Reading SAL Week 6 : Deciding for Others

Cases: Norman Cantor.

These cases raise the important question of what should take precedence—the prior autonomy of a once-competent decision maker, or the present interests of that person when they are no longer able to make their own decisions. .

Terri Schiavo

The Terri Schiavo case polarized the country and serves in our readings to express two different positions on withdrawal of life-sustaining treatment for once-capable patients. The patient had been capable but lost capacity, so the standard of decision making, according to our texts, would have been "substituted judgment": determine, if possible, what the once-capable person would have wished and act in h/h stead to carry out those wishes. This is the standard pretty consistently applied by the courts in such cases. One of the difficulties in the case was that the spouse (the first in the order of surrogates) and the parents (next in order) had different views about what the patient would have wished (see the various arguments in Wolfson and Smith). Of course the publicity, when it became a court case, and the subsequent alignment of ideological and/or political positions, complicated matters immensely.

There is an excellent article about the case in Wikipedia, complete with references to some of the many articles written about the case. We have two readings on the Schiavo case: Jay Wolfson was guardian ad litem for Terri Schiavo for 2 years. Wesley Smith is an attorney and author of books on issues such as cloning, stem cells, assisted suicide, euthanasia, and bioethics. Some details of Terri's medical case and the resulting course case are recounted in this article. The case was in the headlines for much of 2004-5, and polarized the country. The appeal for a stay of removal went all the way to the US legislature, which passed a law in 2005 which President Bush signed; the US Supreme Court refused to grant certiorari *on March 21. The feeding tube was removed and Schiavo died in a hospice on March 31, 2005, 15 years after she fell unconscious.*

Jay Wolfson: Erring on the Side of Theresa Schiavo: Refelections of the Special Guardian *Ad Litem*

Wolfson was given 30 days in 2003 to consider the 30,000 pages of legal and medical records in the case and charged to represent Terri's interests to the court. His intervention came after the second attempt to remove the feeding tube, following Governor Jeb Bush's intervention.

Wesley Smith: Human Non-Person: Terri Schiavo, Bioethics and our Future

Smith is one of the best known opponents of withdrawal of treatment. It is notable in this exerpt from the interview that he describes Terri as "[a person] with profound cognitive disabilities"—a description of a PVS patient that is extremely controversial, which grants her the same status as Ronald Reagan with Alzheimer's. He also raises the question of whether persons in PVS should be "redefined as dead for purposes of organ procurement." (p. 410)

Conroy (1985): excerpts from the NJ Supreme Court reversal of an appellate court decision.

Conroy was an incompetent, institutionalized patient with serious and irreversible physical and mental impairment. She had limited interactions—some signs of pain, some of pleasure—a gangrenous foot and a gastrostomy for nutrition and hydration. Her family member guardian sought to remove her ANH. The trial court agreed. Her court-appointed guardian *ad litem* appealed and the appellate division reversed. The NJ supreme court reversed the appeal and upheld the initial trial court decision to allow withdrawal of the life-sustaining treatment (LST).

Trial court: her life is "impossibly and permanently burdensome."

Appellate court: the right to terminate LST on the basis of a guardian's judgment is (1) limited to the incurable and terminally ill; brain-dead, or irreversibly comatose (PVS); or those who would gain no medical benefit from the treatment in question; AND (2) does not apply to ANH.

Supreme court of NJ: sustained trial court's judgment, reversing the appellate court. (1) they said that 'prior wishes' could count for people who were not in PVS / irreversibly comatose, and (2) does apply to ANH.

The supreme court of NY articulated three standards [*which Arras addresses in their terms in the following article*]:

I: the **subjective** standard: in which we have a record of the patient's stated wishes re LST, either explicitly discussed or in an advance directive; or can infer h/h wishes, from beliefs, or from a consistent pattern of previous decisions. *[a 'substituted judgment' standard]*

II: a **limited objective** standard: when there is some trustworthy evidence that the patient would have refused a treatment and the burdens of life with the treatment outweigh the benefits of the life with the treatment, even without unequivocal evidence of prior wishes, when the treatment prolongs suffering.

III: an **objective** standard: can withdraw LST from a patient not in PVS when the burdens clearly outweigh the benefits of life even with the treatment—in which case no subjective evidence is required. *[both are 'best interests' standards]*

Irrelevant considerations: active v. passive
act v. omission
withdrawing v. withholding
ANH v. other medical treatments

Relevant considerations: the person must have a court appointed guardian *ad litem*

Failures of the previous courts

didn't gather evidence sufficient to meet any of the standards articulated

didn't gather enough evidence on benefits of burdens, especially pain (rejected testimony of a neurologist, for instance.

Handler's dissent: Pain is not the exclusive criterion—it negates other relevant ones, like the value of independence, privacy and personal dignity, or bodily integrity. Further, the SCNJ decision reaffirms the importance of the diagnoses of terminally ill or imminent death, permanent loss of consciousness and organ failure as justifications for withdrawal of treatment.

Arras: The severely demented minimally functional patient (1988) *Note: Arras' case differs from Conroy because in his case a treatment—a gastrostomy tube-- needs to be **inserted**, not **withdrawn**.*

Arras discusses Conroy's "three standards:"

Subjective standard: extrapolates from prior values. But: even consistent and plausible extrapolation is not equal to entailment, and thus is not conclusive. It has at best "some evidentiary value."

Present aversive behavior: it is impossible to determine whether it is an expression of fixed convictions, or a physiological reflex to momentary stimulae

Objective [or 'best interests'] standard: but how can those ever be determined?

Arras' method: look at clear cases on either side, then see if they help us figure out our grey zone case. [*a version of a 'casuistic' method*] So: he looks at a clearly non-functional patient in PVS—who he claims has NO actual interests, no pleasure or pain, no benefit or harm from offered treatments. For such a person, he argues, we can ethically forgo treatment because treatment cannot benefit the patient, physicians have no duty to people they cannot help, and the costs in time, money and emotional anguish are burdensome to others. [Some families will wish to continue treatment others will wish not to, so we can leave it to them; but patients in this category do not require a 'best interests' standard.]

Then he looks at a marginally functional patient, a "pleasantly demented" person who is not rational, but is still a person with present interests. This patient / patient-class is owed a patient-centered 'best interests' analysis, unlike the previous category,.

His sample case is a minimally functional person with a 'biological but not biographical" life. In such cases, he argues, to terminate [or not offer?] LST requires that the burdens of the life [eg., pain] outweigh the benefits. BUT: We can't do that in his case. The "Conroy standard" would say we should implant the G-tube. Handler's expansion of best interests beyond pain couldn't be applied to a minimally functional person.

Arras then recommends the "Rhoden" solution, a procedural one: (1) do not require clear and convincing evidence; accept probabilities instead. (2) When there is no clear determination ("the gray area of uncertainty"), allow family members to decide, so long as their decision does not clearly violate the best interests of the patient. (=surrogate decision making). Relevant considerations: Intractable pain; a balance of burdens over benefits; and he thinks we need to specify that the "interests" be genuinely human interests, eg involving some degree of memory and a sense of self—not just being alive rather than dead.

So: don't impose technologies just because we CAN.

Catholic Bishops: Our (limited) duty is to preserve human life, which is a precondition for all other rights. We are against euthanasia, defined as *an attack on life, by action or omission, which by itself or by intention causes death in order to eliminate suffering.*

. It's ok to relieve the suffering of others, of course—so long as it doesn't interfere with other duties.

. each has a duty to care for his or her life

. it is not necessary to prolong the life of another by every possible means, but others do deserve 'normal care' [*by which can be meant ANH, which counts as 'ordinary' Tx, which cannot be forgone, as contrasted with 'extraordinary' Tx, which can be foregone*]
. prepare for death, but without hastening it.
. attend to justice: the aged and disabled are fully human subjects, with innate, sacred and inviolable rights, especially to life, and as vulnerable subjects demand special scrutiny for care
. there is no difference between acts and omissions
. intent is crucial. We must be sure it is not our intent to cause death, either for its own sake or as a means to alleviating suffering.
. we do need to relieve needless suffering; one can refuse a burdensome treatment; quality of life judgments need to be carefully scrutinized; no exceptions for PVS patients, and we need to take specially scrupulous care of the retarded or demented.

Questions for discussion:

1. How would you decide to act in the five cases presented by Cantor? These cases were designed to show the possible conflict between 'precursor autonomy' (=what the person thought they would want for their future conditions) and the present interests of the person they now are. Do you take a consistent position on one side or another of that dilemma? Is a consistent position desirable? If so, what value does that represent? If not, why not?
2. The Conroy case is very important for distinguishing three different standards for decision making for incapable patients, standards that allow different levels of discretion on the part of the decision makers. Are they named appropriately? What is the subject-position from which one standard is more "subjective' or 'objective' than the other?. (SAL discuss this case on pp. 331-3.)
3. What is Arras' criticism of the Conroy case? How does his method of reaching his own conclusion map on SAL's recommendations of how one should argue in such cases?
4. How does Arras' 'case' differ from the Conroy case?
5. What about the distinction between 'ordinary' and 'extraordinary' treatment? The Conroy court and the US Bishops seem to disagree on that. What is your opinion? Why?
6. What about the distinction between acts and omissions? Can you think of cases where the difference IS morally relevant?