

Chapter 23

The Process of Dying

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Determination of Death
The Dying Patient

Conclusion

The subject of this chapter intersects with a wide range of important topics in legal medicine and biomedical ethics. The author's survey of the critical concepts and issues related to the process of dying will proceed in the following manner. The first section of the chapter is devoted to the general theme of the determination of death. It begins with a brief analysis of current thinking about the nature of human death and its relationship to medical practice, with special attention devoted to brain death. Next, other matters are considered such as certification of death, ascertainment of the cause of death, and issues of consent for autopsy and custody and control of the body.

The second, more extensive section of the chapter is devoted to issues arising out of the care of dying patients. Particularly in the last 10–12 years, issues concerning what constitutes appropriate care at the end of life have received an unprecedented level of attention and critical analysis. This section will compare and contrast the traditional and modern views of the goals of medicine and the models of disease, with particular focus on their relevance to the care of dying patients. The author will then consider the implications for the identification of and care for dying patients inherent in the massive Study to Understand Prognoses, Preferences for Outcomes, and Risks of Treatment (SUPPORT) and the voluminous analysis of the data generated by it. Next, the concept of medical futility will be discussed and the role that it plays in decisions to withhold or withdraw life-sustaining interventions such as mechanical ventilation and artificial nutrition and hydration, as well as in the utilization of Do Not Resuscitate (DNR) orders. The final sections of the chapter will discuss the developing field of palliative medicine and its response to the widespread phenomenon of undertreated pain and the distinction between appropriately aggressive palliative interventions and physician-assisted suicide (PAS) or voluntary active euthanasia. The author takes careful note of an emerging standard of care for dying patients, as well as the legal implications (administrative, civil, and criminal) of such standards for the physician.

DETERMINATION OF DEATH

There is a strong consensus among experts in medicine and related fields such as biomedical ethics that human death is a process, not an event.¹ Consequently, in adopting and implementing a particular formulation of death and

policies and procedures for declaring persons dead according to it, we are not discovering but rather deciding that the person is dead. While there is a certain inescapable arbitrariness to such determinations, there need not be any capriciousness so long as the formulations are consistent with the most current scientific knowledge. Such declarations at an appropriate and specific point in time are essential for a host of legal and social reasons. Nevertheless, the relatively rapid adoption of brain death as a basis for determining death during the 1970s and early 1980s has not been without residual confusion and controversy.² When the traditional cardiopulmonary formulation of death was the exclusive basis upon which to determine death, there was no question that when a physician concluded that there had been complete cessation of cardiopulmonary function, there arose a duty to pronounce the person dead. However, with the advent of the brain death formulation, it could plausibly be suggested that when a physician ascertained that the criteria for brain death had been met, there was simply an opportunity, but not necessarily an obligation, to forthwith declare the person dead.³ The point at which a patient has been declared brain dead not infrequently was the point at which negotiations concerning the withdrawal of "life support" began with reluctant family members. The problem is, in no small measure, a product of the fact that such "patients" look the same to their families after the pronouncement of brain death as they did earlier, when they were receiving very aggressive treatment.

Brain Death

The introduction of the concept of brain death is ascribed to the 1968 report issued by an Ad Hoc Committee of the Harvard Medical School.⁴ The objective of the report was "to *define* irreversible coma as a new *criterion* for death."⁵ What subsequently came to be known as the "Harvard Criteria" were the following:

1. Unreceptivity and unresponsivity: a total unawareness of externally applied stimuli and inner need and complete unresponsiveness, despite application of intensely painful stimuli.
2. No spontaneous movements or breathing: absence of all spontaneous muscular movements or breathing, as well as absence of response to stimuli such as pain, touch, sound, or light.

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3. No reflexes: fixed, dilated pupils; lack of eye movement despite turning the head or ice-water stimulus; lack of response to noxious stimuli; and generally, lack of elicitable deep tendon reflexes.

In addition, the committee advised confirmation of the above criteria by two electroencephalograms (EEGs) administered 24 hours apart, documenting the absence of cortical electrical activity above baseline. It was also considered essential to exclude the presence of any metabolic state, hypothermia, or drug intoxication that might cause or contribute to a reversible loss of brain activity.⁶

Beginning with Kansas in 1970, brain death statutes were, with remarkable rapidity and absence of controversy, adopted by many states. The statutes acknowledged alternative formulations of death—cardiopulmonary (irreversible cessation of circulatory and respiratory functions) and whole brain (irreversible cessation of all functions of the entire brain, including the brainstem)—either of which would support a physician's determination of death based on ordinary standards of medical practice. The Uniform Determination of Death Act (UDDA) has now been adopted by most states, and brain death has become a recognized basis for determining death throughout the United States.⁷

The President's Commission on "Defining Death"

In 1981, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research published a report entitled *Defining Death*. In this report, the Commission readily acknowledged that "the basic concept of death is fundamentally a philosophical matter" in that "philosophical issues persist in the choice to define death in terms of organ systems, physiological functions, or recognizable human activities, capacities, and conditions."⁸ Nevertheless, in arriving at the conclusion that the prevailing formulation of brain death, consistent with the UDDA, ought to be based on physiological functions, the Commission implicitly maintained that the characteristic most essentially significant to a human being is the capacity for bodily integration. The brainstem is the primary locus of this activity. Hence, any brain death formulation consistent with Commission Report must include permanent cessation of all brain function, including that of the brainstem.

Higher Brain Death

No discussion of brain death would be complete without at least a brief consideration of the whole brain versus higher brain debate. The advocates of the higher brain death formulation, also referred to as neocortical or cognitive death, take issue with the Commission's conclusion as to the characteristic essentially significant to a human being. They maintain that the essential characteristic is the capacity for conscious experience. Cessation of higher brain function as a result of the destruction of the neocortical structures that sponsor consciousness permanently deprives the individual of the capacity for conscious experience and hence the ability to live the life of a person. That, the higher brain

death advocates maintain, should be the basis upon which we determine human death, regardless of whether a functioning brainstem continues to support certain physiological functions of the body. Interestingly, Henry K. Beecher, the Chair of the Ad Hoc Committee that offered the original whole brain formulation of brain death, said in a later presentation to the American Association for the Advancement of Science that what is most essential to the nature of human beings is "the individual's personality, his conscious life, his uniqueness, his capacity for remembering, judging, reasoning, acting, enjoying, worrying, and so on."⁹ This statement strongly suggests that Beecher would not agree with the President's Commission that the capacity for bodily integration is what is most essentially significant to human life.

Another indication that the currently prevailing formulation of brain death does not enjoy universal acceptance is a New Jersey statutory exception to the application of brain death criteria when a physician has reason to believe that their invocation would violate the personal religious beliefs of the patient. In such cases, death may not be declared until the cardiopulmonary criteria have been met.¹⁰ At the present time, however, advocates of higher brain death do not have the option of being declared dead according to cognitive criteria or the permanent loss of neocortical function.

Death Certificate

After the patient has been pronounced dead, the attending physician should prepare the working copy of the death certificate, which includes such information as name and address of the decedent, age, place and date of birth, names of parents (including mother's maiden name), birthplace of parents, race, and decedent's occupation. These data are included primarily for statistical and epidemiological purposes. A particularly significant feature of the death certificate is specification of the immediate and contributing causes.

When a patient has been receiving appropriately aggressive palliative measures in the terminal phase of an illness or incident to the withdrawal of life-sustaining interventions pursuant to patient or surrogate consent, it is very important to distinguish between the underlying terminal diagnosis and medical measures that are incident to it. This is also a concern with regard to the autopsy, since on occasion medical examiners have concluded that the cause of death in such instances was the result of the withdrawal of life support or the provision of analgesics rather than the patient's terminal diagnosis.¹¹ The immediate cause of death is not always necessarily the mechanism of death, such as cardiac arrest or ventricular fibrillation, but rather the condition that eventually resulted in death, such as myocardial infarction with arrhythmia.

From this working document, the final death certificate is usually prepared by the mortician, who then presents it to the physician for signature. In most states, disposition of the remains is not permitted until the attending physician has signed the death certificate in complete and final form.

Cause of Death

As noted previously, the cause of death on the death certificate should be the immediate cause, i.e., the condition that resulted in death, rather than the mechanism of death. When the cause of death is obscure or the physician has not seen the patient within the time period specified by statute, state law usually requires that the medical examiner or coroner be contacted. Most states specify that such contact is essential when: the patient is dead on arrival (DOA); the cause of death cannot be determined, e.g., because of an inadequate hospital stay or when death occurs within 24 hours of admission; sudden, violent, suspicious, unexpected, unexplained, or medically unattended death; all intraoperative or perioperative deaths (including preoperative and immediate postoperative deaths); deaths related to industrial employment; deaths resulting from therapeutic misadventure; deaths resulting from alleged, suspected, or known criminal activity; and death resulting from vehicular accidents, including train or airplane accidents.

Physician awareness of the circumstances warranting contact of the medical examiner or coroner is essential, as is the willingness to speak with such officials about the case. Requests for the results of the autopsy or a copy of the autopsy protocol for the physician's records are customarily honored.

Custody of the Body and Authorization for Autopsy

Despite what will be said later in this chapter, as well as other chapters of this text, about patient autonomy and the legal and moral authority of advance directives, the pre-death request of a patient that an autopsy be performed is advisory only. Upon death, the next of kin are recognized by law to have a property interest in the decedent's body. Although the order of priority may vary from state to state, generally it proceeds as follows: surviving spouse, eldest living adult child of the decedent, parent(s) of the decedent, legally appointed guardian, eldest living adult sibling, aunt(s) or uncle(s) of the decedent, or other relatives in order of consanguinity.

The consent for autopsy must follow the formal pronouncement of death, and the request for autopsy form should be executed by the appropriate person prior to the procedure. Consent may be limited to certain portions of the body. However, the physician should advise the consenting party that the quality and definitiveness of the autopsy results may be materially compromised by such limitations. Despite increasing evidence that the percentage of autopsies performed in the United States has steadily declined over the last few decades, the procedure is considered essential to an accurate assessment of the quality of care provided.¹² An autopsy may be necessary in some cases to determine what the patient died from, but it is absolutely essential to determine what the patient died with that had not been diagnosed during the life of the patient. Numerous studies have found that in 25% to 40% of cases an autopsy reveals an undiagnosed cause of death. When considering

the issue of an elective autopsy, the attending physician must strike a delicate balance between coercing consent from unwilling next of kin and discouraging the procedure when it would otherwise be indicated out of individual or institutional concerns about cost or potential liability for iatrogenic (physician-induced) conditions that may have resulted in death.

THE DYING PATIENT Comparing the Traditional View with the Modern Perspective

Historically, physicians were much more comfortable with death, which was viewed as the inevitable consequence of our mortality rather than medical failure. When there was far less that the physician could do to forestall death from a life-threatening illness, the relief of pain and suffering that attended the dying process was openly embraced as a core value and primary responsibility of the physician. With the advent of the curative model of modern medicine, application of increasingly complex medical technology becomes the focus of the care provided to patients with life-threatening illness. Death becomes the ultimate enemy of the physician as much as if not more than the patient, and the relief of suffering that to which we resort only when high-tech medicine has "nothing more to offer." Indeed, as a major study of the last decade to which we now turn revealed, given our current preoccupation with critical care medicine, it has become increasingly difficult to determine when or even if a patient is dying.

The SUPPORT Study

"The Study to Understand Prognosis, Preferences for Outcomes, and Risks of Treatment" (SUPPORT) proposed to "improve end-of-life decision making and reduce the frequency of a mechanically supported, painful, and prolonged dying process."¹³ In the data-gathering Phase I, major deficiencies in the care of patients who died in the intensive care of units (ICUs) of five major academic medical centers were identified, including a disproportionality between the level of care provided and the patient's prognosis, as well as the pervasiveness of pain in the last days of life and a discontinuity between code status and the patient's or proxy's expressed wishes.¹⁴ In reflection upon and further study of the abject failure of the interventional Phase II of SUPPORT to bring about any demonstrable improvement, the investigators noted that even when state-of-the-art prognostic models were combined with the judgment of highly skilled and experienced physicians, the median predicted chance of survival for 2 months was 17% on the day before death and 51% a full week before death.¹⁵ Thus patients, families, and physicians in ICU settings tended to see the patient as a seriously ill person in need of treatment and not as "terminally ill" and certainly not as "dying." This phenomenon poses serious challenges to the timely provision of palliative interventions that have customarily been reserved for patients who are at the end of life or actively dying.¹⁶ The antidote, it has increasingly

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been suggested, is the concept of “simultaneous care,” according to which pain and other troublesome symptoms are aggressively managed even as disease-directed interventions continue.¹⁷

Forgoing Life-Sustaining Treatment

Issues concerning when, how, and by whose authority life-sustaining measures should be withdrawn continue to be the subject of considerable disputation. In the decades of the 1970s and 1980s, many of the so-called “right to die” cases involved efforts by patients or their families to compel physicians to cease and desist from life-sustaining interventions that the patient/proxy deemed inappropriate or ineffective. Some of these cases were aptly described as examples of “therapeutic belligerence.”¹⁸ In 1990, the Supreme Court acknowledged: “The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”¹⁹ The young woman whose care was at issue in that case, Nancy Cruzan, was in a persistent vegetative state (PVS), and it was her parents who, as her surrogate decision-makers, sought the discontinuation of artificial nutrition and hydration.

While the courts have generally acknowledged that a competent patient’s right to refuse treatment, including that without which they will die, survives even the permanent loss of decisional capacity, the states have been given wide latitude to impose evidentiary standards on surrogate decision-makers. In setting such standards, the states exercise their *parens patriae* power over vulnerable individuals. In some instances, the state actually becomes a party to the litigation and asserts one or more of four “countervailing interests” that the court must then balance against the interest of the patient in being free from unwanted medical intrusions. These state interests are consistently identified as: preserving life, preventing suicide, protecting the interests of innocent third parties (minor children), and upholding the ethical integrity of the medical profession.²⁰

An important consequence of the right-to-die jurisprudence of the last 30 years has been a societal and legal consensus on the following propositions. First, the state has no legitimate interest in compelling a seriously ill or dying patient to continue to live when they would prefer to be allowed to die.²¹ Second, refusing life-sustaining measures does not constitute suicide. Third, individuals do not forfeit their right to refuse treatment by becoming parents.²² Fourth, it is not respect for but rather disregard of a patient’s right to forgo necessary medical treatment that compromises the ethical integrity of the medical profession.²³

Medical Futility

After *Cruzan*, the pendulum appeared to swing in the opposite direction, i.e., to cases in which patients or families sought to compel physicians to initiate or continue to provide interventions that were deemed medically inappropriate by the treatment team. The unfortunate term “medical futility” has been applied to such cases. The reason why “unfortunate” is an apt characterization is that efforts

to develop a definition of futility that can claim even a modest consensus among physicians have themselves proven futile.²⁴ One often-cited but also much criticized effort to define futility in the medical context advocates that “the adjective ‘futile’ be used to describe any effort to achieve a result that is possible but that reasoning or experience suggests is highly improbable and that cannot be systematically produced.”²⁵ The Council on Ethical and Judicial Affairs of the AMA has eschewed any attempts to define futility or to delineate a set of futility criteria. However, it has noted that legitimate issues of futility arise in the context of providing life-sustaining interventions to patients who are permanently unconscious or actively dying.²⁶

Despite well-intentioned efforts to distinguish between the quantitative and qualitative aspects of medical futility, the seemingly inescapable fact of the matter is that there is an inherently normative dimension to any conclusion that a particular intervention would be futile that necessarily takes it beyond the realm of purely objective clinical judgment.²⁷ A recent trend has been to shift the focus from efforts to define medical futility or to arrive at a broad consensus on paradigm cases of it, to multi-institutional policies and procedures for handling such disputes between physicians and patients or families. These process-oriented approaches have several positive features: they recognize and address the fact that such controversies are often the result of a breakdown in communication; they provide a mechanism for the mediation of disputes; and they specify an end-point at which the institution will, under appropriate circumstances, support a physician’s decision not to provide measures that he or she deems medically inappropriate.²⁸

One reason for the shift from definitions and paradigm cases to the dispute resolution approach may be the ambiguous treatment of futility cases by the courts. Perhaps the most notorious of these was *In re Baby K*,²⁹ a case in which a hospital and its clinical staff were deemed to be required by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) to provide an anencephalic infant with the medical treatment necessary to stabilize her respiratory deficiencies when brought to the emergency room. The court found no futility exception to EMTALA.

In *Gilgun v. Massachusetts General Hospital*, an unreported case, a jury declined to find negligence on the part of Massachusetts General Hospital or a physician who entered a DNR order and subsequently withdrew life support from a 72-year-old woman over the objection of her daughter. The jury concluded that although there was credible evidence the patient would have wished life support continued, given her comorbidities (including significant brain damage) and poor prognosis, such measures were no longer medically appropriate.³⁰

DNR Orders and Futility

A DNR order is unique in medicine in that it is the only instance in which a physician’s order is required so as to ensure that an intervention will not be provided. Usually the exact opposite is the case. The justification for this anomalous situation is that the custom and practice in

medicine is to resuscitate all patients who experience cardiopulmonary arrest. Thus an order is required to ensure that the standard procedure is not followed. While the autonomy of patients has been noted to be asymmetrical, in that a patient may decline medically necessary treatment but may not demand medically inappropriate treatment, institutional practices often do not reflect this asymmetry. Opting for a risk management, litigation-adverse approach, many hospital policies do not clearly support a physician who, in the *Gilgun*-type situation, writes a DNR order over the objection of a patient with decisional capacity or a surrogate.

Because of the vagaries of the concept of medical futility previously noted, a physician is always well advised to inform a patient and/or the patient's family that CPR is not appropriate under the circumstances and that an order to that effect will be entered in the medical record. Reasonable efforts should be undertaken to address questions and concerns or prevent or resolve misunderstandings. The organized medical staff of each health care facility should advocate for a clearly written policy addressing DNR orders in the absence of patient/family consent. Recently, there have been calls to replace the term DNR because of two misleading implications that it is presumed to convey to the lay public: (1) that in-hospital resuscitation efforts are generally successful,³¹ and (2) that the patient is being denied an appropriate medical intervention. An alternative characterization that addresses the first point is Do Not Attempt Resuscitation (DNAR), and one that addresses the second is Allow Natural Death (AND).³²

Withholding and Withdrawing Treatment from Patients Without Decisional Capacity

It is important at this point to note an important distinction between competence and decisional capacity. Competence (or its reciprocal, incompetence) is a legal determination made by a court in a guardianship or conservatorship proceeding. Decisional capacity is a clinical determination that the patient's physician is medically qualified and legally authorized to make. Moreover, while many physicians seek a psychiatric consult (when readily available) prior to making such a determination, one is not required by law. The clinical literature also suggests, however, that the assessment of decisional capacity is not a skill that many physicians possess.³³ One common misunderstanding, for example, is that a diagnosis of depression negates decisional capacity.³⁴ When making such determinations, physicians should also be mindful that it is a fundamental principle of American jurisprudence that every adult is presumed to possess decisional capacity, and the burden of persuasion falls upon anyone who asserts the contrary.

The Role of Advance Directives

In theory, advance directives can be given orally or in writing. However, many patients erroneously assume that oral directives will suffice, and hence do not execute written directives. The extent to which a patient's oral directive

will ultimately influence decisions about his or her care varies greatly from case to case and from jurisdiction to jurisdiction. While most states will consider a patient's prior oral statements as indicative not only of their values and priorities, but also of what would be in their best interests, there are some jurisdictions that demand clear and convincing evidence that the patient expressed, during a prior period of decisional capacity, a desire not to receive a particular type of intervention, e.g., mechanical ventilation or artificial nutrition/hydration, when diagnosed with a condition identical or quite similar to the one in which they now find themselves, e.g., PVS, end-stage congestive heart failure.³⁵ Statutorily recognized advance directives are, at least in part, a legislative response to public demand for a reliable and legally recognized mechanism by which an individual can prospectively exercise the right to make health care decisions during a subsequent period of decisional incapacity.

The first type of advance directive acknowledged by statute was the living will. In many instances, however, living will statutes promised much more than they delivered. Virtually all required that the patient be certified by one or more physicians to be in a terminal condition before the document took effect, thereby excluding their use in some of the very circumstances—permanent coma, persistent vegetative state—that patients sought to avoid through their use. Also, many statutes specifically excluded artificial nutrition and hydration from the medical interventions that could be discontinued pursuant to a living will. Artificial nutrition and hydration is often the only intervention sustaining the life of permanently unconscious patients.

The next generation of advance directives, the durable power of attorney for health care, was not usually subjected to such severe restrictions. Once a patient has lost decisional capacity, in most jurisdictions the designated proxy is fully empowered to make all decisions regarding the patient's medical treatment, including directing that life-sustaining interventions be withheld or withdrawn, subject only to such restrictions as the patient may have incorporated into the document.

In 1990, Congress enacted the Patient Self-Determination Act,³⁶ requiring all health care institutions participating in the Medicare or Medicaid programs to advise each patient upon admission, or as soon thereafter as practicable, of his or her rights under state law to make decisions about their medical treatment and to execute an advance directive, as well as any policies of the institution or provider respecting the implementation of those rights. If the patient has or subsequently executes an advance directive, that must be documented in the medical record. While the Secretary of Health and Human Services has the authority to exclude noncompliant institutions from the Medicare and Medicaid programs, to date that has never happened.

The latest trend in advance directive legislation has been the adoption by a number of states of the Uniform Health-Care Decisions Act (UHCDA), which is designed to provide individuals with a single document in which they can give instructions for their medical care in the event of

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decisional incapacity, designate a surrogate, and indicate whether they wish to be an organ donor. There is also a residual decision-making section of the act that applies when there is no written directive. The UHCDA was adopted by the National Conference of Commissioners on Uniform State Laws in 1993 and has subsequently been adopted, in whole or significant part, by seven states.³⁷

Despite significant legislative activity during the last 30 years, it remains the case that only about 15% of adults have executed any form of directive. Many reasons have been offered to explain this phenomenon, including physician disinclination to initiate these discussions with patients and patient reluctance to anticipate grave or life-threatening injury or illness.³⁸ However, a seminal article on end-of-life care argues that initiating and carefully documenting such discussions should be considered the minimal standard of acceptable care.³⁹

Care of the Dying Patient

The decade of the 1990s was one in which many deficiencies in the quality of care provided to dying patients were identified and reforms proposed. In addition to the SUPPORT data previously discussed, the Institute of Medicine published a major report calling for improvements in the care of dying patients.⁴⁰ One of the major concerns about the quality of care generally provided to dying patients is the widespread phenomenon of undertreated pain.⁴¹ While nationally recognized clinical practice guidelines have been in existence for some time, there is compelling evidence that the custom and practice of most physicians is significantly below these parameters.⁴²

Medical Malpractice in End-of-Life Care

To date, two cases have produced jury verdicts for substandard care of a dying patient. The first case, *Estate of Henry James v. Hillhaven Corporation*,⁴³ involved a 75-year-old patient who entered a skilled nursing facility with a diagnosis of terminal metastatic prostate cancer. A nursing supervisor declined to administer a pain management regimen developed at the local hospital because she believed the patient was addicted to opioid analgesics. A jury awarded the deceased patient's family \$7.5 million in compensatory damages and \$7.5 million in punitive damages because of the unnecessary pain and suffering this substandard care inflicted on the patient and his family.

The second case, *Bergman v. Chin*,⁴⁴ concerned an 85-year-old man who was hospitalized for 5 days because of severe pain and clinical indications of advanced lung cancer. Nursing records indicated moderate-to-severe pain levels on each day. The patient died 3 days post discharge. The family filed suit under the state elder abuse statute when the state medical board declined to discipline the treating physician despite a finding of substandard pain management. The AHCPR Clinical Practice Guidelines *Managing Cancer Pain* were admitted into evidence.⁴⁵ The jury found such an egregious example of undertreated pain in an elderly patient with an advanced terminal condition constituted elder abuse and awarded damages of \$1.5 million.⁴⁶

In recent years, still more clinical practice guidelines have been promulgated and should provide the basis for ensuring that physicians possess and are prepared to apply the knowledge, skills, and attitudes that are integral to good end-of-life care.⁴⁷

There are additional noteworthy examples of the changing perspective on end-of-life care that should be noted. When the U.S. Supreme Court ruled that there was no constitutional right to physician-assisted suicide, five of the nine justices wrote or joined in concurring opinions emphasizing the importance of appropriately aggressive palliative measures to ensure that dying patients do not suffer.⁴⁸ Citing the doctrine of double effect, they carefully distinguished between physician-assisted suicide and the increased risk of a hastened death posed by large doses of opioid analgesics.⁴⁹ In 1999, the Oregon Board of Medical Examiners became the first such board to pursue disciplinary action against a physician for failure to properly alleviate the pain and distress of seriously ill or dying patients. In 2003, the California Medical Board became the second. When considered in conjunction with the jury verdicts in *James* and *Bergman*, what may have finally emerged is a minimal standard of care for dying patients that includes pain relief and symptom management.⁵⁰

Care of the Dying Patient and the Criminal Law

A very small number of criminal prosecutions of physicians for withdrawing life-sustaining treatment or providing aggressive palliative interventions have had a disproportionate impact on the level of fear that permeates the medical profession with regard to aggressive pain and symptom management for dying patients. However, in both of two high-profile prosecutions the defendant physicians were ultimately vindicated. In the first, the court ruled that physicians who withdrew life support from a dying patient with the consent of his relatives could not be guilty of murder because the act did not constitute the "unlawful killing of a human being."⁵¹ In the second case, an appellate court reversed the conviction for attempted first-degree murder of a physician who administered high doses of opioid analgesics to a dying patient.⁵² The court held that because the defendant physician had presented competent and credible expert testimony in support of his care of the patient, no reasonable jury could have found beyond a reasonable doubt that he had acted with homicidal intent.

Recently, the Attorneys General in states such as Nevada, Maine, and Oklahoma have helped to spearhead the promotion of quality end-of-life care and send the message to health care professionals that state civil and criminal laws support rather than undermine such care. The National Association of Attorneys General has now taken up that initiative as well.⁵³

CONCLUSION

Since the publication of the sixth edition of this textbook, the medicolegal saga of Terri Schiavo, the young woman who had been in a PVS since 1990, reached its climax and ultimate conclusion in her death after the final withdrawal

of artificial nutrition and hydration. Many legal and moral issues that had been deemed “settled” by the close of the twentieth century were directly and vigorously challenged by Ms. Schiavo’s parents and their supporters. Among them were the following: (1) artificial nutrition and hydration are life-sustaining medical interventions that require ongoing consent by the patient or her proxy; (2) patients in a PVS can neither experience pain and suffering nor be rehabilitated; (3) whether there is clear and convincing evidence of the patient’s wishes regarding life-sustaining treatment is a matter for the state courts to determine. While each of these propositions ultimately prevailed in the protracted Schiavo litigation, only the passage of time will reveal the extent to which any of these, or others, will undergo further challenges in the courts and legislatures of this nation.⁵⁴

A number of the topics covered in this chapter, especially those in “The Dying Patient” section, have been the focus of a great deal of recent and continuing litigation, legislation, and regulatory activity at the federal and state level. Health care professionals are well advised to stay up-to-date on developments in their own jurisdiction so as to ensure that their practice is consistent with current standards and requirements. Some of the topics featured in this chapter are given more extensive discussion and analysis in other chapters of this textbook. Among those to which the reader is referred in particular are: Physician-Assisted Suicide (Chapter 24), Competency and Capacity (Chapter 32), and Pain Management (Chapter 62).

Endnotes

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