24.06J / STS.006J Bioethics
Spring 2009

Withdrawal of Life Support

Session L5

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.
Margaret Lock, "Technology in Extremis," in *Twice Dead: Organ Transplants and the Reinvention of Death* (Berkeley: University of California, 2002), pp. 57-75.
Sharon Kaufman, "Life Support," *And a Time to Die: How American Hospitals Shape the End of Life* (New York: Scribner, 2005), pp. 236-255, 259-265.

Before getting into the readings for this week, I wanted to say a few quick things about the history readings and assignments for this course. The readings come in two basic forms. Some of them are primary sources: something written at the time by people engaged in a debate (e.g. last week's reading by Quill). These give you a sense of how people in the past thought about an issue. Others are secondary sources: histories of something, written after the fact, by scholars (e.g. Emanuels, Reiser, Lock). Secondary sources almost always make *arguments*. Historical arguments usually take one of two forms. Some arguments are *causal*: the author makes an argument about *why* something happened. For instance, Emanuels makes several arguments about why different societies have been differently permissive of euthanasia. Other arguments are *normative*: the author argues that because of how something happened in the past, we *ought* to behave in a certain way now. For instance, many people have argued that because euthanasia was misused in the past, we should never accept it today. In each case, historians assemble a series of descriptive claims as *evidence* that they present to support their argument. Just as you evaluate the soundness, validity, and persuasiveness of philosophical arguments, you can do similar things for historical arguments. Are their facts correct? Are they presenting the right facts (i.e. are there other relevant facts that they neglect to mention)? Does their conclusion following logically from the facts presented? Whenever you read the historical articles, be sure to ferret out the argument (sometimes it will be subtle, sometimes obvious) and make your own assessment of it.

The paper assignments for this course generally give you a choice of three questions, one primarily historical (e.g. the one about Rachels), one primarily historical (the one about Emanuels, Reiser, and Lock), and one that asks you to integrate these perspectives. Caspar outlined a basic structure for philosophy papers: introduction, reconstruction of the author's argument, commentary on and assessment of the argument, and conclusions. This basic structure also works quite well for the historical questions. For instance, suppose you chose to answer question 2… Introduction: what is the issue motivating the other authors? What are their arguments? What is your argument about them? Reconstruction: whether you take on all three, or focus on one, what is the argument the author makes about the impact of changing technology on end of life decision making? What evidence is used to support this argument? Assessment: Is the argument credible? Is there counter-evidence? What is your

own argument? What evidence do you have (here it can be useful to draw on material covered by one author to assess another author)? Conclusion: restate your case. As with the philosophy questions, be sure to engage closely with the readings and use appropriate citations.

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)? Did ICU technology change in the 1960s in a way that created the crisis about withdrawal of life support? Had this tension always existed in medicine? How did changing physician ambitions and patient expectations contribute to the controversies? On p. 392 Reiser describes the exchange between Dr. Bruno Haid and Pope Pius XII. Is the Pope's argument persuasive? Why has the debate only increased in intensity since that time?

Lock, "Technology in Extremis": Lock, an anthropologist who has studied end of life decisions in the setting of organ donation and transplantation, traces a narrative that parallel's Reiser's history, but with different emphases. Focus on the first half (pp. 57-64), where she traces the history of life sustaining technology, from early efforts at artificial respiration in the 1500s-1700s to moderns ICUs. She provides a less detailed history that Reiser but gives a better sense of the impact of the technology on human experience. To what extent do ICU's dehumanize patients? The rest of the chapter explores some of the connections and implications of this problem, looking at organ donations, old fears of premature burial, etc. Given the emergence of these technologies, how should death be defined -- as the cessation of function in the heart? in the brain? some other way? Who decides? On p. 75 she mentions the idea of futile treatment: why is this important, how might it be defined, and how does it interact with scarcity of resources to fuel controversies?

Kaufman, "Life Support": This piece, which is more skimmable than the others, is intended to provide some clinical examples to help you fill in the details. In the cases described, how do patients, families, and staff think about end of life decisions? How do they frame the ethical questions? What conflicts arise? Do the frameworks presented by Rachels, Hare, et al., help resolve these issues? What is a good death, and do any of the patients have them?