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## Death of a 78-Year Old Woman

*(Editor's note: This official opinion of the District Attorney of Milwaukee County, E. Michael McCann, represents a synthesis of sound jurisprudence and sound medical-ethical reasoning in a difficult medical situation.)*

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In the early morning hours of Oct. 7, 1986, a 78-year old woman patient was admitted to Victory Memorial Hospital in Waukegan, Illinois. At the hospital, she was cared for by Dr. G. A. Price.

Dr. Price stated that the patient experienced a major heart attack, causing a large area of heart muscle damage. He further stated that three additional factors appeared which contributed to a poor prognosis for the patient: (1) changes in her heart rhythm; (2) fairly severe congestive heart failure, and (3) shock. The doctor further noted that the patient's age and previous heart muscle damage detracted from her prognosis. Dr. Price informed the patient's physician-son of this poor prognosis within the first 48 hours of her hospitalization.

As care continued, Dr. Price concluded that the patient's heart muscle was very weak and that, as her normal heart rhythm alternated into more rapid beating, it limited the efficiency of her heart. While the patient was still in the hospital, on Oct. 26, 1986, the heart rhythm problem became acutely serious and the patient had to be cardio-shocked back into a less lethal rhythm.

Thereafter, doctors at Victory Memorial Hospital determined that it was advisable to transfer the patient to the cardiology service at St. Luke's Hospital, Milwaukee, Wisconsin, in the belief that if the patient's condition so warranted, invasive diagnostic procedures could be instituted and appropriate invasive management could be undertaken at that hospital. No such "invasive treatment" is conducted at Victory Hospital. Dr. Price indicated that the patient may not have been eager to go to St. Luke's, but that the need to address the life-threatening heart rhythm problem apparently quieted her reservations and that she actively participated in the decision to transfer to St. Luke's.

Her physician-son resided in Milwaukee. It was determined that Dr. J. F. King would care for her at St. Luke's.

On Oct. 29, 1986, the patient was transferred to St. Luke's Hospital.

Her condition appeared to improve from Oct. 29 to Nov. 4, 1986. On

that date, the patient had a stress test which apparently left her extremely exhausted. She experienced a difficult night on Nov. 4, had trouble breathing, experienced chest pain, and required oxygen.

On Nov. 5, 1986, the breathing difficulty and chest pain continued. A lung scan was ordered because of the breathing problem. The patient's condition improved later in the day.

In the morning of Nov. 6, 1986, the patient felt tired and nauseated and experienced chest pain.

On Nov. 7, another severe heart rhythm acceleration (supra-ventricular tachycardia) occurred again, necessitating the use of cardio-shock. Sedation was utilized. The patient was intubated with an endotracheal tube (inserted through the mouth and down the windpipe) and placed on a respirator. The drug dopamine was used to address a low blood pressure problem. Dr. King requested Dr. Stuart Levy to examine the patient on a consult and Dr. Levy's report is attached. Another lung scan reflected findings "compatible with worsening congestive failure."

### **Visit from Nephew**

Later on Nov. 7, the patient's 36-year old nephew visited her. The endotracheal tube effectively precluded speech. In communicating with her nephew, the patient made gestures with her left hand to the room and the intensive care equipment and indicated, through pantomime, that the effort was unwise. The nephew observed that the endotracheal tube seemed to cause the patient discomfort.

On Nov. 8, attempts were made to gradually wean the patient from the dopamine and the endotracheal tube linked to the respirator. The patient appeared to be alert and cooperating with her care. By evening, the dopamine was withdrawn.

During the weekend of Nov. 8 and 9, 1986, Dr. G. Dorros, as a substitute for Dr. King, was in charge of the care of the patient. He visited her on Saturday morning and returned again on Sunday morning, Nov. 9. At that time, Dr. Dorros examined a nuclear medicine report of a Gated Heart Study which had been conducted on the patient. The study cited serious difficulties in the patient's heart.

After examining this report, Dr. Dorros discussed its contents with Dr. King and together the physicians determined that the patient should receive a heart catheterization on Monday, Nov. 10. Dorros believed that the catheterization would provide added information assisting Dr. King to determine which of the following options should be pursued in treatment of the patient: (1) heart surgery; (2) angioplasty (insertion of a device into the clogged artery to open it); (3) medication regimen, or (4) do nothing because the patient's problems would not be susceptible to treatment other than basic care.

With Dr. King's consent, Dr. Dorros, sometime between 8 a.m. and 9:30 a.m. on Nov. 9, contacted the patient's physician-son by phone at his home.

Dr. Dorros advised that in his communication to the patient's son, he reported the results of the Gated Heart Study, being careful to note that the aneurism or possible pseudo-aneurism had not been confirmed and that relying on the scan alone results in a high false positive rate. Dorros further stated that he reported the recommendations for cardiac catheterization and what options might be suggested thereafter. Dorros described the general tone of the conversation as neutral, with Dorros doing most of the talking and responding to questions by the patient's son. Dorros states that there was no talk of the patient as being a dying person and that he offered encouraging words and described the patient as "potentially recoverable". Dorros said the son indicated his approval for the heart catheterization.

It is rather clear that the patient's son understood and interpreted this communication from Dr. Dorros as being the opposite of encouraging. The patient's son stated he concluded from the call that the prognosis was quite poor, that the heart was in a disastrous condition and that the only hope would be heart surgery. The son believed his mother would never authorize cardiac catheterization or heart surgery.

There was no question that the woman's condition was serious. Dorros recognized the gravity of her condition, but believed that the cardiac catheterization might well show her able to recover in substantial measure. The physician-son took a much more pessimistic view of her prospects.

The son stated that on Sunday morning, he also learned that his mother had experienced severe blood pressure problems Saturday evening and that it had been necessary to place her back on dopamine. The son perceived the use of dopamine as appropriate for those cases involving serious blood pressure problems. The son states that he arrived at the hospital at about 10:30 a.m. on Nov. 9, and at such time his mother looked gray, her hands were cold, her pulse was very high, her blood pressure was low, she was again on dopamine, and she was getting maximum support from a respirator through the endotracheal tube inserted into her mouth and down her windpipe.

It is clear from the reports of all who observed the patient that day that she was conscious, alert, and competent from the time that Dr. Dorros saw her early on Sunday morning until the time she expired after the removal of the endotracheal tube at or about 12:42 p.m. A substantial number of persons saw her on Nov. 9 and not one believed her to be in other than competent condition.

The patient's son stated that shortly after he arrived at the hospital, his mother gestured to him that she wished the endotracheal tube taken out and the respirator turned off. Further, she indicated that the intensive care effort being made was unwise and tried to take the IV out of her right arm. He believed she was dying. The son stated that a nurse was present at the time and that he informed his mother as to what the results would be if the endotracheal tube was removed. Nurse Heyse was the nurse present in the room and his report of the communication between the mother and son at that time is as follows:

The son asked, "Do you want that tube taken out?" She nodded yes. "Do you know you need that to breathe?" She nodded yes. "And you know that if that tube is taken out, you won't be able to breathe and you'll die?," he said. She nodded yes. "But you still want the tube taken out and nothing else done?," he said. She nodded yes.

The son then requested the nurse to contact Dr. Dorros to secure removal of the tube.

The patient's nephew arrived in the mother's hospital room after her son. The son advised the nephew that he, the son, had been informed that the study showed the heart to be in a disastrous condition with many defects and that the patient was dying.

The nephew stated that when persons would come into the room, the patient would indicate with gestures that she wanted the endotracheal tube and IV tubes removed. At one point, the nephew saw the patient pull the respirator tube connection loose and a nurse appeared immediately and reconnected it. The reconnection is confirmed by a nurse. The nephew stated that this happened a second time and he himself reconnected the tube. In response to the nephew's question, the patient indicated she wanted the tube out of her throat and the IV disconnected.

### **Patient Tried to Remove Tube**

One nurse stated that several times the patient attempted to remove the tube but her son told her not to. A second nurse, Mr. Heyse, stated that on one occasion the patient had put her hand to the tube and the son pulled the hand down, telling her the tube would have to be put back in because of hospital policy. Heyse reported a second exchange between the son and mother about removal of the tube and what the effect would be, with the same questions and answers as are within the above quote marks.

After the first communication between mother and son, which was witnessed by Nurse Heyse as reported above, the son initially requested and then became adamant that the endotracheal tube should be removed. When the nurses resisted, he demanded that superiors be contacted. Upper level personnel became involved but relayed back to the patient's son that the final decision would be the treating doctor's decision, pursuant to hospital policy guidelines.

During the later morning hours of Sunday, Nov. 9, 1986, Dr. Dorros had become aware of the patient's son's intent to implement his mother's desire to be removed from the respirator. Dorros arrived at the hospital room while the patient's son was absent. Dorros entered the room and discussed the patient's condition with the patient and her nephew, advising both that she was "salvageable" and not a terminal case, that she would have the cardiac catheterization on Monday, Nov. 10, and that he would not order the endotracheal tube removed. As Dr. Dorros was completing this discussion, the patient's son re-entered the room. Dr. Dorros stated that in the presence of the nephew, the patient, the patient's son and other hospital personnel he repeated the same information and refused to

remove the endotracheal tube. Dr. Dorros states that the patient was alert and responsive and believes she understood when he informed her of this.

The son asked Dorros to step outside in the corridor so they could converse further. Dorros stated he told the son he would not pull the tube. The son told Dorros he understood Dorros's position and agreed with him. The son said that if it was his patient, he wouldn't pull the tube. The son explained that he and his mother didn't want any heroic measures taken to save her life. The son asked that she be a "No code" patient. The son went on to ask what would happen if the endotracheal tube came out — would it be reinserted? Dorros replied that it would not be reinserted if the patient was a "No code". Dorros characterized the family's feelings about the endotracheal tube as saying it was "cruel and unusual punishment". Dr. Dorros determined to enter a "No code 4" order; that is, under hospital guidelines, to "suspend the otherwise automatic initiation of cardiopulmonary resuscitation." Dr. Dorros then went to the nurse's station to enter the physician's order for "No code 4".

St. Luke's Hospital guidelines for "Do Not Resuscitate Orders" provide that "A mentally competent adult has the legal right to accept or refuse any form of treatment and his/her wishes must be recognized and honored by the physician." The guidelines further provide that "When the patient is competent, do not resuscitate (DNR) decisions will be reached consensually by the physician and the patient." Under the guideline, Dr. Dorros should have discussed this DNR order with the patient. However, the clear communications between the son and mother as witnessed and quoted by Nurse Heyse above, leave little doubt that the mother was supportive of the DNR order. Failure by Dr. Dorros to strictly abide by the guidelines, under these circumstances, constitutes no wrongdoing.

### **View from Nurses' Station**

One of the nurses who had been present and had heard Dr. Dorros's discussion with the patient's son in the hospital room, went to the nurse's station to make appropriate notes. At the nurse's station, there is a television monitor covering the inside of the room in which the patient was being treated. Moments later, this nurse, upon looking up to the television monitor, states that he saw the son grab the hand of his mother, bring it to the endotracheal tube, wrap her fingers around the endotracheal tube, and motion to the mother to pull the tube out. Thereafter, the nurse observed the mother deliberately pull out the endotracheal tube. Immediately thereafter, the son started to hug his mother and began to stroke her hair. A nurse re-entered the room and asked if any help was needed and was advised in the negative. Later, a nurse would be advised by the patient's son that the endotracheal tube came out inadvertently. Under the "No code 4" order, nothing was done and the patient died within a few minutes.

Dr. Dorros was at the nurses' station writing the "No code" order when someone called his attention to the room monitor for the patient's room.

Dorros stated that he observed that the endotracheal tube was already out. Dorros said he was angry and frustrated and drove from the hospital to his home in Fox Point. He received a phone call from a nurse shortly thereafter and was told that the patient had died.

The patient's nephew reconstructed the events somewhat differently. He stated that after the patient's son returned from his discussion with Dr. Dorros in the hallway, the patient's son untied his mother's hand. The nephew states that the mother then brought her hand up to her face, with the son's hand on hers. The nephew states that the patient felt along her cheek and then the son let go of her hand. Thereafter, according to the nephew, the patient grasped the endotracheal tube and pulled it out. The nephew said that the son hugged and kissed his mother, that she gasped for breath, and a minute or two later became unconscious. The nephew states that at no time did the patient indicate she wanted the tube reinserted.

The son stated his mother was very rational, very adamant, and repetitive in expressing her desire to have the tube removed. In the face of this, he stated he agreed with her and pressed the nurses and supervisors to accomplish this. Delay ensued and he was distressed and angered by it. After the passage of a period of time, he left his mother's hospital room to make a phone call to his wife. When he returned, Dr. Dorros was there. The son stated that he heard only the tail end of Dr. Dorros's conversation with the nephew and that Dr. Dorros did not go over the same explanation for the son. The son stated that he and Dorros went out into the hallway. The son told Dorros that if he was in Dorros's shoes, he would not order the tube taken out. The son further indicated that he did not think that Dorros should be put in that position. The son stated he did ask Dorros if Dorros would reinsert the tube if it came out. Dorros said that he would not reinsert the tube. The son stated that immediately after this conversation in the hall, he, the son, went back to his mother's room and told her, "If you want the tube out, you'll have to take it out yourself." The son stated that without any hesitation, his mother grabbed the tube and pulled it out. The son stated he could not be sure whether he was or was not holding his mother's hand, but he is absolutely sure he did not touch the tube nor pull it out nor gesture for her to pull it out. The son stated he felt that his mother was a very devout Catholic and did not intend to take her own life by removing the tube, but merely wanted to end the extraordinary life support measures on which she was depending and that he felt sure she knew she was dying. The son indicated that he had never discussed the prospect of heart surgery with his mother and that he believed, given her condition on Sunday morning, that the mother was dying and that her condition was terminal. When asked in the investigation whether or not a physician should remove the tube, or whether he, the son, should remove the tube, the son replied definitely not. He indicated that if the mother could do it herself, then so be it.

The investigation revealed no ill will between the son and his mother and discovered no evidence of malice on the part of the son. He appears

to have loved his mother.

The above does not set forth all that transpired or all that was reported in the investigation. Some additional facts relevant to the legal questions are included below.

### Legal Comment

The son, under any given version of the facts, could be convicted of assisting a suicide in violation of Wisconsin Statute 940.12 only if the mother's death was a suicide. For a number of reasons set forth below, her death was not a suicide within the meaning of the law.

Wisconsin statutory law does not affirmatively define suicide. The Wisconsin Supreme Court has defined suicide, however, in *Bisenius v. Karns*, 42 Wis 2d 42(1968) at 52 as "the voluntary and intentional taking of one's life by a sane person." Generally, the person committing suicide undertakes a self-destructive act of shooting, stabbing, or hanging oneself or injecting or ingesting a poisonous drug with the intent to kill oneself.

In the instant case, no such self-destructive act was involved. At the heart of the matter, instead, is the patient's decision to refuse to continue the respirator treatment, a refusal she had a right under law to make. Such refusal followed by death does not constitute suicide.

It is fundamental law that when treating a competent, conscious adult, a physician must secure consent of the patient before intruding upon the body in any fashion. The doctor who fails to secure such consent may be found liable in civil law for damages and may be charged under criminal law with battery. In *Schloendorff c. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92, 93 (1914), a case often cited for this principle, the court stated, "Every human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages." In *Matter of Erickson v. Dilgard*, 44 Misc. 2d, 252, N.Y.S. 2d 705 (Supreme Court 1962), the competent adult patient, while authorizing a needed operation, refused to authorize a blood transfusion and the hospital superintendent claimed that this would constitute suicide. The court rejected that argument concluding that "it is the individual who is the subject of a medical decision who has the final say and that this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires." Similarly, in recent years, in most reported cases, courts have refused to order blood transfusions for competent adult Jehovah Witnesses who decline to accept such transfusions on religious grounds. An exception to this rule is found in *Application of President and Directors of Georgetown College Inc.*, 331 F 2d 1000 (D.C. Cir. 1964), where the court ordered a blood transfusion over a young sick mother's objection in order to protect her life, holding that the state had a compelling interest in limiting the potential that her minor children would



become public charges. In *Guardianship of Gertrude Raasch*, Milwaukee County Court Case Number 455-996 (1972), the court refused to order a competent 77-year old woman to undergo surgery although the petitioning hospital administrator alleged that she would die within several days without it. St. Luke's Hospital's "Guidelines for the Removal of Patients from Ventilators" recognize this rule providing that "competent adult patients have the right to make the decision regarding their level of care regardless of the severity of their illness." Further, the hospital's guidelines for "Do Not Resuscitate Orders" provide that a "mentally competent adult has the legal right to accept or refuse any form of treatment and his/her wishes must be recognized and honored by the physician."

Professor Robert Byrn, in an article often cited in cases on this issue entitled "Compulsory Life Saving Treatment for the Competent Adult, 44 *Fordham L. Rev.* 1" (1975) stated:

(A) competent adult is free to reject lifesaving medical treatment unless some other compelling state interest overbalances his claim of right. It is as much an error to distort this freedom to include a right to commit suicide, as it is to condemn its exercise as an attempt at suicide. Rejection of lifesaving therapy and attempted suicide are, and should be, as different in law as the proverbial apples and oranges.

This competent, conscious, and informed 78-year old patient had a right to reject the endotracheal tube and this did not constitute suicide.

### **Element of Suicide is Desire**

Further, an element of suicide is the desire to kill oneself. The facts in this case do not reflect a desire on the part of this patient to die. Persons who knew her said she travelled widely, was basically happy, and loved life. She did not seek, invite, or wish for the heart damage which was the efficient cause of her death. She did lawfully desire to end the respirator treatment. Persons who knew her well, including a priest who had known the family for many years, are in agreement in interpreting her attitude in this matter as founded in acceptance of Divine Providence and basically being:

I can't and don't have to tolerate the tube in my condition. God's will be done. If I can live without the respirator, fine; but if not, then it is time for my eternal reward.

These words, used by those who knew her, find a resonant ring in the case of *Satz v. Perlmutter* 362 so. 2d 160, 162-163 (Fla. App. 1978). There the court stated:

As to suicide, the facts here unarguably reveal that Mr. Perlmutter would die, but for the respirator. The disconnecting of it, far from causing his unnatural death by means of a 'death producing agent' in fact will merely result in his death, if at all, from natural causes . . . The testimony of Mr. Perlmutter . . . is that he really wants to live, but do so, God and Mother Nature willing, under his own power. This basic wish to live, plus the fact that he did not self-induce his horrible

affliction, precludes his further refusal of treatment being classed as attempted suicide.

Those who knew the 78-year old patient relate that she was a devout Catholic, a regular churchgoer who would abhor committing an act of suicide. In this regard, it should be noted that ethicists and moralists in classic terms have indicated that a person need not undergo extraordinary treatment to preserve his or her life. Whether treatment is ordinary or extraordinary is determined not from the perspective of the hospital where sophisticated and onerous invasive procedures are performed on a routine basis, but rather from the perspective of the patient. Was it extraordinary from the perspective of this 78-year old heart-damaged patient, who had been cardio-shocked several times in the recent past, to require her to continue to suffer the endotracheal tube and the respirator? To submit to cardiac catheterization? To heart surgery? As she was a Catholic and probably somewhat familiar with church teaching on that issue, it is worth noting that the "Declaration on Euthanasia" approved by Pope John Paul II (1980) states:

It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligations to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.

At law, the death of this patient was not a suicide. Accordingly, whatever the son did, or did not do, such conduct could not constitute the crime of assisting in a suicide.

### **Influence on Decision**

Our decision in this case is influenced by the fact that these events occurred in a hospital and that all disinterested persons corroborated the statement that the patient was conscious, competent and informed and wanted the endotracheal tube removed.

Further, we note that as the patient was conscious, competent and informed, we are not dealing with "substituted judgment" such as is the situation with a minor or a person in a comatose or vegetative condition. Different considerations play a role in such cases. In addition, as the endotracheal tube and respirator are clearly medical treatments, we are not confronted with such questions as may be raised by hydration and nutrition.

A physician or hospital personnel, in dealing with a competent, conscious adult patient, need not abide by every directive the patient has a right to give. If a patient opts to terminate a particular treatment and the physician and/or hospital personnel disagree, generally (under many circumstances) reasonable time ought be permitted for the patient to

change his mind or to secure another physician in order that the first doctor may withdraw and/or to permit the patient to transfer from the hospital to elsewhere.

In reviewing this case, one may well feel events may better have moved more slowly and deliberately on Nov. 9, 1986, or taken an entirely different course. To their strong credit, many of the nurses and doctors at St. Luke's involved in this matter reflect an admirable and vigorous commitment to the principle that every effort, and with informed consent even bold and unique ones, are to be made to save and restore the lives of their patients. Understandably, they were keenly desirous of proceeding with recuperative efforts on behalf of the patient and were much distressed and greatly concerned by the events that transpired. The forthright candor of some of the personnel is to be much respected.

This case has obviously caused great concern to the son of the deceased patient. It highlights the wisdom of the general counsel that physicians are well advised to leave the care of critically ill family members to other physicians.

**E. Michael McCann  
District Attorney of  
Milwaukee County**

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