The Business Of Dying Essay, Research Paper

The Business of Dying

Prepared for: Peru State College

Business Administration 251: Legal environment and Contract Law

Submitted to:

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April 5, 1998

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CHAPTER 1

Die and Pay Taxes

My father once told me the only things we have no choice but to do in this life are to die and pay taxes. Although he may have been correct, we can probably make some educated choices to affect the result of both. Due to the evolution of our society and advances of modern day medicine, our choices in either of these obligations may be vast but also limited to our knowledge and the planning we engage.

Do we have choices? Henry David Thoreau felt that the taxes imposed by a war that he was apposed to were unjust. He refused to pay the taxes and was imprisoned. Thoreau would still have the right today to protest the tax under the philosophy of Natural Law. He would still more then likely be imprisoned if he refused to pay his taxes, but what of his right to die? Without an advanced directive or some sort of living will in place, in our so called advanced culture, Thoreau might not have a choice in his own death. He could easily be kept imprisoned by being kept alive and at the mercy of his keepers.

Under today’s legal society the health care provider may exercise rights as our keeper. Many of us may assume those health care providers, assured that the law permits them to do so, will respect the decisions of their patients, or of their patients appointed decision maker. As a result, most advanced directive laws impose no adverse consequences on providers who refuse to follow the instructions of an advance directive. Some may even hold that noncompliance is legally acceptable. In contrary, in recent years health care providers who apparently impose medical treatment and ignore the instructions in an advance directive may indeed be guilty of medical battery.

There are different types of advance directives. The two most common are living wills and durable powers of attorney for health care. For example, your living will may say that you do not want your life prolonged with machines or that you do not want tube feedings or an Intravenous (IV) to provide you with fluids. However, your living will could also say that you want everything possible done to keep you alive. It is important that it be a statement of your intent. A durable power of attorney for health care is a document you sign in which you appoint an agent to make your medical decisions for you if you aren’t able to make them due to incapacitation. Nebraska law recognizes both living wills and durable powers of attorney for health care. In order to sign a living will or a durable power of attorney for health care, you must be at least 19 years of age and competent. If younger than 19, you must be either married or divorced and competent.

CHAPTER 2

The Concept and the Cases

History maintains that the concept of our right to die has interested philosophers since the time of the Greeks. However, it has only recently become a pertinent social concern. By the 1950’s, advances in medical technology had allowed the terminally ill and permanently unconscious patients to be kept alive dramatically longer than ever before. In the past these individuals died quickly from complications or from an inability to eat and drink. The new-found capability of medical science brought difficult right-to-die issues into the lives of many dying patients, where the course of nature once seemed unalterable. Doctors, patients, and family suddenly needed to decide when a life should end. The terms “living will” and “power of attorney” were introduced into our vocabulary to assure that our rights in death were protected. Although Americans may feel strongly about their rights in death, the statistics show that we still don’t want to address these rights. According to a 1991 Gallup poll, 75 percent of all Americans approve of living wills. Conversely, the poll also showed that only approximately 20 percent of all Americans presently have a living will or medical power of attorney. Society is still shaping an opinion on the controversy. The events and unfortunate circumstances of several individuals of our decade have defined the rapidly evolving era of social, ethical and legal controversy surrounding the right to die.

The Karen Ann Quinlan case was one of the first ethical dilemmas that emerged in the era of modern medicine. Quinlan suffered a respiratory arrest in 1975 and was diagnosed with severe brain damage as the result of anoxia. She was unable to breathe without a mechanical respirator and unable to eat without a feeding tube. Her family undertook a prolonged legal battle to argue that their daughter would not have wanted to be kept alive in this condition. Finally, the New Jersey Supreme Court granted the relief.

The New Jersey Supreme Court held that Karen had a right of privacy grounded in the Federal Constitution to terminate treatment. The Court however, recognized that this right was not absolute but should be considered on a case by case basis. The court also concluded that the “only practical way” to prevent the loss of Karen’s privacy right due to her incompetence was to allow her guardian and family to decide “whether she would exercise it in these circumstances.

Although the Quinlan case helped define the ethical and legal controversy of the “right to die,” Karen Ann’s case did not entirely change the laws to support those rights. The same court that decided the Quinlan case considered whether a nasogastric feeding tube could be removed from an 84-year-old incompetent nursing-home resident suffering from irreversible mental and physical ailments. While recognizing that a federal right of privacy might apply in the case the court, contrary to its approach in the Quinlan case, decided to base its decision on the common law right to self-determination and informed consent. Since there was no living will or power of attorney in place the court ruled in favor of the nursing home allowing continued feedings. The cases continue to be considered, each on an individual basis.

As recent as 1990 the case of Nancy Cruzan heard by the United States Supreme court in 1990 has raised concern over social policy on the issues. On January 11, 1983, Nancy Cruzan lost control of her car as she traveled down a road in Missouri. The vehicle overturned, and Cruzan was discovered lying face down in a ditch without detectable respiratory or cardiac function. Paramedics were able to restore her breathing and heartbeat at the accident site, and they transported her to a hospital in an unconscious state. An attending neurosurgeon diagnosed her as having sustained probable cerebral contusions compounded by significant anoxia (lack of oxygen). The Missouri trial court in this case found that permanent brain damage generally results after 6 minutes in an anoxic state; it was estimated that Nancy was deprived of oxygen from 12 to 14 minutes. She remained in a coma for approximately three weeks, and then progressed to an unconscious state in which she was able to orally ingest some nutrition. In order to ease feeding and further the recovery, surgeons implanted a gastrostomy feeding and hydration tube in her with the consent of her then husband. Subsequent rehabilitative efforts proved unavailing. Nancy was in a Missouri state hospital in what is called a persistent vegetative state. Hospital employees refused, without court approval, to honor the request of her parents to terminate her artificial nutrition and hydration, since that would result in death. The State of Missouri was bearing the cost of Nacny’s care. Again the family petitioned the state for termination of her feeding and prolongment of medical care. A state trial court authorized the termination, finding that a person in Nancy’s condition has a fundamental right under the State and Federal Constitutions to direct or refuse the withdrawal of death-prolonging procedures. The State Court based their decision on Nancy’s expression to a former housemate that she would not wish to continue her life if sick or injured unless she could live at least halfway normally, suggested that she would not wish to continue with her nutrition and hydration. The case was elevated to the State Supreme Court level by the State of Missouri. The State Supreme Court reversed. While recognizing the right to refuse treatment embodied in the common-law doctrine of informed consent, the court questioned its applicability in this case. It also declined to read into the State Constitution a broad right to privacy that would support an unrestricted right to refuse treatment and expressed doubt that the Federal Constitution embodied such a right. The court then decided that the State Living Will statute embodied a state policy strongly favoring the preservation of life, and that Nancy’s statements to her housemate were unreliable for the purpose of determining her intent. It rejected the argument that her parents were entitled to order the termination of her medical treatment, concluding that no person can assume that choice for an incompetent in the absence of the formalities required by the Living Will Statute or clear and convincing evidence of the patient’s wishes.

The Due Process Clause does not require a State to accept the “substituted judgment” of close family members in the absence of substantial proof that their views reflect the patient’s. Without proof of ones wishes the question of constitutionally-protected liberty and interest in determining the time and manner of ones death will continue to be an issue. CHAPTER 3

Legislation and the Health Care Stand

As Congress looks for ways to curb rising Medicare costs, health care providers and dietetic professions are raising their concerns. Within these institutions, the idea of an ethics committee is being considered. The committees would carry out defined written guidelines for care of the permanent unconscious. In addition, dietitians would be required to be a members of or consultant to such committees and would serve an integral role in development of institutional policy. The dietetics community is involved in the legislative arena at the state and local level to promote the use of advanced directives and to effect legislative and societal changes that result in appropriate care for patients in a prolonged vegetative state.

The Multi-Society Task Force on Prolonged Vegetative States has already established guidelines for feeding a patient in a prolonged vegetative state and within individual institutions. Usually, the nutritional notion of “when in doubt, feed” is considered essential for the patient’s rights.

Considering patients who are permanently unconscious, with respect for personal autonomy, various ethical principals may be in conflict of the “when in doubt” idea. If care providers decide that there is an obligation to feed a permanently unconscious patient, does that obligation ever stop? As yet, there is no official consensus among physicians that treating a patient in a persistent vegetative state is inappropriate or that prolonging life is not an independent and overriding goal of medicine. The possibility of positive outcome should be assumed until the patient has not shown progress over time. According to the position of those in the medical profession, a consensus on the issue of prolonged care and prolonging life may be long in coming. They add that such a consensus may not be desirable. If physicians agreed, society might be foolish enough to give the health care provider unilateral say over what is best for the patient.

The Hippocratic Corpus encourages physicians to recognize when medicine has reached its limit of usefulness. A common method of distinguishing between obligatory and optional is to consider the effects, both benefits and burdens. Nutrition and hydration can be effective to maintain life, but alone they cannot restore consciousness. The Corpus goes on to state, “because the ultimate goal of any medical intervention should be improvement of the patient’s prognosis, comfort, well-being, or general state of health; therefore, nutrition may be futile as a medical treatment.”

The Hippocratic Oath has been the guiding ethical code for physicians since ancient Greece. Medical professionals still take the oath upon their indoctrination. It states in part, “I will maintain the utmost respect for human life from the time of conception; even under threat I will not use my medical knowledge contrary to the laws of humanity.” It is unclear just what mandates the exact laws of humanity. While natural law provides that we use moral and ethical principles inherent in human nature and our natural intelligence, we still must consider what our natural rights may be regarding the evolution of society. A broad definition of the law consists of enforceable rules governing relationships between individuals and between individuals and their society. In today’s society we can joke about death and we can view death on television and in the media, but we still don’t want to think about planning for our own death or the death of those we love. We certainly do not look forward to preparing a documented account of what we would want in an emergency or prolonged life situation. The issues of justice and the right to die with dignity may be growing in intensity, but each individual approaches that universal, common end called death with different religious, philosophical and personal attitudes and values. The legislation passed to protect these rights only made a meager attempt to protect the individual’s rights to prepare for their own death.

The Patient Self-Determination Act, which took effect on December 1, 1991, requires all Medicare/Medicaid health care providers to inform patients of their right to prepare an advance directive and to refuse treatment. The Act is based on principle, which was affirmed in a 1891 case, that “No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his person, free from all restraint or interference of others, unless by clear and unquestionable authority of the law”

The act was established to ensure that patients, not the family or institutions, make their decisions about their medical treatment. In cases where there is no documented evidence of the individuals wishes, the courts are left to decide them on a case by case basis. Certainly not all cases and patient situations are not the same. Some interesting points to deliberate may be what considerations we should make for children verses older adults, or pregnant women. With respect to patients in a persistent vegetative state, the evolution legislation and social changes may be the solution. As time passes and our society evolves, further legislation is likely to be passed, thus molding what defines the future right to die issues. If through the evolution, the definition of death were changed to be the death of higher brain functions, a patient in a persistent vegetative state would be considered dead.

CHAPTER 4

Death a matter Ethics, Religion or Legal Realism

John Stuart Mill established the utilitarian model of ethics. He saw ethical decisions as those that produce the greatest positive balance of value over negative balance of value for all persons affected. To the novice this means that under utilitarian ethics, an action is morally correct or right when it produces the greatest amount of good for the greatest number and when the action affects the majority adversely it is morally wrong. His views focus on the consequences of an action, not on the nature of the action itself or on any set of preestablished moral values or religious beliefs. The deontological viewpoint of ethics, expressed by Immanuel Kant, states that some acts are wrong and other are right independent of their consequences. American society highly values tolerance of conflicting moral values. It also values the right to the individual to control or govern ones own reasoning and ethical values. While health care professionals have an inherent ethical obligation to respect the sanctity of life and to provide relief from suffering. Beneficence, autonomy, and justice are accepted moral principles governing the behavior of health care professional within society. With the technological advances in medicine come conflicts between application of moral principles and use of certain types of medical treatment. The decision of which moral principle takes precedence in what situation creates the conflict. The current guidelines written by health care providers and the American Dietetic Association do support the patient’s right to self-determination as the overriding principle. However, the basis for self-determination hang by the single thread that a living will or some sort of medical power of attorney exists.

Religion may be the only institution that comes close to a possessing consensus. While Orthodox Judaism does not accept the idea of “brain death” it does define death as the absence of respiration, cardiac function, and brain function. The Jewish belief supports that the decision to proved care should be based on a reasonable body of medical opinion that care is not required when a case is hopeless. Roman Catholics and some Protestant church authorities have rejected the notion of prolonging life despite quality. While both conclude that prolonging life by artificial means was distinct from euthanasia, they concur that the removal of life support was acceptable if being allowed to die would be better for the patient. In 1992, the National Conference of Catholic Bishops released a paper opposing all willful suicides but stating that Roman Catholics are not obliged to use extraordinary or proportionate means when there is no hope for recovery. In General most religions support the argument that if there is no benefit, the procedure cannot be obligatory. Just as religion holds that the holy scriptures were given by divine inspiration, so do they believe that life is a gift. While the methods of each church or religion differ, the predominate religions of the western hemisphere do not support prolonging life when their is no benefit to the individual and no hope of their recovery.

Conclusion

“An editorial of sorts”

Although there are several cases involving right to die issue, no clear cut definitions exist in law or legislation about what is considered right or wrong when it comes to the Health Care Provider taking means prolonged life support to a patient in a persistant vegetative state. The fact remains that if an individual does not have living will or some sort of advance directive in place, they are basically leaving the choices up to the hospitals the courts and lastly the family. In some cases the family did not even have the last say.

I have to wonder if it has not become an issue of money to some in the health care profession. When states are picking up the tab the hospitals and nursing homes seem to fight to continue in their quest to prolong life. Frankly I was appalled that the hospitals could even sue to continue care. If the family is fighting to end the care of the patient, what benefit other than money could the hospital or nursing home foresee?

Altogether I hold the same opinion or belief as the held by religion. If there is no hope of recovery, health care providers should not prolong life. I see no benefit to the greater good of society if health care providers are allowed to prolong the inevitable.

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