

BROPHY vs. NEW ENGLAND SINAI HOSPITAL: Ethical Dilemmas in Discontinuing Artificial Nutrition and Hydration for Comatose Patients

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On October 11, 1986, in a bitterly divided 4-3 decision, the Supreme Judicial Court of Massachusetts authorized the removal of the feeding tube which was sustaining Paul Brophy's life. Twelve days later, on October 23rd, Paul Brophy died, becoming the first American to die after court-authorized discontinuation of artificial nutrition and hydration to a comatose patient.¹

The case of Paul Brophy may be destined to play as momentous a role in the medical ethics of the 1980s as that of Karen Ann Quinlan in the 1970s. Since on any given day in the United States, there may be as many as 10,000 patients who are in a similar condition to that of Paul Brophy,² the facts of his case the moral principles involved in such decisions deserve the most careful scrutiny by all those who are concerned about the sanctity of life, the integrity of the medical profession, and the medical and moral trends in our society.

BACKGROUND OF THE BROPHY CASE

On the evening of March 22, 1983, Paul Brophy, then aged 46 and employed as a fireman and emergency medical technician in the town of Easton, Massachusetts, suffered an aneurysm, a ruptured blood vessel in his brain. Brophy became unconscious, and never regained consciousness, being in a condition described as a "persistent vegetative state." On June 18, 1983, Brophy was transferred to the New England Sinai Hospital, where he remained as a patient.³ He was unable to chew or swallow and was maintained by nutrition and hydration received through a gastrostomy tube (G-tube) surgically inserted through the abdominal wall on December 22, 1983.

On February 6, 1985, Mrs. Brophy, after consulting with her children and a priest, requested a probate court in Massachusetts to authorize discontinuation of all life-sustaining treatment for her husband, including hydration and nutrition. On October 21, 1985, the probate judge denied Mrs. Brophy's petition. On September 11, 1986, the Supreme Judicial Court of Massachusetts reversed the lower

court in a 4-3 split decision. The ruling was appealed to the U.S. Supreme Court, but jurisdiction to hear the appeal was not granted.⁴

The justices in the majority in the Brophy case held that Brophy's sentiments, expressed prior to his illness, that his life not be maintained in a vegetative state by artificial means, if he were ever placed in such a circumstance, should be honored. The three dissenting judges protested that the majority view authorized suicide and a form of euthanasia, and that the state was being asked to allow a man to starve himself to death. After eight days without food Mr. Brophy died of pneumonia. His death was said to be "extremely peaceful."⁵

BROPHY: A DANGEROUS PRECEDENT

While one can only have the deepest sympathy and compassion for Patrician Brophy and the family who suffered much mental anguish during this lengthy ordeal, a care observer will surely have serious misgivings about the dangerous precedent set by the Supreme judicial Court of Massachusetts in this case. The medical facts of the case itself, basic normative principles of medical ethics, and the possible long-term consequences all raise serious questions about the wisdom of the decision.

Paul Brophy was not terminally ill; his organs functioned, and he did not need a respirator.⁶ He had suffered serious and irreversible damage to his brain, but was

not brain dead, according to the widely accepted Harvard committee's 1968 definition.⁷ Brophy's cerebral cortex was largely intact, though damage to the thalamus, which conducts impulses to the cortex, and damage to other parts of the brain, seriously impaired brain function.⁸

After the insertion of the G-tube, Brophy appeared to be comfortable, and on the occasions when he showed signs of discomfort, medication was able to alleviate the discomfort. Brophy was not in danger of imminent death from any other medical cause. During a period of approximately eighteen months he had experienced no adverse side effects from the pressure of the G-tube. The probate judge found that the G-tube was not "painful, uncomfortable, burdensome, unusual, hazardous, invasive, or intrusive" in Brophy's case.⁹

Given the facts of the case, it appears that the majority justices in Brophy violated one of the basic normative principles of medical ethics: the moral obligation to use ordinary means to preserve life. Relevant here is the frequently quoted statement of Pope Pius XII in 1957:

Natural reason and Christian morals say that man (and whoever is entrusted with taking care of his fellowman) has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health ... But normally one is held to use only ordinary means - according to the circumstances of persons, places, time and culture--that is to

say, means that do not involve any grave burden for oneself or another.¹⁰

In the case of Brophy, the G-tube was not unduly invasive or burdensome, was essential to maintaining his life, and, in these circumstances, as an ordinary means was ethically obligatory. Such a principle is presupposed in a classic expression of the Reformed theological tradition, the Westminster Larger Catechism. Question 136 asks, "What are the sins forbidden in the sixth commandment?" ("Thou shalt do no murder.") The answer given is as follows:

The sins forbidden in the sixth commandment are: all taking away the life of ourselves, or of others, except in case of public justice, lawful war, or necessary defense; the lawful or necessary means of preservation of life (Emphasis added) . . . and whatsoever else tends to the destruction of life of any.¹¹

The Scripture text cited in connection with the emphasized part is Matt. 25:42. "I was hungry and you gave me no food, I was thirsty and you gave me no drink." This basic principle of the moral obligation to use ordinary means for the preservation of life has been articulated on a number of occasions by authoritative teachers of Roman Catholic doctrine. A 1980 Vatican declaration on the subject of euthanasia stated:

When death is imminent and cannot be prevented by the remedies used, it is licit in conscience to renounce

treatments that can only yield a precarious and painful prolongation of life. At the same time, however, ordinary treatment that is due to the sick in such cases may not be interrupted. (Emphasis added)¹²

On November 25, 1985, Pope John Paul II, speaking to a Conference on "Pre-Leukaemia," stated:

The principle ... while it discourages from employment of purely experimental or completely ineffectual operations, does not dispense from the valid therapeutic task of sustaining life nor from the administration of the normal means of vital support. Science, even when it is unable to health, can and should care for and assist the sick.¹³

In June of 1986 the National Conference of Catholic Bishops in the United States, through its Committee for Pro-Life Activities, issued a statement dealing directly with the issue of nutrition and hydration:

Because human life has inherent value and dignity regardless of its condition, every patient should be provided with measures which can effectively preserve life without involving too grave a burden. Since food and water are necessities of life for all

human beings, and can generally be provided without the risks and burdens of more aggressive means for sustaining life, the law should establish a strong presumption in favor of their use.¹⁴

This and the foregoing statements presuppose that human life has an inherent value in God's sight, a value that is not exclusively a function of brain states. This presupposition is justified biblically in terms of perceptive in which the value of human life is not measured in merely psychological, economic, or sociological terms, but rather from the perspective of God who is the Creator of all life. God valued the life of David long prior to the development of full brain function (Ps. 139:13-16), and the implication is that God continues to value human life made in the image of God even when full brain function may no longer be present.

The Brophy decision can be seen to be a bad decision not only in terms of a normative or rule-oriented perspective, but also in terms of consequentialist ethic. It can be argued that such a decision is likely to have negative consequences both in the medical profession and on other patients whose circumstances are similar to Brophy's.

Discontinuing food and water for comatose patients could undercut the physician's image as a caring professional. According to Dr. Mark Siegler and Alan J. Weisbard, "The dedication of the profession to the welfare of patients might be severely undermined in the eyes of the public even by the apparent complicity of physicians in

the deaths of the very ill, the permanently unconscious, or the pleasantly senile."¹⁵

Dr. Siegler, who is director of the Center for Clinical Medical Ethics, University of Chicago Hospitals and Clinics, noted that it would be "sadly ironic" if the movement for "death with dignity" served to undercut the image of nurses and physicians as caring and nurturing servants.¹⁶

There is also a significant danger that the circle of candidates for non-treatment might be substantially widened under pressure from a variety of social forces. This concern for the danger of the "slipper slope" is not merely hypothetical, in light of both the history of the German euthanasia experience and current pronouncements in the medical literature.

It should be recalled that the German euthanasia movement, which ultimately took some 275,000 lives, did not originate with the Nazis, but with Dr. Alfred Hoche, a professor of psychiatry at Freiburg, and Dr. Karl Binding, a professor of jurisprudence at Leipzig, who in their 1920 book *The Release of the Destruction of Life Unworthy of Life*, popularized the concept of a "life not worth living."¹⁷ Hitler and his followers were able to pursue a euthanasia program because the decadent and permissive moral climate of Weimar Germany had already paved the way for it.

Dr. Leo Alexander, a medical consultant at the Nuremberg Trials, pointed out in his famous article, "Medical Science, Under Dictatorship," that the euthanasia movement had its genesis in a shift in

attitude of the German medical profession toward the non-rehabilitable sick.¹⁸ A change in attitude toward patients in circumstances similar to Brophy's (and less severe circumstances as well) opened the floodgate to later abuses.

The relevance of the German experience to the American situation becomes all the more striking in the face of recently published statement in the medical literature. Dr. S.H. Wanzer and his associates have advocated the withholding of fluids and nutrition from irreversibly demented patients, and at times, even from a group of elderly patients they refer to as the "pleasantly senile."¹⁹

Sentiments such as those of Wanzer, in the current climate of concerns for "cost-containment" in medicine, could place in jeopardy the lives of large numbers of helpless patients. According to Dr. Edmund Pellegrino, "The growing conflict between economics and ethics may be the most serious challenge to medicine's future as a genuine profession."²⁰ And as Siegler and Weisbard have pointed out, in the current climate it may well be all too easy to move from recognition of an individual's "right to die" to a climate enforcing a "duty to die."²¹ The price in human lives for exchanging a "sanctity of life" ethic for a "cost-benefit" ethic may be high indeed.

SOME NARROWLY DEFINED EXCEPTIONS

The general position taken in this paper is that under most circumstances artificial

nutrition and hydration are ordinary means and hence morally obligatory. As any practicing physician will recognize, however, general principles must always be applied in the light of the specific medical facts of each individual case. There are a number of narrowly defined circumstances in which it may be morally appropriate to discontinue artificial feeding and hydration for a comatose patient, e.g.: (a) in the case of brain death; (b) when death is imminent, whatever course of treatment may be prescribed; and (c) when artificial nutrition and hydration would be unduly invasive, painful, or burdensome to the patient.

In the case of brain death, where this is understood according to the Harvard criteria, artificial means are clearly not morally obligatory, since in such a case the procedure constitutes useless treatment that neither preserves life, provides reasonable hope of cure, nor even provides care and comfort. While the moral obligation to provide care and comfort to dying patients still obtains, in the case of patients already dead this is no longer so. There is no ethical obligation to employ useless or futile treatments.

When death is imminent, i.e., reasonably certain within hours or days irrespective of the course of treatment, artificial means may not be morally obligatory. In some cases patients who die without artificial feeding and hydration may die more comfortably than those who receive such treatment. Terminal pulmonary edema, nausea, and mental confusion may be more likely in some instances where the patient

has been treated to maintain fluid and nutrition until close to time of death.²²

In some circumstances the use of artificial means may be unduly invasive or burdensome for the patient, and hence not morally obligatory. In the case of a patient with a nearly total body burn and serious clotting deficiency, for example, nasogastric tube placement may be quite painful, and there may be no skin to suture the stomach for a gastrostomy tube. In other cases a nasogastric tube may lead to pneumonia, cause irritation or discomfort, or require arm restraints for an incompetent patient. The volume of fluid needed to deliver nutrients, itself may in some instances be harmful.²³

It should be carefully noted that decisions to discontinue treatment in such instances are made on the basis of best medical judgments as to what means are most likely to benefit the patient--not on the basis of some "quality of life" ethic or subjective judgments concerning the "worth" of a patient's life. The proper question is not, "How worthwhile is the patient's life?", but rather, "What means can provide medical benefits to this patient in these circumstances?" Such a distinction, while not always easy to discern in practice, is in principle essential to the integrity of the practice of good medicine.

CONCLUSION

While in certain narrowly defined instances, artificial feeding and hydration may be legitimately withdrawn from a comatose patient, in most circumstances

such procedures would constitute ordinary means, and hence would be morally obligatory. The case of Brophy vs. New England Sinai Hospital sets a dangerous precedent which places at risk the lives of a large class of incompetent patients, and which also could erode the ethical integrity of the medical profession. Christian physicians are urged to guide their practice not on the basis of "quality of life" judgments, but rather on the basis of a "sanctity of life" ethic that seeks to provide appropriate medical benefits to the patient whatever the circumstances. "To cure, when possible; to care and comfort when cure is not possible; always, to do no harm."

References

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- 2 James J. Walther, "Food and Water: An Ethical Burden," *Commonweal*, November 21, 1986, p. 617.
- 3 From the court transcript, *Patricia E. Brophy vs. New England Sinai Hospital, Inc.*, N-4152 S.J.C., 4,5.
- 4 Drinan, *op. cit.*, p. 324.
- 5 *Ibid*, p. 325.
- 6 Peter Anderson, "The Final Days of Paul Brophy," *Boston Globe Magazine* January 23, 1987, p. 19.
- 7 According to the Harvard committee, brain death involves "(a) unresponsiveness to normally painful stimuli; (b) absence of spontaneous movements or breathing; and (c) absence of reflexes." These criteria did not apply

to Brophy.

8 Brophy, N-4152 S.J.C., p. 9, n. 10.

9 Ibid., pp. 9, 10, 11.

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23 Areen, op. cit., pp. 291-292.