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DEATH BE NOT PROUD: MEDICAL, ETHICAL AND LEGAL DILEMMAS IN RESOURCE ALLOCATION

*George P. Smith, II**

Death be not proud, though some have called thee
Mighty and dreadful, for, thou art not soe,
For, those, whom thou think'st, thou dost overthrow,
Die not, poore death, nor yet canst thou kill mee;
From rest and sleepe, which but thy pictures bee,
Much pleasure, then from thee, much more must flow,
And soonest our best men with thee doe go,
Rest of their bones, and soules deliverie.
Thou'art slave to Fate, chance, kings, and desperate men,
And dost with poyson, warre, and sickness dwell,
And poppie', or charmes can make us sleepe as well,
And better then thy stroake; why swell'st thou then?
One short sleepe past, wee wake eternally,
And death shall be no more, Death thou shalt die.
J. DONNE, *Holy Sonnet 167*, in *THE COMPLETE POETRY OF JOHN
DONNE* at 342 (J. Shawcross ed. 1967).

Mother Seton, the Foundress and Patronal Saint of The Sisters of Charity, taught that "perseverance is a great grace," and that whatever changing events one passes through, he should act as a Christian.¹ Indeed, she encouraged her sisters to act with purity of intention and to be faithful in corresponding to the grace of God.² She observed that one should suppress all critical or unkind remarks and—instead—say only those that are kind.³ She taught that the reward of sacrifice is peace,⁴ and that the real joy of the soul is in assisting the poor, visiting the sick, comforting the sorrowful, clothing

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1. C. WHITE, *MOTHER SETON: MOTHER OF MANY DAUGHTERS* at x, 226 (1949).

2. *Id.* at 223.

3. See *A Daughter of Charity of St. Vincent de Paul*, in *THE SOUL OF ELIZABETH SETON: A SPIRITUAL AUTOBIOGRAPHY* (1936) [hereinafter *A Daughter of Charity*].

4. M. O'NEIL, *MOTHER ELIZABETH ANN SETON* 39 (1940).

the innocents and teaching them the love of God.⁵ The Sisters of Charity have been valiant and steadfast as pioneers in education, charity and social assistance.⁶

Mother Seton's favorite prayer, and the one which she uttered on her deathbed was: "May the most just, the most high, the most amiable will of God be ever loved, adored and accomplished."⁷ In Sister Rosemary Donley's work and distinguished record of accomplishment as a Sister of Charity, I suggest that the most amiable will of God is loved, adored and accomplished with both grace and vigor.

Those with whom Sister Donley associates are enobled and rewarded by her spirit of selflessness and spiritual tranquility, her abiding faith, her love, her professional zeal and commitment to excellence, her infectious smile, her enthusiasm and kind heart, her keen sense of humor, her powerful intellect, her integrity and her loyalty. In truth, she is the living personification of what the French term, *joie de vivre*. It is fitting that we give thanks for Sister's bountiful harvest at the Nursing School, the University, and within her profession and her religious community.

I. THE ECONOMICS OF HEALTH CARE

Health care costs in the United States have been a source of increasing concern. Expenditures for health care totalled approximately \$287 billion in 1981—this compared, in 1965, with \$42 billion.⁸ In 1983, costs had climbed to \$355 billion.⁹ Interestingly, as to percentage of the gross national product consumed by health care expenses, a six percent figure was recorded in 1965 while by 1981, the percentage had increased to 10.8%.¹⁰ The average American spent \$1,225 for health care in 1981.¹¹

While much of the rise in these costs can be attributed to advances in medical technology, certain forms of lifesaving treatments are acknowledged as being the focal points of these increased health costs. More specifically, approximately \$30,000 a year is spent on each patient receiving hemodialysis treatment—with the 1981 figures showing more than fifty thousand patients

5. *A Daughter of Charity*, *supra* note 3, at 64.

6. See D. BAILY, *ELIZABETH SETON* (1927).

7. *A Daughter of Charity*, *supra* note 3, at 93.

8. See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL RESEARCH, 1 SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 184 (1983) [hereinafter PRESIDENT'S COMMISSION].

9. Crozier, *Data Watch—National Medical Care Spending*, 3 HEALTH AFF. 108 (1984).

10. *Id.* See also PRESIDENT'S COMMISSION, *supra* note 8.

11. TIME, Aug. 9, 1982, at 42.

receiving this particular treatment.¹² The cost of each coronary artery bypass operation is between \$10,000-\$20,000, and these surgical interventions account for one percent of the total annual health care budget—with this one percentage point translating into \$2 billion a year.¹³

Two other examples of high budget items in modern medical technology are to be found in the wide use of computerized tomography or CT scanners and intensive care units¹⁴—particularly in neonatal.¹⁵ Sophisticated neonatal care is not only costly, but scarce, with demand often exceeding the supply of beds, equipment and personnel. What is seen, then, is that physicians and hospitals are oftentimes being forced to choose which newborns receive intensive care and which ones do not.¹⁶ Decisions of this nature—in turn—involve a plethora of medical, moral, legal and economic problems—with the central most issue being how to best distribute scarce neonatal intensive care resources.

Rosemary Donley has observed that because of these escalating health care costs—exaggerated as such by technological advances—the success of medical science will require more clinical judgment. In former days, Professor Donley stated:

[P]atients died during therapeutic heroics. Lack of science and the virulence of disease were fatal combinations. Today, the level of science requires not a painful prescription but rather an informed judgment about the merits, efficacy, benefits and desirability of available and experimental treatments. The power of our knowledge has advanced to the point where the treatment might work. [Accordingly], modern clinicians balance not only the cost to the client (and the system), but also the risk to the patient (and the system). Clinicians must make decisions based on the probability that treatment might restore life and health, albeit compromised. We have given clients new, more painful and more costly ways to live and die. Justice mandates that decisions about access to health

12. Evans, Blagg & Bryan, *Implications for Health Care Policy: A Social and Demographic Profile of Hemodialysis Patients in the United States*, 245 J. A.M.A. 487, 490 (1981). See also Note, *Scarce Medical Resources*, 69 COLUM. L. REV. 620 (1969).

13. Randall, *Coronary Artery Bypass Surgery*, 12 HASTINGS CENTER REP. 13, 14 (Feb. 1982).

14. Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 WIS. L. REV. 239, 240.

15. See Smith, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis?*, 63 NEB. L. REV. 709 (1984).

16. Smith, *Triage: Endgame Realities*, 1 J. CONTEMP. HEALTH L. & POL'Y 143 (1985); see also Childress, *Triage in Neonatal Intensive Care: The Limitations of the Metaphor*, 69 VA. L. REV. 547 (1983).

care should consider benefit as well as cost.¹⁷

In traditional therapeutic equations, cost of care was ignored.¹⁸ Today, however, it is the significant and perhaps overriding variable in the Brave New World that, in reality, is already here. "Return on equity is the outcome," Donley states, "and management of costs is the strategy that drives the new system."¹⁹ Health care professionals must, of necessity, include cost in their decisional paradigms. Sadly, I find myself in total agreement with Professor Donley, when she concludes that "failure to use the best available information, an irresponsible use of power, has brought us to the place where health care is a commodity to be purchased and professional judgment is mediated by arbitrary financial standards."²⁰

More and more, then, the central question of from whom will people seek care in decentralized health systems²¹ becomes tied to the simple reality of their financial backgrounds and their medical salvageability as a consequence of their treatment using scarce medical resources. Modern principles of *triage*²² and cost-benefit analysis dictate, in reality, the extent to which a definitive response can be given to the question of how contemporary and decentralized health systems respond to the needs of an equally contemporary society.²³

Both the thesis and the major conclusion of this Article are identical and state—very simply—that no matter what physicians, lawyers, judges, nurses, social welfare workers, philosophers or ethicists posit re the structuring and validation of treatment or non-treatment of individuals in irreversible comas and irreversibly handicapped newborns, the final reality of decisionmaking is tied to a complex balancing test of weighing economic costs of non-maintenance against the social benefits of maintenance. Stated another way, decisions of this scope and dimension are reached by balancing the gravity of the

17. Donley, *A Brave New World of Health Care*, 2 J. CONTEMP. HEALTH L. & POL'Y 47, 51 (1986).

18. *Id.*

19. *Id.*

20. *Id.* at 52. It has been suggested that as to medical cost control, greater patient choice would have the effect of bringing about a very significant reduction in actual health care consumption. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 295 (1985).

21. See Donley, *A Social Mandate for Nursing: Prescription for The Future*, 1 J. CONTEMP. HEALTH L. & POL'Y 39, 44 (1985).

22. Smith, *supra* note 16. See generally R. FOX & J. SWAZEY, *THE COURAGE TO FAIL* (1974); G. SMITH, *GENETICS, ETHICS AND THE LAW* (1981).

23. Donley & McCarthy, *Technology: Enemy of Ally in Pursuit of Justice*, in *CHRISTIAN PERSPECTIVE ON JUSTICE IN HEALTH CARE* 11 (M. Kelly ed. 1984). See generally G. CALABRESI, *TRAGIC CHOICES* (1978) (with P. Bobbit).

economic harm that will accrue in a particular case of maintenance against the utility of the social good that will occur for non-maintenance.

II. CONTEMPORARY AMBIGUITIES

There is a shifting and, indeed, ambiguous line between doing everything medically possible to prolong a meaningful (i.e., qualitative) life and doing no more than is considered necessary to maintain comfort and avoid a prolongation of the dying process. And, regrettably, the parameters of this line are not universally taught in American medical schools. Rather, the degree of aggressiveness of treatment to be followed is left generally to both the accumulated experience as well as the basic personality of individual doctors, together with their consultations with peers and the patient in distress and his family.²⁴

In a litigious society, many doctors are restrained in their use of humane, yet life-ending modalities of treatment or non-treatment because of the real fear of malpractice actions being maintained against them. For other physicians, the death of a patient is viewed as a professional failure—with every means being taken in order to postpone it—even in clear-cut cases of terminal illness and even sometimes against contrary family wishes.²⁵

Dr. Richard B. Freeman of Rochester, New York, commented recently that although he took the Hippocratic Oath to “do no harm,” with the current state of advanced medical technology, physicians “can often ‘do harm’ by using everything every time.”²⁶ Physicians have commonly distinguished between not saving a life and taking a life. Thus, for example, feeding has been withheld to hasten death by starvation—but there has been a reluctance to give medicine to hasten death that, in turn, would if disclosed surely subject the physician to a criminal charge of murder.²⁷

While the physician must be governed by a single-minded purpose to *benefit* his patient, a prudent sense of proportion as to the means employed must be maintained.²⁸ Answers can never be clear and precise, however, when questions are posited of the nature: What makes life not worth living for a handicapped at-risk newborn or a terminally ill person? Both with child and adult, alike, it would seem but reasonable to suggest (or even advocate) that when either suffers from a disease that brings with it uncontrolled levels of

24. Malcom, *Fateful Choices—Fatal Illness: How Long to Live*, N.Y. Times, Feb. 14, 1986, at 8, col. 3.

25. *Id.*

26. *Id.*

27. Brooks, *Ethical Dilemmas in the Treatment of Critically Ill Newborns*, 1 J. CONTEMP. HEALTH L. & POL'Y 133, 139, 140 (1985).

28. C. RICE, *THE VANISHING RIGHT TO LIFE* 72 (1969).

pain and no hope of survival that life should not be prolonged by means of extraordinary medical measures.²⁹ What is extraordinary will of necessity depend upon the facts of the particular case being evaluated and also very largely upon the judgment (or prognosis) of the attending physician.³⁰

In 1957, Professor Glanville Williams of Cambridge University suggested that when a physician responded—accordingly—to such a decision and acted in *good faith*, he should be relieved of all civil and criminal responsibility for any possible claim that he failed to fulfill his “obligation” to maintain life or—for that matter—assisted, actively or negligently in promoting one’s death.³¹ Any test of the measure of good faith would, then, of necessity, be tied to an evaluation of the costs (medical, economic and social) of maintaining a terminally ill patient versus the benefits of restraint in treatment.³²

Thus the question is whether society leaves the ultimate decision to prolong or release “life” at its edges to the collected wisdom of physicians based on a situational standard, or is the rigidified standard of law, that forbids in *all* cases the purposeful taking of another’s “life” as murder, to be followed unerringly? I predict that within ten years, as more and more tragic incidents of cruel and unusual punishment through the prolongation of lives that in reality are neither humane nor human in their form are witnessed, the law will respond accordingly and allow medical assistance to be rendered to complete the final burden without civil or criminal sanction.

In August, 1985, the National Conference of Commissioners of Uniform State Laws suggested the adoption of a Uniform Rights of the Terminally Ill Act that would go far to establish recognition of rights of self-determination for the terminally ill.³³ Some thirty-six states including Texas have enacted

29. Englehardt, *Ethical Issues in Aiding the Death of Young Children*, in *BENEVOLENT EUTHANASIA* 180, 187 (M. Kohl ed. 1975); Englehardt, *Euthanasia and Children: The Injury of Continued Existence*, 83 *J. PEDIATRICS* 170, 171 (1973). Another authority has suggested that a narrow class of infants may be selected justifiably for non-treatment with a notion of equal respect for the life of all persons when the conscious existence of those infants in the class is so greatly diminished that making an investment in their case would appear to reasonable people to yield no benefits. Additionally, for non-treatment selection to be morally and socially acceptable two considerations must be met: the selection criteria for the non-treatment must be authoritatively articulated and announced publicly and the physicians and parents making the decision should follow a specific process for assuring that a given infant falls within the category of those who may be justifiably selected for non-treatment. Robertson, *Substantive Criteria and Procedures in Withholding Care for Defective Newborns*, in *THE LAW-MEDICINE RELATION: A PHILOSOPHICAL EXPLORATION* 217, 221-23 (S. Spicker, J. Healey, Jr. & H. Englehardt, Jr. eds. 1981).

30. Brooks, *supra* note 27, at 136; Malcom, *supra* note 24. See R. McCORMICK, *NOTES ON MORAL THEOLOGY, 1965 THROUGH 1980* 565 (1981).

31. G. WILLIAMS, *THE SANCTITY OF LIFE AND THE QUALITY OF LIFE* 340 (1957).

32. *Id.*

33. See Newsletter, *Society for The Right to Die*, Fall, 1985.

living will legislation or right to die laws in efforts to preserve the dignity to those whose death is imminent.³⁴

As society begins to move in the direction of respecting the autonomy of decisionmaking at life's end, so—too—do I suggest it should react similarly to misfortuned beginnings of life; misfortunes best assessed and evaluated by involved physicians and the family units wherein the real crisis reposes; for it is these individuals—not a meddling government bureaucracy in Washington—who can best cope with these decisions regarding the edges of life.

Fr. Richard A. McCormick has observed that while every *person* is of equal value, not every *life* is.³⁵ He suggests that if life is regarded as the continuation of vital processes but within a persistent vegetative state; and if value means a good to the concerned individual with equal meaning identical or the same (especially of treatment), then it is false to suggest that every

34. ALA. CODE §§ 22-8A-1 to -10 (1984); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. § 82-3801 to -3804 (Supp. 1985); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985); COLO. REV. STAT. §§ 15-18-101 to -113 (Supp. 1986); 1985 CONN. ACTS 85-606 (Reg. Sess.); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. § 6-2421 to -2430 (Supp. 1986); FLA. STAT. § 765.01 to -.15 (1986); GA. CODE ANN. §§ 31-32-1 to -12 (1985 & Supp. 1986); IDAHO CODE §§ 39-4501 to -4508 (1985 & Supp. 1986); ILL. ANN. STAT. ch. 110½, para. 701-710 (Smith-Hurd Supp. 1986); IND. CODE ANN. §§ 16-8-11 to -21 (Burns Supp. 1986); IOWA CODE ANN. §§ 144A.1 to .11 (West Supp. 1986); KAN. STAT. ANN. § 65-28-101 to -109 (1980); LA. REV. STAT. ANN. § 40:1299.58.1 to .10 (West Supp. 1986); ME. REV. STAT. ANN. tit. 22, §§ 2921 to 2931 (Supp. 1986); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1986); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1985); MO. ANN. STAT. §§ 459.010 to .055 (Vernon Supp. 1986); MONT. CODE ANN. §§ 50-9-101 to -111 (1985); NEV. REV. STAT. §§ 449.540 to .690 (1986); N.H. REV. STAT. ANN. §§ 137-14:1 to -:16 (Supp. 1985); N.M. STAT. ANN. §§ 24-7-1 to -11 (1986); N.C. GEN. STAT. §§ 90-320 to -322 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101 to 3111 (West Supp. 1987); OR. REV. STAT. §§ 97.050 to .090 (1985); TENN. CODE ANN. 32-11-101 to -110 (Supp. 1986); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1986); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1986); VT. STAT. ANN. tit. 18, §§ 5251 to 5262 (Supp. 1985); VA. CODE ANN. §§ 54 -325.8:1 to :13 (Supp. 1986); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (Supp. 1986); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01 to .15 (West Supp. 1986); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1986).

Since 1976, twenty-one states have enacted Natural Death Acts: ALA. CODE §§ 22-8A-1 to -10 (1984); ARK. STAT. ANN. § 82-3801 to -3804 (Supp. 1985); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. § 6-2421 to -2430 (Supp. 1986); FLA. STAT. § 765.01 to .15 (1986); GA. CODE ANN. §§ 31-32-1 to -12 (1985 & Supp. 1986); IDAHO CODE §§ 39-4501 to -4508 (1985 & Supp. 1986); ILL. ANN. STAT. ch. 110 ½, para. 701-710 (Smith-Hurd Supp. 1986); KAN. STAT. ANN. § 65-28-101 to -109 (1980); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1985); N.M. STAT. ANN. §§ 24-7-1 to -11 (1986); N.C. GEN. STAT. §§ 90-320 to -322 (1985); OR. REV. STAT. §§ 97.050 to .090 (1985); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1986); VT. STAT. ANN. tit. 18, §§ 5251 to 5262 (Supp. 1984); VA. CODE ANN. §§ 54-325.8:1 to :13 (Supp. 1986); WASH. REV. CODE ANN. §§ 70. 122.010 to .905 (Supp. 1986); WIS. STAT. ANN. §§ 154.01 to .15 (West Supp. 1986); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1986).

35. McCormick, *The Quality of Life, The Sanctity of Life*, 8 HASTINGS CENTER REP. 30, 35 (Feb. 1978).

life is, indeed of equal value.³⁶ He suggests that what the "equal value" language is attempting to connote is that unjust discrimination in the provision of health care and life supports should be avoided.³⁷ Yet, not all discrimination (or inequality of treatment) is unjust.³⁸ *Unjust* discrimination is avoided when critical decisionmaking centers upon the benefit to the patient—even if the particular benefit must be described primarily in terms of a quality-of-life criteria.³⁹

There is a time when it is proper to acknowledge that death is not the greatest evil and, thus, to acquiesce in its victory. While there is a duty to preserve life, recognition must be made of the fact that death is the door to eternal life. And it can be wrong for physicians, as well as the family unit, to turn the very process of dying into a "technological circus."⁴⁰ This is, of course, not a depreciation of the sanctity of life. But rather, it recognizes that death must come and that—at some point in time—extreme measures of resistance are neither necessary nor appropriate.⁴¹

On March 15, 1986, the Council on Ethical and Judicial Affairs of the American Medical Association issued a policy on withholding or withdrawing life prolonging medical treatment which will affect the estimated ten thousand people who are in irreversible comas in institutions around the country.⁴² In essence, this policy statement maintains that it is ethical for physicians to withhold "all means of life prolonging medical treatment" including water, from patients in irreversible comas. While recognizing the social commitment of the physician to sustain life and relieve suffering, the Council advises that when the performance of one duty conflicts with the other, the physician must act in the best interest of the patient. Thus, in following a course of treatment for a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens and seek to maintain the dignity of the patient at all times.⁴³

The Council states that, for humane reasons, "with informed consent, a physician may do what is medically necessary to alleviate severe pain, or

36. *Id.* See also Smith, *supra* note 15, at 735, 736.

37. Smith, *supra* note 15, at 735, 736; McCormick, *supra* note 35, at 30, 35.

38. Smith, *supra* note 15, at 735, 736; McCormick, *supra* note 35, at 30, 35.

39. See R. VEATCH, DEATH, DYING AND THE BIOLOGICAL REVOLUTION 3, 5 (1976); Fletcher, *Love is The Only Measure*, 83 COMMONWEALTH 427 (1966). See also McCormick, *supra* note 35, at 30, 35.

40. C. RICE, BEYOND ABORTION: THE THEORY AND PRACTICE OF A SECULAR STATE 119 (1979).

41. *Id.*

42. Malcolm, *Reassessing Care of Dying*, N.Y. Times, Mar. 17, 1986, at 1, col. 3.

43. *Id.*

cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death."⁴⁴ In making decisions whether the administration of potentially life-prolonging medical treatment comports with the best interests of an incompetent patient who is unable to act in his own behalf, the physician should determine what the possibility is for extending life under both humane and comfortable conditions. A further determination should be made as to the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody. According to the policy, even though death may not be imminent, but a patient's coma is considered to be beyond doubt irreversible, and there are—furthermore—adequate safeguards in place to confirm the accuracy of the diagnosis, then, with the concurrence of those who have responsibility for the care of the patient, it is not to be regarded as unethical to discontinue all means of life-prolonging medical treatment.⁴⁵

III. PRINCIPLES OF ALLOCATION

The classical definition of *triage* may be acknowledged as being:

[t]he medical screening of patients to determine their priority for treatment; the separation of a large number of casualties, in military or civilian disaster medical care, into three groups: those who cannot be expected to survive even with treatment, those who can recover without treatment, and the priority groups of those who need treatment in order to survive.⁴⁶

Even before "*triage*" found significant application to military or civilian catastrophes, its root meaning in French—"sorting, picking, grading or selecting according to quality"—was subsequently first applied in the English language to the process of separating wool according to quality and even later, to the separation of coffee beans into three categories: "best quality," "middling" and "triage coffee," with the last consisting of beans which had been broken and were, thus, the lowest in grade.⁴⁷ Over the course of time, the use of *triage* has been expanded to other situations where it has become, in actuality, a metaphor for social, economic and even political decisions.⁴⁸

44. AMERICAN MEDICAL ASSOCIATION, STATEMENT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (Mar. 15, 1986).

45. *Id.*

46. STEDMAN'S MEDICAL DICTIONARY 1476 (4th unabr. ed. 1976).

47. Childress, *supra* note 16, at 549.

48. See D. RUND & T. RAUSCH, TRIAGE 3-10 (1981); G. WINSLOW, TRIAGE AND JUSTICE 1 (1982); Smith, *supra* note 16. See also Duncan, *Public Policy and the AIDS Epidemic*, 2 J. CONTEMP. HEALTH L. & POL'Y 169 (1986); Comment, *Protecting the Public from AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191 (1985).

Utilitarian v. Egalitarian

Since the law provides at present no uniformly agreed upon principles which may be applied in order to regulate the allocation of scarce medical resources, current medical practice draws upon a structure for decisionmaking evolved as such from a number of philosophical and ethical constructs.⁴⁹ There are five utilitarian principles of application which are operative in the hierarchy of *triage*: the principles of medical success; immediate usefulness; conservation; parental role and general social value.⁵⁰ Translated as such into decisional operatives, what emerges is a recognition that priority of selection for use of a scarce medical resource should be accorded to those for whom treatment has the highest probability of medical success, would be most useful under the immediate circumstances, to those candidates for use who require proportionally smaller amounts of the particular resource, those having the largest responsibilities to dependents or those believed to have the greatest actual or potential general social worth.⁵¹ The utilitarian goal is—simply stated—to achieve the highest possible amount of some good or resource.⁵² Thus, utilitarian principles are also commonly referred to as “good maximizing strategies.”⁵³

Egalitarian alternatives—contrariwise—seek either a basic maintenance or a restoration of equality for persons in need of a particular scarce resource.⁵⁴ There are five basic principles utilized here: 1) the principle of saving no one—thus priority is given to no one because, simply, none should be saved if not all can be saved; 2) the principle of medical neediness under which priority is accorded to those determined to be the medically neediest; 3) the principle of general neediness which allows priority to be given to the most helpless or generally neediest; 4) the principle of queuing where priority is given to those individuals who arrive first and—finally— 5) the principles of random selection where priority of selection is given to those selected by pure chance.⁵⁵

To the utilitarian, maximizing utility, and hence what is diffusely referred to as the “general welfare,” are both the primary ground and subject of all judgments.⁵⁶ That which is required in order to maximize utility overall

49. Note, *Scarce Medical Resources*, 69 COLUM. L. REV. 620 (1969).

50. G. WINSLOW, *supra* note 48, at 106.

51. *Id.* at 63-86.

52. *Id.* at 87.

53. *Id.* See generally Posner, *Utilitarianism, Economics and Legal Theory*, 8 J. LEGAL STUD. 103 (1979).

54. G. WINSLOW, *supra* note 48, at 106.

55. Smith, *supra* note 16, at 147. See also G. WINSLOW, *supra* note 48, at 106.

56. Gewirth, *Can Utilitarianism Justify Any Moral Rights?*, in ETHICS, ECONOMICS AND THE LAW 167 (J. Pennock & J. Chapman eds. 1982).

may, thus, infringe upon an individual's own entitlements or rights to particular goods.⁵⁷ Accordingly, moral rights are either rejected generally or recognized as certainly not absolute.⁵⁸

Philosophy and religion may well provide us all with the necessary balance and direction for life and allow us to develop an ethic for daily living and a faith as to the future. But in cases of neonatology where law, science, medicine and religion interact so dramatically, great care must be exercised in order to prevent inexplicable fears and emotions—oftentimes fanned by journalistic prophets of the “what if” shock culture—from taking hold of and thereby blocking powers of rationality and humanness.⁵⁹ The basic challenge of modern medicine should be, simply, to seek, promote and maintain a level of real, and when the case may dictate, potential achievement for its user-patients which allows for full and purposeful living.⁶⁰ Indeed, man—himself—should seek to pursue decisionmaking responsibilities and exercise autonomy in a rational manner, guided by a spirit of humanism. He should seek—further—to minimize human suffering and maximize the social good. Defining the extent and application of the social good will vary with the situation of each case, obviously.⁶¹

57. *Id.* at 167, 168.

58. *Id.* at 168. Bentham in effect rejected moral rights generally. H.L.A. Hart, *Bentham on Legal Rights*, in OXFORD ESSAYS IN JURISPRUDENCE 171-201 (2d series A. Simpson ed. 1973).

59. See generally Smith, *Intrusions of a Parvenu: Science, Religion and The New Biology*, 3 PACE L. REV. 63 (1982); Smith, *Uncertainties on the Spiral Staircase: Metaethics and The New Biology*, 41 PHAROS 10 (1978).

60. G. SMITH, *supra* note 22, at 2, 8.

61. *Id.* The extent to which social good complements individual potentials for purposeful living was revealed strikingly in a study of special care nursing treatment of neonates undertaken at the Yale-New Haven Hospital which was released in 1973 and showed that 14% of the two hundred ninety-nine deaths recorded during the period of the study—eighteen months—were related to actions which withheld treatment. The publication of this study initiated a public dialogue and raised issues regarding the treatment of defective newborns or neonates which heretofore had been raised privately by attending physicians, with or without familial consultation.

In 1975, questionnaires were sent to all members of the Surgical Section of the American Association of Pediatricians and to all the chairmen of teaching departments of pediatrics in the United States, as well as to chiefs of divisions of neonatology and to chiefs of divisions of genetics in the first two groups and 197 from the latter groups returned completed questionnaires. The results showed “broad support” for the propositions that: physicians need not attempt to maintain the life of every severely impaired newborn simply because the technology and the skill exists; parents and physicians (in that order) bear the ultimate responsibility for making decisions regarding the withholding or administration of treatment for handicapped at-risk newborns; such decisions should be made on the basis of the best medical predictions regarding longevity and quality of life; under certain “egregious” circumstances physicians

Seeking a Construct for Decisionmaking

The underlying principle of application should always be to minimize suffering and maximize the qualitative potential for fulfilling human relationships, thereby promoting a purposeful life for the at-risk individual.⁶² The extent to which this principle, inquiry or test should be applied depends solely upon the facts of each situation as it arises to present a problem. To have an unyielding *a priori* standard of mandated care for all seriously handicapped newborns, for example, would be unjust not only for the infant, itself, and be promotive of undue suffering to it, but equally unjust and harsh for its parents and present an unreasonably heavy economic burden to society for its maintenance and allocation of scarce and expensive medical support resources and mechanisms. Efforts must always be made to ensure, however, that if a class is structured and labeled, "disabled," it is drawn as narrowly as possible and defined as strictly as possible.⁶³ Thus, the overriding issue, then, is whether a construct can in fact be designed in such a manner as to assist the supervising physicians, the family and their religious counselors and the state (when involved) in defining the parameters of a class of non-salvageable defective newborns?

At various times it has been suggested that the capacity for conscious-

could seek judicial intervention in order to effect treatment and, finally, decisions to treat or not to treat defective newborns were best made on a "case-by-case" or situational basis.

The majority of the members of the medical profession are of the opinion that the autonomy of the parent-physician relationship should be maintained in this critical area of concern. Campbell & Duff, *Moral and Ethical Dilemmas in the Special Care Nursery*, 289 NEW ENG. J. MED. 890 (1973). See also Ellis, *Letting Defective Babies Die: Who Decides?*, 7 AM. J. L. & MED. 393, 399 (1981).

62. Campbell & Duff, *supra* note 61.

63. Kennedy, *Reflections on the Arthur Trial*, 59 NEW SOC'Y 13 (1982). The Department of Health of New South Wales in Sydney, Australia, drafted admission guidelines for neonatal intensive care units in the State which may be considered not only humane, but economically efficient. They state that:

1. The triage principle should be adopted in the neonatal intensive care field.
2. Newborn babies weighing more than 750 grams should generally be accepted for treatment unless they are suffering from serious malformations (including some chromosomal abnormalities) which will seriously impair their quality of life.
3. Newborn babies who, despite skilled resuscitation and exclusion of reversible problems, have not attained their own cardiac output after 10 minutes have elapsed should, for humanitarian reasons, be carefully considered for triage.
4. Some babies weighing more than 750 grams may subsequently be excluded because of severe intraventricular hemorrhage or severe brain damage.
5. Infants with severe abnormalities of cardiac and/or respiratory systems (hypoplastic left heart syndrome, laryngeal and tracheal aplasia) where surgical correction is not feasible should be considered for triage. NICU Admission Guidelines, Department of Health, New South Wales, Australia, 1984. See also Lorber, *Early Results of Selective Treatment of Spina Bifida Cystica*, 4 BRIT. J. MED. 201 (1973). See generally Smith, *Life or Death - Who Decides?*, in 7 PROCEEDINGS MEDICO-LEGAL SOC., NEW SO. WALES 190 (1985).

ness,⁶⁴ social interaction, human relationships (and especially love)⁶⁵ and rational thought were the four most important considerations in determining who was to be placed in a “non-salvageable” classification.⁶⁶ The importance of each capacity in the hierarchy of the classification depends, very obviously, upon one’s particular social, ethical, religious and philosophical perspective. One leading ethicist has stated that, “the warmth of human interaction, the love of one person for another, the emotional bonding that links people in moral communities does not require a capacity for consciousness.”⁶⁷

Balancing Costs and Benefits

The conundrum of seeking to maintain purposeful living yet at the same time protect the recognition of the very sanctification of life finds reality and force when dealing with the plight of genetically defective newborns. This conundrum is also to be recognized as presenting a quality of goals. One goal is and must be balanced against another in attempting to reach a level of distributive justice in the hard decision required here. The situational ethic must be predominant over a harsh, unyielding *a priori* standard. Viewed from another perspective, this balancing test underscores recognition of the fact that human life is, in actuality, but a resource—as are natural, physical and environmental resources. Thus, the primary goal for the conservation of every resource is the maximization of its full use or potential—be it viewed as economic, social, cultural or political. Waste must be avoided. Considered as such, then, in seeking to maximize the good of this precious resource of life, the rights of personal autonomy and spiritual awareness are but vectors of forces which must be additionally factored into any balancing equation. State interest is yet another positive force and also a constraint on autonomous or, in this area, parental-familial medical decisionmaking.⁶⁸

When considering the severely defective newborn, the costs to the individual if maintained *vis-a-vis* the quality of life and extent of life must be weighed against not only the side effects on the parents from a social, emotional and economic level, but on the hospital staff in the nursery watching the infant die and listening to its strangled cries,⁶⁹ as well as on society as to

64. Fletcher, *Indicators of Humanhood: A Tentative Profile of Man*, 2 HASTINGS CENTER REP. 1 (Nov. 1972).

65. R. McCormick, *To Save or Let Die: The Dilemma of Modern Medicine*, in HOW BRAVE A NEW WORLD 339 (1981).

66. R. VEATCH, A THEORY OF MEDICAL ETHICS 244 (1981).

67. *Id.* at 245.

68. G. SMITH, *supra* note 22.

69. Smith, *Long Days Journeys Into Night: The Tragedy of The Handicapped At Risk Infants*, in MORAL ISSUES IN MENTAL RETARDATION (R. Laura ed. 1984) [hereinafter *Long*

the loss of a young citizen and the potentially dangerous recognition that death may have for future similarly disposed citizens. Indeed, the goal of achieving a manageable level of sustenance may well involve incalculable levels of suffering for both the active and passive participants.⁷⁰

An African Paradigm

The Akamba people of Kenya, Africa, approach the problem of allocating scarce medical resources in a most interesting manner. For example, where only one person can be saved, the Akamba would favor an older person over a younger person—this being in direct contrast with the posture taken in the United States where the young are prized more highly than the old because of their economic productivity—or at least their perceived productivity. The Akamba insist that life is much more than “atomistic sums of individual economic contributors.”⁷¹ Rather, it is viewed as “a social fabric of interpersonal relations.”⁷² Thus, under their philosophy, the more advanced age a person reaches, the more strongly related that person becomes to the lives of others and the greater wisdom he shares with the community. This relationship is thus viewed as a significant social resource.⁷³

Similarly, a man without children would be saved over one with five. Again, in the United States, an opposite position would be taken—with the view that for the sake of the children their father should be treated medically and saved.⁷⁴ The Akamba maintain “that the man without children faces annihilation and must be allowed to live so that he can ‘raise up a name’ for himself by having children.”⁷⁵

And finally, the Akamba prioritize half-treatments to each of two dying patients rather than allow one to receive full treatment, even when the record of experience indicates that a half-treatment is insufficient to save either at-risk individual. This they do under their theory of substantive equality.

Days Journeys]; Smith, *Defective Newborns and Government Intermeddling*, 25 MED. SCI. & L. 44 (1985) [hereinafter *Defective Newborns*]; Smith, *The Plight of The Genetically Handicapped Newborn: A Comparative Analysis*, 9 HOLDSWORTH L. REV. 164 (1984) [hereinafter *Handicapped Newborns*].

70. See *Long Days Journeys*, *supra* note 69; *Defective Newborns*, *supra* note 69; *Handicapped Newborns*, *supra* note 69. See also Smith, *Lost Horizons, Captains Courageous and Disabled Newborns: Raging Against The Dying Light*, in 1 REPORTS OF THE SEVENTH WORLD CONGRESS ON MEDICAL LAW 75 (1985); Smith, *Handicapped Babies and The Law: The United States Position*, 1984 INT’L LEGAL PRAC. 86.

71. Kilner, *Who Shall Be Saved? An African Answer*, 14 HASTINGS CENTER REP. 14, 19 (June 1984).

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

In the United States, procedural equality (or, what is commonly acknowledged as equal access) would dictate a course of action where only one person would be saved—all according to a first come, first served principle.⁷⁶

A Distributional Standard

Distributing scarce medical resources involves obvious problems of distributive justice. Although acknowledged as existing, they are quite difficult to resolve in a pragmatic manner. Consequently, owing to this often insurmountable difficulty, the question of how the distribution will be made is reduced to the issue of who will make the first order decision. Yet, unless *triage* decisions are to be recognized as but arbitrary and capricious, some criteria must be in place for scrutiny and examination.

The Hemodialysis Program of Seattle, Washington's Artificial Kidney Center studied eighty-seven such centers around the country in order to develop a set of criteria for allowing patients to be admitted to their programs. The dialysis candidate profile that emerged found the following criteria to be used always in the selection and admissions process: medical suitability (good prognosis with dialysis); absence of other disabling disease; intelligence (as related to understanding treatment); likelihood of vocational rehabilitation; age; primacy of application for available vacancy in the hemodialysis program; and a positive psychiatric evaluation (re acceptance of the kidney disease and goals of the actual treatment). The following conditions were judged as excluding selection of a patient for participation in the program: mental deficiency; poor family environment; criminal record; indigency; poor employment record; lack of transportation; and lack of state residency.⁷⁷

Fault may be found with one or more of these factors used in selection. But, absent a unifying philosophy of medicine which defines with precision its goals for achievement, acknowledges whether such achievement is possible and determines whether it reflects a desirable goal of contemporary human culture, and develops rational guidelines for making necessary critical choices, medicine will not be successful.

Today, there is a recognition that an admirable goal of a national health policy is quality health care at an affordable cost. Cost containment thus has become a major force of wide significance and application in all levels of health-care decisionmaking. There is little disputation of the fact that resources are scarce relative to wants and that they have alternative uses; and furthermore that differences in individual wants mean an assignment of dif-

76. *Id.*

77. R. FOX & J. SWAZEY, *THE COURAGE TO FAIL* 7, 8 (1984).

ferent values to these wants. The basic dilemma, then, is where to determine a line of compromise between competing interest groups.⁷⁸

Love As A Construct

From a Judeo-Christian theological perspective, the meaning, the substance, and—indeed—the consummation of life is tied inextricably to expressions of Love: love of God and love of neighbor. It is through the love of others that God is recognized and loved. The meaning of life under this interpretation, then, is to be found in human relationships and the qualities of respect, concern, compassion, and justice that support such relationships.⁷⁹

Social justice demands that each individual be given an opportunity to maximize his individual potential. Yet, a point is often reached where maintenance of an individual is in defiance of all concepts of basic humanitarianism and social justice. When an individual's condition is such that it represents a negation of any "truly human" qualities or relational-potential, then the best form of treatment should be arguably no treatment at all.⁸⁰

Life should not be viewed as an end in and of itself, but rather as something that should be preserved so that other values can be fulfilled. Life should be preserved when it holds a potentiality for human relationships. Although this standard does not admit of mathematical precision and must be applied with great humility and caution, it is nonetheless a beginning from which particular medical formulations may be developed.⁸¹

The concepts of ordinary versus extraordinary life-sustaining processes are highly relative, not only in time and locale, but also in their application to individual cases. These concepts in essence serve as value judgments which determine whether a given modality of treatment poses an undue hardship on the patient or provides hope for a direct benefit. If a particular mode of medical or surgical intervention either imposes too great a hardship on the patient, or offers no reasonable hope of benefit, the treatment could be correctly viewed as extraordinary and, thus, non-obligatory.⁸²

If an act renders more harm than good to the individual in crisis, and to those around him, the act would properly be viewed as unloving. The crucial point of understanding is that a basic cost-benefit analysis is almost always undertaken—consciously or unconsciously. Of course, the method-

78. Smith, *supra* note 16, at 146.

79. *Id.* at 149-50.

80. *Id.*

81. *Id.*

82. *Id.* See generally Smith, *Manipulating The Genetic Code: Jurisprudential Conundrums*, 64 GEO. L.J. 697 (1976).

ology utilized in this assessment will be situational and incapable of absolute determination. Yet of necessity, the basic norm to be used will be that of love.⁸³

CONCLUSIONS

Life—viewed as a human resource—should be developed and preserved along those lines which allow for the achievement of its fullest potential for total economic realization, maximization or productivity. Indeed, human life—at whatever stage of development or decline—is both a precious and sacred *resource*.⁸⁴ Its initial advancement or abrupt curtailment should be guided always by a spirit of humanism. Viewed thusly, attainment of the quality of purposeful, humane living becomes a coordinate or complement to total economic utility.⁸⁵

Child protection laws and laws prohibiting murder are, of course, necessary. Their design and promulgation by the government at the state and federal levels are crucial if standards of equal protection for all of its citizens—regardless of age or physical stature—are to be assured. It is a dangerously thin line to tread between familial privacy in decisionmaking matters of this nature and government intervention.⁸⁶ The judiciary, when called upon to evaluate cases of alleged abuse of handicapped newborns, or murder or euthanasia, can be aided by a close working partnership with the medical profession in seeking to determine those situations where the withholding of needed medical or surgical modalities of treatment would be in the individual's best interests—as well as all others immediately concerned.⁸⁷

83. Smith, *supra* note 15, at 709, 734. See R. MCCORMICK, *supra* note 65, at 339-46. See generally J. RAWLS, A THEORY OF JUSTICE (1971).

84. P. RAMSEY, THE PATIENT AS PERSON viii (1970). See generally G. CALABRESI, IDEALS, BELIEFS, ATTITUDES AND THE LAW (1985).

85. G. SMITH, *supra* note 22.

86. Dickens, *The Modern Function and Limits of Parental Rights*, 97 L. Q. REV. 462 (1981).

87. Burger, *Reflections on Law and Experimental Medicine*, in 1 ETHICAL, LEGAL AND SOCIAL CHALLENGES TO A BRAVE NEW WORLD 211 (G. Smith ed. 1982). See generally Destro, *Quality-of-Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent*, 2 J. CONTEMP. HEALTH L. & POL'Y 71 (1986).

