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THE PARADOXICAL PRESERVATION OF A PRINCIPLE

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EXTENSION OF THE POWER to sustain and revive signs of life by application of improved medical techniques raises problems which impinge not only upon medical practice but also upon the domains of law, ethics, and social policy. It is necessary to sort out carefully the issues entailed and to clarify the processes of reasoning by which practices are judged to be acceptable. If we rest content with expedient unreasoned "solutions" at present, legal and moral precedents may be established which will lead to less tolerable conclusions as their implications unfold in new situations.

It is paradoxical that the source of the central dilemma regarding the "artificial prolongation of life" rests in strict adherence to the fundamental moral principle that has endowed the practice of medicine with its high status among men. Faithful observance of the physician's *prima facie* duty to sustain life as long as possible now engenders unanticipated costs. It has been expected that physicians, mindful of the fallibility of their prognoses, would never give up the battle for life, but would persevere on behalf of every patient as long as there is hope of sustaining the vital signs of respiration and heartbeat. If practice at times has fallen short of the ideal, the norm itself has seldom been challenged or contradicted in principle.

But now, when medical and technological advances make it possible to sustain the traditional signs of life for extended periods through the application of various life-supporting systems and devices, firm adherence to the principle of sustaining life as long as possible creates strains which stimulate the temptation to compromise the simplicity of the central principle of medical practice.

When a patient is sustained indefinitely in a state of irreversible coma a high cost may be extracted (1) from his family, which may be drained emotionally and financially; (2) from the community, which must help bear the costs of providing complex and costly medical facilities; (3) from potential recipients of medical services who may be denied access to hospital beds occupied by those lingering between life and death; and (4) in the minds of some observers in this era of organ transplantation, perhaps from prospective recipients of organs, who, granted the gift of a healthy organ, might significantly extend their participation in the common life of self-conscious interaction with

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others in a manner forever denied to potential donors who have sunk into an irreversible coma.

As continuing medical progress makes it possible to extend both the scope and the duration of the "artificial prolongation of life," the costs of absolute adherence to the principle of sustaining the signs of life as long as possible will become increasingly evident. If the simple principle were to be observed with perfect fidelity, a situation could be envisioned in which immense resources would have to be employed to provide care for ever increasing numbers of irreversibly comatose patients being sustained indefinitely at a level of existence commonly disparaged as akin to that of a "vegetable." A great variety of social and legal adjustments would have to be made if great numbers were to enter into a status between life and death, a prolonged but unpredictable period in which they had lost the capacity to will, to act, and to communicate, but could not be considered deceased.

The problem created by the extension of the capacity to sustain signs of life is how to preserve the principle that life is to be sustained without bringing on the grotesque consequences which might follow from absolute adherence to the principle. In the attempt to preserve the principle while avoiding its apparent implications, two ways of thinking have been tested.

The first appears as a commonsense extension of traditional habits of thought. Patients lapsed into irreversible coma are acknowledged to be alive and therefore entitled to the protection and medical assistance implied by the principle that all life is to be sustained as long as possible. In considering the cessation of treatment and care, the burden of proof is cast firmly upon those who would suggest withholding any "ordinary," or even any "extraordinary," measure. But the possibility of exceptions is entertained. The "costs" to the family, to the community, to those in dire need of hospital care, or to those who could benefit from the transplantation of organs, may be cited as "indications" for the cessation of the support of life. A "balancing logic" is introduced in which the commitment to sustain life must be weighed anew against other considerations in each particular circumstance.

The weakness of this commonsense "balancing logic" is that it operates not merely to mitigate the severity of absolute adherence to the principle of sustaining life but tends also to erode the principle itself. It opens the way for a troubling doubt in the mind of every potential patient regarding the exact formula by which his own life will be weighed in the balance. A suspicion may arise that the factors or "costs" to be weighed over and against the commitment to sustain life may gradually expand or may fluctuate from time to time, or from

place to place, thereby introducing an added element of uncertainty and inconsistency to the painful unpredictability of life and death.

Inconsistency on the part of physicians striking different balances in assessing the legitimacy of exceptions to the obligation to sustain life is likely to lead to the intervention of nonmedical agencies intent upon insuring more equal treatment and preventing possible abuses. If physicians cannot agree in theory and practice on when supporting measures are to be withdrawn, they are likely to forfeit the responsibility and prerogative of delivering a virtually unchallenged declaration of death.

Under the "balancing logic," the determination of death is not a strictly medical issue. In simpler times, it was sensible to claim that a physician, acting alone, could alone determine when death had occurred since the definition of death as the cessation of heartbeat and respiration was considered secure, and his technical medical skills could determine the question of fact regarding the absence or continued presence of these traditional vital signs. But the "balancing logic" implies that in some situations in which vital signs might be recovered or sustained, it is better not to resuscitate or continue to support life. Such a conclusion can be reached only through a complex process of reasoning that includes many nonmedical components which are not treated in the scientific or technical portions of the medical school curriculum. The physician here must weigh social, legal, moral, personal, and religious considerations which fall beyond his technical scientific competence.

The decision whether to place a patient on a respirator or remove him from it is a "medical issue" in the sense that society presently deems it prudent to leave such decisions to medical personnel. It is an issue that must be decided by members of the medical profession. But it is not a "medical issue" in the sense that the substantive questions involved can be dealt with by medical personnel on the basis of their distinctive technical and scientific training alone. Other values come into play, values which may be assessed differently by members of a profession drawn from diverse backgrounds and bound together not by uniformity of belief concerning various philosophical and social values but by common respect for certain procedures in the accumulation and application of a body of medical knowledge. Physicians may differ sharply in their assessment of the nonmedical elements which inevitably are entailed in the decisions regarding life and death that now fall to medical personnel. If the role of broader human values increases through forthright use of the "balancing logic" and the significance of technical medical determination diminishes in decisions regarding life and death, an increasing diversity and inconsistency of judgments rendered by the medical profession may be anticipated.

Given such inconsistency with its hint of arbitrariness and lack of strictly "scientific" bases, it seems inevitable and appropriate that citizens will ask: "Why are physicians considered to be especially competent to make such decisions?" The present willingness to entrust such decisions to physicians seems to rest not so much upon their presumed competence as arbiters of fundamental human questions as upon recognition of the likelihood that their proximity to the situation in which the decision must be made will enable them to be better informed than any other potential judge. It is their command of technical medical skills that accounts for their presence in a situation. By being on the scene, they presumably acquire more detailed knowledge and a broader awareness than would be readily available to any other class of persons. In a sense, decisions which have strong nonmedical ingredients fall to medical personnel by default. They are not necessarily best equipped to assess the nonmedical elements of decisions, but overall, they are best situated to render a judgment. Unless inconsistency and arbitrariness become evident, it is likely that the idea will persist that it is too awkward and unwieldy to introduce representatives of the community at large into the hospital to check systematically upon the practice of the medical profession. But if a few cases of seemingly premature declarations of death come to light and cause a public furor, citizens may be less willing to allow the physician's assessment of the non-medical values that influence his "medical" decisions to pass without more regular and intense examination and review.

The commonsense "balancing logic" may lead not only to arbitrariness and inconsistency that would invite intervention into the traditional form of medical practice, but it may also establish a habit of thought that would undermine related principles designed to protect the sanctity of life. Once it is established that it is not always morally obligatory to support life with all the means at one's disposal, it is uncertain where the "balancing logic" will lead. Should support be withheld not only from the irreversibly comatose but also from those whose afflictions, though borne bravely, impose a severe load upon their society? Will those in the habit of balancing other values against life itself gradually seek greater benefits by expunging life where the gain seems large and the loss small? The tenuous life of the fetus threatened by abortion is not made more secure by the prevalence of the "balancing logic." Innocent noncombatants who find themselves in the vicinity of "military targets" in time of war may be more easily sacrificed as their lives are balanced against what, in the midst of battle, appear to be high political stakes. Would-be assassins may estimate that, once again, it

is expedient that our man should die for the welfare of the nation.

Given the intensity and the persistence of man's depredations against his neighbors and his capacity for clever rationalization, it is wise to surround each life not only with the protection that may come from common acknowledgment of an obligation to do no harm to one's neighbor but also with the added security which flows from the certainty that there are those committed to preserve one's life by all means at their disposal. When life is truly prized men are reluctant to relinquish to others the unchallenged license to calculate and weigh an uncertain list of factors against the continuation of life itself in whatever form. Society at large and the medical profession in particular needs a simple, chaste principle such as, "Preserve life by all means possible for as long as possible," not only for pedagogical purposes but also for the guidance of the physician in the course of his duties and for "public relations" and the retention of the traditional relationship of trust between physician and patient. The "balancing logic" sounds appealing. It is, however, difficult to find men so wise that every member of the community is willing to entrust them with the task of actually doing the balancing. If the "balancing logic" is to be employed, it is by no means self-evident that the training and experience of physicians endows them with an extraordinary measure of the human wisdom which must be the basis of decisions to begin or to end treatment with a respirator or related devices. The "balancing logic," by definition, entails the assessment of human factors that extend beyond the technical scientific skill which is the distinctive result of medical training. Individual physicians may be among the most sensitive judges of the intimate and intricate matters that must be weighed by the "balancing logic." But this quality belongs to them as human beings and cannot be ascribed to physicians as a class by dint of their professional training.

The disadvantages of the "balancing logic" have led to the exploration of a second mode of thinking about what to do with patients who might be sustained for lengthy periods in an irreversible coma. Again, the quest is for some way to avoid the overburdening of medical facilities with the care of "hopeless cases" that will not jeopardize the power and simplicity of the fundamental principle that requires physicians to strive to sustain life. The second style of thinking preserves the simplicity and rigor of the principle by redefining the boundaries of life and death in a manner calculated to exclude many of those in irreversible coma from the category of the living. It thus becomes possible to say: "Surely, if someone is alive we have an obligation to sustain his life by all possible means. But those who sink into an irreversible coma are not to be considered alive." This second approach is char-

acterized by the attempt to redefine "death" and, in so doing, to absolve physicians of the obligation to strive to preserve signs of life in an irreversibly comatose patient.

The crucial intellectual "move" is analogous in form and effect to the reasoning employed by those who ground their assertion that abortion is not a serious moral problem in the assumption that fetal life is not "truly human life" and is, therefore, not under the protection of the legal and moral sanctions that guard the sanctity of human life. By excluding certain forms of existence from the realm in which the principle that "life is to be sustained" is presumed to have effect, it seems possible to affirm the principle while escaping the inconvenience anticipated by its strenuous application.

With analogous moves come analogous problems. If a person in an irreversible coma is not alive, what is he? The proposal in its strong form insists that he is dead. But this requires a redefinition of death that may not win ready acceptance from those accustomed by immorial usage to identify death with the cessation of heartbeat and respiration. A weaker form of the proposal would allow for the persistence of linguistic conventions while yet accommodating changes in behavior. It says, in effect, that, "If it can be demonstrated by prescribed tests that there is no present activity in the brain and no hope of future activity, the patient may be treated as if he were dead; that is, a declaration of death may be made and the respirator may be turned off." This suggestion seems to assist physicians perplexed about when they should turn off the respirator. It should be turned off after the patient has been declared dead. But, in fact, it simply transfers the focal point of controversy to the moment in which it is decided that a patient may be declared dead. Controversy could easily come to rage over the declaration of death. Members of the medical profession might judge it better to have controversy focus upon the relatively rare instances in which a decision must be made concerning the disconnection of a respirator rather than to bring the entire practice of the declaration of death into question.

The second approach, which hinges upon a change in the definition of death, brings about a decided shift in the burden of proof. It is presumed that a patient in an irreversible coma is to be treated as if he were dead. Those who would demand that his tenuous hold upon life be sustained must present arguments for keeping him alive. What types of arguments could be marshalled?

The threat of legal action might constitute an effective argument for a physician confronted by a family insisting that a patient be maintained even in his evidently hopeless state. Until legal definitions become clarified, a prudent practitioner may not wish to risk a test in

court of a new practice even if it is receiving the general endorsement of medical colleagues. There is the possibility that, as the determination of death becomes less closely linked with clear physiological indices generally understood and accepted by laymen, the public may be less inclined to view the power to declare that death has occurred as an unchallenged prerogative of physicians. The more the declaration of death becomes grounded upon subtle and complex judgments of a large number of factors, the more room there is for dispute regarding judgments that might be rendered differently by other competent authorities, and the more the public will be inclined to appeal to the courts or other agencies for supervision or review of decisions. The medical profession has a high stake in the establishment of clear criteria for the declaration of death in the difficult cases of those in irreversible coma.

A second argument that might be given in support of the sentiment that a patient in irreversible coma should not be declared dead flows from the perception of the fallibility of medical prognoses. Physicians might be in error, and their error could lead to the loss of the potential for further life. The prospects for a full life may seem meager and mean, but at the core of our tradition is the conviction that the value and meaning of even a small fragment of a restricted existence is not for any outsider, however well-intentioned, to assess. Again, it is important to promote and publicize research that will increase the degree of certainty that can be ascribed to a prediction that a patient will never recover any function in the brain. Clear criteria and procedural directives to which medical authorities can subscribe in near unison should be sought immediately.

A third argument against a change in the theory and practice of physicians in declaring comatose patients dead rests upon the conviction that the determination of death in such instances is not simply a medical issue. Even absolute certainty regarding the diagnosis that a coma is irreversible does not automatically "solve" the question of how a hopeless case should be treated. Various reasons could be cited for continuing care, perhaps to appease a family, or to set an example of high regard for life in all its forms, or to avoid an example of apparent indifference to even the weakest form of existence. Others have pointed out that in particular cases questions of inheritance may hinge upon the moment at which death is declared. When life is sustained by a machine that could be unplugged at any time, the moment of death becomes arbitrary enough to be troublesome in certain legal contexts. A claimant to an estate could ask, "Why did the physician choose this moment and not some instant either earlier or later?"

Even if few such cases emerge, even if such questions are purely hypothetical, they are nevertheless useful in exposing the degree to which, in the circumstances posited, the declaration of death has become divorced from immediate, generally verifiable observation of certain conditions readily comprehensible to laymen. The declaration is made not on the basis of simple observation of what has happened but upon an interpretation of what has happened that is made to yield predictions of what would happen if the machine were to be turned off (heartbeat and respiration would cease) and what would not happen if the machine were to be left on (activity in the brain would never resume). Even if the possibility of error in medical diagnosis is reduced to the barest minimum, nonmedical men can claim that their social, legal, or moral prognoses give reasons for sustaining life even when the effort seems futile in the individual case and costly for the community.

What type of questions are entailed in the debate concerning when a comatose patient should be declared dead? Medical questions and answers are only one element of the decisionmaking process. Medical skill may be used to establish that a patient has now entered and is likely to remain in a certain condition. But medical personnel along with the other members of the community must then ask: "What are we to do with patients in this condition?" The answer to that question does not flow directly from any medical knowledge. It is a question of social policy which must be decided by the entire community. Implementation of the communal policy may be left in the hands of physicians, but they act as agents of the communal conscience.

How shall that conscience be formed? "What are we to do with patients in irreversible coma?" is a moral question, a question concerning the responsibility and conduct not only of the medical profession but of the entire community. A tolerable answer can be achieved only through careful and temperate discussion in which the insights of a wide range of disciplines are welcomed. The scientific disciplines of medicine and biology alone cannot yield an answer. Those skilled in these disciplines may be able to determine precisely when the criteria of death have been met, but the criteria and convictions concerning what is to be done when the criteria are met come from sources beyond biology and medicine, and as the dispute itself illustrates, are not fixed once and for all by biological fact.

In a legal context, the question, "When is a person properly to be declared dead?" might be translated to mean, "At what point will society cease to enforce negative sanctions upon those who do not persist in the endeavor to sustain the existence of a patient?" The question concerning when such sanctions should and should not be enforced is a

moral question. It is difficult to claim that any particular discipline or segment of society has a special competence to settle such an issue. It is a question for the public. We need to think carefully about what evidence is pertinent, what contributions can be made by various groups, and what vocabulary is most appropriate for the public discussion of public issues. It is important to realize that there is no "non-moral" answer to the question of how we should treat those who have lapsed into irreversible coma. Every conceivable response is grounded in moral convictions and exerts an effect upon future moral sensitivities. We should try to be self-conscious in our espousal of moral values and be willing to explicate the reasons for our conclusions without pretending that they flow directly from technical competence in a discipline beyond the grasp of the uninitiated.

In pressing the question concerning how we are to respond to those in an irreversible coma we must sooner or later begin to inquire into the meaning of life, its value, and the bases of our responsibility toward one another. These are human questions. Expertise in such matters is not conveyed automatically through the curriculum of a medical school, a law school, nor, I fear, a divinity school. It is by living together and sharing reflections upon fundamental human experiences as well as the technical aspects of our several disciplines that the rare but indispensable sensitivities can be refined. With regard to the profound human issues involved in the question how to treat patients lapsed into irreversible coma there is room for modesty among "experts" and benefit to be gained by our counseling together as we have done in the *Villanova Law Review* Symposium.