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Terminal Decisions: Landmark Cases in the Path Toward Ethical End-of-Life Care

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Abstract
This brief article discusses the history of end-of-life care from a legal perspective. The article highlights important cases in Minnesota.

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Terminal decisions

Landmark cases in the path toward ethical end-of-life care

By Phebe Saunders Haugen, J.D.

When the U.S. Supreme Court issued its recent opinions on physician-assisted suicide, the ethics of end-of-life care took center stage in a national debate.

Minnesota has a long, rich history of thoughtful discussion on clinical ethics issues, including end-of-life decision making. Leading this effort has been Hennepin County Medical Center's (HCMC) biomedical ethics committee, the first of its kind in the country. Established as the thanatology committee 25 years ago, this committee has provided a model for emulation by medical centers around the country.

Withdrawal of treatment

One of HCMC's most enduring legacies in end-of-life decision making was the Rudolpho Torres case, which was the first withdrawal-of-treatment case to reach the Minnesota Supreme Court. In 1983, Torres was recovering slowly at HCMC from a bad fall when he was discovered one morning in a state of complete cardiopulmonary arrest. He had been choked in his bed by an improperly attached Posey restraint.

Though Torres was resuscitated, he suffered massive brain damage and retained only low-level brain stem function. His physicians agreed that his prognosis was hopeless and his ventilator should be withdrawn. Since Torres had no close family, the hospital initiated conservatorship proceedings and a probate court hearing was scheduled to determine the appropriate level of medical care Torres should receive. This was done with the understanding that if the conservator concluded it was in Torres's best interests to have his ventilator withdrawn, court approval to do so would be sought.

HCMC's biomedical ethics committee took the extraordinary step of consulting with three other hospital ethics committees prior to the hearing. As a result, the judge had not only HCMC's records and recommendations before him, but the considered views of the ethics committees for North Memorial, Mt. Sinai and the University of Minnesota hospitals. All of these committees supported the decision to withdraw the ventilator. The probate court authorized the conservator to order the ventilator removed, and Torres's counsel appealed the decision to the Minnesota Supreme Court.

In its 1984 opinion, the Supreme Court stated in clear language—still commonly cited today—that it may not be in the best interests of all patients to be kept on life support with little or no chance of recovery. The court ruled that to withdraw Torres' ventilator would likely be in his best interests and would probably reflect his wishes, had he expressed them. The opinion went on to recognize the important contributions of the other ethics committees that had consulted on the case and the value of their agreement with HCMC's recommendation. The court's endorsement of the ethics committees' work has been a source of continuing support for the ethics committee process pioneered at HCMC.

Physician liability in end-of-life care

Another important case in the annals of Minnesota bioethics never went to court, fortunately, but had an extraordinary and enduring impact. In 1989, two patients in separate hospitals in Hennepin County died following the withdrawal of their ventilators. One was a young man who had waged a long battle with common variable immunodeficiency syndrome; the other was a woman in the advanced stages of lung disease. In each case, the patient had requested that treatment stop. Each was given large doses of morphine to minimize suffering and ease agonal breathing.

As the result of a highly unusual request by a hospital nurse, the Hennepin County medical examiner was asked to investigate the deaths. He certified both as instances of morphine poisoning and therefore as homicides. The responsible physicians were referred to the county attorney for possible criminal prosecution.

These investigations and the medical examiner's conclusions were enormously distressing to the medical community in Minnesota. Many physicians feared criminal prosecution should their efforts to relieve terminal suffering be considered too aggressive. There were numerous anecdotal reports of cancer patients who were inadequately medicated for their pain and died in terrible agony because their doctors were unwilling to risk legal scrutiny.

The publicity surrounding these investigations highlighted the difficulties physicians face when attempting to provide good palliative care to dying patients. Fortunately, the prosecuting authorities in Hennepin County took the opportunity to learn something about the difficulties of pain and suffering control. They educated themselves about the medical realities of air hunger, agonal breathing and tolerance to morphine. They learned about the ethical principle of double effect, which protects the physician who unavoidably risks hastening death while attempting to control end-of-life suffering with narcotics, as good medical care demands.

In the end, the county attorney wisely declined to bring the cases to the grand jury for criminal prosecution. Instead, the Hennepin County authorities issued guidelines supporting physicians' efforts to manage the suffering of dying patients without interference, while encouraging better physician documentation. The Hennepin Medical Society wrote a position paper on the subject as well, and both documents were discussed at length in health care institutions throughout Minnesota. Many hospitals developed their own thoughtful institutional policies on the issue.

Improving care of the dying

In issuing last summer's opinions denying constitutional protection to physician-assisted suicide, several Supreme Court justices expressed grave concerns about the suffering of dying patients in this country. The court recognized what many physicians already know: We must do a much better job of caring for the dying if we are to quell the popular demand for legal physician-assisted suicide. Minnesota physicians are better prepared than most to meet this vital need, as they have the continuing support of a hard-working bioethics community and a respectful court system. ■

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