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THE DYING PATIENT, THE DOCTOR, AND THE LAW

J. RUSSELL ELKINTON, M.D.†

I. INTRODUCTION

THE PRIME FUNCTION of the law is to protect human values; hence, the law is concerned frequently with human death. The prime function of medicine is to promote human health; hence, the physician is concerned intimately with the prevention or postponement of human death. In carrying out this professional activity the physician is constantly making decisions that are determined by his understanding of the needs of the patient, by his professional competence, and by the moral, ethical, and legal framework of the society in which he functions. Thus, the law and society have a direct interest in these decisions, an interest that is heightened by the greatly increasing power that rapid biomedical advances have given to such decisions. As Judge Burger has said: "The law always lags behind the most advanced thinking in every area. It must wait until the theologians and the moral leaders and events have created some common ground, some consensus."¹ As lawyers, theologians, and physicians concerned with the care of the dying patient, we are holding this Symposium to assist in the search for such a consensus.

II. MEDICAL DECISIONS ABOUT THE DYING PATIENT

The doctor has always had to make decisions about his patient who is threatened with death. Until recently, such decisions have been less crucial because he has had relatively little power to bring to bear on the issue. Now, for at least some of his patients, new knowledge and its tools — antibiotics, potent drugs, intravenous fluids, resuscitation apparatus, artificial and transplanted organs — enter into the decisions that affect the time and nature of the act of dying. In his efforts to preserve life and restore health, the physician sometimes may fail to give enough consideration to his other obligation, namely, to relieve suffering and to allow the patient, if he is to die, to die with comfort and dignity. This *if*, of course, lies at the very heart of this dilemma that repeatedly faces the physician.

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There is another aspect to the decisions which the doctor has to make today in the care of dying patients: never before has he had to make such decisions so squarely in the public eye. During the past few months the lay news media have given extensive coverage to a series of dramatic medical stories which have seized the public interest and which illustrate this problem. The first of these was the posting in a hospital in England of a notice directing which patients — in the case of cardiac or respiratory arrest — should be resuscitated *and which should not*; those over 65 years of age or with certain diseases fell under the interdict. More widely reported have been the stories of human heart transplants. For the first time in medical history, the human heart is being transplanted from patients just dead into patients who are dying. With such eye-catching phrases in news stories as “who shall die,” “when are you really dead,” and “playing God,” and with serious feature articles and discussions on television, the lay press and news media are bringing home to the public some of the basic ethical, social, and legal problems involved. The public is becoming much more aware and wants to know, and indeed should know, about these problems; after all, not only are they the final arbiters of the moral standards and the laws operative in our society — they are the patients.

Every experienced doctor knows the problems in general care of the dying patient and his family. There is nothing new about these problems; they have been written about by physicians who have stressed the need for understanding and compassionate support of the patient to the very end² and by sociologists who have emphasized the importance of the awareness of the impending death by each member of the social unit involved.³ The physician tries very hard to meet his responsibilities in this situation, but he knows that sometimes his diagnosis, and particularly his prognosis, can be wrong. This knowledge tempers his decisions as to what to do and what not to do for an apparently dying patient. But given a patient who in the doctor's best medical judgment has no foreseeable chance of recovery, to what lengths does one go to prolong the patient's life? Specific answers to this question can only be given in specific cases, but always the answers involve making value judgments concerning the quality of the patient's remaining life in addition to estimating its possible duration. These judgments are not easy ones to make.

2. See J. HINTON, DYING (1967); A. WORCESTER, THE CARE OF THE AGED, THE DYING AND THE DEAD (1st ed. 1935); Alvarez, *Care of the Dying*, 150 J.A.M.A. 86 (1952); Aring, *Intimations of Mortality*, 69 ANNALS INT. MED. 137 (1968). Bean, *On Death*, 101 ARCHIVES INT. MED. 199 (1958); Bulger, *Doctors and Dying*, 112

3. See B. GLASER & A. STRAUSS, AWARENESS OF DYING (1965).

III. CATEGORIES OF DYING PATIENTS

There are four main categories of dying patients in whose cases prolongation of life is a problem: (1) the patient with acute cardiac or respiratory arrest who requires instant resuscitation; (2) the patient whose prognosis is hopeless and who is being maintained on supportive therapy; (3) the dying patient who is a potential cadaveric donor of an organ — kidney, liver, or heart — to another dying patient; and (4) the patient who is dying of an intractable disease but whose life may be prolonged and indeed rehabilitated by the transplantation of a living organ or the use of an artificial organ. The problems of the first two types of patients are the ones that are met most frequently by physicians in their day-to-day practice. There are many fewer patients in the last two categories, but their problems currently are presenting dramatic examples of the moral, ethical, and legal dilemmas being posed by the rapid advances in biomedical science. The fourth category, however, differs from the other three in that survival for a much longer period, and even rehabilitation, is under consideration, and hence grave socioeconomic problems are raised as well.

A. The Acutely Dying Patient

The patient with acute cardiac or respiratory arrest seldom presents — at the moment of urgent decision — any great ethical problem. This is the patient who has had a sudden coronary occlusion, or has been electrocuted, or is drowning. Every effort should be made to resuscitate him immediately. Contra-indications to such efforts include a period of cerebral anoxia long enough to cause failure of return of cerebral function, and any other relevant medical factor known to the responsible physician concerning that particular patient. With the rapidly increasing number of intensive care units, opportunities for such resuscitation are becoming much more frequent.

B. The Patient with a Hopeless Case

For the patient with a hopeless case, relief of suffering is surely the primary goal — that is, if the case really is hopeless. Most of us who are physicians remember patients who, with vigorous treatment, have lived, at least for a while longer, when we had predicted that they would die; hindsight tells us that the prognosis had not been as hopeless as we had thought. But many patients almost surely do have

intractable pain? If the patient is unconscious for a very long time (*i.e.*, decerebrate either because of intracranial disease or injury or as the result of a partially successful attempt at resuscitation), he is unaware of pain; but again his case poses the problem: should life be prolonged in a "living" organism that no longer is a person? One way that the compassionate physician can answer these questions is to withhold therapeutic measures that would prolong life — an "invisible act" of omission.⁴ If therapeutic measures include machines already in use, such as respirators or cardiac pacemakers, the decision becomes more difficult and less "invisible" (someone has to pull the plug or turn the switch). It is still an act of omission but the ethical and legal dilemma remains: is this an act of mercy or an act of murder?

Theologians and lawyers, as well as physicians, have given attention to this dilemma. Perhaps the most famous pronouncement of a Christian church is that of Pope Pius XII. In 1957, in response to a question as to whether a doctor should stop artificial respiration in a moribund patient, he replied that the doctor is required to use *ordinary*, but not *extraordinary*, means to prolong life.⁵ If extraordinary treatment (such as use of a respirator) is stopped, the patient dies not from that act but from the underlying disease or injury. The use of this guideline, however, presents a twofold problem; first, precisely what is extraordinary treatment must be defined, and second, what is extraordinary treatment today may be ordinary treatment tomorrow, or such treatment may be extraordinary in Tibet but ordinary in the United States. Anglican opinion on this problem has been expressed recently by the Church Assembly Board for Social Responsibility:⁶ life is good, a gift of God, and death should be a voluntary surrender. In a given case the decision to extend treatment so far *but no farther* can be arrived at both from a utilitarian approach (balancing the patient's interests with those of society) and the Christian approach (that it may be God's will and an act of love to relinquish a life that no longer has meaning as a human person). The responsibility for the decision lies squarely on the individual physician, but he must remain answerable to society and to God.

4. More than 20 years ago, I was responsible for the care of a young woman in the end state of multiple sclerosis. She was in great pain and had widespread ulcerations over the surface of her body from which she developed a septicemia (infection of her blood stream). At that time a new antibiotic, penicillin, had just become available. With the agreement of the patient's family, I withheld the penicillin and the patient died quickly — her suffering was relieved. Penicillin is an ordinary treatment today but I would still make the same decision.

5. Pope Pius XII, *Replies to Some Important Questions Concerning "Reanimation"*, in DISCOURSES AT MEDICAL CONFERENCES, BOARD OF SOCIAL RESPONSIBILITY, DECISIONS ABOUT LIFE AND DEATH (1965).

Physicians who have written of this heavy responsibility agree, in the main, with this conclusion but quite naturally underscore their fallibility in making an absolutely sure prognosis and in judging the quality of the human life remaining.⁷ Physicians are also well aware that they must make these decisions with due regard to the patient's family for they (the members of the family) are the ones who have loved the patient over the years and who may find it difficult to accept him, in his hopelessly unconscious state, as a "non-person" and as equivalent to being dead.

The law is helpful but does not solve this dilemma. An act of commission to end the life of another human being is as illegal for a doctor as for anyone else, the law being based on the principle of the sanctity of human life.⁸ The legal status of an act of omission of therapy that results in the death of the patient is less certain: the physician has legal obligations to his patient but has much more room for exercising judgment. As the theologian, Joseph Fletcher, has pointed out in discussing the legal aspects of the decision not to prolong life, the legal status of omission stems from the relationship of the doctor to his patient rather than the principle of the sanctity of human life.⁹ Perhaps for this reason no doctor has been convicted for causing death by omission of treatment for compassionate reasons.

The definition of death is also germane to this problem and has been subjected recently to fairly intensive scrutiny.¹⁰ In the past, cessation of heartbeat and respiration has been the accepted medical and legal criterion for death; now, new criteria are being proposed in light of the knowledge that different organs and tissues die at different rates and that a functioning cerebrum is essential to the life of a human being as a person. These new medical criteria — not yet recognized by the law — include evidence that activity of the central nervous system has ceased irreversibly, as shown by flat electroencephalographic (EEG) tracings (cerebrum), bilateral mydriasis (upper brain stem), no res-

7. See Giertz, *Ethical Problems in Medical Procedures in Sweden*, in *ETHICS IN MEDICAL PROGRESS* 139 (M. O'Connor & G. Wolstenholme eds. 1966); Ayd, *The Hopeless Case*, 181 *J.A.M.A.* 1099 (1962); Williamson, *Life or Death*, 197 *J.A.M.A.* 793 (1966).

8. See generally G. WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1957).

9. Fletcher, *Legal Aspects of the Decision Not to Prolong Life*, 203 *J.A.M.A.* 65 (1968).

10. Murray, *Organ Transplants: The Practical Possibilities*, in *ETHICS IN MEDICAL PROGRESS* 54 (M. O'Connor & G. Wolstenholme eds. 1966); Björck, *On the Definitions of Death*, 14 *WORLD MED. J.* 137 (1967); Halley & Harvey, *Medical vs. Legal Definitions of Death*, 204 *J.A.M.A.* 423 (1968); Muller, *Legal Medicine and the Delimitation of Death*, 14 *WORLD MED. J.* 140 (1967); Voigt, *The Criteria of Death, Particularly in Relation to Transplantation Surgery*, 14 *WORLD MED. J.* 143 (1967); Wasserman, *Problematical Aspects of the Determination of Death*, 14 *WORLD MED. J.* 146 (1967).

piration when the respirator has been turned off for at least 5 minutes (medulla), and abolition of reflexes (spinal cord). To these have been added: a falling blood pressure when vasopressor drugs are withdrawn, cessation of cerebral blood flow as shown by angiography, and cessation of reaction to atropine.¹¹ These refinements should be helpful in the case of the long-unconscious patient with brain damage whose heart continues to beat. Thus, a flat EEG tracing may be of considerable help in deciding that the cerebrum is damaged to the extent that the patient can never again become a conscious human person.¹² The EEG tracing should be flat for a minimum of 4 hours; where barbiturate toxicity is involved or the patient is hypothermic the minimum probably should be 24 hours and, in the case of young children, several days. The validity of this physiological evidence of the death of the cerebrum must be established beyond any doubt. It is known that 75 to 90 percent of patients with severe head injury who have been unconscious for 1 month or more make a partial or complete recovery.¹³ If the remaining 10 to 25 percent who do not recover can be shown to have met these neurological criteria for cerebral death, then these criteria might be used by a conscientious and compassionate physician to support his decision to withdraw supportive treatment from such a patient. If medical science can establish the validity of these criteria for the death of the cerebrum (the higher centers of the brain), then the law will need to establish the special circumstances under which such cessation of function of the brain alone, without parallel cessation of the heart-beat and respiration, is acceptable as a definition of death.¹⁴

The problem of *euthanasia* — the deliberate act of commission to end the life of a suffering patient — is highly controversial and, for most physicians, lies outside the realm of practical medical problems. Joseph Fletcher has stated cogently the case for "Euthanasia: our right to die,"¹⁵ basing it primarily on the belief that the quality of life or personality is far more important than mere physical exist-

11. See Hamlin, *Life or Death by EEG*, 190 J.A.M.A. 112 (1964); Schwab, Potts & Bonazzi, *EEG As An Aid in Determining Death in Presence of Cardiac Activity (Ethical, Legal and Medical Aspects)*, 15 EEG CLINICAL NEURO-PHYSIOLOGY 147 (1963).

12. See note 11 *supra*.

13. Lewin, *Severe Head Injuries*, 60 PROCEEDINGS ROYAL SOC. MED. 1208 (1967).

14. Halley & Harvey, *supra* note 10.

The Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, entitled *A Definition of Irreversible Coma*, has just been published (205 J.A.M.A. 337 (1968)). Death of the brain is defined by the presence of the following criteria: (1) total unresponsiveness to stimuli, (2) no spontaneous muscular movements or breathing, (3) no elicitable reflexes; a flat electroencephalogram is confirmatory; all tests to be repeated 24 hours later with no change, and in the absence of hypothermia and central nervous system depressants such as barbiturates. The Report suggests that if the medical profession should agree on these criteria of brain death, no statutory change in the law should be necessary.

ence and that severe pain and suffering demoralizes personality, destroys personal integrity, and thus negates the importance of life and its quality. Under most circumstances in which the question might arise, experienced physicians are acutely aware of their fallibility as to prognosis, are cognizant of the importance of their patients' faith in the physician's total commitment to the safeguarding of life, and are very hesitant to contravene the judgment of society, if not of their own religious belief. There is, however, a "grey" area in which society and the law would do well to grant some discretion to the conscientious physician. To administer to a dying patient in great pain heavy doses of narcotics is a compassionate and frequently performed act and as such is an act of commission. But the primary intent is to relieve suffering, not to end life, and the law and society should recognize that this is so.

C. The Dying Potential Donor of an Organ

The dying patient who is a potential donor of an organ for transplantation presents new and special problems. Because of the need, at present, to perform the transplantation as quickly as possible after the death of the donor, his care as a patient may be jeopardized or his moment of death prematurely anticipated. The first of these hazards might be diminished by keeping the primary responsibility for his care in the hands of doctors other than the transplantation team. Doctors engaged in transplantation surgery are acutely aware of this need to protect the rights of the dying potential donor¹⁶ — and on some occasions have helped to reverse the apparent fatal course of such a patient.¹⁷ Avoiding the second hazard turns again on careful definition of the nature and time of death. This is especially true if the patient's death is being caused by acute intracranial trauma or disease. In this case, the time required to obtain neurological signs of death of the central nervous system — including a flat EEG tracing over a period of 4 hours — is too long to wait to remove an organ that is sufficiently viable for transplantation. Moreover, such neurological signs have less meaning in the acute situation measured in hours rather than in days. Hence the more conventional criteria of cessation of heartbeat and respiration must be used by the physicians responsible for such dying patients. We do not want to apply a double ethical standard: one for the unconscious patient with a head injury who is not being considered as a possible donor of an organ and another for the same kind of

16. See Murray, *supra* note 10; Starzl, *Ethical Problems in Organ Transplantation*, 67 ANNALS INT. MED., Supp. 7, Sept., 1967, at 32.

17. See ETHICS IN MEDICAL PROGRESS (M. O'Connor & G. Wolstenholme eds. 1969).
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patient who is. If the clinical situation in the latter patient is such that there clearly is no chance for survival after his heartbeat or respiration has ceased spontaneously, then there is no ethical problem. But if there is any chance at all that he might recover after resuscitation, oxygenation of all organs might be maintained mechanically for the number of days necessary to establish that the minimum neurological criteria had been met for irreversible damage and death of the central nervous system, particularly the cerebrum. Only then might it be ethically justified in this kind of a patient to remove an essential organ and turn off the mechanical aids. In such circumstances, the patient might be considered to have died *before* the transplantation rather than after, and by the same criteria that are suggested for non-donor dying patients with head injuries. Admittedly such precautions may be less than satisfactory to the doctors responsible for the recipient patient. But to the public they should be reassuring, and the public *will* need reassurance as more and more dying patients are sought as a source of organs for transplantation.

Many legal problems can be anticipated in a situation where rapid decisions have to be made concerning the unusual disposal of parts of the body of a person who usually has met an unexpected violent or accidental death. One of the earliest legal cases deriving from uncertainty of definition and time of death in the donor of an organ was reported from Newcastle-upon-Tyne in England in 1963.¹⁸ The potential donor of a needed kidney had been assaulted, had sustained a severe head injury, and had been admitted to the hospital in coma. When he stopped breathing on June 16 he was placed in a respirator and oxygenation was maintained for 24 hours until the recipient patient was ready to receive a kidney. On June 17 the kidney was removed, the respirator was then turned off, no spontaneous respiration remained, and the heartbeat and circulation ceased. The physicians believed that the patient died medically on June 16 when respiration ceased due to brain damage. The coroner ruled that death occurred legally when the heart ceased to beat on June 17 but that the doctors were not responsible for the death. The assailant was convicted of manslaughter. This case illustrates the urgent need for law and medicine to reach agreement on the definition of death, especially as applied to the potential donors of organs for transplantation.¹⁹

18. See Williams, *Renal Transplantation from Mortally Injured Man*, 2 LANCET 294 (1963).

19. This need for a legally acceptable, as well as a medically and morally acceptable, definition of death has become even more apparent in some of the current instances of transplantation of the heart. In Houston, Texas, a 62-year-old man received the heart of a 36-year-old man whose brain was severely damaged as a result of a beating and whose respiration ceased and brain waves were absent but his heart was

D. *The Dying Patient Recipient of an Organ*

The dying patient whose life might be prolonged by benefit of artificial or transplanted organs poses yet other ethical, legal, and socioeconomic problems to the medical profession and to society.²⁰ Replacement of failing livers and hearts is only just beginning; replacement of the failing kidney has provided the bulk of experience to date in this field. Great technological advances in procedures for chronic hemodialysis, and in tissue matching and immunosuppressive therapy, have drastically improved the chances of prolonging the lives of a portion of the approximately 7,000 patients in this country deemed suitable for such therapy who otherwise would die each year of chronic renal failure. Now, approximately 85 percent of patients in chronic dialysis programs²¹ and 38 to 70 percent of patients with transplanted kidneys (varying according to whether the donor is a cadaver, sibling, or parent, and according to the type of medical center) survive for at least 1 year.²² This is a tremendous achievement. But the difficult problem remains of choosing who is to be given the chance to live and who must be left to die — a problem that will be with us as long as the number of candidates outstrips the necessary medical facilities. Thus, the very success of these procedures confronts society with decisions as to whether to greatly expand these facilities to meet the need. A committee of scientists, appointed by the Bureau of the Budget, recommended in September 1967 that the Federal Government undertake just such a massive program at the cost of many millions of dollars.²³ Whether the Congress will decide to do so in the face of limited resources remains to be seen. Meanwhile, physicians must continue to make this most difficult of decisions on the uncertain moral criteria of who is needed most, who will contribute most, who is most likely to be rehabilitated, and, not infrequently, on the basis of first come, first served.²⁴

still functioning. The patient was pronounced dead by one physician although another physician disagreed. The donor was placed in a respirator until the heart was removed 3 hours later. The county medical examiner anticipated difficulty in prosecuting the donor's assailants for homicide. N.Y. Times, May 13, 1968, at 14, col. 4.

20. ETHICS IN MEDICAL PROGRESS (M. O'Conner & G. Wolstenholme eds. 1966); Elkinton, *Moral Problems in the Use of Borrowed Organs, Artificial and Transplanted*, 60 ANNALS INT. MED. 309 (1964); Schreiner & Maher, *Hemodialysis for the Chronic Renal Failure*, 62 ANNALS INT. MED. 551 (1965).

21. Bluemle, *Current Status of Chronic Hemodialysis*, 44 AM. J. MED. 749 (1968).

22. Murray, Barnes & Atkinson, *Fifth Report of the Human Kidney Transplant Surgery*, 5 TRANSPLANTATION 752 (1967).

23. UNITED STATES BUREAU OF THE BUDGET, REPORT OF COMMITTEE ON CHRONIC RENAL DISEASE (1967).

24. Sand, Livingston & Wright, *Psychological Assessment of Candidates for a Hemodialysis Program*, 64 ANNALS INT. MED. 602 (1966); Schreiner & Maher,

Transplantation of the heart or the liver probably will pose even greater problems along these lines, and the public is rapidly becoming aware that this is so. Will this lifesaving procedure — if it works — be available to all who need it and not just to the wealthy or those situated by chance near the necessary medical facility? Will there be a black market in transplantable organs? Or will such a black market be prevented by the adoption of laws that will permit anyone to will any part of his body for such a purpose?²⁵ If the required medical facilities and programs are expanded, will it be at the expense of other programs of vital medical prevention and care, or of urgent social programs such as those for education or for urban renewal? Already these questions are being asked by many thoughtful men,²⁶ and one United States Senator has called for a national commission to examine these very problems.²⁷ In the final analysis, society, by a process of pragmatic political accommodation, will assign its own priorities. And

25. Efforts are being made to modernize the law on this subject. A committee, headed by Professor E. B. Stason of Vanderbilt University School of Law, has been drawing up a model law for a Uniform Anatomical Gift Act for consideration by state legislatures and the Commissioners on Uniform State Laws. The essence of such a law would include the right of a person to will his body for such purposes (and to revoke that decision if he wishes), the right of his survivors to make such a donation after death if the deceased has expressed no opinion on the matter, organ gifts to be made only to recognized hospitals and physicians, and donor cards carried on one's person to constitute legal permission. Diamond, *Are We Ready to Leave Our Bodies to the Next Generation?*, N.Y. Times, April 21, 1968, § 6 (Magazine), at 26. A bill written along these lines has been introduced into the General Assembly of Pennsylvania during the 1968 Session (House Bill No. 2314).

26. The National Academy of Science's Board of Medicine, under the chairmanship of Dr. Walsh McDermott, released a statement in February on cardiac transplantation. *Cardiac Transplant in Man*, 204 J.A.M.A. 805 (1968); N.Y. Times, Feb. 28, 1968, at 21, col. 1. The Board emphasized that the procedure is totally experimental and recommended that the operating team must be thoroughly competent in the requisite surgical technique and knowledge of the biology of immune reactions, that a group of physicians independent of the transplanters should care for, and approve the use of, the prospective donor, that a similar group should certify the recipient's need because of irreversible damage to his heart, and that the new knowledge gained should be available to all interested parties. The Board did not offer an opinion as to the moral or social desirability of the procedure.

A few weeks later the American Heart Association established a special committee, under the chairmanship of Dr. Eugene A. Stead, to study the ethical implications of heart transplantation and to set standards for the procedure. N.Y. Times, March 18, 1968, at 15, col. 1.

During the past several years, groups of doctors, lawyers, theologians, biomedical scientists, and philosophers have been holding conferences and symposia on the ethical and legal problems of medical advances, including transplantation: the CIBA symposium in London, reported in *ETHICS IN MEDICAL PROGRESS* (M. O'Conner & G. Wolstenholme eds. 1966); the American College of Physicians Colloquium in San Francisco, reported in *The Changing Mores of Biomedical Research: A Colloquium on Ethical Dilemmas from Medical Advances*, 67 ANNALS INT. MED., Supp. 7, Sept., 1967; a conference sponsored by the Institute of Religion at the Texas Medical Center and Rice University, held in March in Houston; and this *Villanova Law Review* Symposium. In addition, countless responsible lay reporters and science writers are writing on this subject and are so contributing to the education of the public.

27. S.J. Res. 145, 90th Cong., 2d Sess. (1968). Senator Walter Mondale (D-Minn.) is the sponsor. Most of the medical men and scientists testifying at a hearing on this proposed legislation expressed great reservation about the desirability of federal regulation at this stage of our knowledge. *Hearings on S.J. Res. 145 Before the Subcommittee on Manpower Resources of the Senate Comm. on Gov't Operations*, 90th Cong., 2d Sess. (1968).

in doing so it will have to make up its mind collectively as to what extent, and at what cost, one segment of society is to have life prolonged by borrowing organs from the rest of society.

The ultimate question concerns the personal identity of a patient: When is it lost? Personal identity, or the self, is surely centered in the brain — the organ that is the seat of the mind with its memory, past associations, instincts, and habit patterns. Although transplantation of the brain has already been attempted experimentally in the dog, there is no scientific evidence at present that it could be done with any neural control of the body. I hope that society will never sanction, either morally or legally, such a procedure in a human being, for surely the identity of his person or self would be lost.

IV. EPILOGUE

When Adam and Eve ate of the fruit of the Tree of Knowledge, they lost their immortality. Do we really want it back? Perhaps we have lost our perspective on death as a natural part of the life that has evolved on this planet. Each generation must die to make room for the next; only in this way can the forms of life evolve. For man, part of our perspective depends on the age of the dying patient: death is more natural for the old than for the young and middle-aged. A physician friend has told me of the occasion when, visiting his elderly, widowed, and very lonely father, the father suddenly collapsed with an arrested heart. The son began external cardiac massage — and then he stopped. It seemed to him that it was the right time for his father to die. My friend had the perspective of which I speak.

Whatever society may decide in the future about the moral, legal, and philosophical problems surrounding the dying patient, the individual physician has to meet them right now. The pressure of biomedical advances that give him his power to modify the time of death no longer permits him to avoid decisions or to find easy answers within the confines of conventional habits and professional customs. The decision that he does make about the dying patient must come from his own conscience, his religious faith or philosophy, his knowledge of the legal and moral boundaries that society has set for him, and, most importantly, his sense of his primary responsibility for the person of his patient as a human being.