

Withdrawal of Life Support
February 23rd

Reading: Stanley J. Reiser, "The Intensive Care Unit: The Unfolding Ambiguities of Survival Therapy," *International Journal of Technology Assessment in Health Care* 8 (1992): 382-394.
Clinical Care Committee, Massachusetts General Hospital, "Optimum Care for Hopelessly Ill Patients," *New England Journal of Medicine* 295 (12 August 1976): 362-364.
George J. Annas, "'Culture of Life' Politics at the Bedside -- The Case of Terri Schiavo," *New England Journal of Medicine* 352 (21 April 2005): 1710-1715.

Optional: Timothy E. Quill, "Terri Schiavo -- A Tragedy Compounded," *New England Journal of Medicine* 352 (21 April 2005): 1630-1631, 1633.

Reiser, "The Intensive Care Unit": Reiser, a doctor, historian, and ethicist, traces the history of intensive care units. As he describes in the introduction, ICU's are both strange and wonderful places, where human triumph and tragedy both unfold. They are also the place where decisions about withdrawing life support are often made. How did these places come into existence? He traces the history of both the diagnostic technology (e.g. physiological monitoring) and the therapeutic technology (e.g. CPR) that make ICU's possible. Reiser documents an enormous range of factors that contributed to the emergence of ICU's. Is he convincing? Did intensive care take a step forward every time some biomedical engineer developed a new technology (e.g. intermittent positive pressure ventilation)? Did they appear in response to specific crises (e.g. polio epidemics, the Coconut Grove fire)? Did they become possible when a way to pay for them appeared (the Hill-Burton Act in 1946, which increased funding for hospital construction; Medicare in 1965, which extended health insurance to everyone over the age of 65)? How would you make and defend an argument that explains the rise of intensive care? On p. 392 Reiser describes the exchange between Dr. Bruno Haid and Pope Pius XII. This was one of the opening exchanges in the modern debate about withdrawal of life support. The next two articles illustrate aspects of the continuing debate.

Clinical Care Committee, "Optimum Care": In response to the controversies triggered by the advent of intensive care, hospitals in the United States in the 1970s attempted to reform their policies and practices both to improve the quality of care they provided and to protect their doctors from legal liability. In 1976 Massachusetts General Hospital (where I trained) published their critical care policies as a model for others to follow. Pay attention to several things. First, what classification do they recommend for patients? Is it obvious what kind of patients would go into each category? Once a patient had been assigned to a category, would it be clear how to proceed (especially for Class C)? Second, who has the power and authority in this plan? Who assigns a patient to a

category? Who has the right to challenge these decisions? I assume (but it is not clear) that this system only applied to patients who are unable to participate in discussions about their own care. Third, look at the composition of the committee (psychiatrist, lawyer, nurse, oncologist, surgeon, patient). Is this the right committee to be making these decisions? Why do you think these sorts of people were chosen (and why was a psychiatrist put in charge)? One detail, that becomes relevant in the Terri Schiavo case: Class D was “generally reserved for patients with brain death” -- but as Schiavo’s case shows, determining brain death can be controversial.

Annas, “‘Culture of Life’”: Annas, a lawyer and ethicist, directs the Department of Health Law, Bioethics, and Human Rights at the Boston University School of Public Health. He tries to explain why the Schiavo case, and others like it, have been so challenging. He starts by reviewing the history of the two most famous previous right-to-die cases, those of Karen Ann Quinlan and Nancy Cruzan. The history of these cases, the precedents they set, and the guidelines issued by the U.S. Supreme Court in 1990, have all prevented controversy in most end-of-life decisions. Why did Schiavo’s case erupt in controversy? Will the precedents set by the Schiavo case increase or decrease controversy in the future?

Optional: Quill, “Terri Schiavo”: Quill, who became famous for his description of Diane’s physician-assisted suicide (which you read two weeks ago), remains an outspoken defender of the “right to die.” In this piece, first published on-line the day after President Bush signed the emergency law to reinsert the feeding tube, he offers his interpretation of the Schiavo affair. It provides a more detailed clinical and legal description of her 15-years on life support. Why does Quill think this case attracted so much controversy? What can be done to prevent similar controversies in the future?