we should be shocked by the questions raised by the current practice of terminating and withholding life-sustaining medical treatments on the ground that they are "nonbeneficial" and hence "medically futile." While it is true

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153. *See supra* note 119 and accompanying text. Although the discretion to apply tort law would not exist if the parties before the court failed to assert tortious arguments, this Comment is premised on the view that, in the age of liberal pleading, parties to a futility dispute would surely assert both constitutional and common law tort arguments.

154. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 164 (5th ed. 1984).

155. *See, e.g.*, Gardner, *supra* note 118, at 833-37 (discussing how, more than any other type of case, constitutional cases pit disparate social visions against each other).

that constitutional pronouncements pit disparate social visions against one another more than any other legal ruling,[156] constitutional decisions tend to moot the crucial questions on which these visions so sharply differ.[157] The medical futility issue involves complex economic and moral questions about resource allocation, as well as questions about the limits of physician authority.[158] To ensure that these crucial questions are not ignored as the similarly tough questions were in *Roe* and *Bowers*, courts should decide the issue of medical futility under tort principles. Although the use of tort principles would be no guarantee that these questions would be openly confronted, tort law's overarching focus on reasonableness will do more to keep these types of questions central than the doctrinal focus commonly used in constitutional decisions of similarly volatile issues.[159]

Finally, tort law is less conducive to legal formalism than is constitutional law. While interpretations of constitutional text and doctrine easily take the form of rules (e.g., the "ordered liberty test" used in *Roe* and *Bowers*) that can be stated as syllogistic premises,[160] articulations of what is reasonable tend to be more context specific and, thus, less easily stated as general propositions. In *Helling v. Carey*,[161] for example, the Washington Supreme Court held that "reasonable prudence" required ophthalmologists to administer a simple, inexpensive glaucoma test to all patients regardless of their age.[162] Although the issue raised in *Helling*—the standard of care for ophthalmologists—is not nearly as controversial as the issue of medical futility, the policy considerations the court used in deciding it illustrate how tort law makes such considerations central to legal analysis.[163] Similarly, in the classic case of *The T.J. Hooper*,[164] Judge Learned Hand applied

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156. *See id.* at 841-43 (arguing that the only genuine basis for the policy of constitutional restraint—refusing to decide an issue under the Constitution where other grounds exist—is that the Constitution is seen as embodying "fundamental values," thus giving constitutional decisions the inevitable effect of privileging one social vision over another).

157. *See supra* notes 136, 152 and accompanying text.

158. *See supra* notes 10, 51 and accompanying text.

159. This Comment does not take the position that courts are better suited than legislative bodies to make policy-based decisions, but rather seeks to show that policy-neutral decisionmaking is, in some cases, incompatible with intellectually honest decisionmaking. *See supra* note 121. The position taken here is simply that, as far as the issue of medical futility is concerned, the cost of sacrificing honesty for neutrality is unacceptable.

160. *See supra* notes 131, 132, 145, 146 and accompanying text.

161. 83 Wash. 2d 514, 519 P.2d 981 (1974).

162. *Id.* at 519, 519 P.2d at 983.

163. The *Helling* court grounded its holding on the test's minimal cost, overall effectiveness, and considerable preventative benefits. *Id.* at 518, 519 P.2d at 983.

164. 60 F.2d 737 (2d Cir.), *cert. denied*, 287 U.S. 662 (1932).

cost-benefit analysis in holding that the standard of care for tugboat masters required them to equip their tugs with radios.[165] Like the decision in *Helling*, the decision in *The T.J. Hooper* illustrates how tort law's focus on determining reasonableness encourages nonformalistic decisionmaking that takes account of practical questions.

When courts free themselves from explaining the bases of discretionary rules by using such rules as syllogistic premises, however, the resulting conclusion is not only logically invalid, it is intellectually dishonest.[166] The process of interpreting and applying legal rules in hard cases is not a simple deductive one;[167] to pretend that it is by framing common law and constitutional rules as syllogistic premises leaves the real bases of decision in these cases unstated. In medical futility cases, the potential ramifications of either permitting or denying physicians the authority to terminate life-sustaining treatments are too severe to indulge in this deception any longer, however comforting it may be.

A variety of existing common law torts could be updated to address the issue of medical futility.[168] For example, a negligence model would require proof of the following three elements: (1) the existence of a legal duty to the person harmed; (2) the breach of that duty by the defendant; and (3) damage to the plaintiff caused by the breach.[169] "In a case in which a patient is dependent on a life support system, the physician would have a duty to act as a reasonable physician would act in dealing with that patient."[170] Where the physician terminates life support against the wishes of the family, proof by the family that the physician's decision was unreasonable would show that the physician breached his or her "duty to the patient to act with due care, and that [the] breach was the proximate cause of the plaintiff's death."[171] If the decision was also shown to be reckless, the physician could be liable for punitive damages in addition to compensatory damages for wrongful death.[172]

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165. *See id.* at 739.
166. *See supra* note 121 and accompanying text.
167. *See supra* note 121 and accompanying text.
168. Mordarski, *supra* note 1, at 765-71.
169. *Id.* at 766.
170. *Id.* at 763.
171. *Id.* at 765.
172. *Id.*

## IV. CONCLUSION

Medical futility is a complex issue that implicates profound moral, ethical, and economic questions. When a physician concludes that a life-sustaining treatment is medically futile, he or she may seek to terminate such treatment regardless of the wishes of the patient or the patient's family. Although the connotations of the term "medical futility" are clinical and scientific, a determination that life-sustaining treatments should be withheld or terminated represents a policy decision, not a medical decision.

In deciding the issue of medical futility, judges should choose a legal framework that allows their decision to center on the difficult moral, ethical, and economic questions inherent in the issue. As shown in Part II, issues of policy cannot honestly be separated from issues of law in hard cases. While applying a formalistic constitutional model, as was applied in *Roe* and *Bowers*, would likely limit judicial inquiry to whether an absolute duty to preserve life at all costs is required by the nebulous concept of "ordered liberty," use of a tort model would encourage judges and legislatures to honestly confront the difficult policy questions that medical futility raises. As shown in Part III, tort law's overarching focus on reasonableness keeps these types of questions central, while the formalistic model common to constitutional decisions makes such questions legally irrelevant.

There is currently no statutory or decisional law addressing the issue of medical futility. Society in general, and public officials in particular, are reluctant to directly confront this increasingly important and problematic issue. For this reason, it is especially important that courts decide the issue of medical futility in a manner that deals directly with the troublesome questions that are so tempting to avoid. Asking whether it is reasonable for physicians to terminate or withhold life-sustaining treatments is more consistent with this goal than asking whether such a practice is constitutional.