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Randy Howe

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HIV transmission; (2) To take care of HIV-infected persons (to reduce mor-
bidity and mortality associated with HIV-infections; the care of HIV-in-
fected persons is not limited to medical management or to AIDS or AIDS-
Related Complex (ARC) patients; combatting discrimination against HIV-
infection persons is as vital to the global strategy as provision of medical
care); and (3) To unify national and international AIDS control efforts. In
a recent symposium on AIDS, the special needs of healthcare workers in-
ternationally was addressed.

Many well-written articles and books about both the public health as-
pects and legal issues surrounding the AIDS epidemic continue to appear.
Perhaps a scholarly analysis of international efforts to control AIDS by pub-
lic health and legislative action will be forthcoming, but this book misses the
mark.

**Final Choices: Autonomy in Health Care Decisions.**

*Reviewed by Randy Howe, M.D.*

The core argument of this book is that competent individuals should be
permitted to take their own life so long as their decision is rational. This

43. Id. at 439-43.
45. Fluss & Zeegers, AIDS, HIV, and Health Care Workers: Some International Legisla-
46. See, e.g., Acquired Immunodeficiency Syndrome Associated With Intravenous-Drug
Use—United States, 1988, 261 J. A.M.A. 2314 (1989); Dalakas, Wichman, & Sever, AIDS
and the Nervous System, 261 J. A.M.A. 2396 (1989); Turnock & Kelly, Mandatory Premarital
Testing for Human Immunodeficiency Virus, 261 J. A.M.A. 3415 (1989); Joseph, Premarital
AIDS Testing: Public Policy Abandoned at the Altar, 261 J. A.M.A. 3456 (1989); Quinn, AIDS
in the Americas: An Emerging Public Health Crisis, 320 NEW ENG. J. MED. 1005 (1989);
Howe, supra note 2; Matthews, supra note 3; Duncan, supra note 2; Comment, supra note 2.
47. See, e.g., R. BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES: AIDS AND THE POLITICS
OF PUBLIC HEALTH (1989); AIDS PROFILE, supra note 8; R. SHILTS, AND THE BAND
PLAYED ON (1987); AIDS AND THE LAW (H. Dalton, S. Burris and the Yale AIDS Law
Project eds. 1987); AMERICAN MEDICAL ASSOCIATION, AIDS: INFORMATION ON AIDS FOR
THE PRACTICING PHYSICIAN (1987); AIDS ETIOLOGY, supra note 1.

* Associate Professor of Psychiatry, Director of Programs in Ethics, Uniformed Serv-
ces University of the Health Sciences; Editor, Journal of Clinical Ethics. B.A., Yale Univer-
sity; M.D., Columbia University; J.D., Catholic University of America.
argument is extended to incompetent patients, asserting that their option to
die without undue suffering or indignity should be equal to that of compe-
tent patients. If patients in either group need assistance in ending their lives,
under limited circumstances, active euthanasia should be permitted.

The critical assumption underlying these arguments is that there is a dis-
tinction between rational and irrational suicide which is morally significant. A
rational decision, Professor Smith asserts, is choosing the course one
would prefer if one were in a “normal frame of mind” and death and all the
alternatives “correctly and vividly” lay before him. It is judged by the de-
gree to which decisions are free of mysticism and have undergone self-criti-
cism by the decisionmaker. Irrationality, on the other hand, is exemplified
when an individual, in a state of despair, abandons all commitment to make
rational decisions.

Professor Smith considers voluntary euthanasia a form of rational suicide.
He asserts that “if committing . . . suicide [was] recognized as but an exer-
cise of enlightened self-determination, . . . euthanasia [would] be similarly re-
classified.” He believes that this rethinking would “show a new sensitivity
to the quality of life,” and would enhance human dignity “by permitting
each man’s last act to be an exercise of his free choice between a tortured,
hideous death and a painless dignified one.”

In addition to supporting his view by discussing historical precedents and
the legal feasibility of the changes he advocates, Professor Smith presents
and analyzes sociological, psychological, and ethical perspectives. His selec-
tion of material is comprehensive and balanced. Consequently, this book
provides not only a well argued thesis, but a synthesis of current views and
controversies regarding the decision to allow or assist a patient to die.

The material Professor Smith brings to bear on this discussion is interest-
ing in its own right, and, as in his other writings, he renders complex

[hereinafter FINAL CHOICES].
2. Id.
3. Id.
4. Id.
5. Id.
6. Id.
7. See, e.g., id. at 4.
8. If voluntary active euthanasia were not de-criminalized as a consequence of the
re-classification scheme propounded, then surely an immunity from prosecution
should be allowed for those assisting in allowing a competent or incompetent individ-
ual to complete such an act of self-determination. Alternatively, the traditional con-
cept of euthanasia could be allowed as an affirmative defense to a charge of murder
and accepted if the participating parties acted in good faith.

FINAL CHOICES, supra note 1, at xii (footnote omitted).
thoughts both lucid and enjoyable to read. In this book, the latter, particu-
larly, is no small accomplishment, considering the seriousness of the subject
matter.

Professor Smith builds his argument for substantive changes through the
first five chapters, and then, in the last chapter, discusses optimal proce-
dures. This review will discuss Professor Smith's arguments in the same
order in which he presents them. It will amplify several issues he raises en
route to his conclusions, and examine how, if at all, this further analysis
might affect them.

CHAPTER I: THE ETIOLOGY OF SUICIDE

In Chapter One, Professor Smith discusses the etiology of suicide. He
identifies, for instance, the frequent association of alcoholism and depression
with suicide and the causes of suicide in selected groups, such as the eld-
ery, who tend to have more "genuine" intent, and teenagers, who seem
exceptionally prone to committing "imitative" suicides. He also analyzes
indirect self-destructive behaviors, such as smoking and skydiving.

He then describes not only why persons participate in dangerous sports
but why others enjoy watching them, and asserts that these reasons have
significant implications regarding the likelihood that, in time, this society
will adopt his proposals. Behind all normal functioning is the fear of
death. Since this fear could be "totally debilitating" if it were ever-present, it
must be repressed. Therefore, participants engage in dangerous acts to
deny their fear of death and to replace this feeling with enhanced self-esteem;
and spectators identify vicariously with such participants also to deny
death. If the latter hypothesis is correct, he argues, society views these
potentially self-destructive acts with ambivalence or even condonation, and
may be more accepting of rational suicide and voluntary active euthanasia
than present circumstances might suggest.

9. Id. at 11.
10. Id.
11. Id. at 12.
12. Id. at 13.
13. Id. at 14.
14. Id. at 16.
15. Id. at 45.
16. Id. at 16.
17. Id. See generally Wanzer, Federman, Adelstein, Cassel, Cassem, Cranford, Hook, Lo,
Moertel, Safar, Stone & Eys, The Physician's Responsibility Toward Hopelessly Ill Patients, 320
NEW ENG. J. MED. 844 (1989). For a most recent example, see Gianelli, Death By Injection
Ruled "Homicide," But Prosecutor Opted Not to Charge MDs, AM. MED. NEWS, Jan. 19, 1990,
at 2, 43.
Chapter One concludes by describing model legislation which would permit assisted suicide: Legally, physicians—or anyone—should be permitted to furnish competent persons the means to take their life as long as these persons take the last step. A mandatory witness might also be involved to protect against foul play "masquerading as an assisted suicide." Surrogate decision-makers should have comparable immunity to insure that incompetent persons have the same protections as those who are competent.

Professor Smith states that, notwithstanding these innovations, society should continue to allow some interventions to prevent suicide. The ideal standard for involuntary commitment would require that a mentally ill person lack "sufficient insight or capacity to make a rational decision concerning treatment." Although this standard is untested, it should go far to protect the rights of patients who want to die.

As indicated, the linchpin of these arguments is that a "morally significant" difference exists between rational and irrational suicides. In theory, these two categories are distinguishable, but unless, as a matter of practice, irrational suicides can be identified and excluded, Professor Smith's proposals regarding rational suicide could not be applied.

"Irrational" Suicides Which Warrant Intervention

In his Introduction, Professor Smith distinguishes two kinds of suicide: acts in which one intends to end one's life, and acts in which one intends principally to bring about relief from some condition, knowing that certainly or probably the result will be death. This distinction is morally significant, but in an opposite way from what might be deduced.

Persons who directly intend suicide may in part genuinely want to die, but in part also be crying for help. With effective treatment, these patients may no longer want to take their lives. A strong justification exists, at least

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18. Final Choices, supra note 1, at 23.
19. Id.
20. Id.
21. Id.
22. Id. at 29 (quoting Herman, Barriers to Providing Effective Treatment: A Critique of Revision in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment, 39 VAND. L. REV. 84, 100 (1986)).
23. Id.
24. Id. at ix.
25. Id.
initially, for intervening to prevent these individuals from attempting suicide.

Patients who have a condition that causes them unbearable pain, on the other hand, have learned over time that they cannot obtain relief from their physical or mental condition. In these instances, a stronger justification exists for not intervening, but rather for permitting these patients to die by refusing treatment or in some cases, as Professor Smith urges, for assisting them.

Imitative Suicides and Other Suicides Which May Involve "Suggestion"

Some patients attempt suicide seemingly in response to having learned of others’ attempts. This phenomenon of "contagious," "cluster," or "imitative" suicides has been recognized for many years. Over two centuries ago, for example, it was observed that a rash of persons had attempted suicide after the publication of Goethe’s book about a young man who committed suicide.

Since these suicidal impulses are likely to be short-lived, paternalistic intervention can be justified. The boundaries of this category and others, however, may be unclear. A patient’s reasons for wanting to die may have both an imitative and rational component. One example is a patient hospitalized due to AIDS who first expresses the desire to refuse life-prolonging treatment after another patient with AIDS on the same ward has attempted or committed suicide.

Other patients may refuse treatment not to imitate another patient, but for much the same psychological reason: they, too, also respond to suggestion. For instance, consider a retired clinical psychologist with aplastic anemia who had been hospitalized for several months. Since his body could no longer make blood or platelets, he needed periodic blood and platelet transfusions to keep him alive. He could have lived on indefinitely in the hospital, but a new careprovider discovered that the patient had never been told that he could refuse further treatment. Accordingly, the careprovider informed the patient of his right and asked the patient whether he wished to discontinue treatment. The next day the patient requested that the blood and


28. FINAL CHOICES, supra note 1, at 13.

29. GOETHE, THE SORROWS OF YOUNG WERTHER (1787).
platelet transfusions be discontinued. His request was granted and he died shortly thereafter.

It is impossible to know in this or any case whether “suggestion” is the true basis for a patient’s decision. This careprovider’s intervention, conventionally, would be considered optimal since it enhanced the patient’s autonomy and gave the patient “permission” to refuse treatment. Yet, this patient’s family visited him daily for several hours and the patient knew that as a result of these visits, they could not pursue personal goals incompatible with these visits. It is possible that the patient felt guilty that his family might be sacrificing some of their interests for his, and, as a result of this guilt, the careprovider’s questions and/or non-verbal communication suggested to the patient that he should refuse treatment.

The complexity of the careprovider’s intervention in the above case is best understood in a broader context. It is generally assumed that the careprovider’s questioning of the patient about suicidal thoughts will decrease, rather than increase, the likelihood that the patient will commit suicide, because it gives the patient an opportunity to verbalize suicidal feelings. Yet, when patients require ongoing hospitalization for the rest of their lives, they are exceptionally vulnerable to feeling that they pose a burden to their family, and/or to other patients and society because they are utilizing limited medical resources.

When a careprovider offers such patients the option to refuse treatment, therefore, an opposite effect from the one which is intended may result. Instead of enhancing autonomy by providing another choice, it may evoke in patients the belief that they should refuse treatment for others’ sake, though, for their own sake, they would want to continue to live.

Careproviders unwittingly may pose a further dilemma to a patient by suggesting implicitly: that he should want to live. Consider a patient who had terminal cancer, was being treated in an intensive care unit (ICU) for a serious bodily infection, and became comatose. He had not indicated previously what he would want done in the event he lost consciousness. He awoke after several days in a coma, and when asked what interventions he would want in the event he again became comatose, he indicated that he would want all possible treatments. After he left the hospital, however, during a brief period of remission, he stated that he wished life-prolonging treatment had been withheld so that he could have died while comatose.

It is possible that between the time he first stated his preference and later said the reverse, this patient changed his mind. Yet, he also may have responded initially in the ICU to what he believed his questioner wanted to
hear. In cases such as these, it may be difficult or impossible to differentiate rational suicide from imitative or "suggested" suicide.

**Indirect Suicides**

Professor Smith's assertion that some persons commit suicide indirectly by acts such as smoking or skydiving is, descriptively, correct. Psychologically, however, there may be other reasons. Persons may participate in dangerous acts, for instance, because they enjoy them, and not because of the risk of death but in spite of it.

The motivation Professor Smith attributes to spectators also has been noted. Speaking of "death-defying" circus acts, he asserts that spectators identify with the circus performers, and, as the performers defy death, feel momentarily elated and immortal.30 "Surely, if a large segment of . . . society . . . [views] indirect self-destructive behaviors with ambivalence, . . . hope . . . exists for direct forms of enlightened self-determination . . . to be tolerated . . . in due course."31

Yet, as Professor Smith indicates, societal ambivalence, like the proverbial knife, can cut both ways. Society's "exaggerated fear of death" also impairs its taking a more enlightened view towards patients who refuse treatment.32 He asks rhetorically, "Should patients' freedom to refuse treatment be sacrificed so that others can deny the fear of death," and answers, unequivocally, that it should not.33

Professor Smith's assertion that this population's fear of death is a significant factor in its opposition to voluntary euthanasia is subject to debate. There are other, comparably plausible explanations. Yet, it is at least consistent with, if not supportive of Professor Smith's speculation that this society's current "paternalistic view" towards euthanasia is exceptional. In other areas of medical decisionmaking, the United States places higher value on respecting patients' autonomy than most other countries.

**Suicides To Make a Point**

An intriguing category of suicides which Professor Smith identifies is that of persons who die to "make a point," such as those who undergo a hunger strike.34 The Roman Catholic Church views such individuals differently from those who commit suicide for other reasons.35 A secular example of

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30. **Final Choices**, supra note 1, at 16.
31. *Id.*
32. *Id.*
33. *Id.* at 109.
34. *Id.* at 36 n.112. See generally M. Battin, *Ethical Issues in Suicide* 147 (1982).
35. **Final Choices**, supra note 1, at 36.
this distinction was recognized in a holding of the Georgia Supreme Court, which declared that under the United States Constitution, a state has no right to prevent a prisoner from starving himself to death to make a point or statement.

This holding is, however, discrepant from that of the few other appellate courts which have addressed this question. In the best known case, Mark Chapman, convicted killer of former Beatle John Lennon, wanted to die by starvation. He argued that death by starvation was "symbolic speech" protected by the first amendment. The Appellate Division of the New York Supreme Court disagreed, and held that the state's obligation to protect the health and welfare of persons in its custody and its interest in maintaining orderly procedures in its institutions prevailed over any right of an institutionalized person to cause his own death. A court in Massachusetts went still further and rejected a prisoner's request to refuse kidney dialysis on similar grounds.

Even when suicides to make a point are ostensibly rational, the boundary between these and irrational suicides may be uncertain. Patients may refuse nutrition and hydration to prove to family members that they retain power even though they are patients. This scenario is especially likely, for example, when patients believe that family members are demeaning or infantilizing them. Should this motivation be considered starving to make a point?

Rational Suicides

Excluding, then, a wide-range of irrational suicides, such as those described above, when should a person's suicidal wishes be considered rational? Centuries ago, it was assumed that a person's capacity for reasoning was cut off from other parts of the brain, and thus, that a person's reasoning could remain intact even when other parts of the brain had been severely

36. Id. at 40 n.214 (citing Zant v. Prevante, 248 Ga. 832, 286 S.E.2d 715 (1982)).
37. Id. (citing Zant, 248 Ga. at 834, 286 S.E.2d at 717).
39. Id. at 70, 450 N.Y.S.2d at 627.
40. Id. at 67, 68, 450 N.Y.S.2d at 625.
41. Commissioner of Corrections v. Myers, 379 Mass. 255, 265-66, 399 N.E.2d 452, 458 (1979). The New York and Massachusetts courts, however, implicitly recognized a distinction between suicides to make a point and other suicides. Von Holden, 87 A.D.2d at 70, 450 N.Y.S.2d at 627; Myers, 379 Mass. at 259, 399 N.E.2d at 454. The balancing approach exemplified in all three courts parallels Professor Smith's approach in deciding whether a patient should be allowed or assisted to die.
42. One author reports a case in which a young woman shot herself rather than her dog when her parents insisted that she kill her dog as punishment for coming in late at night. He questions whether this act should be classified as an act of suicide. Beauchamp, Suicide, in MATTERS OF LIFE AND DEATH 78-79 (T. Regan ed. 1980).
damaged. If individuals were profoundly depressed, it was believed that this feeling would not affect their thinking.

It is now acknowledged that persons’ brain chemistry, emotions, and thought processes are profoundly and inextricably interrelated. Persons may think logically when they are depressed but the logic itself may be skewed or otherwise altered. Depressed persons may see, literally, only those aspects of an experience which have self-derogatory implications. Then, they may make inferences on the basis of these perceptions which, though “logical,” are fallacious. Cognitive therapy, a psychological treatment particularly effective for depression, helps depressed persons become aware of such “sampling errors” so that they can recognize and correct them.

Professor Smith implicitly recognizes that emotions can affect reasoning when he emphasizes the importance of giving patients sufficient time after they first express a desire to refuse treatment to better determine whether the request is “genuine.” “Perhaps, after a waiting period of some six months wherein . . . psychological counseling can be given, a re-evaluation . . . [sh]ould be made.”

The importance of permitting such time before granting patients their request to refuse treatment is exemplified when persons suffer a sudden injury, such as a car accident, which renders them quadriplegic. Immediately after the accident, these persons may want to refuse treatment for such “rational reasons” as having lost the capacity to walk and eat independently, their previous lifestyle and their anticipated future. Many of these individuals, however, after several months, may be glad that they are alive and want to continue living.

When initially deciding whether to respect a patient's request to be allowed to die, two considerations are potentially relevant: First, is their condition reversible; and second, if it is not, does past experience with other persons, similarly situated, suggest that those with such losses are likely to later accept their limitations and eventually to enjoy their radically altered lives. If the condition is reversible or it is likely that the patient with irreversible impairment will subsequently “do well,” a strong, but by no means


44. FINAL CHOICES, supra note 1, at 152.

conclusive, argument exists for paternalistic intervention immediately after the traumatic injury.

Professor Smith discusses, by contrast, the request of Ms. Elizabeth Bouvia\textsuperscript{46} to die by starvation in a hospital. Ms. Bouvia had been functionally quadriplegic since birth and had had her entire life to accept her handicap. In this instance, neither of the above considerations were present. How in such cases can it be determined whether a patient's request is "genuine?"

\textit{Assessing the Competence of Patients Who Request That They be Allowed to Die}

Professor Smith points out that persons should not be deemed incompetent solely because they wish to make a choice which will result in their death.\textsuperscript{47} In certain jurisdictions, the criteria for judging a patient incompetent to refuse life-prolonging interventions may depend on the possible outcomes for the patient.\textsuperscript{48}

The latter so-called "shifting standards of competency"\textsuperscript{49} approach works as follows: When there is little difference in the possible outcomes for a patient, the best criteria for competency may be those which give patients the greatest opportunity to decide which outcome they prefer. Some patients are so severely burned, for instance, that it is known with virtual certainty that they will die within several days.\textsuperscript{50} These patients often experience an initial lucid period before becoming comatose, and during this period they can be asked whether they would prefer "ordinary" or "heroic" treatment after they subsequently lapse into a coma.\textsuperscript{51}

When asked this question, these patients' physiology is significantly altered, and they are profoundly affected psychologically from having just learned that they will lose consciousness in hours and die within days. A "lax" standard of competency which requires only that patients respond yes or no, consistently, to questions regarding their preferences may be optimal because it permits these patients greatest autonomy.

\textsuperscript{46} Bouvia v. Superior Court of Los Angeles County, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).


\textsuperscript{49} This approach is also known as the "sliding scale" or "rational standard" model. See Drane, supra note 48, at 18.

\textsuperscript{50} Imbus & Zawacki, \textit{Autonomy for Burned Patients When Survival is Unprecedented}, 297 N\textit{EW ENG. J. MED.} 308 (1977).

\textsuperscript{51} Id. at 309-10.
Other patients’ outcomes, however, are highly discrepant. One example is the diabetic patient who has a gangrenous leg. Surgery will be life-saving, but without it, the patient probably will die. A “strict” standard of competency might be optimal in this instance because it would permit factors other than the patient’s literal rationality, such as the patient’s mood - which could be the cause of the patient’s refusing surgery - to be taken into account. Under a strict standard requiring more than literal understanding, such patients could be judged legally incompetent, and the surgery performed.

Consider an unusual case which demonstrates the advantage of using shifting criteria to determine competency. A patient who had appeared to enjoy his life in a nursing home developed sudden pain in his abdomen. Since a relative had died after initially experiencing a similar pain, the patient believed his own pain was also the first symptom of a fatal disease. On this basis, he refused surgery. His doctors tried to convince him that they believed that he had appendicitis, but the patient remained adamant in his refusal. The hospital staff finally overrode the patient’s objections and performed an appendectomy. After the operation the patient thanked the staff profusely for most likely having saved his life.

The lax standard which only requires that patients show literal understanding most respects patients’ autonomy, but it also may result in the death of more patients, such as the one just described; namely, patients who “genuinely” want to live, but are convinced that a highly improbable circumstance is present or are temporarily overwhelmed by an emotion such as fear or depression. Conversely, the strict standard, which requires deeper understanding, may “save” the lives of more patients who genuinely want to live but at the price of denying autonomy, or in Professor Smith’s words, the right to enlightened self-determination.52 The strict criterion also permits greater inconsistency among psychiatrists’ judgements, because psychiatrists may differ in the findings they consider most important when they determine a patient’s incompetency.53

When determining competency, physicians also may look to their own ethical views in the exercise of discretion. Physicians may be more like, for instance, to infer that a patient is incompetent and consult a psychiatrist only when they feel that a patient’s choice is “wrong.”

Who, then, should decide which criteria should be used when physicians are uncertain? When the strict standard requiring deeper understanding is used and psychiatrists disagree regarding a patient’s competency, who

52. Final Choices, supra note 1, at 28.
should decide? And who should decide when it is necessary to consult a psychiatrist? All these questions may be referred to the court, but, as Professor Smith states in the last chapter, referral to an ethics committee is likely to be preferable, in most instances, for all parties involved.  

CHAPTER TWO: PHILOSOPHICAL ARGUMENTS REGARDING SUICIDE

In Chapter Two, Professor Smith analyzes philosophical views regarding persons who refuse life prolonging treatment or request active euthanasia. Initially, he raises the question whether the quality of a person's life or life itself is of greater value, but asserts that this question usually is answered by assessing costs and benefits.  

He declares that it has become increasingly difficult to justify permitting "a slow and dehumanizing death" over assisting persons to die with dignity. Traditionally, physicians "pre-empted" patient authority when making medical decisions. Although there has been a shift from professional dominance towards individual self-determination, the law has not yet responded in a "sufficiently forceful . . . manner" to recognize patient autonomy.  

Professor Smith then offers several rationales for permitting most patients to refuse life-prolonging treatments. The primary reason, to respect individuals' autonomy, was expressed by Mill over a century ago. One of the few justifications Mill recognized for interfering with another's liberty was to restore or enhance that person's ultimate autonomy. In Mill's view, this restoration would be the only rationale for paternalistically intervening when patients' wish to commit suicide was irrational, as in some of the situations previously discussed.

Other Grounds for Paternalistic Interventions

Professor Smith indicates three conditions which must be present to justify paternalistic medical interventions: a high probability of harm to the patient unless the act is undertaken; a failure by the patient to understand or rationally reflect on the questioned decision; and a probable benefit from

54. FINAL CHOICES, supra note 1, at 171-80.
55. Id. at 46.
56. Id. at 47.
57. Id. at 52.
58. Id. at 53.
59. Id. at 51. See generally J. MILL, ON LIBERTY (1974).
60. FINAL CHOICES, supra note 1, at 51.
61. Id.
intervention outweighing that of inaction. Even when these conditions are met, however, a comprehensive cost-benefit analysis should be carried out and the "proportionality" of all other morally significant factors should also be considered.

Interests of Family Members

Professor Smith states that one important "other factor" in determining whether or not a patient should be permitted to refuse treatment or assisted to die is the interests of third parties. In particular, the interests of a patient's family are important, since the family is likely to be closest to the patient and most directly affected by the patient's choices.

Currently, there is general societal consensus that as long as a patient has a terminal illness, the patient's wish when competent, or prior wish and/or burden-benefit ratio when incompetent, should be the exclusive factor(s) determining the outcome. But are there any situations in which families' and/or friends' interests and feelings ought to have sufficient moral weight to affect a patient's decision to die? Could it be argued that when a patient is incompetent and has stated that he or she wants no "extraordinary" treatment, but the family wants the patient kept alive, so long as the patient experiences no pain, the family's wishes should override the patient's preference?

Family members' wishes are often prioritized when a comatose patient is kept alive a day or two longer so family members can travel to have some time with the patient before the patient dies or so family members who have been with the patient can have additional time to grieve. Although additional expense is incurred in order to benefit such families, it is not inconsistent with additional expenses incurred to benefit families in other ways, for example, when physicians take extra time to explain to family members medical aspects of a patient's illness. Keeping a patient alive for just a short period of time would seem, then, to exemplify the kind of situation Professor

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62. Id. at 53-54.
63. Id. at 54.
64. Id. at 155.
65. One author's statement after his son committed suicide is representative of the agony some parents feel: "We know that Michael's death will shadow our remaining hours on earth [sic]." J. WESCHLER, IN A DARKNESS 12 (1972), quoted in Emery, Adolescent Depression and Suicide, 18 ADOLESCENCE 245, 250 (1983).

To some, the harm to family members alone makes suicide unjustifiable. See generally Hendin, Suicide: A Review of New Directions in Research, 37 HOSP. & COMM. PSYCHIATRY 148 (1986); H. FEDDEN, SUICIDE: A SOCIAL AND HISTORICAL STUDY 209 (1983); Lebacqz & Engelhardt, Suicide, in DEATH, DYING AND EUTHANASIA 695-96 (D. Horan & D. Mall eds. 1977).
Smith has in mind when he recommends that the proportionality of third parties' interests be considered.

A more controversial question exists when a patient with cortical, but not brainstem "death" has indicated that he or she would not want to be kept alive, but the family disagrees and wants life prolonging measures carried out indefinitely. In jurisdictions where physicians are not required to carry out patients' prior requests, physicians may respect such families' wishes to benefit the family and/or to avoid the risk of the family's bringing suit. When the family's wishes are given priority, in addition to violating the patient's prior request, hospital and societal resources are expended. It is unclear, however when physicians would ever be ethically justified in carrying out a family's desire to keep a patient alive over and against the patient's prior wishes for more than a few days' time.

The reverse situation also can occur. A patient can have cortical death and have indicated that he or she would want to be kept alive in this condition, but family members may disagree. In rare instances, persons have risked criminal prosecution to bring about the death of a relative who was in an irreversible comatose state. Presumably, such persons' motivation would be less strong when a patient had indicated that he or she wanted to be kept alive. Regardless, if family interests prevailed under these circumstances, in addition to violating patients' prior requests, patients who were competent could anticipate that if they became incompetent, their family's wishes might prevail. It could be assumed that this foreknowledge would cause significant harm. But would it?

Certain patients might want their family's interests to take priority if they were incompetent and their own interests were in conflict with their family's. The durable power of attorney is, paradoxically, one means by which patients who want family or friends to exercise their preference could effect this wish. Although appointed to make decisions on the basis of what they believe the patient would want, these persons could, to a certain degree, make choices on the basis of their own desires.

Alternatively, patients could waive their own preference and delegate it to family members explicitly. One women in her eighties who knew that she was dying, for instance, instructed her son that if she lost consciousness, she wanted him to do what he preferred for his own sake. If such a request is well-documented, it probably would be respected.

Interests of Other Patients and Society

Professor Smith suggests that, in addition to families' interests, other pa-
tients' and society's interests also should be considered when determining patients' outcomes.

In the final analysis, . . . [t]he root question of suicide or its “rightness” is tied to one of distributive justice—and, more specifically, of the achievement of a balance between the benefits of an individual's exercise of self-determination and personal good or satisfaction against the burdens, social obligations or claims of others that militate against such an act.66

Interests of other patients and society usually are not considered, at least explicitly in this country, when care is withheld or withdrawn. Still, when more than one patient needs an ICU bed, a patient with a poor prognosis may be transferred from the ICU to an ordinary ward, even though it could result in greater morbidity for the patient transferred. In actuality, however, these transfers may make little or no difference in these patients' eventual outcome.67

If the competing needs of patients becomes a more acceptable ground for giving certain patients' interests priority over others, the doctor-patient relationship also may be affected.68 If a physician chooses which of his or her own patients receive a limited resource, the patients may no longer trust that their physician primarily seeks to maximize their welfare. Unless implicitly deceiving a patient by remaining silent when making “triage” decisions, the physician might have to tell one patient needing ICU care that although he or she could benefit from being admitted to the ICU, the physician was admitting another patient to the one available bed because this patient had a better prognosis. If, however, careproviders or others outside the treatment relationship, or even an ethics committee made these decisions,69 this loss of trust perhaps could be minimized or avoided.

The Elderly

A closely related question which Professor Smith addresses, though primarily in a later chapter, is the degree, if any, to which age should be a factor when deciding who should receive limited medical resources.70 Ethical arguments regarding this question are less than compelling. From a utilitarian perspective, it can be argued that since elderly patients have fewer

66. FINAL CHOICES, supra note 1, at 59-60.
70. FINAL CHOICES, supra note 1, at 133-34.
statistical years to live, it might not be unjust to expect them to sacrifice their optimal medical interests to benefit younger patients. Such arguments tend to be biased inherently against older persons' interests.71

On the basis of one interpretation of justice as equity in which the value of persons' lives are viewed at only one point in time, an older patient's life is as important as a younger life. Yet, on the basis of another interpretation of justice as equity in which the value of persons' lives is viewed longitudinally, older persons have had the opportunity to live much longer than younger persons. Accordingly, it would be just to give more societal resources to younger persons.

How society decides to distribute its resources may best be determined by the kind of community desired.72 If this statement is true, it is significant that when Professor Smith argues that a community should be willing to allow (a few of) its members to exercise enlightened self-determination even at the expense of the interests of the greater population (in denying death),73 implicitly, he is asserting that society should sacrifice an important interest to benefit its more vulnerable persons. If older persons are considered exceptionally vulnerable at least in the respect that they statistically face an earlier death, similarly, a community which would sacrifice some of its interests for them may be desirable.

Denying Care Which is Medically Futile

Another approach to conserving resources which Professor Smith addresses is withholding or withdrawing "medically futile" care.74 This issue is presently controversial.75 Some physicians assert that when resuscitation of a patient is medically futile, physicians should write a Do-Not-Resuscitate (DNR) order without asking the patient's consent and need not even inform the patient, except, perhaps, as a courtesy.76 Others argue that patients always should have the choice of withholding consent for a DNR order.77

There are many meanings of futility. Futility can refer to a patient's not being expected to leave the hospital. A few years ago, for instance, the likelihood that a patient with AIDS who had pneumocystis pneumonia and had

73. FINAL CHOICES, supra note 1, at 136-38.
74. Id. at 173-74.
75. See Youngner, supra note 72.
76. Younger, supra note 72, at 2094.
77. Id. at 2095.
been intubated would leave the hospital was fourteen percent.78 This figure is low enough that some physicians and patients might consider aggressive care to be futile.79

A different meaning of futility is that a patient will not improve. This meaning was used when careproviders at one hospital debated whether surgery should be performed on a severely retarded infant whose mental capacity could not improve. Yet, this infant’s parents cared deeply for this child, and from their standpoint, the surgery was anything but futile. Should the positive feelings of others toward a patient have independent and sometimes decisive moral weight when the infant lacks inherent “human” capacities, such as the ability to think, feel, and relate to others?

Jecker argues that others’ love for a patient is an “extrinsic” factor which, like “intrinsic” factors, should contribute to a person’s worth.80 Alternatively, Loewy argues that the relief of humans’ suffering should be prioritized over other values.81 On the basis of either perspective, parents’ positive feelings for infants with severe defects could affect decisions regarding these infants to a much greater extent.

The least controversial meaning of futility as a ground for physicians withholding or withdrawing interventions is when there exists an extremely low probability that the intervention will be successful, as when the likelihood of the patient’s recovering from cardio-pulmonary resuscitation (CPR) is less than one percent.82 Yet, when physicians discuss the improbability of successful CPR with patients, many patients may accept the DNR order, whereas, if physicians make this decision themselves, patients may experience distrust. The preservation of patient/physician trust relationship may warrant the expenditure of resources used in performing CPR on the few patients who do not consent to a DNR order.

But is such patients’ distrust warranted? Possibly. If physicians decide that CPR is futile to further the competing interests of other patients, as when physicians decide which of their own patients should receive a limited


79. Id.


resource, physicians may no longer be serving the best interests of each of their patients.

Yet, when physicians decide that an intervention is futile, they may do so for another reason; because they believe that a patient faces imminent death and must be helped to accept his or her fate. These physicians are trying primarily to further what they believe is in such patients' best interests. Whether they are justified or not, they are likely to be acting out of compassion.

The Place for Compassion

Professor Smith suggests that when physicians make particularly difficult decisions, they should use as a guideline what seems most “loving.”83 “Love should be the basic normative value used in each situation to resolve the balancing test.”84

In making this statement, implicitly, at least, Professor Smith seem to be bringing to bear on these questions the so-called “care perspective,” stemming from the work of Dr. Carol Gilligan.85 This perspective emphasizes persons' relationships to one other, such as careproviders' relationship with their patients and patients' relationship with their families, as opposed to the more traditional approach which emphasizes the identification of prima facie principles, such as respect for persons, justice or utility.86

The relevance of the care perspective to resolving ethical dilemmas is, however, controversial. Some believe that the care perspective is fundamentally adjunctive to these principles and may sometimes even oppose them.87 Others believe that this perspective is basically unnecessary and superfluous, because the importance of persons' relationships already is inherent in ethical principles, and particularly those of beneficence and non-maleficence.88

If there is a valid difference between these perspectives, consider a case which may be seen as posing a conflict between them. For reasons that were unclear, a patient with untreatable metastatic cancer became comatose. His doctors believed that he had only a small chance of recovery. The patient's spouse was considered the most appropriate surrogate decision-maker. She

83. Final Choices, supra 1, at 46.
84. Id. at 46-47. See Smith, Quality of Life, Sanctity of Creation: Palliative or Apotheosis? 63 Neb. L. Rev. 709, 734-35 (1984). See also Fletcher, Love is the Only Measure, 83 Commonwealth 427 (1966).
85. C. Gilligan, In A Different Voice (1982).
86. Final Choices, supra note 1, at 46-47.
87. See generally Levine, Medical Ethics and Personal Doctors: Conflicts Between What We Teach and What We Want, 13 Am. J.L. Med. 351 (1987).
88. Final Choices, supra note 1, at 47.
asserted that, when her husband was competent, he had stated clearly that life-prolonging interventions such as a respirator should not be continued under these circumstances. The patient's parents and siblings, on the other hand, believed that the patient was a "fighter" who would want all interventions continued so long as there was any chance of his regaining consciousness.

The staff had two views on how to resolve the spouse's and family's disagreement. One view was that since the spouse was the most appropriate decision maker, the staff should help her decide what interventions should be withheld and help the family to accept the spouse's judgement. The opposing view was that the staff should attempt to help the spouse and family to arrive at a compromise which both could accept. This second view was based largely on the fear that if the spouse decided, the patient's family might resent her so strongly that their relationship with the spouse would be irreparably harmed. This outcome was particularly undesirable because the patient and his wife had children. The first view, to allow the spouse to decide, was based on determining the priority of conflicting moral principles; the latter, on the overriding importance of the spouse's and family's relationship.

A second case also illustrating a possible conflict between these two perspectives involves a terminally ill, unconscious woman who had a small chance of regaining consciousness. Her closest relative was an adult daughter suffering from a severe chronic mental illness. This daughter insisted that her mother would want all possible interventions, but more distant relatives and staff reported that the patient had told them that she would not want "heroic" treatment or even CPR under these circumstances.

The staff struggled with the decision of whether to take initiative to appoint a family member other than the daughter as the patient's guardian. They believed that this initiative would further to a small degree the patient's best interest. They also feared that if a guardian was appointed, the highly supportive and harmonious relationship between the daughter and other family members, one of whom would most likely be the guardian, could be destroyed.

Slippery Slope Arguments

Professor Smith identifies two slippery slope arguments that have been raised against active euthanasia. The first is the possibility that permitting euthanasia could open the door to practices being carried out in this country

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89. Id. at 60.
comparable to the atrocities committed in Germany during World War II. While theoretically possible, it is most implausible for several reasons, including that “the forced homogeneity of the Nazi society doesn’t exist in America today.”

He further asserts that this most unlikely possibility must be weighed against the certainty of harms which would occur as a result of limiting patients’ right to having assistance in ending their lives. Merely withdrawing life-prolonging interventions would result in some patients experiencing unbearable and unnecessary pain for several days. Sufficient pain medication can now be given to most patients to make their pain bearable - but not to all.

Patients’ emotional pain may, in some cases, also be refractory to treatment, as when a patient finds no pleasure or meaning in continuing to live. Permitting active euthanasia for patients with untreatable emotional pain, however, illustrates more clearly than for patients with untreatable physical pain a potential danger in Professor Smith’s proposal. That is, when patients are suffering emotionally or physically, it may be that their pain could be relieved. If the option of assisted euthanasia is available, however, it may be selected “prematurely,” before it is discerned that an intervention is effective.

The second slippery slope argument Professor Smith addresses is psychological: Persons performing euthanasia could come to have less regard for the sanctity of life. Even if this result is a risk, it should be no different from the adverse risk to careproviders from withholding or withdrawing life-prolonging interventions.

Both of the latter now, of course, are permissible, and there is no evidence that careproviders withholding or withdrawing these treatments have been harmed. It may be with active as passive euthanasia that the psychological effect on careproviders depends on the meaning of these acts to them. In both instances, physicians may see themselves as “saving” patients from

90. Id.
91. Id. at 61. See D. Majure, Death By Choice 134 (1975); Wanzer, supra note 17.
92. Final Choices, supra note 1, at 56.
93. Id. at 93.
94. Id. at 61. Professor Smith cites as an exception a patient whose kidneys have failed. Without dialysis and transplant surgery, the patient “will normally experience . . . nausea and vomiting, an inability to concentrate and - eventually - convulsions.” Id. at 93.
95. But see Brown, Henteleff & Barakat, Is It Normal for Terminally Ill Patients to Desire Death?, 143 Am. J. Psychiatry 208, 210 (1986) (most patients who are terminally ill do not wish to die unless they are depressed).
96. Final Choices, supra note 1, at 61.
97. Id. at 155.
experiencing unbearable pain; accordingly, they may justifiably feel some gratification from doing these acts.\textsuperscript{98}

\textit{Physicians Refusing to Act on the Basis of Personal Values}

Professor Smith then discusses whether physicians should ever be obligated to assist a patient to die when doing so would violate physicians’ personal morality.\textsuperscript{99} “[N]o force or coercion can be extended to compel a physician to proceed with a treatment . . . if that physician considers [it to violate] . . . an ethical, moral, or professional obligation.”\textsuperscript{100} In a earlier chapter and in a different context, this caution is added: “[V]igilance must ever be maintained . . . to safeguard against the physician’s ready eagerness to substitute one form or another of ‘motivated’ paternalism for his patient’s right of enlightened self-determination.”\textsuperscript{101} Could physicians not also substitute “one form or another” of their personal morality also to undermine this right?

It is unequivocal that physicians can and should be permitted to refuse to carry out acts which strongly violate their moral beliefs. The paradigmatic example is abortion. In less “viscerally offensive” instances, no doubt, this principle also should apply. A physician probably would be justified in refusing to comply with a patients’ request that a physician (implicitly) deceive the patient’s family by not informing the family that the patient has a fatal illness.\textsuperscript{102}

Certain physicians have extended this principle much further, carrying out a “slow code” because they hold the “moral view” that if resuscitation is successful, further treatment for a patient would be a misuse of society’s resources. Others have refused to treat patients with HIV infection, because they hold the “moral view” that if a physician died as a result of a needle-stick, the loss to the physician’s patients would outweigh the gain he or she could offer patients with HIV infection by treating them.

Physicians refusing to perform an abortion or to deceive family members,

\begin{itemize}
\item \textsuperscript{98} In some instances, careproviders have given care only arguably distinct from active euthanasia. Sufficient analgesia has been given in hospices to relieve patients’ pain though this medication may in some cases hasten patients’ deaths. As a second example, doctors sometimes give infants with irreversible, cortical brain death dosages of pain-relieving drugs prior to removing them from the ventilator to ensure that the infants do not suffer from “air hunger.” These dosages, too, may hasten these infants’ death.
\item \textsuperscript{99} \textit{Id.} at 120.
\item \textsuperscript{100} \textit{Id.}
\item \textsuperscript{101} \textit{Id.} at 54.
\item \textsuperscript{102} Howe, supra note 53, at 174-76. See also Howe, \textit{When Physicians Impose Values on Patients: An Ethics Consultant’s Responsibilities}, in \textit{Ethics Consultation in Health Care} 144-46 (J. Fletcher, N. Quist & A. Jonsen eds. 1989).
\end{itemize}
presumably, are ethically justified. Performing a slow code or refusing to treat patients with HIV infection, for these reasons at least, is questionable and perhaps egregious.

Physicians who would refuse to perform active euthanasia on the basis of personal moral beliefs surely would fall in the former category. Yet, physicians who hold such beliefs also would have affirmative obligations to anticipate when these beliefs could conflict with patients' interests and, in the event of this conflict, to inform such patients as early as possible. If they do not, they could place on patients who are already ill the unnecessary burden of having to find another physician, and possibly hospital as well, who would grant these patients' request.

Professor Smith reports one court decision which recognized the extent of the burden to a patient from having to transfer to another hospital. In this instance, a Catholic-affiliated hospital would not accept the refusal of a patient with amyotrophic lateral sclerosis (Lou Gehrig's Disease) to be tube fed. The court ruled that this burden outweighed even the importance of protecting careproviders' emotional sensibilities, because these sensibilities were "subordinate to the psychological pain and trauma the transfer of the dying patient would bring to the patient." But what if a physician could anticipate the conflict but fails to give this "warning"? Such a physician would have some justification in not giving this warning, because to the degree that his or her warning helped the patient find a physician who would carry out the act the physician considered immoral, the physician's beliefs would be violated. That is, physicians who believe that life is absolutely sacred might feel that the assistance given a patient to find another physician who would help the patient die by providing an early warning would be morally objectionable.

Yet, when doctors could give a warning but do not, they incur some obligation to offset the unnecessary harm they caused by failing to act. This obligation to the patient and to the physician's own values would conflict. Since physicians arguably have made an implicit a priori promise when becoming doctors to subordinate some of their own interests to their patients', their obligation to such patients probably should override their personal values in this instance.

103. Final Choices, supra note 1, at 169 n.299 (citing In re Requena, 213 N.J. Super. 443, 444, 517 A.2d 869, 870 (App. Div. 1986)).  
104. Id.  
CHAPTER THREE: PERSONHOOD, BRAIN DEATH LEGISLATION AND ADVANCE DIRECTIVES

In Chapter Three, Professor Smith presents several criteria for personhood. In light of these criteria, he then discusses brain-death legislation, living wills, and the durable power of attorney.

In his discussion of brain-death criteria, Professor Smith states that death is best understood as a gradual deterioration of multiple parts of the body in which some parts die sooner than others. He asserts that the current medico-legal criteria for brain death have “one great practical merit”: They endeavor to place the moment of death earlier in the deterioration of life than was previously permitted. He believes that this and other legal developments are “clear and unmistakable evidence” that complex social mechanisms are now establishing the right of individuals to participate in decisions regarding their own death.

While passive euthanasia and rational suicide presently are “offensive words,” autonomy and enlightened self-determination are not.

Advance Directives

Advance directives have much enhanced patients’ opportunity to influence their future care. Although their use has increased greatly over recent years, their development still must be regarded as in its infancy.

Living wills, for example, sometimes refer only to interventions which patients do not want. Permitting patients to add interventions they want would seem a significant step forward. This step is controversial, however, because some interventions patients want might be “medically futile.” One patient, for example, with terminal cancer and progressive deterioration of multiple organs had indicated prior to becoming irreversibly comatose that she would want all possible interventions, including total parenteral nutrition (TPN). The entire staff opposed TPN, but gave it regardless, because they believed that legally, they had no other choice.

Living wills also tend to involve only patients who have a terminal ill-
ness.\textsuperscript{112} It would seem another important next step to permit more patients with non-terminal illnesses to write living wills. This change also would be controversial, since there is disagreement regarding the conditions under which persons with non-terminal illness should be allowed to die.

The appointment of proxy decisionmakers through the durable power of attorney is another significant development. Persons who are appointed substitute decisionmakers, however, may have never discussed with patients their future wishes. Even when they know patients well, they may predict poorly what patients would want.\textsuperscript{113} Further, those who have discussed with patients their specific preferences may be less willing than patients to terminate patients' care.\textsuperscript{114}

Several approaches have been recommended to ameliorate these difficulties. In addition to physicians possibly asking both terminal and certain non-terminal patients what they would and would not want, doctors can also ask patients what general values, such as dying with dignity or being free from pain, are most important to them.\textsuperscript{115}

When physicians should ask patients such questions, and to what extent, is uncertain.\textsuperscript{116} Very specific questions such as whether a patient would accept brief intubation during CPR but not afterwards, or brief ICU care after CPR but not afterwards, could be useful, but some physicians believe that asking patients such specific questions may unduly frighten and perhaps even physically harm them.\textsuperscript{117}

**CHAPTER FOUR: EUTHANASIA**

In Chapter Four, Professor Smith begins his discussion of euthanasia by pointing out that the most common fear among seriously ill patients is that they will die under protracted circumstances in a hospital.\textsuperscript{118} Because patients are “victims” of modern technology to an ever increasing extent, society has a corresponding, greater obligation to treat its members

\begin{footnotesize}
\begin{itemize}
  \item 112. Emanuel, \textit{supra} note 110.
  \item 116. Id.
  \item 117. Doctors have voiced this concern to the author, for example, in a discussion as to whether physicians should ask patients with HIV infection who were asymptomatic their preferences regarding advance directives. These physicians feared that such discussions might shatter these patients' “healthy denial” and hope, and possibly exacerbate their illness.
  \item 118. \textit{Final Choices}, \textit{supra} note 1, at 89.
  \item 119. Id.
\end{itemize}
\end{footnotesize}
At times however, merely allowing patients to die is not being kind.\textsuperscript{121}

What justification is there for treating patients when it causes them suffering?\textsuperscript{122} He offers several possible responses and then rebuts each of them.

\textit{Omission vs. Commission}

One response is based on the assumption that acts of commission are significantly different from acts of omission. Professor Smith asserts that “in antiquity” doctors were not permitted to terminate a life, but also were not required to prolong it.\textsuperscript{123} Acts such as turning off a respirator may be accurately classified as commission or omission.\textsuperscript{124} The crucial element, however, in determining whether such an act is justified is not its classification, but its motive.\textsuperscript{125} The motive of an act can and should be objectively assessed.\textsuperscript{126} So long as the doer is attempting to relieve suffering and will not incur personal gain, the act should be presumed to be morally permissible.\textsuperscript{127}

\textit{The Principle of Double Effect}

A second response is based on the principle of double or indirect effect. Professor Smith gives two examples in which this principle could be applied: When a physician removes a cancerous, fetus-bearing uterus, and when a physician administers pain-relieving medication that could produce respiratory depression and death.\textsuperscript{128} This principle has been attacked on the ground that it can excuse wrongful acts and has been supported on the ground that it is psychologically valid.\textsuperscript{129} For the reasons discussed previously, Professor Smith declares that the latter claim seems “dubious, at best,” and concludes that the double effect principle should be replaced by the “simple and enduring” criterion: what is reasonable.\textsuperscript{130}

But what is reasonable? Professor Smith states that in general, an unyielding \textit{a priori} statement cannot be made since what is reasonable inevitably will depend on the facts of each case.\textsuperscript{131} Notwithstanding this disclaimer, a rea-
sonable person would consider treatment refusal unreasonable if the treatment could effectively treat the patient’s condition - though not necessarily save the patient’s life - but not give rise to any significant patient objection based on physical or mental burden; familial, social, or economic concern; or religious belief.  

Legal Precedents

Professor Smith next reviews twelve American court decisions regarding euthanasia and describes international perspectives. He discusses in more detail the practice in the Netherlands. After a patient repeatedly requests euthanasia, a second physician must verify that the patient is dying. Then, a team of careproviders, which includes a religious authority, reviews the patient’s situation and assesses the patient’s alternatives, one of which is euthanasia.

Professor Smith asserts that if the United States adopted a policy similar to the Dutch policy, a competent patient who wanted to carry out rational suicide or euthanasia would be viewed as exercising enlightened self-determination. When a surrogate decisionmaker chose euthanasia for a patient who was incompetent, the only pertinent question would be whether the decisionmaker had acted rationally, humanely, and consistently with the patient’s best interests.

CHAPTER FIVE: DNR ORDERS AND WITHHOLDING AND WITHDRAWING LIFE-PROLONGING INTERVENTIONS

In Chapter Five, Professor Smith discusses several recent developments regarding DNR orders and withholding and withdrawing life-prolonging treatments. He maintains that these developments, considered as a whole, are incremental steps towards passive euthanasia.

132. Id.
133. Id. at 106. Only one case, involving a man who killed his six-month old son, resulted in a conviction.
134. Id. Professor Smith points out that Switzerland, Uruguay, Peru, and Germany allow physicians to assist a suicide. Id. at 118 n.163 (citing M. Heifetz, The Right To Die 96 (1975)).
135. Id. at 107. For a description of recent developments, see de Wachter, Active Euthanasia in the Netherlands, 262 J. A.M.A. 3316 (1989).
136. Final Choices, supra note 1, at 107-08.
137. Id. at 108.
138. Id. at 108-09.
139. Id. at 119-20.
Hopelessly Ill Patients

Initially, he describes the 1976 Massachusetts General Hospital Protocol on Optimal Care for Hopelessly Ill Patients. Under this protocol, primary physicians ostensibly have ultimate authority over decisions regarding their patients. This authority appears to be mitigated by further provisions which allow the Intensive Care Director to go directly to the Chief of Service and request ethics committee consultation.

These latter provisions exemplify Professor Smith's procedural recommendation that ethics committees should resolve most difficult questions.

Institutional efforts of this nature present a model for effective and principled decision making. They also structure a verifiable process for evaluating the costs and benefits of treatment and non-treatment and thereby aid not only the health care providers in their decision making, but also the family members or surrogate decision makers who are advised, consulted or approve the ultimate decision.

DNR Policy

He subsequently reviews the new DNR policy in New York State. According to Professor Smith, this policy is the most balanced and comprehensive effort to date defining and strengthening the rights of persons with serious illness. Under this policy, an attending physician must obtain a patient's consent prior to issuing a DNR order, except when the patient may be seriously harmed by this discussion, as when the patient has an arrhythmia and discussion could trigger a cardiac arrest, or the patient is severely paranoid and depressed, and discussion could provoke a patient's suicide. The policy also requires patients to agree with the DNR order and does not permit physicians, themselves, to decide that CPR would be futile.

Therapeutic Privilege

The therapeutic exceptions in the New York policy limit patients' autonomy for paternalistic reasons similar to those Professor Smith criticizes in

140. Id. at 120-21.
141. Id. at 121.
142. Id.
143. Id.
144. Id. at 121-25.
145. Id. at 124.
146. Id. at 122.
147. Id. at 122-23.
other contexts. Physicians' therapeutic privilege in this and other instances permits doctors to not inform patients fully when they believe that information might seriously, unduly harm patients.

Is it true, however, that if physicians ask patients with a heart arrhythmia or with paranoid and depressed feelings to consent to a DNR order, those questions will be more likely to harm them than if physicians do not ask? If physicians choose not to ask patients their preference, patients could perceive that these doctors were withholding information. Patients also might infer from these physicians' silence that the patients' conditions were more grave than they are.

In addition, patients could feel emotionally isolated. Professor Smith indicates (in Chapter One) when he discusses the etiology of suicide, that the feeling of isolation can be more painful than most other emotions and is often a factor contributing to suicide. "Perhaps the most common denominator of suicides is loneliness, a motive arising from marital discord, sickness, unrequited love affairs, and non-social factors such as unemployment, divorce, widowhood, and imprisonment."

The feeling of isolation on a ward might be added to this list.

Patients who are fully informed could also even benefit, perhaps, as a result of feeling more in control. In one study, AIDS patients were asked to respond after being asked their preferences regarding advance directives. A majority stated that they felt better as a result of these discussions for just this reason.

Physicians wrongfully believing that patients cannot bear the truth is not without precedent. Careproviders feared in the past that patients with cancer would be likely to kill themselves if physicians told them the truth regarding their illness, and consequently often withheld this information from patients. Over the past few decades, it has been recognized that this assumption is erroneous. Physicians now know that by telling patients the truth, they can help most patients.

148. Id. at 122.
149. Id.
150. Id. at 10.
151. Id.
153. Id.
A good example of a patient benefiting from the truth involved a patient I treated during my internship. This patient entered the hospital with severe liver damage and kidney shutdown. Despite ongoing peritoneal dialysis for his kidney failure, his condition continued to worsen. His wife stayed with him almost twenty-four hours a day and as her husband's condition deteriorated, she grew increasingly critical and demanding of the medical staff.

I then informed the patient and his wife that many of the physicians aware of the patient's condition believed that he would die, but that personally I believed that he would recover. Both statements were true. Since the patient showed no sign of improving, most of the doctors believed that there was no ground for hope. Yet, since the medical cause of his deterioration was uncertain, I believed that he could recover.

After learning of the other physicians' opinions, the patient and his wife began to share previously unexpressed positive feelings for one another. The wife stopped criticizing the staff and instead carried out the caretaking functions previously performed by the staff. The patient's liver and kidney function improved and he subsequently left the hospital.

Anecdotal reports do not prove an assertion. It probably was coincidence that the patient improved. Still, since the patient and his wife were criticizing the medical staff, they probably were denying the seriousness of his condition. Confronting the patient's denial, at the very least, did not harm him. The patient's improvement, therefore, is a counter-example to the assumption underlying doctors' therapeutic privilege, that telling patients the truth when patients have strong denial is most likely to do harm.

When, if ever, physicians should withhold information from a patient remains controversial. Some physicians believe that when doctors are in doubt, they can gain some indication whether a patient could "tolerate" the truth by asking the patient whether a hypothetical patient would want this information. If the patient answers, "Yes," the patient can be told; if, "No," it is more likely that the patient's denial is severe and should be told, if at all, at a later time.

Other physicians state that they have never seen a patient harmed by having been told the truth in a sensitive manner, and on this basis, argue that physicians are never justified in exercising their therapeutic privilege. The responses of these physicians' patients have not, however, been compared with those of a control group. Thus, these physicians' "clinical experience" is also anecdotal and has limited value.
Withholding and Withdrawing Treatment from Terminally Ill or Irreversibly Comatose Patients

Professor Smith points out that the AMA's 1986 Guidelines for Withholding or Withdrawing Life Prolonging Medical Treatment from Terminally Ill or Irreversibly Comatose Patients emphasizes the importance of patients' quality of life by suggesting that when patients have lost their "truly human qualities" or potential for relationships, the best treatment may be none. As noted previously, an additional significant factor which might have moral weight in such cases is the positive feelings of others for the patient.

The Termination of Life Sustaining Treatment and Age-Based Rationing

Professor Smith subsequently reviews the Hastings Center's 1987 Guidelines on Termination of Life Sustaining Treatment and The Care of the Dying, and Dr. Daniel Callahan's book, Setting Limits: Medical Goals in an Aging Society. He praises both books, and, particularly the tenet in the latter work that if a life-prolonging intervention cannot benefit a patient, it should not be offered.

He challenges, however, Dr. Callahan's "refusal to accept elderly patients' right to self-determination," the right, through legislation, to assisted suicide or euthanasia. Whereas Dr. Callahan fears that this right might "serve as a threatening symbol of [the] devaluation of old age," the opposite is true. To base a denial of full rights of self-determination for the elderly on fears of what might happen devalues the whole value of autonomy and constricts its application to only approved or presently legitimate purposes. . . . It is the individual—regardless of age or infirmity—who should make the final determinations about his health care or medical needs.

Handicapped Newborns

Professor Smith strongly criticizes the final rule put forth in 1985 by the Department of Health and Human Services regarding handicapped newborns. He suggests that when "treatment has a high probability of

156. Final Choices, supra note 1, at 126-28.
157. Id. at 132-34.
158. Id. at 134.
159. Id.
160. Id.
161. Id.
162. Id. at 135-36. For an opposing viewpoint, see United States Commission on Civil Rights, Medical Discrimination Against Children with Disabilities (1989).
causing suffering but a low probability of preserving a life valuable to the patient," such persons probably should not be treated, and finds the discrepancy between the treatment of newborns effected by this rule and the treatment of critically ill adults "alarming." This discrepancy may result from adults having stronger feelings and aspirations for the young. Regardless of the cause, Professor Smith believes that when patients are young or old, cost-benefit considerations should be paramount when deciding what treatments should be given or withheld.

Professor Smith ends this chapter by discussing several leading court cases which involve the decision to allow a patient to die, such as the Saikewitz, Convoy, and Bouvia decisions. These opinions illustrate with "unremitting clarity" that increasingly courts are respecting acts of enlightened self-determination by competent patients and by surrogate decision-makers on behalf of patients.

CHAPTER SIX: PROCEDURAL RECOMMENDATIONS

In Professor Smith's final chapter, he indicates the procedural means by which he believes the substantive changes he has espoused could best be implemented. Advance directives may help considerably to further patients' autonomy, but inevitably circumstances will arise which neither physicians nor patients could foresee. When such conflicts arise, an ethics committee should attempt to reach a solution, and only if unsuccessful should the conflict be brought before a court.

He asserts, however, that if a court must be involved, the court should not decide the outcome. Rather, a surrogate decisionmaker should be appointed and permitted wide decisionmaking discretion and authority, since

163. Id. at 135.
164. Id. at 136.
165. Id.
166. Id.
168. Final Choices, supra note 1, at 155.
169. Id. at 171-79.
170. Id. at 171.
171. Id.
172. Id.
“expeditious and sensitive decision making” is, in general, “more obtainable through intra-institutional processes than protracted judicial inquiry.”

Professor Smith does not address most specific aspects of ethics committee functioning, because, as with guidelines regarding “what is reasonable,” he believes that the morally relevant factors may vary. This claim appears true. Some ethics committees appear to function most effectively, for example, if the physician, nurse, or patient bringing the dilemma presents it to the entire committee; others seem to function most effectively if the physician, nurse or patient bringing the dilemma presents it to only a few persons from the committee who then present their findings to the entire committee.

Yet, the effectiveness of ethics committees also may depend on specific factors. Three examples follow.

**Who Can Request Ethics Committee Consultation**

One important consideration is who can request an ethics committee consultation. In some hospitals, patients or staff can request that an ethics committee be involved, and patients are informed of this option. In other institutions, a patient’s attending physician is the only person who can request ethics committee involvement.

The latter approach enhances the likelihood that patients, physicians, and/or nurses will resolve disagreements among themselves before the ethics committee is involved. This approach places a greater burden on patients and staff, however, to confront the attending physician directly. Patients and staff may prefer to take no action rather than confront these physicians. Patients may fear that if they disagree with their physician, conscious or unconscious retaliation by the doctor may occur in the form of sub-optimal care.

**Whether the Committee is Advisory or Decision-making**

A second important consideration is whether the ethics committee serves primarily an advisory or decisionmaking role. An ethics committee may be described as advisory but, in actuality, only be advisory if it offers several alternatives rather than one and does not take a vote on these options. That is, if an ethics committee indicates that only one approach is acceptable or gives a majority and minority opinion, physicians may fear - with some justification - that if they go against the committee’s recommendation or majority view, they will be more vulnerable to being successfully sued.

173. *Id.*

174. *Id.* at 174.
Who Should Attend Ethics Committee Discussions

An important consideration is whether patients, their families, and/or surrogate decisionmakers should be invited to participate in all ethics committee discussions. If these parties are invited, ethic committee members may feel inhibited and not be completely honest. Furthermore, if ethics committee members express their honest views, patients and their families could feel traumatized and resentful.

The risk of traumatization can be minimized, however, if a careprovider who knows the parties discusses their questions and emotional reactions immediately after the meeting. Inviting these parties also can reduce the suspicion that, when the committee meets “behind closed doors,” the whole truth is being kept from them. Finally, attendance by these parties enables them to become both more medically and ethically informed.

An example in which the participation of a patient's spouse probably would have been desirable occurred when a patient was in a coma and his spouse was a nurse. The nurse found differences among doctors' reports to her of her husband’s prognosis upsetting, and suspected, accurately, that these differences reflected uncertainty which the doctors were unwilling to acknowledge. Had she attended the ethics committee’s meetings when these physicians presented their uncertainty, this might have reduced her distrust.

Who Should Attend “Prognosis Committees”

A related question which is, perhaps, more difficult, is whether patients, their families and/or surrogate decisionmakers should be invited to attend meetings in which physicians meet to discuss a patient’s prognosis. While there are valid objections to the presence of these parties, the gains from their inclusion in at least the more important discussions may outweigh the costs.

Inviting these parties to attend departs from customary practice, but it is actually more consistent with ethical and legal norms. Ethically, if a consulting physician’s opinion differs substantially from that of a referring physician, the consulting physician should assure that this difference is communicated to the patient. Legally, if the consulting physician does not, he or she could be sued for “abandonment.”

Patients and their families may be frightened as a result of learning that doctors disagree or are uncertain, but this fear can be minimized if a careprovider meets with them after these discussions. On the other hand, if these parties are included, they may better understand their physicians’ dilemmas and, to some extent, even identify with the physicians. The result could be enhanced rapport between these parties and physicians. If retro-
respectively, physicians have made choices which harmed a patient, the parties probably would be less likely to sue. 175

**Legal Liability**

Professor Smith stresses the importance of physicians being free from fear of civil and criminal liability when they permit or help patients to end their lives. 176 Freedom from liability probably could be best achieved by the staff's using a "team approach." 177 The "obvious parallel" is seen in the use of a team in ethics and prognosis committees in the United States and the way physicians carry out active euthanasia in Holland.

Professor Smith asserts that when persons such as Elizabeth Bouvia wish to die but lack the ability to take their own life, a team approach is particularly advantageous. 178 Persons with non-terminal as well as terminal illness who are suffering greatly should be permitted or assisted in ending their life, but this should occur not only after committee review and an appropriate trial of counseling. 179

**CONCLUSION**

Professor Smith predicts that in time most persons in this society will agree with his views. 180 If so, it will then be necessary to achieve consensus on both substantive standards and procedural safeguards which would maximize patients' opportunity to exercise enlightened self-determination but minimize the likelihood that these limits would be breached or abused.

By providing broad-based, deeply-grounded arguments for expanding patients' choices, Professor Smith has contributed most significantly to the legal and moral debate on these questions which continues to grow. Others no doubt will critique, refine, and further analyze Professor Smith's proposals. This outcome would itself, however, represent the reification of Professor Smith's hope - that in the not too distant future, passive euthanasia and rational suicide cease being "offensive words," but rather, become options self-evidently meriting this society's reflection.

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176. *Final Choices, supra* note 1, at 175.
177. *Id.*
178. *Id.* at 174-75. According to Professor Smith, referees or committees were advocated as "the least cumbersome approach" to evaluating requests for euthanasia as far back as 1958. *Id.*
179. *Id.* at 175-76.
180. *Id.* at 179-80.