Helping the Dying Die: Two Harvard Hospitals Go Public with Policies

One day a couple of years ago, Mitchell Rabkin, director of Harvard's Beth Israel Hospital in Boston, was walking down a corridor when he came upon a nurse standing outside a patient's room, crying. The patient, upon whom the nurse apparently had lavished particular care, was a man dying of metastatic cancer. A few minutes before, he had suffered a cardiac arrest and, as the nurse stood helplessly in the hallway, a crack resuscitation team was bringing him back to life. "Why," she asked Rabkin, "can't they let him die in peace?"

Rabkin did not know how to answer her question, but the incident stuck with him and he thought about it a lot. It became, he recently told *Science*, an important factor in his decision to formulate an official hospital policy defining those circumstances in which it would be acceptable, indeed, desirable, to issue "orders not to resuscitate" a dying patient.

With the help of lawyers, ethicists, and other scholars, Rabkin spent much of last year drafting a policy which he published in the 12 August issue of the *New England Journal of Medicine* in hope of finding out what people think about it. The same issue also carries a report from the Massachusetts General Hospital (MGH) where a formal policy about letting people die has been in effect for about 6 months. A third article talks about living wills.

It is well known in medical circles that physicians sometimes quietly let a patient die. When it seems certain that nothing more can be done, the physician may decide to turn off a respirator or withhold antibiotics or otherwise give up the use of so-called "heroic" measures to keep someone alive when death is imminent. Physicians do it, but they don't talk about it much.

Given the closeness with which this subject has been held, it is noteworthy that the administrators of two major hospitals have decided—independently of each other—to go public. In an editorial in the *New England Journal*, Charles Fried of the Harvard Law School calls their willingness to "come out of the closet" an event of the "first importance." Several other lawyers and ethicists contacted by *Science* said they had not yet read or had time to assess the merits of the two hospitals' somewhat different policies but agreed that by opening public debate they are doing something that should have been done long ago.

But the debate can be a thorny one because once the subject comes up, it leads sooner or later to the emotionally charged question of euthanasia. Physicians clearly do not want what they consider the humane act of letting the dying die to be confused with mercy-killing. So far, no anti-euthanasia group has stormed the doors of either the MGH or the Beth Israel but there is reason to think, because of their stated opposition to living wills, that such groups will see any policy such as these as one step on the path to hell.

It is interesting that the two hospitals that are first to speak out are in Boston, a largely Roman Catholic city where questions of physicians' respect for the sanctity of life were raised so dramatically, and threateningly, in the abortion issue and the trial of Kenneth Edelin (*Science*, 7 March 1974). But on this matter of letting people die, the hospitals may find themselves on safer ground. The Church does not condone euthanasia, but the Pope has said that it is morally justifiable to withhold heroic measures from those who are about to die.

The policies of the two Boston hospitals should be seen, perhaps, only as an initial attempt to come to grips with a difficult fact of life. Neither, really, is perfect. Fried calls them "incomplete and troublesome in various ways."

The MGH policy, called "Optimum Care for Hopelessly Ill Patients," is the work of the hospital's Critical Care Committee headed by Henning Pontoppidan, an anesthesiologist. As is typical of hospital committees these days, in addition to physicians the group includes nurses, a psychiatrist who is also a Jesuit priest, a lawyer, and a patient—in this case, a woman who has recovered from cancer.

Under the new MGH protocol, the first step in the process of determining care for the critically ill is to classify such patients according to the probability of their survival, as follows:

- Class A: "Maximal therapeutic effort without reservation."
- Class B: Same as A but "with daily evaluation because probability of survival is questionable."
- Class C: "Selective limitation of therapeutic measures." In these cases, there might be orders not to resuscitate, a decision not to give antibiotics to cure pneumonia, and so on.
- Class D: "All therapy can be discontinued." Class D is generally only for patients with brain death or who have no chance of regaining "cognitive and sapient life"—a Karen Quinlan.

The MGH guidelines, apparently written with the presumption that patients ill enough to be candidates for treatment withdrawal are likely to be comatose, as often is the case, deal in detail with the relationships that should exist among the patient's primary physician, nurses, and other staff, and a new, permanent hospital committee on the optimum treatment of the hopelessly ill. In theory, the primary or "responsible physician" has full authority over the patient's treatment, including the option of rejecting the advice of the committee, or not seeking it at all. But that absolute authority would seem to be somewhat mitigated by provisions in the guidelines such as one that says if the physician does not want to discuss treatment rationale, the director of intensive care can go to the chief of service and the committee can be called into action whether the physician wants to hear from it or not. It would take a courageous, or foolhardy, physician to act against the institutional judgment of his peers, whether it was he who wanted to terminate treatment and they who wanted to keep trying, or the other way around.

The MGH reports that in its pilot study of its guidelines, 209 patients have been classified A to D, but the hospital refuses to disclose how many individuals were assigned to each of those classes, how many were switched from one to another as their health improved or declined, or what the outcomes were. (That information, an MGH spokesman says, is being saved for another *New England Journal* article. The authors are afraid that their paper will be turned down if they give away their data now.) On 15 occasions the committee was called upon to help resolve issues about the appropriateness of classification or treatment.

The main criticism of the MGH policy is that, by focusing on the relationship between the physician and hospital staff, it appears to have little regard for the rights of the patient and his family. Although it does say that no "definite act of commission," such as pulling the plug on a respirator, can be done without the concurrence of the family, the tone of the MGH statement reflects what one ethicist called the "missing patient syndrome."

By contrast, the Beth Israel policy focuses directly on the right of the patient to make decisions about his own care, and is consistent with that hospital's leadership in the patients' rights movement. (In 1972, Beth Israel was the first hospital to draw up a "patients' bill of rights" which is given to every patient at the time of admission.) Although the Beth Israel statement, "Orders Not To Resuscitate," calls for the establishment of a committee, its role seems limited to advising the primary physician on whether the patient's death is so "certain" and so "imminent" that resuscitation would serve no purpose. Once such a decision is made, on what Rabkin defines as "physiologic grounds," responsibility for actually deciding to issue orders not to resuscitate shifts to the patient and his family, which can give consent for a patient who is not able to speak for himself. Where there is no consent, there can be no orders not to resuscitate.

Whereas the Beth Israel position outdoes that of the MGH in its expressed concern for patients' rights, it falls short with respect to medical scope, dealing only with cardiac resuscitation rather than the full range of death-prolonging technologies. Rabkin says he hopes to remedy that this year.

One potential solution to the dilemma over the patient's right to give informed consent at a time when he may be unable to do so is the so-called "living will," in which an individual declares his desire not to be kept alive at all costs. In the third article of the *New England Journal*'s trilogy on the right to die, ethicist Sissela Bok calls the best known of the living wills, that of the Euthanasia Education Council (*Science*, 26 December 1975), "vague in such a way that real risks of misinterpretation arise"—it refers to but does not define "physical and mental disability," for example. She proposes a version of her own.

Unlike other versions of a living will, Bok's will is written as an order, not a plea that others will be good enough to see things your way, and it provides space to authorize two persons—relatives, friends, lawyers, whomever—to see to it that one's wishes are carried out. In addition, the Bok will leaves room for the inclusion of very personal instructions. She has in mind the fact that some patients might want pain-killers, even in amounts that might hasten death, while others would not. One person might want to be kept informed of his condition, no matter how bad, while someone else would not want to know.

Bok's version of a living will has the advantage of meeting many more contingencies than do others. But it also requires more thought and effort on the part of anyone wishing to execute it which, one could argue, is the way it should be. (At present, no state recognizes any version of a living will as legally valid, although several legislatures are considering laws to change that. On 30 August, California became the first state in the nation to pass a bill that would sanction a living will, but the governor has yet to sign it.)

One of the great unresolved issues in this whole matter of helping the dying to die is the legality of withdrawing or withholding treatment. Fried reports there has been little litigation on the subject and not much in the way of legislative law. As long as a patient is mentally competent, there is no doubt about his legal right to refuse treatment. In fact, to force treatment on such an individual could be considered battery. It is when a case can be made that the patient's judgment is impaired that problems arise. As Fried explains it, once a physician begins to treat a patient, he assumes an obligation to do everything that is reasonable on his behalf. To do otherwise would be negligent. The hard question then becomes, What is "reasonable?" And that is something about which there is not much agreement.

Decisions, Fried predicts, are going to end up being made by juries as cases are brought before the courts, and that is where legally binding living wills and formal hospital policies may come to have their greatest effect.

With respect to hospital policies on withdrawing or withholding life support, Fried believes they could be important in helping a jury assess the "reasonableness" of a physician's action—it could be argued that it is reasonable to act in accord with hospital policy. However, he doubts that any policy, of itself, could ever provide immunity from prosecution.

There are problems with the prospect of hospitals establishing formal guidelines for the care of those about to die, and the greatest may lie in the inevitable fact that committees will now be introduced to a facet of human life that many people believe is already too much in the hands of institutions. As a surgeon from Walter Reed Army Hospital said in a letter to Fried, official guidelines will benefit only lawyers and administrators, while making it infinitely more difficult for physicians to do for the dying what most of them have been doing all along.

On the other hand, the idea has its virtues, one of which is that guidelines would let physicians, hospital personnel, and patients and families know where they stand. It is fanciful but not inconceivable to imagine a time when patients might chose one hospital or another on the basis of its particular policy, assuming that hospitals in any community have clearly different views about the right thing to do.

"The idea that we will ever reach a consensus on these matters is ridiculous," says Fried. "What I'd like to see is the evolution of a more flexible attitude, an admission that wishing to die is not always unreasonable." What we need is room enough to allow for individual choice.—BARBARA J. CULLITON

Robert Gillette, a member of the News and Comment section since 1971 and a Nieman fellow at Harvard University for the past year, has joined the Los Angeles *Times* as a science writer.

APPOINTMENTS

William R. Johnson, interim vice president for academic affairs, Texas Tech University, to vice president at the university. . . . **James Sawrey**, dean, School of Social Sciences, San Jose State University, to vice president for academic affairs, Austin Peay State University. . . . **Eldon Sutton**, associate dean of graduate studies, University of Texas, Austin, to vice president for research at the university. . . . **Louis D. Volpp**, professor of economic theory, marketing, and mathematics, Columbia University, to vice president for academic affairs, California State University, Fresno. . . . **Cedric Davern**, professor of microbiology, University of Utah, to dean, College of Medicine at the university. . . . **Vel Nair**, vice chairman, pharmacology and therapeutics department, University of Health Sciences/Chicago Medical School, to dean, School of Graduate Postdoctoral

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The Beth Israel and Bok papers grew out of discussions of the Law and Ethics working group that is part of a multidisciplinary faculty seminar that meets every other Thursday at the Harvard School of Public Health and includes scholars from the entire Boston-Cambridge academic community.