Journal of medical ethics, 1983, 9, 113–115

Report from America

Public debate on issues of life and death

Bernard Towers *University of California, Los Angeles, USA*

The issues of when and when not to resuscitate after cardio-pulmonary arrest, and when not to withdraw 'extraordinary means of life-support' from a patient who is judged clinically to be on a trajectory leading to imminent death (or who may actually be dead already according to some definitions), have been publicly debated for at least a decade and a half. In England in 1968 the medical director of a hospital in North London (Neasden) was hounded by the media for the guidelines he issued to house-staff on the kinds of clinical situations in which it would be appropriate to write NTBR ('Not To Be Resuscitated') on a patient's chart. He was vilified by some commentators as though he were the commandant of a Nazi internment-extermination camp. In the same year in America a prestigious Harvard committee issued its famous report (1) on circumstances of irreversible coma where one could legitimately declare that death had already occurred. In those circumstances, said the report, it would be permissible to withdraw respirator and other life-sustaining supports prior to or even after removal of fresh and indeed still living organs for the purposes of transplanting them into a needy patient.

The debate has continued ever since, both in private and in public and with fluctuating intensity. The name of Karen Ann Quinlan is almost a household phrase. People are often astonished to learn about her current clinical condition. The usual response is one of distress and even horror. One rarely meets anyone who thinks of her continued survival as a cause for joy or gratitude for the 'miracles of modern technology' that supported her cardio-respiratory systems at a time when they would almost certainly have ceased to function if nature had been allowed to take its course.

The recent charge of murder against two California physicians (2) focused intense light both on these issues in general and, more especially, of course, on the specific circumstances of the death of Clarence Herbert in California on September 6, 1981. His death had followed on a post-operative cardio-pulmonary arrest on August 26 and the subsequent disconnection, at the family's request, of all life-support systems.

The preliminary hearing, previously set for December 3, 1982, finally began on January 18, 1983 in the Los Angeles County Municipal Court before Judge Brian D Crahan. The evidentiary portion, which was very closely followed and was widely reported in press, radio and television, concluded on February 16, when the defence rested. Judge Crahan requested prosecution and defence attorneys to file written briefs by February 25. The oral arguments were heard at the beginning of March, and on March 9 the judge issued a thirteen-page Decision in which, after summarising the facts and some of the testimony (mostly for the prosecution) he posed 'The issue: Have the People produced sufficient evidence to hold the attending physicians to answer to the charge of murder, or to the second charge of conspiracy to commit murder?'

The Decision continues with statements and clarifications of the law, and with summaries of some of the testimony of witnesses for the defence. Prominence is given to the testimony of Father John J Paris, SJ, Chairman of the Department of Religious Studies at Holy Cross College (Worcester, Massachusetts) and Professor of Medical Ethics at Tufts Medical School. Fr Paris had argued that physicians have no obligation to give intravenous fluids to a patient who has no hope of 'recovery' which he defined as staying alive without intolerable suffering or, in the case of a comatose patient, returning to a state of awareness. Reports of this testimony in the *Los Angeles Times* gave rise to sharp exchanges between Fr Paris and a representative of the Archdiocese of Los Angeles and theologians from Loyola Marymount University. The Catholic position is uncertain, and the Catholic Hospitals Association is currently drawing up its own Guidelines. The judge states the issue boldly: 'Should one prolong the *living* or the *dying* process by heroic efforts?' He states the pros and cons and concludes that

'. . . if termination of heroic support or IV treatment of a severely comatose patient is a crime, then obviously we are proposing to the medical community that to avoid committing such a crime, one *never* hooks up patients to heroic support, whenever there is a collapse or signs of potential terminal illness. One who is not connected to such equipment can never be disconnected. Obviously, it would be contraproductive to medical science to put the medical profession on such notice.'

The judge ruled that there was *not* enough evidence to order the physicians to stand trial on charges of murder

and conspiracy to commit murder.

That, of course, is not the end of it. It is reported that the District Attorney's office will appeal the decision. Moreover, there is a civil malpractice suit in file against the hospital and doctors. This has been brought by the widow and children of the deceased, who complain that they were told the patient was 'brain-dead' or 'clinically dead,' to persuade them to allow for withdrawal of all life-support systems.

The results of the preliminary hearing were greeted with relief by local physicians who had been hesitant to exercise their best clinical judgments in similar cases during the past few months. The obligation to exercise best judgment was stressed by Judge Crahan towards the end (page 11) of his decision:

'The medical community has a duty to provide at all times reasonable patient care using its collective best judgment on what is appropriate. In severely terminal cases, the community understanding is clear; that is, termination of all life-support systems is indicated at some point in time during the dying process.'

The judge also made it clear that

'this conclusion does not, however, necessarily give comfort to the medical community in future similar decision-making processes. A decision in this case adverse to the prosecution in no way precludes the prosecutor in this County, or for that matter in any other place, in an *appropriate* case, from filing similar charges when "unlawful conduct" can be shown clearly and simply. The problem in this case is not "the taking of a life," but rather the absence of evidence that the taking, if indeed there was such, was done by means of unlawful conduct on the part of the attending physicians.'

In other words, each and every clinician has the personal responsibility to exercise not only sound clinical judgment but also sound ethical judgment. Sound legal judgment then suggests careful recording in the chart of all the steps that were taken (and with whom) in the decision-making process.

There are four current 'movements' in America related to this theme:

1) A flurry of statements from national and state medical associations and hospital associations about appropriate management of dying patients, and the issuance or the promise of written guidelines for member-organisations to promulgate and for individual physicians to follow. It will be recalled that Drs Barber and Nejdl *had* followed local medical-legal Guidelines, but were not thereby protected from a zealous public prosecutor.

2) There is a possibility that the California Legislature will shortly have before it a Bill that, if enacted into law, would be calculated to protect physicians in similar circumstances from prosecution. The drafting of such a Bill, and handling all the conflicts it will generate, will require great skill, knowledge and insight on the part of the legislative body and its advisers.

3) The Federal Government recently jumped head-first into the issue of the provision of life-prolonging measures for newborn infants with severe and even terminal malformations and deformities. President Reagan made many promises to the 'Right to Life' movement. The politically-appointed Surgeon-General, C Everett Koop, is a paediatric surgeon who is well-known for his advocacy of extreme measures for 'saving' malformed newborns no matter how severe might be their condition or how grave the prognosis. Rules published in the Federal Register on March 7, 1983, and scheduled to take effect before the end of the month, require hospitals to display treatment rules that in effect *require* intravenous administration of water and nutritional substances if the baby cannot take them by mouth. The language that was previously used by the sensational press is now incorporated into government documents, namely the implication that any patient who died without an intravenous line was being 'denied food and water' or was 'starved to death'. Protests from the American Academy of Pediatrics and from ten or more other medical associations have been filed, with a request that these regulations be deferred until there has been public debate on the implications. One implication is that of costs.

4) The dollar cost of life-sustaining or death-prolonging procedures is a highly-charged topic in which a whole spectrum of views is beginning to emerge. The quality of debate may be reduced by the fact that existence of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research will terminate on March 31. One of its last reports will be on 'Resuscitation and the Decision Against'. The minutes of the meeting at which the final draft of the report was debated indicate that the commission's views include (a) that health care institutions may restrict the availability of options in order to use limited resources effectively, and (b) that society may limit the availability of certain options to advance equity or the general welfare.

The practical effects of such triage in a period of financial constraints will be the source of much heated debate in all sections of society. Given the variety of health-care systems and all their various modes of funding in the United States, it is clear that charges of 'penny-pinching' (2) will proliferate against any and all systems. One health insurance system (Blue Shield of California) recently recommended that every hospital establish a bioethics committee to consider life-and-death decisions. The cost might be borne by the insurers. That sounds innocent enough, and may indeed be praiseworthy. A critique currently in press, however, is entitled 'Ethics Committees: A Turn for the Worse (3). The American Society of Law and Medicine and the organisation called Concern for Dying were at the time of writing co-sponsoring a conference on 'Institutional Ethics Committees: Their Role in Medical Decision-making' in Washington, DC, April

21–23, 1983. One hopes that some of the dangers of shifting clinical decision-making away from the bedside into a committee-room, especially when financial considerations loom large, will have been clearly spelled out.

American medicine is finally beginning to realise that resources are *not* unlimited. Given that there is now little or no hope for a national health-insurance system, one can expect that the next ten years will see intense competition between old and new systems of health-care. Already in California there is open competition for state and industrial contracts between individual hospitals and newly-created groups of health-care providers offering a wide range of coverage at all kinds of prices. In the open market the buyer must always beware. Is there a difference between buying health care (or 'sickness care') and buying other goods and services in a free economy? We can expect many years of very costly conflicts in America.

References

(1) A definition of irreversible coma, Report of an *ad hoc* Committee of the Harvard Medical School to examine the definition of brain death. *Journal of the American Medical Association* 1968; 205: 337–340.

(2) Towers B. Irreversible coma and withdrawal of life support: is it murder if the IV line is disconnected? *Journal of medical ethics* 1982; 8: 203–205.

(3) Ross J W, Towers B and Winslade W J. Ethics committees: a turn for the worse. *Möbius* 1983; 3(3): University of California Press (in press).

News and notes

Workshop on ethical issues

The Hastings Center, Institute of Society, Ethics and the Life Sciences, is holding a workshop on Ethical Issues in the Health Professions and the Biomedical Sciences at Vassar College (75 miles north of New York) from June 19–24.

The purpose of the workshop is fourfold: To bring together those from a variety of different professions and disciplines within health care to examine key issues in biomedical ethics; To allow those from the same profession within health care to work together in a systematic fashion on significant moral issues within their own area; To enhance the knowledge and analytical skills of those concerned with the teaching of ethics in health care and the biomedical sciences; To provide ideas, techniques, and topics to those concerned with establishing courses or programmes on ethics within the health professions and biomedical sciences.

The workshop is meant to serve health care professionals, teachers, government officials, university professors, and others who want to examine the social and ethical impact of medicine and the biomedical sciences.

The workshop fee is $300 in addition to room and board charges.

Application forms can be obtained from Workshop on Ethical Issues in the Health Professions, The Hastings Center, 360 Broadway, Hastings-on-Hudson, New York 10706, USA. Telephone: 914/478-0500.