

Doc Knows Best
It'll be too late for you, if he's wrong.
By Wesley J. Smith, January 6, 2003

Who should have the right to decide whether you receive life-sustaining medical during a critical or terminal illness? Most would say with great confidence, "Me. Or, if I am unable to decide, then my family."

That should be true. Indeed, it used to be true. But in a growing number of hospitals, your right-to-decide is being taken away from you (or your family) by bioethicists and members of the medical intelligentsia who believe that *their* values and priorities should count more than yours when determining whether you shall receive wanted medical treatment. To put it bluntly, even if you *want* to live, even if you *want* medical treatment to enable you to fight for your life, you may be told that the hospital reserves the right to refuse service.

Welcome to the world of "futile-care theory," one of the hottest and most-dangerous topics in contemporary bioethics. While you may never have heard of it, stories about the spread of futile-care theory are rife throughout medical and bioethics literature, reported and argued about in such influential publications as *The Journal of the American Medical Association*, *The New England Journal of Medicine*, and *The Hastings Center Report*.

Unfortunately, few people read these highbrow publications. Worse, despite being a bombshell story, this growing threat has mostly been ignored by the popular media.

This better change fast. As you read these words, quietly, slowly, inexorably, mostly behind the closed doors of hospital ethics committees, "futile care" or "inappropriate care" protocols are being put into place in hospitals throughout the country. The first time most patients and their families become aware that doctors are being given the right to say "no" to wanted medical treatment (other than comfort care) is during a medical crisis when they are at their most defenseless and vulnerable.

Hospitals in Des Moines, Iowa, appear to be the latest institutions to stealthily adopt futile-care policies. As reported by the January 2, 2003, *Cedar Calls Courier*, some area hospitals now have rules in place that permit "medical staff to withdraw treatment over a family's objection." True, when there is a dispute, families and patients have a right to a hearing in front of a hospital ethics committee. But that isn't much solace. Such committees could easily become more stacked decks than dispassionate decision makers, mostly comprised of well-meaning people who either are part of the institutional culture or who have been trained to believe that futile-care theory is the right thing to do.

According to the *Courier* report, if patients lose the right to receive treatment in the ethics committee, they have two choices. First, they can find another hospital. But this would be no easy task given that patients refused treatment are likely to be the most expensive to care for. With the coming of HMOs, and the Medicare Diagnosis Related Group (DRG) capitated payment system, hospitals now generally lose money on patients requiring intensive or extended care. Thus, getting another hospital to accept a patient that a current hospital doesn't want to treat anymore may be a near impossible task.

That leaves the courts and filing a lawsuit to force the hospital to sustain the patient's life. That could work, but it is no sure bet. There have been lawsuits filed in various parts of the country over refused treatment, but the results have gone both ways. Moreover, no definitive case has yet been litigated to the appeals court stage. Thus, there are no legal precedents governing the legality or permissible scope of these quickly spreading futile-care policies.

But even though a lawsuit could be successful in theory, it might very well prove utterly impracticable to pursue. These are not the kind of cases that lawyers accept on a contingency basis. This means that if you try to legally force a hospital to continue treatment, you would probably have to pay your lawyer by the hour. Lawyers often charge hundreds of dollars an hour, meaning that a fully litigated case, even without appeals, could cost literally tens, if not hundreds of thousands of dollars.

On the other hand, having very deep pockets, the hospital administration would not be concerned in the least about the cost of their lawyers. If fully unleashed, the hospital's corporate lawyers could file enough motions, take enough depositions, and pursue every possible appeal, to the point that you, quite literally, could litigate yourself into bankruptcy.

Beyond the financial impracticalities of suing a hospital, one of the primary reasons for crafting futile-care protocols has been to improve the chance that the hospital would prevail in court. Indeed, an article in the Fall 2000 *Cambridge Quarterly of Health Care Ethics* explicitly advised hospital bioethicists to put these protocols in place as a way to prepare for the litigation bioethicists presume would be filed by people furious at having wanted medical treatment refused. As the authors of *The Cambridge Quarterly* article opined, "Hospitals are likely to find the legal system willing (and even eager) to defer to well-defined and procedurally scrupulous processes for internal resolution of futility disputes."

Nobody knows just how many hospitals have adopted these protocols, or where they have been put in place. But if the professional literature is to be believed, futile-care theory is spreading quickly. The *Cambridge Quarterly* article cited above found that 24 out of 26 surveyed hospitals in

California had such policies in place and that of these; only seven left the final decision to the patient or family. I have read about policies being adopted by some hospitals in Houston, Philadelphia, and Detroit, just to mention a few.

It used to be that people were afraid of being hooked up to machines when they wanted nothing more than to go home and die a peaceful, natural death. The early bioethics movement deserves great thanks for helping do away with that form of abuse by pointing out that patient autonomy means the right to say no to unwanted interventions.

But that was before the bioethics movement largely abandoned the sanctity of life ethic for an express or implicit utilitarianism that views the value of human life through a distorting prism of "quality." That was before most bioethicists came to believe that health-care rationing should be imposed.

Now, a new medical hegemony is arising, one that proclaims the right to declare which of us have lives worth living and therefore worth treating medically, and which of us do not. In essence, what is being created in front of our very eyes (if we would only see) is a duty to die. Unless people object strongly and legislatures take active steps to intervene, this new and deadly game of "Doctor Knows Best" will be coming soon to a hospital near you.

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