

November 1997

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Recommended Citation

Byrne, Paul A.; Colliton, William F.; Evers, Joseph C.; Fangman, Timothy R.; L'Ecuyer, Jerome; Simon, Frank G.; Nilges, Richard G.; Shen, Jerome T.Y.; Kramper, Ralph J.; and Sadick, Mary H. (1997) "Life, Life Support, and Death Principles, Guidelines, Policies and Procedures for Making Decisions That Respect Life," *The Linacre Quarterly*: Vol. 64: No. 4, Article 1.
Available at: <http://epublications.marquette.edu/lnq/vol64/iss4/1>

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Life, Life Support, and Death Principles, Guidelines, Policies and Procedures for Making Decisions That Respect Life

by

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The following is the third edition of a booklet by the American Life League, Inc. The section on Ordinary/Extraordinary Means has been revised. The sections on Quality of Life, Pain, Paired Organ and Non-vital Organ and Tissue Transplant, and Determination of Death have been added. There are other changes throughout the booklet.

Introduction

Some aspects of the euthanasia movement are clear, but many others are subtle, and the truth is not easily discerned. There is a paucity of truthful education regarding "brain death," death with dignity, living wills, and death by dehydration and starvation. *All in society, especially physicians and health care personnel, must become as familiar with these topics as they are with abortion.* Both abortion and euthanasia are forms of imposed death.

While most articles appearing in the medical literature have supported a public policy that would lead inexorably to the deaths of many of our patients, some good has resulted from this cacophony. All physicians, including those who support the principles detailed here, have been called to remember the dictum of Francis Peabody that "the secret of the care of the patient is in *caring for the patient*."¹ The most essential ingredient required to accomplish this goal is two-way communication with *the patient and his or her family*. Beginning with the first visit of an adult patient, the doctor should strive to establish that kind of rapport which allows for an understanding of the responsibilities, obligations and duties of the patient himself or herself. Other medical personnel also should be involved in establishing such rapport.

The topic of "brain death" has been pursued for many years by Dr. Paul Byrne; Dr. Joseph Evers; Dr. Richard Nilges; the late Dr. Sean O'Reilly; the late Fr. Paul Quay, S.J.; Attorney Peter Salsich; and others.² The understanding and insight gained about the immorality of the use of the current criteria for "brain death" make it easier to take a stand against killing that is done by withdrawing or withholding food and water, and/or giving a lethal injection.

We see a young, strong, vigorous man slam-dunk a basketball. Within seconds of all that activity, he collapses and then dies. He was surrounded by persons trained to do CPR (cardio-pulmonary resuscitation). Let's presume that everyone administered "all the best" that medicine had to offer. Still he died. The reality is that treatment does not always succeed at keeping a patient alive.

Some treatments are helpful and do result in a patient's living longer. When a disease is lethal and there are multi-organs or multi-systems involved, the prognosis often is not good. Patients do die even while on a ventilator. At that time everyone can observe and know that death has occurred, even though the ventilator continues to move air into and out of the chest.

What approach should be taken by a physician, patient and others regarding the use or non-use of a ventilator and other forms of medical treatment? How should the dying patient be treated? When has death actually occurred? How should a patient's relatives consider these issues? The answers are not simple. Every decision must be individualized, especially when life and death are at stake. The

common law right of a *competent* patient to refuse medical treatment does not diminish the duty of the physician or the moral obligation of the patient. Presented here are some principles, guidelines, policies and procedures to guide those making these and other medical decisions.

The Major Premise

Let's begin with *human life is sacred*. Leon Kass has written in *Commentary* that ". . . life is in itself something holy or sacred, transcendent, set apart—like God Himself . . . [L]ife is something before which we stand (or should stand) with reverence, awe, and grave respect—because it is beyond us and unfathomable . . . [T]o regard life as sacred means that it should not be violated, opposed or destroyed, and, positively, that it should be protected, defended and preserved . . ."³

God alone is the Author of a person's life, and He alone may determine when a person's life will end. Since human life is a gift from God, there is a primary moral obligation to show reverence for that life at all times from its beginning until death. Any failure to show reverence for or to safeguard life is an attack on the individual patient, on others involved, on the medical profession, on society, and on God.⁴

No physician, nurse, other personnel or caregiver should participate in euthanasia. By euthanasia, we mean an action or an omission that of itself or by intention causes death. No one should be deprived of basic care, including food and water, suitable bedding, an optimal thermal environment, an unobstructed airway, exits for stool and urine, and effective treatments, medications, procedures and operations. A hospital exists to diagnose and treat ill patients. While not every illness can be cured, every patient must be cared for. The object is always to provide the best medical care to the whole person, physically, mentally, emotionally and spiritually. To purposefully expedite death by omission or commission violates a fundamental principle of medicine—"First, do no harm." Recognizing that not every illness can be cured but that every patient must be cared for, a hospital cooperates with other facilities and services as well as the patient's family to deliver the best care possible to the patient.

Ordinary/Extraordinary Means

Decisions to use or not to use a particular medical treatment, medication, procedure or operation should be considered according to "ordinary" and "extraordinary means." "Ordinary" and "extraordinary means" represent ethical constructs enabling an understanding of such decisions by the *individual patient*.

As a general principle, a person has an obligation to try to live the entire life span given by God. Therefore, he/she must not kill him/herself by intentional act or omission. When it comes to specific decisions regarding medical treatment, this obligation requires the patient to use all "ordinary means" to preserve his/her life.

"Ordinary means" include any treatment, medication, procedure and operation which offer a reasonable hope of benefit without requiring heroic virtue, that is, virtue above and beyond the ordinary. For example, an effective treatment which does not cause pain, expense or other burden that is grave or too excessive for the patient himself/herself to bear is ordinary means.

On the other hand, life on earth for everyone will end, even when everything possible to be done is done. Thus, while the responsibility to avoid deliberately causing one's own death is absolute, the responsibility to preserve and prolong life is not. Because the constitution of the person, the ability of the person and the burdens of medical treatment differ from person to person, the obligation to obtain medical treatment varies, and there is no general obligation to obtain every treatment all the time. The burden of medical treatment could be extremely great, that is, beyond what would be expected of human beings in general, or even for this particular human being under certain circumstances. Therefore, some treatments, medications, procedures and operations are optional, and these have been classified by ethicists as "extraordinary means."

"Extraordinary means" (or disproportionate means, as preferred by some in modern times) include any treatment, medication, procedure and operation that would be gravely burdensome for the patient to bear or otherwise would require heroic virtue. Here we are emphasizing that it is the means, that is, the treatment, medication, procedure or operation, which is gravely burdensome or otherwise requires heroic

virtue. We use strong language—*gravely* burdensome; others use excessively burdensome or excessively difficult. Also, we use *heroic* virtue. We are not trying to be scrupulous, nor do we want others to be so. However, we do wish to make clear that the burden must be extremely great or the virtue required must be beyond ordinary virtue, before the means can be classified as extraordinary. In other words, the means must involve an excessive hardship—tremendous effort, suffering, cost (unreasonable expense)—more than moderately difficult to obtain or to use. Personal fear, horror or repugnance on the *patient's* part about a particular means could cause it to be considered extraordinary.

Generally speaking, the patient is not obligated to use extraordinary means; he/she may decide to do so. Such a course could constitute an act of heroic virtue. Examples might include a treatment that requires travel to a distant location in a very weakened condition. Similarly, some varieties of chemotherapy could cause overwhelming malaise and fatigue so that the treatment, from the patient's perspective, would be far worse than the disease. Note, however, that medical progress may render today's extraordinary means tomorrow's ordinary means. For example, renal dialysis, a method of clearing the patient's blood of nitrogenous waste products and other toxins, was unknown when several of the co-authors were in medical school; today it is available in virtually all urban areas.

In the ethical construct of ordinary versus extraordinary means, extraordinary means are limited to treatments, medications, procedures and operations that *may* or *may not* be employed by a patient himself/herself to preserve his/her own life. It should not be implied by an extraordinary means that such means *must not* be used. A decision not to use an extraordinary means does not foreclose other treatments,* and certainly all ordinary means must still be used. A diagnosis of an irremediable illness does not make it acceptable, within the ethical construct of ordinary/extrordinary means, to withhold treatment that is effective and not gravely burdensome. Moreover, extraordinary means cannot be withheld or withdrawn in order to kill the patient or to advance other immoral ends. A physician may not encourage a

* When used alone throughout this booklet, "treatment(s)" generally includes "medication(s)", "procedure(s)", and "operation(s)", unless otherwise indicated.

patient to violate his or her moral obligations, help him/her to do so, or refuse a patient's request for treatment that is obligatory. The physician and the hospital are obliged to try to provide an extraordinary means of treatment when the patient wishes it.

Although generally optional, extraordinary means would become obligatory for the patient if he or she is not reconciled with God or if the lives of others depend on the life of the patient. Alternatively, the patient may not use an extraordinary means if it would cause him/her to fail in some more serious duty.

In sum, not to commit suicide is always required and expected. One should live a virtuous life in all ways, including taking care of one's own health. To obtain the ordinary means of medical treatment and to take good care of one's health is virtuous. If the medical means are gravely burdensome or if they otherwise would require heroic virtue, the means generally are optional. There is no requirement to obtain such means; in other words, one is dispensed from an obligation to obtain them.

When the patient is unable to speak for himself/herself, the decision regarding treatment becomes more complicated. As a general rule in such a case, the physician must find out any wishes the patient had expressed previously. Then, the physician must try to obtain consent from a proxy. The instruction to the physician must be as close as possible to that which the patient himself/herself, if able, would give. Almost always the patient has a close family tie with a spouse, a parent or a child. As a result of these bonds, when the patient is unable to communicate for himself/herself, the physician has an obligation to communicate with the family. Pertinent information from relatives and close friends is extremely helpful at these times. Communication with loved ones offers the best chance for personalized care for the patient unable to speak for himself/herself.

Decisions regarding health care must be *current* decisions based on *current* information. While one may have thoughts about how one *would* make a decision under a given set of circumstances, the decision *actually* must be made using current facts, including applicable treatments, medications, procedures and operations, all of which are constantly being updated. The necessity to use current information should be sufficient, in itself, to invalidate so-called living wills. While a "durable power of attorney for health care" meets this requirement of

access to current data, one must make certain that the philosophy of the durable power of attorney and the decision making by the proxy designated under the durable power of attorney are consistent with the life principles and policies discussed herein. When the decision must be made and what the patient would want isn't known, one may have to make a judgment based on the patient's best interest, always keeping foremost that human life is sacred and that life and the life span on earth are gifts from God, a span that must be determined only by God Himself.

When the patient is unable to communicate and it has been made known that the patient still has obligations to others that an extraordinary means of treatment could help the patient to meet, the physician should gently encourage its use. There is a similar obligation when the patient is unable to communicate and it has been made known that the patient's spiritual needs have not been met. In this circumstance the family and/or proxy should be involved with the hospital staff to provide for the patient's spiritual well-being.

In the absence of instructions by the patient or proxy, and while the patient's entire situation is being evaluated in accordance with the principles, guidelines, policies and procedures included herein, life-saving, life-sustaining and/or life-prolonging measures must be used to preserve the life of the patient.

Resuscitation—Life Support

When it is directed by a patient or the patient's proxy that an extraordinary means of medical treatment will not be administered, a specific order for that specific non-treatment must be written. Written orders must be as precise as possible.

"Do Not Resuscitate" (DNR) or "No Code" are examples of ambiguous orders widely—and wrongly—accepted by physicians and courts. Do these orders mean no maintenance of an airway, or no ventilation, or no cardiac resuscitation, as well as no new or additional treatment? Furthermore, in light of the weakness of human nature, once the course has been plotted by a DNR or a "No Code" order, there is a tendency to preclude, eliminate or reduce ordinary treatments, such as visits by physicians and care given by nurses and others. Therefore, broad orders of "Do Not Resuscitate," "No Code," and similar orders

must be avoided. At no other time in medicine are treatment orders that are broad and non-specific considered to be within the standard of care.

When it is anticipated that a patient could sustain a complication that would be immediately life-threatening and not allow time for reflection and decision, specific orders to direct the Code Blue team response regarding a specific extraordinary means can be written by the primary physician. For example:

1. In the event of cardiac arrest, use or do not use external cardiac massage, defibrillation, etc.
2. In the event of hypotension, use or do not use Dopamine, Levophed, volume expanders, etc.
3. In the event of respiratory arrest, use or do not use bag and mask ventilation, endotracheal intubation, ventilator, etc.

A companion entry must be made in the medical record, including the diagnosis, prognosis, patient's wishes, recommendations of the treatment team or consultants with documentation of their names and the date. When the patient is unable to communicate for himself/herself, every attempt, including communication with relatives, must be made to obtain informed consent from a proxy.

Ventilation-Respiration

The ventilator, commonly but less properly called a respirator, is a device that is used to move air and/or oxygen in and out of a patient's lungs. Ventilation is the movement of air, while respiration is the exchange of oxygen and carbon dioxide. This exchange occurs in the lungs, as well as in the living tissues throughout the body via circulation. Ventilation and respiration are essential requirements for life on earth to continue. When these are supported by the use of a ventilator (respirator), such use is more often than not an ordinary means of treatment. In the *exceptional* case, when the ventilator is an extraordinary means, the initiation or the continuation of the ventilator generally is optional. In such case, after proper consent and direction,

ventilatory support may be slowly decreased (known as weaning from the ventilator), which allows the patient to breathe spontaneously if capable of doing so. When the use of a ventilator allows a patient to be more comfortable, it should be continued.

Food and Water

Withholding or withdrawing food (nutrition) and water (hydration) leads only to death. Death by starvation and dehydration is a very undignified and inhumane death. It demeans the patient. The patient's mouth dries out and becomes coated with thick material. Lips become parched and cracked. The tongue swells and might crack. The eyes sink back into their orbits. The lining of the nose may crack and bleed. The skin becomes loose, dry and scaly. The urine concentrates, then decreases until there is no urine. The stomach lining dries, causing dry heaves. The respiratory tract dries out, giving rise to thick secretions that could plug the lungs and may cause death. Eventually, major organs fail, including the lungs, heart and brain.

Methods of administering food and water include being fed or given a drink with a glass, a spoon or a straw. When a person is unable to swallow or has difficulty with swallowing and risks aspirating food into the airway, a nasogastric tube (plastic or rubber tube passed through the nose into the stomach) or gastrostomy (a tube going through the abdominal wall into the stomach, which can be done nowadays in a patient's room with minimal discomfort) is used to administer food and water. While a nasogastric tube uses an opening that is present naturally, it can be safer and easier for patients prone to aspiration to have a gastrostomy tube. Water and nutrition also can be given intravenously when medically indicated.

The obligation to supply food and water, even artificially if necessary, remains intact even when caring for patients in a coma or so-called "persistent vegetative state" (see p. 10). Mental incapacitation on the patient's part does not relieve this responsibility. Withholding or withdrawing food and water is euthanasia apart from the *exceptional* case where the method of administering food and water is extraordinary means, that is, the method in itself is gravely burdensome in excess of the burdens already being experienced by the patient, it renders the whole medical situation gravely burdensome, or it otherwise requires

heroic virtue. As discussed above, there generally is no moral obligation to obtain or to continue treatment that is gravely burdensome or otherwise would require heroic virtue. It must be emphasized, however, that most methods of administering food and water should not be considered extraordinary for the vast majority of patients.

Ineffective Treatments

Any treatment that is completely ineffective should not be used. Likewise, if a treatment will not prolong life, restore function or relieve symptoms including pain, it is medically contradicted, and there is no obligation to obtain or provide it. (Some would call such treatment futile, as that term is properly understood.) The decision to use or not to use a treatment that is predicted to be wholly or even partially effective must be considered according to the ethical construct of ordinary/extraordinary means. When all traditional and modern treatments fail, the patient should be allowed, or in certain cases even encouraged, to try non-traditional approaches predicted or known not to cause physical, mental, emotional or spiritual harm. To instill rational hope (not necessarily cure) and positive thinking are very important to the patient, no matter how severe or mild the condition may be.

Persistent Vegetative State (PVS)

There are times when a patient has altered brain functions. This is sometimes manifest as a state of unresponsiveness to visual, auditory and tactile stimuli. When this lasts for longer than seconds, minutes, hours or days, it is considered "prolonged" and sometimes called "persistent vegetative state" (PVS).

One must be cautious in referring to a patient in a prolonged state of unresponsiveness as a "vegetable." A human being is never a string bean, a squash or a pumpkin, thus, never a vegetable. Even when a patient is in a prolonged state of unresponsiveness, including so-called PVS, he or she is neither dying of a lethal disease nor in immediate danger of death. Like every living person, he/she is worthy and deserving of care and treatment. The principles of ordinary/extraordinary means apply. A means considered ordinary for

other patients should not be considered extraordinary for patients with a prolonged state of unresponsiveness because of a judgment that their lives are not worth living.

Quality of Life

Human life is sacred, a gift from God. Created in His image, each human being is unique, yet of equal worth and dignity. No matter the circumstances, we must not deliberately shorten the life span given to each of us by God.

There are many definitions and considerations of "Quality of Life." Often these are entertained to justify shortening life. Specifically, it is argued, when the quality of a person's life is determined to be "low," it is no longer desirable or necessary to sustain that life. In effect, the constructs of ordinary/extraordinary means are reformulated to include evaluation of the "benefit" to the patient's "Quality of Life" and the "burden" of remaining alive in the patient's debilitated condition. The focus, then, is shifted improperly from determining the medical and moral worth of a medical treatment, medication, procedure or operation—its potential effect on the patient and his/her medical condition—to the "worth" of the patient's life. Thus, for those with a so-called low quality of life, such as those with certain physical or mental disabilities, ordinary (mandatory) means are viewed as extraordinary (optional) means and denied.

This way of thinking is antithetical to the sanctity-of-life principle: The value of life of each individual person is absolute and intrinsic, and is not conditional on some actual or perceived quality.

This "Quality of Life" way of thinking is also illogical. There is no basis to conclude that, for example, mentally or physically disabled persons, who cannot or are not allowed to speak for themselves, would "choose" to die rather than lead what someone else considers a meaningless existence. Although we may have a thought or comment about our own feelings should we become unable to speak, walk, think or do whatever it is that we can do now, no one can predict with certainty future thoughts or feelings. Furthermore, it is known that negative thoughts and feelings before injury or serious illness may differ from post-injury/illness thoughts and feelings, and that negative thoughts and feelings after an injury or serious illness change over time.

Traditionally, medicine has insisted that diagnostic and treatment decisions require current knowledge of facts about a disease or injury. While arguing that a person would be better off dead may reflect how someone else might respond, it does not necessarily and probably does not reflect how *that person* would respond if he/she could, nor how anyone would respond *actually in that situation*.

Thus, for reasons of logic and, more important, principle, any and all considerations of and references to "Quality of Life" that might be used to justify non-treatment decisions are not acceptable and must be rejected by the patient and the patient's physician(s), other caregivers, proxy and family.

Pain

A sick or injured patient can have pain. The pain can be physical, mental, emotional, spiritual or a combination of these. Such a patient also can have difficulty with sleeping. Treatment and care can be indicated for one or all of these. When a patient with physical pain also has mental, emotional or spiritual difficulties and/or is unable to sleep or to sleep soundly, additional and specific treatments may be required.

Medications used in the treatment of pain have the potential to alter consciousness, change the state of mind, and even cause death. Pain relief must not prevent or impair carrying out a patient's religious/spiritual and moral duties or family obligations. Provision of pain-relieving medication should be in the amount needed for comfort with the least possible amount of alteration of consciousness or other change in the patient's state of mind, and not such that would constitute a lethal dosage or cause death. Treatment and care used to help the patient sleep should mimic natural sleep with minimal side effects while avoiding lethal dosages. It should be emphasized that proper treatment ordinarily results in relief of the pain.

A dying patient can have pain and may request medication for relief. Medication for pain can be given even when it is predicted that death will occur within hours, but the object and motive for treatment must be to relieve pain, and death must not be sought or intended by the administration of pain-relieving treatments. The possibility that a non-intentional overdosage occasionally may hasten or cause death should not interfere with well-intentioned efforts (as outlined herein)

to relieve pain. In severe pain of incurable disease and/or terminal cases, addiction to medication for pain is not an issue.

A dying patient can accept suffering as a means for atonement and as a source of merits in order to progress in love of God. Such patients should be aided to follow their own way. Medication to relieve pain should not be forced on them.

Dying

When it is determined that the patient is dying of a lethal disease that is medically irremediable and it is predicted that death will occur within hours, with or without treatment, the decision may be made to refuse treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. (Here we use "hours" to avoid "imminent" and related terms given overly broad medical/legal interpretation to mean even up to one year and perhaps beyond.⁵) When making this decision, consideration must be given to whether there is any likelihood that the patient may not be morally or spiritually prepared for death. For example, continuation of life, even for a brief period, could provide an opportunity for repentance.

Responsibility for such decision remains with the patient him/herself as long as he/she can communicate. When the patient cannot communicate, the physician must try to obtain consent from the patient's proxy. The instruction to the physician must be as close as possible to that which the patient him/herself, if able, would give. The physician must be morally certain that he/she has done all in his/her power in accord with the proper wishes of the patient to help him or her to live the life span given by God. Always do what's best to conserve life, fully realizing that life on earth will eventually end for each and everyone. Never withhold or withdraw any treatment with the intention of killing the patient.

Praying

Praying *for* the patient is encouraged at all times, especially when a patient appears to be dying. When praying *with* the patient, the kind of prayers generally should be in accord with the patient's own

religious traditions, method of worship, and clergy. Prayers with a seemingly unconscious patient should be said aloud since the sense of hearing may persist even in apparent unconsciousness. The patient (or in the case of an incompetent patient, the family and/or proxy) should be told that it is common practice to ask if a chaplain, clergy or the hospital pastoral care service is desired.

Unpaired Vital Organ Excision

It is immoral to remove an unpaired vital organ before death. To satisfy a desire for transplantable organs, an ingenious method was devised to get around this ethical problem: certain comatose patients were simply defined as "dead." Translating "coma" into "death" was first accomplished in 1968 with the publication of the Harvard Criteria, which defined death as "irreversible coma" and initiated use of so-called brain-related criteria for determining death.⁶ *It must be realized, however, that only someone alive can be in a coma, even when the coma is "irreversible."*

May one excise a beating heart from someone who is warm, has blood pressure, blood circulation readily apparent when pressure is applied to blanch the skin and the color returns within seconds of removal of the pressure, and many other intact, functioning organs and systems maintaining the unity (oneness) of the organism as a whole? Further, if there is doubt that death has occurred, may one excise a vital organ? The answer to both questions should be no. Yet, in accordance with brain-related criteria for death, every time a heart transplant is done, *it is a beating heart that is excised*. Such organ excision has become so commonplace that fewer and fewer persons question the morality of such action, but there are still some who do.⁷

The Human Brain and Death

The approach of defining death on the basis of brain-related criteria is flawed in both theory and practice. As we will discuss in more detail below, the approach assumes, without adequate scientific or logical basis, that impairment of the function and/or structure of the human

brain experienced by certain comatose persons means the absence of "human-ness" and, therefore, life. Moreover, in practice, determination of "brain death" is often made in the absence of some *but not all* brain functions.

Let us first address the flawed scientific basis for the "brain death" approach. The cerebral cortex is the largest part of the human brain, and the human cerebral cortex is larger than those of other animals. While the attributes of reasoning, thinking and processing information are dependent upon structural integrity of the brain and environmental requirements, it is from structural and/or environmental alterations of the brain and the body of a patient, as well as from animal experiments, that the importance of the cortex for these attributes has been learned. It is the cortex that is primarily responsible for processing these attributes of human beings. Nevertheless, a functioning cortex is not the only part of the brain and body required for these activities.

It is well known that other organs and systems of the body also are required for normal cortical functioning. Could an isolated cortex "possess" rationality?—Who knows, but we doubt it. Others would say the entire brain is required, nevertheless stating that rationality resides in the cortex. Based upon the interdependence of organs and systems of the human body, it is doubtful that the isolated brain could have rationality. While there can be philosophical speculation or thought experiments (still only a fantasy), the experimental attempts to develop in animals an isolated cortex or isolated brain have met with minimal success or clear failure. Even if one could perfuse the isolated brain and record electrical activity, there is no reason to make electrical activity equivalent to or demonstrative of a rational being or even of rationality.

Brain-related criteria are flawed not only in scientific theory but also in application.⁸ In order to fulfill the current "brain death" criteria, the entire brain stem must not be functioning. In fact and in practice, however, often only *some* brain stem *reflexes* (response of pupil to light, response to ice-water in the ear, gag and swallowing reflexes, etc.) are evaluated. The apnea test (taking the patient off the ventilator) is done to evaluate the function of spontaneous breathing. Although there are other functions of the brain stem, including maintaining a normal body temperature, producing hormones via the hypothalamic-pituitary axis, neurogenic control of heart rate and maintenance of normal blood pressure, either these brain functions are

not considered at all or they are said to be inapplicable or insignificant for determining death. Even though the "brain death" criteria of the Uniform Determination of Death Act (UDDA) call for "... irreversible cessation of all functions of the entire brain, including the brain stem,"⁹ it is and has been acceptable practice that at the time of "brain death" determination, some of these functions often are present but not evaluated.

Indeed, in the more recently published "Guidelines for Determination of Brain Death in Children", the #3 *requirement* is that the "patient must not be significantly hypothermic or hypotensive for age" when the determination of "brain death" is made.¹⁰ But if, under this requirement, body temperature is normal without control by environmental warming or cooling and blood pressure is normal without control by pressor drugs, doesn't it only stand to reason that the brain *must be functioning*? Even if the temperature and blood pressure are normal as a result of medical treatment, isn't it likely that one is still dealing with someone who is alive rather than dead?

As the foregoing indicates, the observation of the vital signs of a normal temperature and normal blood pressure, as well as the possibility of the presence of non-evaluated and non-tested brain functions, is medically and legally acceptable as compatible with a determination of "brain death." Not only has it been acceptable at all other ages, now it also is *required* that these vital signs of normal temperature and normal blood pressure be present when making a determination of "brain death" in children. What, then, is it that we are being made to accept under brain-related criteria for death? We are being made to accept an entree for organ transplant teams to obtain vital organs in good physiological condition. From an ethical point of view, however, removal of an unpaired vital organ from an individual should not be permitted if there is any question that she/he might be alive.

While the automobile is a poor analogy for any comparison to a human being, some thoughts expressed here may help elucidate the difference between functions and functioning. An automobile currently parked is not functioning. While its functioning has ceased for the time being, its functions are still present—it takes only a driver and an ignition key to activate the auto. These differences are not merely semantics, but are factual differences that have resulted in so many

having been misled in this serious matter of "brain death." When brain-related criteria are applied in making a determination of death, an absence of *functioning* is observed. It is then erroneously, indeed illogically, concluded that there is an absence of functions.

In sum, there are more than 30 different sets of brain-related criteria that are in use. Not one is based or applied on adequate theory or data. When a determination of "brain death" is made and is then followed by excision of a beating heart, the criteria become self-fulfilling for death.

It is not possible to excise an unpaired vital organ from a *corpse* and then use the organ for transplant. Specifically, for a heart to be suitable for transplant, it must be taken while beating from someone with intact circulatory and respiratory systems and often with a functioning brain stem, as well as many other intact organs and systems that are functioning and maintaining the unity of the body. If there is *any* question that death has not occurred for these vital organ donors, there exists a moral prohibition to excise an unpaired vital organ, which would insure their death.

Typically, the patient determined to be "brain dead" under brain-related criteria is on a ventilator in an intensive care unit. As noted earlier, the ventilator (less properly called a respirator) moves air. A ventilator can cause air to move in and out of the chest of a corpse, but it can never cause a corpse to respire. Respiration is a vital function carried out only by someone who is alive. In a corpse there cannot be any respiration, that is, exchange of oxygen and carbon dioxide across the alveolar membrane, although a ventilator could move air in and out of the chest. In the typical "brain dead" patient on a ventilator, however, respiration is still occurring.

A functioning brain is not necessary for the heart to beat. The beating of the heart is intrinsic to the heart, but heartbeat of such cardiogenic origin is at a slower rate than heartbeat of neurogenic origin that one ordinarily observes in a healthy person, such as during routine physical examination. When the heart is beating without a functioning brain stem, the rate is much slower than normal and the blood pressure quickly goes down. When the "brain dead" donor and his or her beating heart are being prepared for transplantation, the heart is still beating—and often not even at this slower rate indicating that the heartbeat is only of cardiogenic origin.

Caution and Courage

While the intention of some authors is good and well meaning, it is essential to be aware of the intricacies of activities and movements of proponents of "brain death" and euthanasia to hurry the comatose, "less than perfect," unresponsive patients off the earth. Such activities and movements are not so subtle as to go undetected, but the lack of understanding by many who would otherwise take a respect-for-life stand results in their taking a position not only of accepting brain-related criteria for death, but also of actively or passively fostering and supporting "brain death."

"Brain death" is not death. If it were identical and equivalent to death, why would it be necessary to coin a new term? Semantics, verbal engineering, emotional and social reasons have resulted in creating a fiction for the determination of death—to carry out research and vital organ transplantation. At present, those in a "persistent vegetative state" do not satisfy currently accepted criteria for "brain death." But, euthanasia via "brain death" has been followed by the killing of others who are unresponsive; food and water have been removed imposing death via dehydration and starvation—often after a court ruling. These activities will be followed by other forms of killing; indeed, further definitions of death to encompass PVS patients and more already are being proposed. These activities will continue until there are sufficient numbers who have the courage to say, "No!—No, to 'brain death' and mercy killing!"

Determination of Death

Death must not be determined or declared unless and until there is no doubt that life on earth for this human being has ended.

Death signifies the breakdown of the unity of the organism, which unity is served by the intercooperation of at least three vital systems, namely, the *circulatory and respiratory systems, and the entire brain*. Therefore, *death cannot and must not be determined or declared unless and until there is destruction of at least these three basic unifying systems*. Our insistence on "destruction" is not a concern with the impossibility of a restoration to function of these systems. Death

signifies not only no further functioning in the future, but also *the radical incapacity of these systems to function at the present moment*. In other words, once death (properly understood) has occurred, it is totally incapable of being in any way affected by medicine or medical progress. (For a detailed discussion of this standard for determination of death, see note 2, *Gonzaga Law Review*.)

In an organism as sophisticated and complicated as a human being, it is proper to refer to and insist on *destruction of systems* in matters of death. Destruction of the heart does not imply concomitant destruction of the circulatory system; for example, an artificial heart can, for a while, take its place. Likewise, cessation of breathing, no matter how protracted, does not mean destruction of the respiratory system since respiration is not merely the breathing motion but principally the exchange of oxygen and carbon dioxide; therefore, evidence that the biological basis for respiration has disintegrated is needed. The third system is not named by or for its function. Destruction of the entire brain must entail evidence that each part of the entire group of brain parts (cerebrum, cerebellum, pons, etc.) has become incapable, through loss of structural integrity, of any further unitary activity.

Obviously, proof of destruction of these systems rarely can be based on visual observation alone. Such proof should be based on indices of destruction universally accepted among physicians at the time determination of death is considered. The requirement that such indices be "universally accepted" reflects the certainty needed when potentially lethal action such as organ and tissue excision, and embalming and burial are contemplated. "Universal acceptance," however, does not require that every single possessor of a medical degree concur, but that there be no strong, reasoned opposition by physicians as exists to the very concept of "brain death."

The standard for determining death set forth above avoids the fatal flaws of brain-related criteria for death. This standard is not currently honored by today's medical establishment as the only way to determine death. Although its application would preclude transplantation of unpaired vital organs, it is the only acceptable standard to ensure that living human beings are not treated with the scientifically inaccurate and morally repugnant haste that leads to a premature grave.

Paired Organ and Non-vital Organ and Tissue Transplant

While living, a person may give charitably one of a paired organ and non-vital organs and tissues to someone else. Excision of one of any paired organ and any non-vital organ and tissue may be done only if such procedure would not threaten the life or health of the person from whom the organ or tissue is taken, and only if the donation is specifically for the benefit of the life or health of the recipient person but not solely for scientific purposes. After death some organs and tissues—for example, cornea, heart valves and bone—may still be useful for transplant.

No donation of one of a paired organ or non-vital organ or tissue should be made without the prior, explicit, free and conscious decision on the part of the donor, or after the donor's death by someone who legitimately represents the donor. At no time may the donor's care or treatment be altered in any way to the detriment of his/her life or health for the purpose of better preserving organs or tissue for donation before or after death.

Life Support . . .

Principles, Guidelines, Policies and Procedures

Principles and Guidelines:

1

Human life is sacred; God alone is the author of a person's life, and He alone may determine when a person's life will end. Since human life is a gift from God, there is a primary moral obligation to show reverence for that life at all times from its beginning until death. Any failure to show reverence for or to safeguard a patient's life is an attack on the individual patient, on others involved, on the medical profession, on society, and on God.

2

No physician, nurse, other personnel or caregiver should participate in euthanasia. By euthanasia is meant an action or omission that of itself or by intention causes death. No one should be deprived of basic care, including food and water, suitable bedding, an optimal thermal environment, an unobstructed airway, exits for stool and urine, and effective treatments, medications, procedures and operations. A physician may not encourage a patient to violate his or her moral obligations (see below), help him or her to do so, or refuse a patient's request for a treatment that is obligatory.

3

The patient has a moral obligation to use all ordinary means: any treatment, medication, procedure and operation which offer a reasonable hope of benefit without requiring heroic virtue, that is, virtue above and beyond the ordinary. For example, an effective treatment which does not cause pain, expense or other burden that is grave or too excessive for the patient himself/herself to bear is ordinary means.

4

Generally, the patient has the moral option to consent to or to refuse extraordinary means: any treatment, medication, procedure and operation that would be gravely burdensome to himself/herself or otherwise would require heroic virtue. If the patient is not reconciled with God or if the lives of others depend on the life of the patient, what would otherwise be considered an extraordinary means becomes obligatory. Alternatively, the patient may not use an extraordinary means if it would cause him/her to fail in some more serious duty.

5

A hospital exists to diagnose and treat ill patients. The object is always to provide the best medical care to the patient. Consequently, for a hospital to purposefully expedite death by omission or commission violates a fundamental principle of medicine—"First, do no harm." Recognizing that not every illness can be cured but that every patient must be cared for, a hospital cooperates with other facilities and services as well as the patient's family to deliver the best care possible to the patient.

6

Any and all considerations of and references to "Quality of Life" that might be used to justify non-treatment decisions are not acceptable and must be rejected by the patient and the patient's physician(s), other caregivers, proxy and family.

7

The physician and the hospital are obliged to try to provide an extraordinary means of treatment to the patient when the patient wishes it.

8

When the patient is unable to communicate and (a) it has been made known that the patient still has obligations to others that an extraordinary means of treatment could help him or her to meet, or (b) it has been made known that the patient's spiritual needs have not been met, the physician should gently encourage use of such treatment to the family and/or proxy.

9

Provision of pain-relieving medication should be in the amount needed for comfort with the least possible amount of alteration of consciousness or other change in the patient's state of mind, and not such that would constitute a lethal dosage or cause death. Pain relief must not prevent or impair carrying out a patient's religious/spiritual and moral duties or family obligations. Proper treatment ordinarily results in relief of pain. Medication for pain can be given even when it is predicted that death will occur within hours, but in all cases the object and motive for treatment must be to relieve pain, and death must not be sought or intended by the administration of pain-relieving treatments. Pain medication, however, should never be forced on a patient.

10

When it is determined that a patient is dying of a lethal disease that is medically irremediable and it is predicted that death will occur within hours, with or without treatment, the patient has the moral option to request or refuse treatment that would only secure a precarious and burdensome prolongation of life. (Here we use "hours" to avoid

"imminent" and related terms given overly broad medical/legal interpretation to mean even up to one year and perhaps beyond.¹¹⁾ All normal care due to the sick person in similar cases, however, must not be interrupted. When making such decision to request or refuse treatment, consideration must be given to whether there is any likelihood that the patient may not be morally or spiritually prepared for death. For example, continuation of life, even for a brief period, could provide an opportunity for repentance. The physician must be morally certain that he/she has done all in his/her power in accord with the proper wishes of the patient to help him or her to live the life span given by God.

11

Praying *for* the patient is encouraged at all times, especially when a patient appears to be dying. When praying *with* the patient, the kind of prayers generally should be in accord with the patient's own religious traditions, method of worship, and clergy. Prayers with a seemingly unconscious patient should be said aloud since the sense of hearing may persist even in apparent unconsciousness. The patient (or in the case of the incompetent patient, the family and/or proxy) should be told it is common practice to ask if a chaplain, clergy or other hospital pastoral care service is desired.

Policies:

1

It is generally the right of a patient capable of giving informed consent to make his or her own decisions regarding medical treatment and care after having been fully informed about the benefits, risks and consequences.

2

There shall be ongoing clarification to the patient (and participating family members) of the risk/benefit of specific treatments. This must be documented in the medical record.

3

Within the parameters of these principles and guidelines, when a patient is not able to give informed consent, the physician must try to obtain consent from a proxy. Ideally, a responsible relative, the parents, the conservator of an adult or the designated proxy makes the decision in the way the patient would make the decision if he or she were able and had all the current information. Thus, a current decision is made about current matters based on current information. To do this, the physician must keep those responsible for decision making currently informed. If there is insufficient knowledge to make such a decision, one may have to make a judgment based on the patient's best interests, always keeping foremost that human life is sacred and that the life span on earth must be determined only by God Himself. All, including physicians, must always provide ordinary care and treatments. If the patient or the proxy would direct to withhold or withdraw treatment that is effective and not gravely burdensome, no one, including physicians, may participate in carrying out such a directive.

4

In the absence of instructions by the patient or proxy, and while the patient's entire situation is being evaluated in accordance with the principles, guidelines, policies and procedures included herein, life-saving, life-sustaining and/or life-prolonging measures must be used to preserve the life of the patient.

5

When it is directed by a patient or the patient's proxy that an extraordinary means of medical treatment will not be administered, an order for that specific non-treatment must be written. Broad orders of "Do Not Resuscitate," "No Code," and similar orders must be avoided. When it is anticipated that a patient could sustain a complication that would be immediately life-threatening and not allow time for reflection and decision, specific orders to direct the Code Blue team response regarding a specific extraordinary means can be written by the primary physician. For example:

(a)

In the event of cardiac arrest, use or do not use external cardiac massage, defibrillation, etc.

(b)

In the event of hypotension, use or do not use Dopamine, Levophed, volume expanders, etc.

(c)

In the event of respiratory arrest, use or do not use bag and mask ventilation, endotracheal intubator, ventilator, etc. A companion entry must be made in the medical record, including the diagnosis, prognosis, patient's wishes, recommendations of the treatment team or consultants with documentation of their names and the date. When the patient is unable to communicate for himself/herself, every attempt, including communication with relatives, must be made to obtain informed consent from a proxy.

Procedures:

1

The physician's orders shall direct the treatment staff, including the Code Blue team.

2

The physician's orders shall indicate the desired response to specific events that may be anticipated in the clinical course of the patient.

3

The nursing staff's care plan must carry the complete orders for the patient, including any orders relevant to a Code Blue; therefore, the nursing staff shall immediately make such orders known to the responding Code Blue team.

4

When a proxy must be contacted by phone to obtain permission for treatment, guidelines for witnessing consent to a care plan on behalf of

the patient unable to consent for himself or herself shall be followed. The physician and a second staff witness (medical or nursing) shall listen to the informed consent discussion and decision by the proxy. The physician must document this discussion in the medical record, and the second staff member must document his or her participation as a witness.

Determination of Death . . .

Principles, Guidelines, Policies and Procedures

Principles and Guidelines:

1

The medical determination of whether or not a person has died is a physician's responsibility. The following is intended to direct the physician in making this decision.

2

Human life is sacred; God alone is the Author of a person's life, and He alone may determine when a person's life will end. Because human life is a gift from God, there is a primary moral obligation to show reverence for that life at all times from its beginning until death. Any failure to show reverence for or to safeguard a patient's life is an attack on the individual patient, on others involved, on the medical profession, on society, and on God.

3

Human beings have a primary moral obligation to respect life and to safeguard it. A person who is dying is still alive, even a moment before death, and must be treated as such. Death must be declared only after, not before, the fact. To do the latter is to assent to a falsehood that can lead to actual death prematurely, even through killing. This would be a

fundamental injustice.

4

When there is doubt about the fact of death, it is immoral to take an action by which grave harm would be inflicted if the doubt were wrongly resolved, especially since such harm could include premature death. Any doubts must be resolved with the benefit of the doubt always given to the patient's life.

5

From experience it seems clear that once the brain is formed, human life usually, but not always, requires some kind of functioning of the brain to survive. However, cessation of brain function, functions or functioning, no matter how determined or qualified, is not of itself proof that the person is dead.

6

A person in a coma is still alive and may or may not still demonstrate some evidence of brain function.

7

To regard the irreversibility of cessation of brain functions (at best, a deduction from a set of symptoms) as synonymous or interchangeable with destruction of the entire brain (one but not the only possible cause of these symptoms) would be erroneous in two ways: identifying the symptoms with their cause and assuming a single cause when several are possible.

Policies:

1

Death shall not be determined or declared unless and until there is no doubt that life on earth for this human being has ended.

2

Other factors, such as the desires of others, including the desire to have organs for use by others, must not be considered in making a determination of death.

3

No one shall be determined or declared dead unless and until there is destruction of at least the three basic unifying systems of the body, namely, the circulatory and respiratory systems, and the entire brain. "Destruction" means the radical incapacity of these systems to function at the present moment.

Procedures:

1

The history of the clinical situation shall be considered in every detail. The physical examination of the patient must not show any sign of life. In other words:

- (a) The heart must not be beating;
- (b) There must not be a recordable blood pressure;
- (c) There must not be any respiration, that is, there not be any exchange of oxygen and carbon; and
- (d) There must not be any brain function, functions or functioning.

2

These findings and others should be based on universally accepted standards of medical practice, and must be sufficient to confirm destruction of the circulatory and respiratory systems, as well as the entire brain.

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