

Oklahoma Law Review

Volume 68 | Number 3

2016

Live and Let Die: The Consequences of Oklahoma's Nondiscrimination in Treatment Act

Kendra Norman

Follow this and additional works at: <https://digitalcommons.law.ou.edu/olr>



Part of the [Medical Jurisprudence Commons](#)

Recommended Citation

Kendra Norman, *Live and Let Die: The Consequences of Oklahoma's Nondiscrimination in Treatment Act*, 68 OKLA. L. REV. 585 (2016),
<https://digitalcommons.law.ou.edu/olr/vol68/iss3/4>

This Comment is brought to you for free and open access by University of Oklahoma College of Law Digital Commons. It has been accepted for inclusion in Oklahoma Law Review by an authorized editor of University of Oklahoma College of Law Digital Commons. For more information, please contact Law-LibraryDigitalCommons@ou.edu.

COMMENT

Live and Let Die: The Consequences of Oklahoma's Nondiscrimination in Treatment Act

Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence.

— Justice William Brennan¹

I. Introduction

In 2013, the Oklahoma legislature passed the Oklahoma Nondiscrimination in Treatment Act (the Act).² This Act further complicates the already complicated landscape of medical futility by restricting physicians' ability to adhere to ethical obligations and make decisions in accordance with their own professional consciences. The legislature did this with almost no political discussion in a state with no reported medical futility or withdrawal of life-sustaining treatment appellate cases. The Act³ raises the issue of medical futility, which in this context, refers to the situation where a patient or their surrogate decision maker demands treatment and a physician refuses to administer that treatment on the basis that it provides no medical benefit.⁴ The Act forbids physicians from deciding not to extend the life of an elderly, disabled, or terminally ill individual through life-sustaining treatment (LST) if (1) the decision is based on the view that these patients' lives are of lower value than other patients because of one of these traits or (2) there is a disagreement between the physician and proxy regarding treatment.⁵ Under a plain-language standard of interpretation, the Act could require a physician to administer treatment to a patient even though doing so could, in her medical opinion,

1. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 310-11 (1990) (Brennan, J., dissenting).

2. 63 OKLA. STAT. § 3090 (Supp. 2014).

3. "A health care provider shall not deny to a patient a life-preserving health care service the provider provides to other patients, and the provision of which is directed by the patient or a person legally authorized to make health care decisions for the patient . . ." *Id.* § 3090.3.

4. Judith F. Daar, *Medical Futility and Implications for Physician Autonomy*, 21 AM. J.L. & MED. 221, 221-22 (1995).

5. 63 OKLA. STAT. § 3090.3.

ultimately cause harm to the patient and conflict with her professional conscience. The Act further constrains physicians by preventing them from considering all aspects of their patient's condition and treating them on a case-by-case basis because the Act implies that age, disability, and terminal illness cannot be considered when making this value judgment.⁶ The Act also deters physicians from presenting patients or surrogate decision makers with all available medical options, including discontinuation of treatment, for fear of violating this statute. Finally, the Act inhibits the ability of doctors and may cause physicians to flee the state.

This Comment first addresses the landscape of medical futility and patients' rights by discussing relevant case law, the roles of physicians, and advanced directives. Next, it discusses the background, text, and consequences of Oklahoma's Nondiscrimination in Treatment Act. Then, it presents statutes from Idaho and Texas and contrasts them with the Oklahoma Act. Finally, this Comment proposes a statutory model, which borrows from the Texas Advanced Directive Act (TADA), to replace the current Act in Oklahoma. This proposal would defer disputes between physicians and patient/surrogate decision makers to an ethics committee, while always leaving open an option to transfer the patient to another facility as a last resort.

The scope of this Comment is limited to the denial of LST as addressed in Oklahoma's Nondiscrimination in Treatment Act. The Comment does not address legally brain-dead individuals and the ethical dilemma of denying them treatment, as brain-dead individuals cannot receive LST.⁷ It also does not discuss the Act's effect on disagreements between family members of a patient. This Comment will focus on the decisions made by physicians and the disagreements between physicians and patients/surrogate decision makers as to the proper treatment of patients suffering from illnesses where LST is an option, and how the Act affects these decisions and disagreements.

This Comment assumes that conflicts will arise most often, if not always, between a surrogate decision maker and a physician (rather than the patient and a physician). In treatment decisions, physicians often defer to the wishes of the patient, especially when the patient is able to articulate those

6. *Id.* § 3090.3(A)(1).

7. Life sustaining treatment does just that—it sustains life. Brain-dead individuals, however, are no longer alive under the laws of Oklahoma so they cannot receive treatment that could sustain life. Uniform Determination of Death Act, 63 OKLA. STAT. § 3122 (2011). However, brain dead individuals can receive futile treatment as medical treatment provides no medical benefit to them.

decisions themselves. However, when the patient is unable to make decisions, or has failed to indicate her wishes in an advanced directive, treatment decisions are much more difficult to make because no guidance is available. When the doctor does not know the patient's wishes and the decision is left up to a surrogate decision maker, conflicts can arise between what the surrogate decision maker wants or thinks the patient would have wanted and what the physician thinks is the best course of treatment. Since patient autonomy is so valued in the medical field, a clash at the bedside between doctors and a patient actually able to make medical decisions would probably occur much less often in regard to discontinuing LST for medical futility reasons than the clash between doctors and family members of patients unable to make these decisions. This paper proceeds under this assumption.

II. The Landscape of Medical Futility and Patient Rights

The Act, while it does not specifically address medical futility, concerns medical futility because it states that physicians are restricted from denying LST under certain conditions.⁸ The concept of medical futility is ancient,⁹ but physicians have only recently turned away from pushing aggressive treatment to using the court system to help them discontinue LST based on medical futility. The medical and technological advances have outpaced the public's understanding of life and death as well as the legislative response to properly addressing medical futility issues and LST.¹⁰ Medical advances have saved lives, but, unfortunately, they have also left us with "living" individuals in their end stages with no quality of life. Physicians struggle to ethically treat these patients—attempting to carry out patients' wishes while trying to do no harm. LST can prolong life but often at the high cost of pain and suffering.

While LST can extend life, it often does so while causing the body to deteriorate severely. As an example, consider Barbara Howe. Howe received LST for Amyotrophic Lateral Sclerosis (ALS), during which she suffered a rapid decline in bodily functions and the ability to

8. *See, e.g., id.* § 3090.3.

9. LAWRENCE J. SCHNEIDERMAN, *EMBRACING OUR MORTALITY: HARD CHOICES IN AN AGE OF MEDICAL MIRACLES* 118 (2008) [hereinafter *EMBRACING MORTALITY*]; LAWRENCE J. SCHNEIDERMAN & NANCY S. JECKER, *WRONG MEDICINE: DOCTORS, PATIENTS, AND FUTILE TREATMENT* 6 (2d ed. 2011).

10. *See* SCHNEIDERMAN & JECKER, *supra* note 9, at 4-5.

communicate.¹¹ As her physicians continued to administer LST, Howe alerted them to her severe pain until she was unable to communicate, reducing her to episodes of “prolonged sobbing.”¹² As the disease progressed, Howe lost the ability to lubricate her eyes, eventually forcing doctors to remove her right eye.¹³ She suffered rib fractures, a broken humerus bone (both discovered by chance from an unrelated x-ray), cuts to her face, and osteoporosis, among several other ailments, all while she wore a permanent grimace on her face.¹⁴ Watching Howe suffer tormented her doctors and caregivers.¹⁵ Finally, the Optimum Care Committee (OCC) of the hospital met and announced that “this inhumane travesty has gone far enough. This is the Massachusetts General Hospital, not Auschwitz.”¹⁶ They released the following statement:

They [the Hospital staff] have lived for two years with the appalling realization that they are under orders to resuscitate her and so guarantee that her gallant life will be wiped out by a senseless act of brutality. The administrative mandate demands that the dimension of emotion in their care be shut out, repressed, stamped on, derogated, or just plain pretended away. It is therefore not only delusional but unfair. It demands that the entire body of caregivers violate their professional oaths, the standards of medical and nursing practice, the standards of the Massachusetts General Hospital, and the standards of ethics, morality, human decency and common sense.¹⁷

When facing treatment decisions like Howe’s, many ask the question: what have I got to lose? People view illnesses as a fight or a battle. We say things about the ill like “she’s strong” or “she’s a fighter.” This perspective of sickness makes us view dying as losing this fight or giving up. People ask, “What have I got to lose?” because whether you lose your battle, or you just give up on it, the end is the same: death. Few realize, however, that while all of our lives certainly end in death at some point, as Plato said,

11. *In re Howe*, No. 03 P 1255, 2004 WL 1446057, at *2 (Mass. Prob. & Fam. Ct. Mar. 22, 2004).

12. *Id.* at *6; see also Patrick Moore, Note, *An End-of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment That Physicians Are Unwilling to Provide*, 48 B.C. L. REV. 433, 434-35 (2007).

13. *Howe*, 2004 WL 1446057, at *10-11; Moore, *supra* note 12, at 435.

14. *Howe*, 2004 WL 1446057, at *12-13; Moore, *supra* note 12, at 435.

15. *Howe*, 2004 WL 1446057, at *8.

16. *Id.* at *11.

17. *Id.* at *12; Moore, *supra* note 12, at 435.

“death is not the worst that can happen to men.”¹⁸ So what do individuals have to lose from receiving medical treatment? They can lose their dignity. They can be put in constant, horrible pain. They can lose the ability to say goodbye to their loved ones while wasting away in a cold, sterile intensive care unit room.¹⁹ The danger of ignoring medical futility lies in requiring physicians to provide medical treatment when they believe it will result in tragic consequences. Physicians should not be forced to facilitate a painful, undignified end.

The danger of the Oklahoma Act, if interpreted through a plain-language approach, is that it requires physicians to render treatment that potentially causes their patients to suffer as their health declines. Given courts’ record of interpreting statutes in medical futility cases under a plain-language approach²⁰ and the pervasive pro-life landscape in Oklahoma, a court faced with this statute will likely adopt a plain-language interpretation over alternative approaches, such as purposive or original intent.

A. Case Law Regarding Medical Decision-Making Rights

The following three cases highlight the rights courts have recognized in patients and doctors, as well as how courts have treated disputes between them.²¹ The first two cases arose when aggressive treatment was the most acceptable treatment in the medical field. *In re Quinlan* was the first case to recognize the common-law right to discontinue life support—and did so even though the case involved a decision by a proxy decision maker.²² *Cruzan ex rel. Cruzan v. Director, Missouri Department of Health*, a later case, recognized the same right but rooted it in the constitutional right to liberty under the Fourteenth Amendment’s Due Process Clause.²³ Finally, *In re Baby K*, the most recent of the three, involved a medical futility dispute where the hospital used the courts to decide whether LST could be discontinued for medical futility reasons.²⁴

18. Jon D. Feldhammer, Note, *Medical Torture: End of Life Decision-Making in the United Kingdom and United States*, 14 CARDOZO J. INT’L & COMP. L. 511, 511 (2006) (quoting Plato).

19. *See id.* at 512.

20. *In re Baby K*, 16 F.3d 590, 598 (4th Cir. 1994).

21. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990); *In re Baby K*, 16 F.3d 590; *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

22. 355 A.2d at 53.

23. 497 U.S. at 262.

24. 16 F.3d at 598.

1. In re Quinlan

The Supreme Court of New Jersey decided *Quinlan* in 1976.²⁵ This case concerned a father who sought guardianship over his twenty-two-year-old daughter in order to discontinue her life support.²⁶ The daughter, Karen Quinlan, was a persistently vegetative patient stuck permanently into a rigid fetal position with no chance of recovery.²⁷ The court, expressing sadness, held first that Karen could no longer competently choose whether to stay on life support or discontinue it and second, that a guardian could assert the choice for her.²⁸ The physicians in this case did not believe that Karen should be taken off life support, but Karen's father was ultimately appointed by the court to be her guardian with the power to remove her from life support, and he did so.²⁹

Quinlan is premised on the idea that patients have a common-law right to refuse treatment. It also showed that proxy decision makers can assert a patient's wishes on their behalf and that courts can override physician judgment based on the professional standard of care. This case was decided in 1976, however, and there have been many subsequent developments in how we understand and use medical technology, the standard of care, and medical futility.

2. Cruzan ex rel. Cruzan v. Director, Missouri Department of Health

The Supreme Court decided *Cruzan ex rel. Cruzan v. Director, Missouri Department of Health* in 1990.³⁰ This case arose after Nancy Cruzan was injured in a car accident and ended up in a persistent vegetative state due to a sustained lack of oxygen.³¹ Cruzan had motor reflexes but no sign of cognitive function.³² Cruzan's parents wished to withdraw LST by terminating her artificial nutrition and hydration; the hospital, however, refused to do so because it would cause her death.³³ Based on Cruzan's prior statements, her parents believed that if she had the choice, she would want to discontinue LST.³⁴

25. 355 A.3d at 647.

26. *Id.* at 651.

27. *Id.* at 656.

28. *Id.* at 664, 671.

29. *Id.* at 672.

30. 497 U.S. 261 (1990).

31. *Id.* at 265-66.

32. *Id.* at 266.

33. *Id.* at 265, 268.

34. *Id.* at 268.

The Supreme Court considered whether Cruzan “ha[d] a right under the United States Constitution[,] which would require the hospital to withdraw life-sustaining treatment from her”³⁵ The Court drew on the common-law elements of battery and the informed-consent doctrine to demonstrate that a patient has a right to refuse treatment.³⁶ The Court determined that, implicit within the Fourteenth Amendment’s word “liberty,” exists the historic right of a patient to refuse treatments such as vaccines and antipsychotic drugs.³⁷ The Court proclaimed that “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment *may be inferred* from our prior decisions.”³⁸ Rather than announce that the right to refuse medical treatment includes the right to refuse LST generally, the Court stated that “for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”³⁹ While the Court limited this declaration to the facts of *Cruzan*, subsequent decisions applied this statement broadly.⁴⁰

Cruzan reiterated the importance of a patient’s right to refuse medical treatment, even if that refusal results in death, and found a basis for this in the Constitution. A problematic question unanswered in this case is whether there is a right to demand treatment just as there is a right to refuse it.

3. In re Baby K

After *In re Wanglie*⁴¹ was decided as the first medical futility case, the Fourth Circuit Court of Appeals decided the landmark case of *In re Baby K*

35. *Id.* at 269.

36. *Id.* at 269-70.

37. *Id.* at 278.

38. *Id.* (emphasis added).

39. *Id.* at 279.

40. See, e.g., *Sama v. Hannigan*, 669 F.3d 585, 591 (5th Cir. 2012); *Raich v. Gonzales*, 500 F.3d 850, 864 n.12 (9th Cir. 2007); *Blouin v. Spitzer*, 356 F.3d 348, 359 (2d Cir. 2004).

41. *In re Wanglie* was the first medical futility case decided by a court. Jerry Menikoff, *Demanded Medical Care*, 30 ARIZ. ST. L.J. 1091, 1096 (1998). Helga Wanglie broke her hip and became dependent on a respirator. *Id.* She then had a heart attack and was diagnosed as being in a persistent vegetative state. *Id.* Her doctors recommended discontinuation of LST (taking her off the respirator), but her husband disagreed arguing that to remove her from her respirator would be playing God, and later that she wanted all LST measures to be taken. *Id.* The hospital asked a court to have an independent guardian appointed to make Wanglie’s medical decisions rather than her husband, but the court refused. *Id.* This case is an example of substituted judgment (the husband possibly substituting his judgment for that of his wife’s), as well as an example of the hospital going to the courts for a declaratory judgment. *Id.*

in 1994.⁴² Baby K was born with anencephaly, which is “a congenital malformation in which a major portion of the brain, skull, and scalp are missing.”⁴³ Baby K lacked a cerebrum, causing permanent unconsciousness, but had a working brain stem, which allowed her to still have autonomic functions.⁴⁴ Due to breathing difficulties, Baby K was put on a respirator, and because she could not see, hear, or interact with her environment, doctors encouraged her mother to agree to a “Do Not Resuscitate Order” (DNR) so that lifesaving procedures would be withheld in the event that Baby K required resuscitation, as most anencephalic infants die shortly after birth due to complications.⁴⁵ Ms. H, Baby K’s mother, did not agree with the doctors and wanted the hospital to place Baby K on a respirator whenever there was breathing difficulty.⁴⁶ Baby K was transferred to a nursing home but was readmitted to the hospital three times due to the breathing difficulties.⁴⁷ Because the hospital found this treatment “medically and ethically inappropriate,” the hospital asked a court to decide whether it was obligated to provide medical treatment to Baby K.⁴⁸

The court based its decision in the language of the Emergency Medical Treatment and Labor Act (EMTALA). Congress enacted EMTALA to prevent hospitals from “dumping” patients who were unable to pay for emergency medical treatment.⁴⁹ Additionally, EMTALA requires hospitals to treat patients diagnosed with an emergency medical condition.⁵⁰ Because EMTALA required stabilizing care for infants, the court required the hospital to give Baby K mechanical ventilation to keep her in a stable condition.⁵¹ The court, however, acknowledged there were problems with its decision:

We recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate, but we cannot ignore the *plain language* of the

42. 16 F.3d 590 (4th Cir. 1994).

43. *Id.* at 592.

44. *Id.*

45. *Id.* at 592-93.

46. *Id.* at 593.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.* at 593-94.

51. *Id.* at 594.

statute because “to do so would ‘transcend our judicial function.’”⁵²

The court used a plain-language approach when interpreting EMLATA. If a court applied the same approach to the Oklahoma Act, it would ignore the ethical dilemma physicians face acknowledged in *Baby K* because the Act, as written, drastically restricts physicians and their ability not to provide treatment they deem morally and ethically inappropriate.

4. *The Foundations of Medical Futility*

These cases show that courts heavily consider the right to refuse treatment, as well as the intent and desires of the patient or the guardians when deciding disputes about discontinuing LST. *Quinlan* acknowledges that patients have a fundamental right to refuse treatment based in common law, and *Cruzan* shows that this fundamental right is anchored in the Constitution.⁵³ Thus, the patient’s wishes usually supersede other opinions on care when *refusing* treatment. The Supreme Court, however, has not addressed the right to *demand* treatment.

B. *Medically Futile Treatment—A Term with Infinite Definitions*

Medical futility is a concept that is difficult to define, and the statutory definitions adopted by states have differed substantially.⁵⁴ Medical futility seems to be made up of two concepts: scientific futility and ethical futility. Scientific futility embodies the components of medical futility such as treatment “of no medical benefit,”⁵⁵ “life-sustaining measures . . . becom[ing] so painful as to be abusive,”⁵⁶ or medically ineffective treatment.⁵⁷ In contrast, ethical futility considers the resultant quality of life and whether such treatment is ethical under the rules of the medical profession. Thus, treatment can be medically futile if it either fails to

52. *Id.* at 596 (emphasis added) (citation omitted).

53. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 261-62 (1990); *In re Quinlan*, 355 A.2d 647, 652 (N. J. 1976).

54. *See, e.g.*, IDAHO CODE ANN. § 39-4514 (West 2014).

55. Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician’s Professional Conscience*, 44 HASTINGS L.J. 1241, 1242 (1993).

56. *Id.* at 1250 (quoting Ronald Smothers, *Atlanta Court Bars Efforts to End Life Support for Stricken Girl*, 13, N.Y. TIMES, Oct. 18, 1991, at A10).

57. Daar, *supra* note 4, at 230.

overcome the illness at hand or makes the patient's quality of life worse than withholding treatment.⁵⁸

Medical futility is controversial because it invariably requires a subjective value judgment.⁵⁹ It is not an objective medical standard because it requires a physician to determine whether treatment is futile using personal values and medical judgment.⁶⁰ The concept of medical futility is particularly important in the context of LST, and thus the Act, because there are times when even prolonging life with LST can prove futile in the physician's expert opinion.

The physician has a responsibility to render a certain standard of care to patients, and therefore, a physician must determine whether LST is medically futile and thus would fall below that standard of care.⁶¹ The American Medical Association Code states that while a patient's judgment should sometimes prevail over that of the physician, a physician is not required to deliver care simply because a patient demands a treatment.⁶² Moreover, a physician is not required to deliver care that has no reasonable chance of benefiting the patient.⁶³ However, if a physician does not render treatment that conforms to the standard of care, then she opens herself to liability.⁶⁴ While the Act only allows for an injunctive remedy, if a court decided this legislation required futile treatment, it could establish a new standard of care for the state, possibly one that subjects physicians to another source liability. If giving every treatment imaginable that a family demands becomes the standard as a result of the Act, then if doctors fail to do so, they could find themselves subject to negligence actions or other medical malpractice liability.

58. See Howard Brody, *Medical Futility: a Useful Concept?*, in *MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS* 1, 2 (Marjorie B. Zucker & Howard D. Zucker eds., 1997).

59. See Meir Katz, *When Is Medical Care "Futile"? The Institutional Competence of the Medical Profession Regarding the Provision of Life-Sustaining Medical Care*, 90 NEB. L. REV. 1, 25-26 (2011).

60. *Id.*

61. Lisa L. Dahm, *Medical Futility and the Texas Medical Futility Statute: A Model to Follow or One to Avoid?*, HEALTH LAW., Aug. 2008, at 25, 26.

62. *Id.* at 26.

63. *Id.*

64. Meghan C. O'Connor, *The Physician-Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform*, 46 TORT TRIAL & INS. PRAC. L.J. 109, 117 (2010).

Other states protect physicians' ability to refuse to render futile care.⁶⁵ The Uniform Health Care Decisions Act (UHCDA) provides that "[a] health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution."⁶⁶ New Mexico,⁶⁷ Mississippi,⁶⁸ Maine,⁶⁹ Hawaii,⁷⁰ and Alaska⁷¹ adopted statutes based on the UHCDA to protect doctors from rendering futile care they believe falls below the acceptable standard. Oklahoma, however, has done the opposite; it has facially precluded a physician from refusing to render treatment that conflicts with her conscience.⁷²

C. The Right to Refuse Treatment vs. the Right to Demand It: Negative and Positive Rights

There is well-established case law that a patient's "negative" right to refuse medical treatment is cemented in the Constitution. This right to refusal stems from the concept of battery—touching others without their consent.⁷³ The concept was eventually extended to consent in medical treatment, including LST.⁷⁴ Out of medical futility, however, comes the question of whether people have a "positive" right to also demand treatment—even treatment that a doctor may find medically unnecessary or harmful. The right to refuse treatment was reinforced by the *Cruzan* and *Quinlan* decisions, where each court found it existed in the rights to liberty and privacy, respectively, as applied to the states through the Fourteenth Amendment.⁷⁵ The right to receive treatment, however, does not have a historic foundation like that of the right to refuse treatment.⁷⁶ At least one

65. BARRY FURROW & THOMAS GREANEY, *BIOETHICS* 446 (7th ed. 2013).

66. UNIF. HEALTH-CARE DECISIONS ACT § 7(f), pt. 1B U.L.A. 118 (2005).

67. N.M. STAT. ANN. § 24-7A-7 (West 2011).

68. MISS. CODE ANN. § 41-41-215 (West 2007).

69. ME. REV. STAT. ANN. tit. 18-A, § 5-807 (2014).

70. HAW. REV. STAT. ANN. § 327E-7 (West 2008).

71. ALASKA STAT. § 13.52.060 (2014).

72. 63 OKLA. STAT. § 3090.3 (Supp. 2014).

73. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269-70 (1990).

74. *Id.*

75. *Cruzan*, 497 U.S. at 278; *In re Quinlan*, 355 A.3d 647, 663 (N.J. 1976).

76. William Prip & Anna Moretti, *Medical Futility: A Legal Perspective*, in *MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS* 136, 141 (Marjorie B. Zucker & Howard D. Zucker eds., 1997).

court has found that there is no right to receive futile treatment,⁷⁷ but other courts have discussed the importance of self-determination in medical treatments.⁷⁸

The case that rejected the “positive” right to receive futile treatment was *Gilgunn v. Massachusetts General Hospital*. In *Gilgunn*, an elderly woman in poor health developed seizures that resulted in brain damage, leaving her comatose.⁷⁹ While her family said she would have wanted everything done for her, meaning keeping her alive on life support through LST measures, the doctors went to the OCC of the hospital and entered a DNR on her chart.⁸⁰ The hospital eventually took her off of the ventilator that was keeping her alive, and she died.⁸¹ Her family filed suit against the hospital and the attending physicians in Massachusetts Superior Court, and a jury found that the hospital and *Gilgunn*’s physicians were not liable because the treatment would have been futile.⁸² Although decided by a jury and never subjected to appellate review,⁸³ *Gilgunn* rebuts the idea that a patient has a right to futile treatment.

D. Historical Perspective of Physicians and the “Do No Harm” Principle

From the beginning of the practice of medicine, the concept of medical futility has existed and been central to physicians’ ethical duty to their patients.⁸⁴ Historically, the goals of medicine were directed more at improving or sustaining the quality of life rather than prolonging the duration of life.⁸⁵ Hippocrates warned in *The Art* that “[w]henver the illness is too strong for the available remedies, the physician surely must

77. Amir Halevy, *Medical Futility, Patient Autonomy, and Professional Integrity: Finding the Appropriate Balance*, 18 HEALTH MATRIX: J. L.-MED. 261, 276 (2008) (citing *Gilgunn v. Mass. Gen. Hosp.*, No. 92-4820 (Mass. Super. Ct., Apr. 21, 1995)).

78. ALAN MEISEL, KATHY L. CERMINARA & THADDEUS M. POPE, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* 13-18 to -18.1 (3d ed. Supp. 2010).

79. Halevy, *supra* note 77, at 276 (citing *Gilgunn*, No.92-4820).

80. *Id.* at 276-77 (citing *Gilgunn*, No. 92-4820); Moore, *supra* note 12, at 450-51.

81. Halevy, *supra* note 77, at 276-77 (citing *Gilgunn*, No. 92-4820); Moore, *supra* note 12, at 450-51.

82. Halevy, *supra* note 77, at 277 (citing *Gilgunn*, No. 92-4820).

83. *Id.*

84. SCHNEIDERMAN & JECKER, *supra* note 9, at 6. According to the Hippocratic corpus, “three roles were prescribed for the physician: alleviating suffering in the sick, reducing the violence of their diseases, and refusing to treat those who were ‘overmastered by their diseases, realizing that in such cases medicine is powerless.’” *Id.* (citation omitted).

85. *Id.*

not expect that it can be overcome by medicine.”⁸⁶ Doctors were expected to have knowledge of not only medicine itself but also the limits of medicine.⁸⁷ Medicine has advanced and allowed people to live longer but arguably at the cost of lower qualities of life. Approaches to illness and disease became more aggressive, deriving from the mantras of “‘life is sacred’ and ‘preserve life at all costs.’”⁸⁸

These medical decisions have become less of a private matter between patients, their families, and physicians and have instead become a public spectacle.⁸⁹ Often these events develop into a clash between right-to-die and pro-life advocates insisting that the outcome in an individual case affects a much larger, perpetual debate.⁹⁰ This new view of physicians and state-legislation constraints has negatively affected patients, as well as physicians.⁹¹

Throughout all of this history, however, the primary principle in medical ethics has remained the same: “do no harm.”⁹² But what is harm? Medical futility has become such a controversial issue because harm has different meanings. While harm could refer to causing death to come sooner and life to be shorter, it could also refer to causing harm to the body—breaking it down, making it weaker, or causing a person to become less lucid or even vegetative through LST.⁹³ Just like any other profession, physicians have ethical standards they must follow when treating patients.⁹⁴ When a doctor decides to provide treatment to a patient, she must do no harm, but really she must decide which “harm” to avoid in the situation. The ultimate

86. EMBRACING MORTALITY, *supra* note 9, at 118; SCHNEIDERMAN & JECKER, *supra* note 9, at 6.

87. SCHNEIDERMAN & JECKER, *supra* note 9, at 6.

88. *Id.* at 7.

89. *Id.* at 5.

90. Michael Ollove, ‘Life Preserving’ Law in Oklahoma Raises Questions for Doctors, HUFFINGTON POST (May 16, 2013), http://www.huffingtonpost.com/2013/05/16/life-preserving-law_n_3285324.html?utm_hp_ref=politics.

91. EMBRACING MORTALITY, *supra* note 9, at 123.

Patients and patients’ families have been forced to endure and pay for inhumane, unwanted care either because of individual physician’s misguided notions of medical duty or the law or as a result of ill-conceived court decisions. Physicians have practiced ‘defensive medicine,’ fearing that anything less than mindless continuation of aggressive treatments would make them legally vulnerable.

Id.

92. SCHNEIDERMAN & JECKER, *supra* note 9, at 6-7.

93. *Id.* at 18.

94. *Id.* at 6-7.

decision comes down to a quality-of-life judgment.⁹⁵ The physician must use her medical training and professional ethics to make this decision, and, while patients and families deserve to have their input heard, ultimately the physician is charged to “do no harm.” Legislative bodies should not take away a physician’s ability to make this decision by forcing her to provide treatment unethical in her medical opinion.

Patients and family members are often faced with guilt and blame, as well as an overwhelming wave of conflicting emotions when faced with the death of a loved one. This is why they cannot bring themselves to make the decision to end LST.⁹⁶ With death, especially the death of children, comes a feeling of injustice, making it more difficult to discontinue treatment.⁹⁷ This ethical dilemma makes the role of the physician even more important because, while physicians are emotionally invested in the fates of their patients, they are able as to act logical and unbiased decision makers who can understand what is at stake regarding quality of life.⁹⁸

E. How Advanced Directives Fit into the Oklahoma Landscape

An advanced directive for health care in Oklahoma is a legal document that acts as clear and convincing evidence of a patient’s desires about how a person wants a physician to proceed when faced with possible use of LST.⁹⁹ In order to create an advanced directive in Oklahoma, a person need only be eighteen years of age and of sound mind.¹⁰⁰ The Oklahoma Advance Directive form allows the signer to indicate in which situations he or she would like to receive, or not receive, LST; appoint a healthcare proxy; and designate anatomical gifts.¹⁰¹ These forms are extremely important because they can provide clear and convincing evidence of a person’s wishes in regard to LST.¹⁰² When doctors have no indication of what treatment, or lack of treatment, a person would want to receive, the doctors and the family of the person often struggle to make a treatment decision. However, if someone has executed an advanced directive, she guides her physicians

95. *Id.* at 17-20.

96. *Id.* at 31.

97. *Id.* at 32.

98. *Id.* at 17-20.

99. *What Is an Advance Directive for Health Care (Living Will)*, OKLA. BAR ASS’N (Oct. 2012), <http://www.okbar.org/Portals/14/PDF/Brochures/advance-directive-2012.pdf>.

100. *Id.*

101. *Advance Directive for Health Care*, OKLA. BAR ASS’N, at 1, <http://www.okbar.org/Portals/14/PDF/Brochures/advance-directive-form.pdf> (last visited Feb. 3, 2016).

102. *Id.*

and family on this matter when she is able to voice her desires regarding LST.

While it seems that an advanced directive provides greater clarity in medical decisions related to LST, the terms used in the Oklahoma advanced directive form are ambiguous and potentially confusing to laypeople, even though the legislature has attempted to define the words used. One provision lets individuals decide instructions for LST “[i]f [they] have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months.”¹⁰³ Another option is “[i]f [they] have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective.”¹⁰⁴ While designed to encompass several different medical situations, the general language could pose a problem: these different categories are difficult for laypeople to understand as they may not know what medical situations specifically would fall into each category. Therefore, the lack of clarity in advanced directives may cause people to fill them out incorrectly, or deter people from filling them out altogether, even when they have strong beliefs about their medical preferences because they do not understand the paperwork.

In the Barbara Howe case mentioned above, Howe created an advanced directive designating her daughter as her healthcare proxy.¹⁰⁵ Howe made it verbally clear to everyone involved that “as long as there was any possibility left to communicate to her beloved family,” she wanted to receive LST.¹⁰⁶ Although Howe set out these wishes, her physician and her healthcare proxy still disagreed on whether Howe was able to meaningfully communicate and thus whether she should continue to receive LST according to her statements.¹⁰⁷ Therefore, while advanced directives and verbal wishes can help determine the intent of a patient, the actual application can still present problems, causing doctors and surrogate decision makers to disagree.

103. *Id.*

104. *Id.* at 2.

105. *In re Howe*, No. 03 P 1255, 2004 WL 1446057, at *2 (Mass. Prob. & Fam. Ct. Mar. 22, 2004); see Moore, *supra* note 12, at 434-35.

106. *Howe*, 2004 WL 1446057, at *11; see Moore, *supra* note 12, at 434-35.

107. *Howe*, 2004 WL 1446057, at *5; see Moore, *supra* note 12, at 433-35.

III. The Oklahoma Nondiscrimination in Treatment Act

It's getting almost to the point that you need a government permit in order to die in this state.

— Marguerite Chapman¹⁰⁸

A. The Pro-Life Beginnings of the Act

The Act was offered up to the Oklahoma House of Representatives as a pro-life initiative along with several other pro-life bills introduced in the same session.¹⁰⁹ Based on legislation written by the National Right to Life Committee,¹¹⁰ and submitted for vote in a state in the “Bible Belt,” the bill faced little opposition or inquiry when brought before the floor of the House.¹¹¹ In general, the outcome and the media frenzy of the Terri Schiavo case influenced the Act’s authors to write the bill.¹¹² There was no debate on the floor of the House to show the conflicting sides of this usually controversial issue.¹¹³ When prompted by the only question asked about the bill before voting took place, Representative Dennis Johnson explained the bill in extremely simple terms, saying that it barred discrimination, but he seemed unable to answer the simple question about how the bill would actually function in practice.¹¹⁴ One is left with the impression that little research went into determining the possible consequences the bill could have.

108. Ollove, *supra* note 90. Marguerite Chapman, a law professor at the University of Tulsa College of Law located in Oklahoma, made this comment about the state of Oklahoma when it passed the Nondiscrimination in Treatment Act.

109. See ArchOKC, *Walk for Life 2013*, YOUTUBE (Mar. 26, 2013), <https://www.youtube.com/watch?v=trJ14YM6fDk> [hereinafter *Walk for Life 2013*].

110. Ollove, *supra* note 90.

111. *Bill Information for HB 1403: Video*, OKLA. ST. LEG. (Mar. 5, 2013), http://okhouse.granicus.com/MediaPlayer.php?view_id=&clip_id=550&meta_id=24178 (Rep. Johnson and Rep. Sherrer at 00:10:34 to 12:47); *Bill Information for HB 1403: Video*, OKLA. ST. LEG. (Apr. 18, 2013), http://okhouse.granicus.com/MediaPlayer.php?view_id=&clip_id=590&meta_id=41099 (Rep. Johnson at 02:54:10-55:17).

112. Ollove, *supra* note 90.

113. *Bill Information for HB 1403: Video*, OKLA. ST. LEG. (Mar. 5, 2013), http://okhouse.granicus.com/MediaPlayer.php?view_id=&clip_id=550&meta_id=24178 (Rep. Johnson and Rep. Sherrer at 00:10:34 to 12:47); *Bill Information for HB 1403: Video*, OKLA. ST. LEG. (Apr. 18, 2013), http://okhouse.granicus.com/MediaPlayer.php?view_id=&clip_id=590&meta_id=41099 (Rep. Johnson at 02:54:10 to 55:17).

114. *Bill Information for HB 1403: Video*, OKLA. ST. LEG. (Mar. 5, 2013), http://okhouse.granicus.com/MediaPlayer.php?view_id=&clip_id=550&meta_id=24178 (Rep. Johnson and Rep. Sherrer at 00:10:34 to 12:47).

Oklahoma has no state supreme court or reported appellate decisions concerning LST withdrawal or medical futility, so there is little guidance for the state on these issues. Often, medical futility disputes are resolved in some way before being brought to court and no actions regarding the Act have made it to court.¹¹⁵ This could be for many reasons. For example, physicians and patients, or their surrogate decision makers, could agree on the course of treatment regarding LST, and therefore disputes do not even occur. The Act, however, could be having a chilling effect on physicians, preventing them from broaching the subject of LST because, in a disagreement, a court will likely defer to the decision maker or grant an injunction against non-treatment. This effect may cause Oklahoma physicians to disregard any treatment, or non-treatment, that could present a difficult choice for the family, even if, in their expert medical opinion, it is the right treatment for the patient. While patients, their families, and physicians could agree in Oklahoma 100% of the time, that is probably not the case; a chilling effect upon Oklahoma physicians seems to be the real danger stemming from the Act.

The general landscape of Oklahoma law favors continuation of LST in other ways as well. One Oklahoma statute—the Oklahoma Hydration and Nutrition for Incompetent Patients Act—creates an automatic presumption in favor of artificial nutrition and hydration if there is no clear and convincing evidence of the patient’s intent to the contrary.¹¹⁶ The statute says that artificial “[h]ydration or nutrition may not be withheld,” and prevents courts from issuing orders that withdraw artificial hydration and nutrition absent an exception under the statute.¹¹⁷ Since there have been no cases in the Oklahoma Supreme Court challenging this statute, we do not know if it would actually stand as it is, or how far it could even extend. This statute, however, contributes to the overall pro-life landscape of Oklahoma.

B. Language of the Act

The language of Oklahoma’s Nondiscrimination in Treatment Act is as follows:

A. A health care provider shall not deny to a patient a life-preserving health care service the provider provides to other patients, and the provision of which is directed by the patient or

115. Thaddeus Mason Pope, *Legal Briefing: Medical Futility and Assisted Suicide*, 20 J. CLINICAL ETHICS 274, 274 (2009).

116. 63 OKLA. STAT. § 3080.4(A)(2) (2011).

117. *Id.* § 3080.4(C) (2011).

a person legally authorized to make health care decisions for the patient:

1. On the basis of a view that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill; or
2. On the basis of disagreement with how the patient or person legally authorized to make health care decisions for the patient values the trade-off between extending the length of the patient's life and the risk of disability.

B. In an action pursuant to this act, if the plaintiff pleads a prima facie case, the health care provider may defend his or her or its actions by pleading a legitimate, nondiscriminatory reason or reasons that provided a basis for the denial of treatment, subject to an opportunity for the plaintiff to plead that the reason or reasons for the denial of treatment are discriminatory in their application.¹¹⁸

C. Ambiguity of the Discrimination Section

The Act forbids doctors from denying LST based on their view that a patient's age, terminal illness, or disability renders the patient's life to have a "lower life value" from these factors.¹¹⁹ Few courts have addressed or defined any kind of medical discrimination so there is little guidance in this area. Further, the Oklahoma Nondiscrimination Act fails to employ any kind of "similarly situated" language or include any definitions explaining terms used in the statute including discrimination.¹²⁰ The lack of this important language creates problems for the Act's interpretation as it does not define discrimination, disability, or terminal illness, and it also does not identify how discrimination functions in the context of medical decisions.¹²¹

The constitutional discrimination framework consists of protected classes, the determination of whether individuals are "similarly situated,"¹²²

118. 63 OKLA. STAT. § 3090.3 (Supp. 2014).

119. *Id.*

120. *See id.* § 3090.

121. *Id.*

122. "However, citing *Plyler*, the *Cleburne* Court also used 'similarly situated' in describing the overarching concerns of equal protection, writing that the Equal Protection Clause of the Fourteenth Amendment 'is essentially a direction that all persons similarly situated should be treated alike.'" Giovanna Shay, *Similarly Situated*, 18 GEO. MASON L.

and the corresponding levels of scrutiny. When the *government* makes distinctions based on immutable characteristics, including race¹²³ and national origin,¹²⁴ courts will employ a strict scrutiny analysis. Additionally, courts employ intermediate scrutiny when the government draws distinctions based on gender.¹²⁵ Finally, courts apply rational-basis scrutiny to government actions that make distinctions on other characteristics like age¹²⁶ and disability.¹²⁷

Private parties, on the other hand, are statutorily prohibited from discrimination in the employment and housing contexts based on age, race, or gender.¹²⁸ However, the same statutory framework and historical foundation does not exist for the characteristics of age, disability, and terminal illness for private parties *in the context of medical treatment*. While these kinds of characteristics are not relevant to employment or housing decisions, age, disability, and terminal illness characteristics can be relevant to medical-treatment decisions. These characteristics are considered when measuring test results and for diagnostic purposes, so it does not make sense to include these characteristics for certain medical determinations but exclude them from medical-treatment decisions.

Another ambiguity is what constitutes “similarly situated” in this context. This concept is necessary in the discrimination context because, for discrimination to exist, individuals must be similarly situated for a discriminatory distinction to be made.¹²⁹ In the medical context, however, two individuals will rarely have the same afflictions yet differ only in their age, disability status, or degree of medical illness. Medical determinations are extremely individualized, taking many factors into account. Thus, it would be difficult for a court to apply a traditional similarly situated framework to determine when discrimination has occurred in these cases.

All of these undefined or blatantly absent components demonstrate the confusion in trying to understand the Act as a legal framework. But the ambiguity does not stop there. Indeed, the Act also fails to provide any

REV. 581, 612 (2011); *see also* *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985).

123. *Korematsu v. United States*, 323 U.S. 214, 215 (1944).

124. *Id.* at 218.

125. *Craig v. Boren*, 429 U.S. 190, 218 (1976).

126. *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 309 (1976).

127. *Cleburne Living Ctr.*, 473 U.S. at 442-43.

128. *See* Civil Rights Act of 1964, Title VII. 42 U.S.C. § 2000e-2 (2012); Age Discrimination in Employment Act of 1967, 29 U.S.C. §§ 621-634 (2012).

129. *Cleburne Living Ctr.*, 473 U.S. at 439.

guidance on how to actually apply it to the substantive characteristics that trigger it: disability, age, and terminal illness.

I. Disability

Several federal statutes already address discrimination based on disability in the context of federal programs and funds. Section 504 of the Rehabilitation Act already prohibits discrimination by reason of disability “under any program or activity receiving Federal financial assistance”¹³⁰ Most U.S. hospitals and healthcare facilities receive federal funds through Medicaid and Medicare and are thus subject to this Act and may not deny medical treatment on the basis of that disability alone.¹³¹ But to receive the protection from section 504, an individual must be “otherwise qualified,” meaning the individual must actually qualify for the programs or activities provided by the public entity.¹³² Similarly, the Americans with Disabilities Act (ADA) also prohibits discrimination against the disabled, even by private entities, and goes into great detail by defining discrimination, disability, and the entities covered.¹³³ The ADA, however, has a very broad reach due to its coverage of private entities and contains no “otherwise qualified” requirement.¹³⁴ Therefore, if the goal of the Oklahoma Nondiscrimination Act was to prevent discrimination against disabled individuals, then section 504 of the Rehabilitation Act and the ADA makes the Oklahoma Act redundant as to the disability prong.¹³⁵ This is especially true because the Rehabilitation Act and ADA include clearer, more defined language than the Oklahoma Act.

Additionally, the Act’s general ban on medical decisions based on disability ignores the fact that a patient’s disability plays a crucial role in dictating her medical treatment. The Tenth Circuit Court of Appeals’ discussion of disability discrimination in the context of section 504 of the Rehabilitation Act highlights this problem.

130. 29 U.S.C. § 794 (2012).

131. Phoebe Weaver Williams, *Age Discrimination in the Delivery of Health Care Services to Our Elders*, 11 MARQUETTE ELDER’S ADVISOR L. REV. 1, 28 (2009), <http://scholarship.law.marquette.edu/cgi/viewcontent.cgi?article=1078&context=facpub>.

132. 29 U.S.C. § 794; William D. Goren, *Concepts Underlying the ADA and Key Definitions (Part 2)*, GPSOLO EREPORT (Sept. 2012), http://www.americanbar.org/publications/gpsolo_ereport/2012/september_2012/concepts_underlying_ada_key_definitions_part_2.html.

133. 42 U.S.C. § 12131, 12182 (2012).

134. *Id.*

135. U.S. COMM’N ON CIVIL RIGHTS, MEDICAL DISCRIMINATION AGAINST CHILDREN WITH DISABILITIES 62 n.12 (1989).

In *Johnson ex rel. Johnson v. Thompson*,¹³⁶ a case that originated in Oklahoma, the personal representatives of infants with spina bifida sued a hospital alleging discriminatory treatment.¹³⁷ In their ruling on the discrimination claim, the Tenth Circuit borrowed from *United States v. University Hospital*.¹³⁸

[T]he term *otherwise qualified* cannot ordinarily be applied “in the comparatively fluid context of medical treatment decisions without distorting its plain meaning. In common parlance, one would not ordinarily think of a newborn infant suffering from multiple birth defects as being ‘otherwise qualified’ to have corrective surgery performed.” The court reasoned, “[w]here the handicapping condition is related to the condition(s) to be treated, it will rarely, if ever, be possible to say . . . that a particular decision was ‘discriminatory.’ ”¹³⁹

Thus, the Tenth Circuit Court of Appeals adopted the view that if a disability is *related* to the treatment being rendered, then refusing that treatment cannot be considered discriminatory. By prohibiting discrimination based on disability generally, the Act fails to acknowledge that disability can be relevant to medical decisions.

While the Act states that only “discrimination” based on a patient’s lower-valued life would violate the law, this is vague, and any actions that resembled discrimination could be problematic for physicians. *University Hospital* and *Johnson* show that a physician refusing treatment based upon a disability itself is not discrimination. But, in the case of the disabled patient, issues other than the disease or disability itself could be relevant when determining the best treatment option for the patient. The following is an example of this distinction regarding medical treatment:

[S]uppose we have two patients with leg problems which we can treat at the same cost. The leg problems of one can be completely cured; the other will, even with treatment, limp for the rest of his life. The QALY¹⁴⁰ value for the former treatment will thus be higher than that for the latter because the condition requiring treatment can more fully be cured in the former case.

136. 971 F.2d 1487 (10th Cir. 1992).

137. *Id.* at 1493-94.

138. 729 F.2d 144 (2d Cir. 1984).

139. *Johnson*, 971 F.2d at 1493-94 (quoting *Univ. Hosp.*, 729 F.2d at 156, 157).

141. Quality-adjusted life-year.

Now suppose instead we must choose between unblocking the esophagus of a person with a healthy leg and another person with a limp, and that, if unblocked, both would have the same expected lifespan. Here the QALY values should be the same for both treatments even though the person with the limp suffers the same condition that results in a quality adjustment in the last example. Not being relevant to the condition under treatment, the limp is excluded as a personal characteristic.¹⁴¹

Ultimately, while characteristics that are irrelevant to treatment options should not be a factor in treatment decisions, disabilities will often be relevant to treatment and should be considered when crafting a medical-treatment plan. Although the writers of the Act may have intended to recognize the distinction highlighted above, that legislative intent and how the Act achieves that intent is not clear. Thus, because physicians often consider disability when creating treatment plans and the Act does not recognize the Tenth Circuit's distinction between discriminatory and nondiscriminatory decisions made based on disability, the Act unnecessarily limits a physician's ability to render proper medical treatment.

2. Age

Most federal statutory law addressing age discrimination only addresses discrimination against employees.¹⁴² But the Age Discrimination Act of 1975 has broad coverage prohibiting age discrimination in relation to "any program or activity receiving Federal financial assistance."¹⁴³ This law may preclude hospitals and doctors receiving federal funds from discriminating on the basis of age.¹⁴⁴ Courts, however, have been divided on the issue.¹⁴⁵

The Oklahoma Act prohibits discrimination based on age in LST decisions.¹⁴⁶ In making medical decisions, physicians must consider age as a factor when determining not only the quality of life or outlook of the patient, but also the treatment plan of a patient. It is obvious that a twenty-five-year-old man and an eighty-five-year-old man have different health

141. Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1515 (1994).

142. Peter H. Schuck, *The Graying of Civil Rights Law: The Age Discrimination Act of 1975*, 89 YALE L.J. 27, 40 (1979).

143. 42 U.S.C. § 6102 (2012).

144. Williams, *supra* note 131, at 28 n.154.

145. *Id.*

146. 63 OKLA. STAT. § 3090.3 (Supp. 2014).

concerns and needs with regard to medical treatment. Age factors into medical treatment because the elderly have medical concerns such as not being able to heal quickly or recover as well after surgery.¹⁴⁷ A physician may recommend surgery for a young person in order to extend his life—balancing the harm to his body from the surgery against the positive results that would last throughout a long life. However, a physician may not recommend the same for an elderly person with the same ailment simply based on his age. It could take longer for an elderly person to heal, possibly exposing the patient to dangerous illnesses at the hospital, or high risks of serious side effects and may not improve life for very long. Thus, the risks of treatment could outweigh the benefits for elderly patients. The physician, however, would not decide to treat these patients differently out of the idea that the elderly man's life was worth less than the younger man's—what is suggested in the “lower value” portion of the Act—but rather out of the concept that the two must be treated differently because they have different medical concerns. The danger in the Act lies in the difficulty of arguing this position.

3. *Terminal Illness*

Discrimination based on terminal illness also does not have the same legal foundation as disability. Physicians may not believe certain LST is appropriate for those with terminal illnesses because they will not be able to recover from those treatments or the treatment will significantly impair their quality of life. A terminal illness is something that a doctor must take into consideration when giving treatment, not because she believes those with terminal illnesses have a lower life value, but because, if those treatments are applied, the patient's life will be worse or of a lower quality.

4. *The Problem with Ambiguity*

While the Act states that treating patients differently “[o]n the basis of a view that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill”¹⁴⁸ violates the Act, physicians may struggle to defend against a discrimination allegation. This “lower value” concept present in the Act is vague and undefined. Does it mean that the physician looks at the patient and concludes that their life does not have the same value as another patient's, or does it mean that the same physician

147. Helen A. Thomason & Matthew J. Hardman, *Delayed Wound Healing in Elderly People*, 19 REVS. CLINICAL GERONTOLOGY 171 (2009).

148. 63 OKLA. STAT. § 3090.3.

looks at a patient and determines that, if given LST, that patient's life will have a lower quality value? Even if a physician does not believe that a disabled person has less of a right to life than a nondisabled person, but simply gives them different medical treatment based on their different medical needs, it would be difficult for that physician to defend her actions. Since courts have not addressed or defined medical discrimination for most of these situations, there is little guidance from the court system in this area.

D. Consequences of the Act: Intended and Unintended

While it seems that the authors of this legislation had good intentions in creating the Act, under the plain-language interpretation approach, the Act could have devastating effects on the Oklahoma medical field. The text of the Act may force physicians to provide individuals with medical treatment even when that treatment is futile or harmful to that individual. When a physician encounters someone with a grave disease or someone at the end of her life, the physician is forced to make a value judgment, not necessarily judging the lives of these people as "lower in value," but rather of low quality depending on the prognosis. The Act prohibits these judgments determining quality of life where they are simply natural for physicians to make.

During floor discussion, the one question asked of Representative Dennis Johnson was whether the Act would apply to organ transplants, and he said that as far as he knew, it would.¹⁴⁹ But, Representative Johnson did not seem to understand the gravity of the one question asked of him or how this Act would actually affect medical procedures such as organ transplants. Quality of life judgments are imperative in medical determinations, like organ transplants, where physicians consider the general health of the patient to determine who should receive an organ.¹⁵⁰ Organ transplant centers often set their own age limits for potential candidates.¹⁵¹ This Act could invalidate those age limits and force transplant centers in Oklahoma to perform organ transplants on patients who may not only fail to qualify as candidates but also to survive the procedure itself due to age or illness.

149. *Bill Information for HB 1403: Video*, OKLA. ST. LEG. (Mar. 5, 2013), http://okhouse.granicus.com/MediaPlayer.php?view_id=&clip_id=550&meta_id=24178 (Rep. Johnson and Rep. Sherrer at 00:10:34 to 12:47).

150. UNITED NETWORK FOR ORGAN SHARING, TALKING ABOUT TRANSPLANTATION: WHAT EVERY PATIENT NEEDS TO KNOW 11-13 (2013), <http://www.unos.org/docs/WEPNTK.pdf>.

151. *Contraindications for Lung Transplant*, CEDARS-SINAI, <https://www.cedars-sinai.edu/Patients/Programs-and-Services/Lung-Transplant-Center/For-Physicians/When-to-Refer/Contraindications-for-Lung-Transplant.aspx> (last visited Nov. 17, 2015).

Furthermore, certain medical disabilities, such as schizophrenia, can make patients unlikely to adhere to the strict immunosuppression drug schedule required after an organ transplant.¹⁵² The inability to take all of the medication required for a successful organ transplant makes some patients bad candidates due to their prior medical conditions and disabilities.

Physicians are sometimes the only ones who realize how certain treatments will affect their patients. Some families refuse to sign a DNR, saying that they want every available treatment for their dying loved one because they do not want to give up preserving every last moment of available life. They often fail to realize that if resuscitation is attempted, “ribs might be fractured, and [the patient] would be pushed, pulled, and defibrillated to no avail.”¹⁵³ Providing this type of treatment for certain patients can certainly violate a doctor’s duty to “do no harm,” especially when physical harm is the only likely outcome or a when patient has a high chance of being revived only to exist in a persistent vegetative state.

We have to face that as we age and diseases attack our bodies, we are able to do less. We are able to interact with the world in lessening ways until we are barely on the precipice of life, and when continuing to live causes great pain and suffering, life is not worth living. Ending treatment is a decision that pains family members, but these decisions are easier to make for physicians because they can objectively recognize this pain and lapse of human dignity and are also required to make these determinations regularly. Yet, Oklahoma is determined to take this input away from physicians, a choice that affects the morality of physicians and mandates prolonged suffering. Doctors should be able to refuse to give treatment when such treatment would fall below the acceptable standard of medical care to which they are held.

The Act cripples the power and judgment of physicians by giving the family complete and ultimate veto power considering the end of LST. If the patient’s surrogate decision maker disagrees with the doctor as to the discontinuance of LST, the law clearly states that the physician must provide LST to that patient; if they do not, the patient or family can get an injunction to force the physician do so.¹⁵⁴ There is no recourse or reconsideration by a committee. While other states with similar laws

152. Thaddeus Mason Pope, *Defending Disability Discrimination*, *BIOETHICS* (May 31, 2013), <http://www.bioethics.net/2013/05/defending-disability-discrimination/>.

153. James J. Strain et al., *Conflict Resolution: Experience of Consultation Liaison Psychiatrists*, in *MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS* 98, 99 (Marjorie B. Zucker & Howard D. Zucker eds., 1997).

154. 63 OKLA. STAT. § 3090.4 (Supp. 2014).

qualify this provision to exclude care that would be futile, “[t]he Oklahoma law contains no such qualifier.”¹⁵⁵

In fact, the Act could cause a chilling effect on physicians. “Palliative care experts fear the new law will prevent doctors from having honest and candid conversations with patients at the end of life to make the medical condition completely clear and the various options and the ramifications of each.”¹⁵⁶ Critics of the Act think that doctors may not inform surrogate decision makers about the risks of procedures because it could be construed as going against the wishes of the patient or proxy concerning LST.¹⁵⁷ Therefore, patients and proxies may not even be educated in making healthcare decisions because doctors are too afraid to speak up about how patients may be harmed by LST and not give them the option to discontinue treatment—even if it is the best option in their medical opinion.

Public opinion on the discontinuation of LST indicates that the public does not fully understand how the treatment actually affects patients. Instead, the public focuses simply on the fact that LST discontinuation may hasten death. At a Walk for Life 2013 event sponsored by the Archdiocese of Oklahoma City, Kevin Calvey,¹⁵⁸ the state vice chairman of Oklahomans for Life at the time, spoke about the “pro-life” bills up for vote.¹⁵⁹ Discussing the bill that has become the Oklahoma Nondiscrimination in Treatment Act, Calvey gave the following scenario as one in which the bill would function:

Let’s say you have a doctor who is an atheist, and he thinks, ‘oh, you know, if you’re not gonna be walking around and talking and all that, you might as well kill yourself. So I’m not going to

155. Ollove, *supra* note 90.

156. *Id.*

157. *Id.*

158. Kevin Calvey was a Republican member of the Oklahoma House of Representatives at the time this article was published, but was not in office at the time the Act was passed. Calvey has been outspoken on pro-life issues, including dramatically reacting to an Oklahoma Supreme Court ruling against a proposed restrictive abortion law by saying,

If I were not a Christian, and didn’t have a prohibition against suicide, I’d walk across the street and douse myself in gasoline and set myself on fire! . . . To protest the evil that is going on over there, killing, giving the death penalty, to the will of the people and the will of this body and protecting the least among us.

M. Delatorre & Leslie Rangel, *Oklahoma Lawmaker Threatens to Set Himself on Fire Over Abortion Ruling*, KFOR (Apr. 27, 2015, 8:00 PM), <http://kfor.com/2015/04/27/state-rep-calvey-i-would-set-myself-on-fire/>.

159. *Walk for Life 2013*, *supra* note 109.

give you this treatment because I don't think your quality of life is very good."¹⁶⁰

Calvey called this disagreement in providing LST a “differing of philosophy” between doctors and patients or their representatives that does not give doctors “the right to put [people] to death.”¹⁶¹ He also called these decisions by doctors arbitrary and continued to use the phrase “put to death” to refer to the discontinuation of LST throughout his speech.¹⁶² This is an example of the distrustful attitude that portrays doctors as cold executioners, when really the situations where LST would be discontinued are dire and rare.

Oklahoma is already in the top ten states with the fewest doctors per person and is ranked forty-third overall.¹⁶³ Not only is there a shortage of doctors in one of the unhealthiest states in the country,¹⁶⁴ but the Act may cause the doctors Oklahoma does have to leave the state. The Act could force physicians to perform high-risk procedures on patients, which could “put a physician in the position of murdering someone.”¹⁶⁵ In fact, Dr. Jennifer Clark, an Oklahoma physician, said, “I know if this law had existed before I came here, I wouldn't have come here, and I know many of my colleagues who are in advanced specialties, such as cardiovascular surgery, general surgery, cardiology and so forth, would question about leaving.”¹⁶⁶

Doctors are charged with determining what the acceptable standard of medical care is for their patients.¹⁶⁷ That determination, as well as the

160. *Id.*

161. *Id.*

162. *Id.*

163. Samuel Weigley et al., *Doctor Shortage Could Take Turn for the Worse*, USA TODAY (Oct. 20, 2012, 2:45 PM), <http://www.usatoday.com/story/money/business/2012/10/20/doctors-shortage-least-most/1644837/>.

164. *America's Health Rankings: Oklahoma*, UNITED HEALTH FOUND., <http://www.americashealthrankings.org/OK> (last visited Nov. 17, 2015) (showing that Oklahoma is ranked the fifth most unhealthy state in the nation and has a high prevalence of physical inactivity, low immunization coverage among children, and limited availability of primary care physicians).

165. Ollove, *supra* note 90 (quoting Dr. Frank Gaffney).

166. Burke J. Balch, *Despite Attacks on Elderly and Those with Disabilities, Oklahoma Enacts Bar to Discriminatory Involuntary Denial of Treatment*, NAT'L RIGHT TO LIFE NEWS TODAY (May 1, 2013), http://www.nationalrighttolifeneews.org/news/2013/05/despite-attacks-on-elderly-and-those-with-disabilities-oklahoma-enacts-bar-to-discriminatory-involuntary-denial-of-treatment/#.VN6NTPPF_v0.

167. Prip & Moretti, *supra* note 76, at 137.

decision whether to treat, should belong to doctors rather than surrogate decision makers as mandated by the Nondiscrimination in Treatment Act.

IV. Alternative Laws and Approaches

A. Idaho Medical Futility Statute

Several years ago, Idaho was close to enacting healthcare legislation that would have allowed healthcare providers to withhold LST if they deemed it appropriate.¹⁶⁸ In 2012, however, Idaho drastically changed positions and enacted legislation that prohibits healthcare providers from refusing LST if a patient or her surrogate decision maker requests it—unless the situation fits into a narrowly defined futility category.¹⁶⁹ The statute reads:

Assisted feeding or artificial nutrition and hydration may not be withdrawn or denied if its provision is directed by a competent patient in accordance with section 39-4503, Idaho Code, by a patient's health care directive under section 39-4510, Idaho Code, or by a patient's surrogate decision maker in accordance with section 39-4504, Idaho Code. Health care necessary to sustain life or to provide appropriate comfort for a patient other than assisted feeding or artificial nutrition and hydration *may not be withdrawn or denied* if its provision is directed by a competent patient in accordance with section 39-4503, Idaho Code, by a patient's health care directive under section 39-4510, Idaho Code, or by a patient's surrogated decision maker in accordance with section 39-4504, Idaho Code, *unless such care would be futile care as defined in subsection (6) of this section.*¹⁷⁰

The statute defines “futile care” in the following way:

Futile care does not include comfort care. Futile care is a course of treatment:

(a) For a patient with a terminal condition for whom, *in reasonable medical judgment*, death is imminent within hours or at most a few days whether or not the medical treatment is

168. Thaddeus Mason Pope, *Idaho Anti-Futility Bill Signed into Law*, MED. FUTILITY BLOG (Apr. 8, 2012, 3:46 PM), <http://medicalfutility.blogspot.com/2012/04/idaho-anti-futility-bill-signed-into.html>.

169. *Id.*

170. IDAHO CODE ANN. § 39-4514(3) (West 2014) (emphasis added).

provided and that, *in reasonable medical judgment*, will not improve the patient's condition; or

(b) The denial of which *in reasonable medical judgment* will not result in or hasten the patient's death.¹⁷¹

This Idaho law, unlike the Oklahoma Act, provides an exception for futile treatment.¹⁷² Also unlike Oklahoma, the Idaho statute defines medical futility,¹⁷³ although it is an extremely narrow definition allowing for very few exceptions. The problem with the medical futility section is that it defines medical futility with vague language and in such a way that few situations will fall under the definition. LST is effectively ruled out of the medical futility definition because, without it, death will necessarily occur. Denial of LST can also make death come quicker, taking LST again out of the medical futility definition. Futile LST could not include mechanical ventilation, resuscitation, or defibrillation under the Idaho law, as the lack of these would probably also hasten the death of a person. Therefore, prong (b) of the definition rules out denial of LST in most cases, and prong (a) limits the exception to patients *so* sick as to die within hours or a few days—narrowing this exception to an *extremely* small pool of eligible patients. Therefore, the definition of medically futile treatment in the Idaho statute allows for exceptions but quickly prohibits most futile LST through its narrow definition of medically futile care.

Idaho set the precedent for Oklahoma for this kind of statute; however, Oklahoma took a more severe approach and refused to make an exception for medically futile care while also refusing to define medically futile care at all.

B. Texas Advanced Directive Act (TADA)

Texas has introduced a unique framework for LST disputes differing from most other states in the country.¹⁷⁴ Not only does it take into consideration patient autonomy, but it also considers physician autonomy and gives a procedure for resolving these disputes through ethics committees, always offering the decision to transfer the patient to a facility willing to treat them.¹⁷⁵ The TADA goes further than other state laws by

171. *Id.* § 39-4514(6) (emphasis added).

172. *Id.*

173. *Id.*

174. John M. Zerwas, Jr., *Medical Futility in Texas: Handling "Reverse Right-to-Die" Obstacles Without Constitutional Violation*, 43 TULSA L. REV. 169, 170 (2007).

175. TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2010).

defining the procedure for LST disputes between patients/surrogate decision makers and physicians.¹⁷⁶

First, a hospital ethics or medical committee must conduct a review of the treatment dispute, with at least forty-eight hours' prior notice to the surrogate decision maker, who is entitled to attend the review session. The hospital is also obligated to provide the surrogate with a detailed "Statement Explaining the Patient's Right to Transfer" and may also provide an additional "written description of the ethics or medical committee review process and any other policies and procedures . . . adopted by the health care facility." Once the review process is over, any decision shall be reduced to writing, which will be given to the surrogate and placed in the patient's medical record. If anyone involved in the process disagrees with the outcome of the ethics committee's review, the physician (with the assistance of the facility's staff) shall try to transfer the patient to another physician, an alternative care setting, or another facility where the surrogate's treatment decision can be complied with.¹⁷⁷

If a "duty to die" case is at issue, the statute provides ten days before treatment is discontinued during which a transfer can be sought.¹⁷⁸

The Texas framework attempts to resolve disputes between the family and physician rather than simply barring the physician from taking the action she deems appropriate or ethical given her medical training. The Texas method is less restrictive than the Oklahoma method and gives doctors the power to make decisions that correspond with their ethical conscience. The statute lays out the entire procedure that physicians with ethical objections must follow when advocating for discontinuing treatment, so as to satisfy due process. Laying out these procedures is extremely important because it gives both sides expectations. Some have come to distrust the medical community, but this framework mitigates that distrust by showing fairness to both sides. The physicians cannot simply override the patient or their surrogate decision maker's wishes, but surrogate decision makers do not get the final say in the situation either. The disagreement goes through an ethics committee, which reviews the case and gives a recommendation. These unbiased third parties review this

176. Thomas William Mayo, *The Baby Doe Rules and Texas's "Futility Law" in the NICU*, 25 GA. ST. U. L. REV. 1003, 1005-06 (2009).

177. *Id.* at 1005-06.

178. *Id.* at 1006.

information, like any hospital system would, and then make a decision, but there is no “death panel.” While an ethics committee may recommend that the LST be discontinued, the family can always try to find another facility to transfer the patient, and then both parties come out on top—the patient receives LST and the original physicians are relieved of the burden of performing treatment they deem unethical.

Individual hospital procedures for handling ethical dilemmas vary widely, and the family does not always know what the process is for making these decisions.¹⁷⁹ The legislature, by providing a framework, makes the system more transparent, thus making the process easier on medical professionals, patients, and their families. The TADA tries to protect doctors and their professional morality by allowing for a review process rather than barring the denial of LST altogether, like the Oklahoma Act.

C. The Use of Ethics Committees to Make Decisions on Medical Futility—A Unique Tool

Ethics Committees are qualified third parties who can make objective, ethical decisions regarding the denial of LST. In the TADA, Texas delegates authority to the ethics committees of the hospital where the patient is being treated. The committee then reviews the situation and decides whether an individual should continue to receive LST or whether that individual should not receive LST at that hospital anymore, thus triggering the ten days for transfer or cessation of LST.¹⁸⁰

These hospital ethics committees have different makeups of members.

The advance directives law requires hospitals to convene ethics committees to resolve disputes that emerge when the patient’s family disagrees with a physician’s assessment that life-sustaining treatment be discontinued. The precise composition of the committee is not dictated by law, but typically they are composed of medical professionals not directly connected with the case under review, clergy, social workers and community leaders. The patient’s attending physician is not a member of the committee but presents the medical case to the committee. This group of compassionate, informed and objective individuals

179. Alice Herb & Eliot J. Lazar, *Ethics Committees and End-of-Life Decision Making*, in *MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS* 110, 111 (Marjorie B. Zucker & Howard D. Zucker eds. 1997).

180. TEX. HEALTH & SAFETY CODE ANN. § 166.046(a), (e) (West 2010).

examine and assess the patient's medical case to determine whether treatment should continue. Patient liaisons are usually assigned to families in these situations to help them navigate the process.¹⁸¹

Individual hospital committees can have a better understanding of why the physician is recommending the discontinuation of LST than the family or a court. Ethics committees are often better forums for resolving disputes, like those over the denial of LST, because courts lack medical and ethical expertise to make these decisions.¹⁸² Courts expend time and money when considering the expert testimony required to hear these cases—assuming the family or patient can afford the expert in the first place.¹⁸³ An ethics committee can also consider an LST case in a more intimate setting than a court, as issues are kept private rather than made public record in an adversarial setting.¹⁸⁴ In addition, since ethics committees are not bound by precedent as courts are, committees can better consider these issues on a case-by-case basis.¹⁸⁵

The ideal Oklahoma statute would delegate decision-making power to a committee like this. The committee would be an objective panel made up of community members, physicians, and health administrators so as to incorporate many different perspectives. This group, acting as an objective third-party decision maker, could be more objective than representatives from the hospital where the dispute is occurring. Oklahoma could create one committee to consider all of the disputes statewide. This would also probably be ideal since each individual hospital ethics committee differs in composition, policies, and intent of the administration.¹⁸⁶ It would probably be helpful for individual hospital committees to make a recommendation to this statewide committee in order to better resolve the process.

D. Transfer of a Patient—A Win-Win for Both Parties

If an ethics committee decides that LST should be discontinued, that is not the end of the issue in Texas. The most that TADA allows, if the ethics

181. TEX. HOSP. ASS'N, *Advance Directives*, <http://www.tha.org/Public-Policy/Issues/Advance-Directives> (last visited Mar. 10, 2016) (click on "Overview of Texas Advanced Directives Law" under the "Legislation" tab to download the PDF).

182. Robin Fretwell Wilson, *Hospital Ethics Committees as the Forum of Last Resort: An Idea Whose Time Has Not Come*, 76 N.C. L. REV. 353, 370-76 (1998).

183. *Id.* at 376-78.

184. *Id.* at 378.

185. *Id.* at 378-80.

186. Herb & Lazar, *supra* note 179, at 112.

committee decides that LST should not be continued, is a transfer to another facility.¹⁸⁷ In rare situations, no other hospital or facility will take the patient because they believe it is unethical to treat the patient. However, if the family wants the patient to be transferred, that is usually possible.

An example under TADA where transfer did not occur is Sun Hudson—one of the very rare cases where the hospital removed a patient from life support against a family member's wishes and without an advanced directive from the patient.¹⁸⁸ Sun was born with thanatophoric dysplasia that caused, among many other medical problems, respiratory distress, and because his chest cavity and lungs would never grow, he would eventually suffocate to death.¹⁸⁹ Sun's mother¹⁹⁰ opposed discontinuation of treatment and wanted him to continue to be on a ventilator.¹⁹¹ She was evaluated in a psychiatric facility but released, and she accused doctors in the hospital of wanting to murder her son because they recommended removing him from a ventilator and feeding tube.¹⁹² The ethics committee of the hospital considered this situation and found that Sun was in excessive pain from the fatal condition and, under the TADA, notified the mother that they would be removing Sun from treatment unless a transfer facility could be located within ten days.¹⁹³ The hospital accommodated her by granting her several extensions when no facility could be found, and when she reached the end of her extensions, the hospital found her legal representation and even paid her legal fees.¹⁹⁴ She sought an injunction to stop the hospital from taking Sun off of life support, and received relief for five months.¹⁹⁵ Eventually, the probate judge ruled in favor of the hospital and found that, even if they kept giving her extensions, there was no reasonable expectation that another

187. TEX. HEALTH & SAFETY CODE ANN. § 166.046(d) (West 2010).

188. Craig A. Conway, *Baby Doe and Beyond: Examining the Practical and Philosophical Influences Impacting Medical Decision-Making on Behalf of Marginally-Viable Newborns*, 25 GA. ST. U. L. REV. 1097, 1125-26 (2009); Zerwas, *supra* note 174, at 180.

189. Conway, *supra* note 188, at 1125-26; Zerwas, *supra* note 174, at 180.

190. Sun's mother named him Sun because she believed that he was conceived not by a human father, but instead by the sun and the sky and that because of this, he could never die. Zerwas, *supra* note 174, at 180.

191. Conway, *supra* note 188, at 1126.

192. *Id.*

193. *Id.* at 1126-27.

194. *Id.* at 1127.

195. *Id.*

facility would take Sun in for treatment.¹⁹⁶ The hospital then removed Sun from life support, and he passed away.¹⁹⁷

This example shows that, unlike the picture painted by Kevin Calvey, hospitals and physicians faced with medically futile situations go through great lengths to do what is best for their patients, whether it is transferring a patient under TADA or even helping with legal fees. The Sun Hudson case also shows that if no hospitals will accept the patient transfer to their facility many members of the medical community probably agree that the quality of life of that person is low and would not wish to have any part in extending it.

Oklahoma should allow physicians, as the TADA does, to use their medical training to make this decision and come to this consensus that it would be unethical to treat the patient, rather than forcing them to do so by acting against their morals. The current Act prohibits this. Oklahoma should adopt a new statute that allows physicians to decline treatment when they believe treatment would be medically futile and thus fall below the appropriate standard of care. The state should do this by putting ethics committees and a system of transfer in place, as well as adopting the UHCDA.¹⁹⁸

V. Conclusion

There are worse things than death. While we do not know how the Act is affecting physicians or patients in Oklahoma, a plain-language interpretation of the Act would restrict the ability of physicians to make medical decisions that correspond to their professional ethics. While there is a right to refuse medical treatment, there is no corresponding right to demand medical treatment from physicians, and therefore physicians should only have the responsibility to provide treatment that corresponds with the standard of care—especially if LST would, in a physician’s opinion, not reach that standard. Supplying a framework for the ethical dilemma of discontinuing LST, as Texas has done with TADA, benefits both the patient, or surrogate decision maker, and the physician by providing expectations for dispute-resolution procedures and by establishing a fair decision-making process for a physician faced with an ethical dilemma.

The historic goal of the medical profession to “do no harm” should continue to guide the decisions of physicians rather than the pro-life motto

196. *Id.*

197. *Id.*

198. *See supra* Section II.B.

“at all costs.” If the legislature allows physicians to do their jobs in an ethical way, public attitudes might change to view physicians not as those condemning patients to death but instead allowing them to exit this world peacefully.

Kendra Norman