# Correspondence

**Why a hospital seeks to discontinue care against family wishes**

Dear Editor,

Over the objections of her family, a Minneapolis hospital is seeking a court's permission to discontinue a respirator being used to treat a permanently unconscious woman. From the vantage point of an ethics committee consultant assigned to this case, I summarize it and offer my view of the issues it raises.

On January 1, 1990, Helga Wanglie was taken from a nursing home to Hennepin County Medical Center (HCMC) for treatment of a broken hip and respiratory failure cause by chronic lung disease and pneumonia. After treating both, physicians were unable to wean the 87 year old woman from the respirator. She was conscious, able to recognize her family and acknowledge comfort or discomfort. Five months later she was discharged, still on a respirator, to a chronic care facility. Two weeks later she had a cardiac arrest, was resuscitated and taken to a hospital for intensive care. At her family's request, the now-comatose woman was transferred back to HCMC for more evaluation and treatment.

HCMC staff concluded that the woman had severe anoxic encephalopathy which would prove to be a persistent vegetative state. She was treated with a respirator, antibiotics for recurrent pneumonia, tube feedings, and normalization of frequently monitored biochemical parameters. Medical staff suggested that aggressive life-sustaining care be terminated. Her husband, daughter, and son insisted on all life-sustaining treatments. After extensive debate, the family agreed not to contest a DNR order proposed on the medical conclusion that treatment for cardiac arrest would be extremely unlikely to result in survival. Despite many opportunities, the family did not mention any specific views of the patient about the future use of life-sustaining treatments.

Five months after the cardiac arrest, a new attending physician reviewed her condition and treatment. Pulmonary and neurology consultants concluded that she was irreversibly respirator dependent and unconscious. The attending physician concluded that the respirator could not serve the patient's personal medical interests because her irreversible unconsciousness precluded the possibility of her ever appreciating a quality of life.

After informing the family of his conclusion, the physician urged them to find a medical provider who considered the respirator to be appropriate and was willing to assume care. The family insisted that HCMC provide her care. The family was told that HCMC staff would provide care if ordered to do so by a court order. The physician told the family that the hospital would seek judicial clarification of its obligations under these circumstances. The medical director asked the Hennepin County Board of Commissioners (HCMC's board of directors) to allow the hospital to seek judicial clarification of its obligation to continue the respirator. The Board granted permission by a 4-3 vote. Several board members were friends of the husband. The husband now cites extensive conversations in which the patient allegedly expressed her preference for life-sustaining treatment. We do not have any documented evidence that this woman's views are different from the vast majority of persons who would not want to be sustained if permanently unconscious.

Several other facts are noteworthy. First, the cost of this woman's care is borne by private insurance and is not an issue for the clinicians or the county board. The first hospitalization cost $300,000. The second HCMC hospitalization, through December, was about the same. There has been no communication with the HMO paying for her care. Second, we are unaware of any HCMC physician who believes that the use of the respirator is medically appropriate. Third, the ethics committee has been involved in this case from shortly after the admission but has functioned as an advisor, not as a decision-maker. Fourth, though the nurses who have cared for this woman throughout her hospital stay do not believe that continued treatment is appropriate, they support an impartial judicial review of the obligation to provide this treatment. Fifth, we do not know of any other facility which will take this patient. The only chronic care facility capable of this care was the one where the arrest occurred and is unacceptable to the family. Sixth, the hospital has not released any medical information about this patient's care; it has reacted to information which the family has given to reporters. Seventh, the hospital is not asking for the termination of antibiotics or tube feedings. If the respirator is discontinued (and the patient survives) we would transfer this woman to another provider.

Many of the features of this case strike me as compatible with the premises of existing "right to die" policy and ethics. Medical care serves a broader definition of health than the maintenance of physiologic life. Life-sustaining treatment may be withdrawn if its burdens are disproportionate to the benefits it can achieve. Persons should not be treated for the benefit of others. The withdrawal of life-sustaining treatment from hope-



https://doi.org/10.1111/j.1748-720X.1990.tb01159.x Published online by Cambridge University Press

lessly ill persons is not the cause of death. It would be novel and ironic to conclude that this person has a right to remain on a ventilator in a country where there is no general right to health care. It also does not strike me that the physician is imposing his quality of life standard on this patient in that he would provide treatment if this woman had any personal sensation of her quality of life.

It is unusual to challenge the conclusions of a family in these decisions. The rarity of such challenges, however, may sometimes be an acknowledgement of the legal difficulties of doing so rather than the lack of merit to such an action. We believe that informed consent or refusal refers to therapies which would be medically indicated as possibly serving the patient's personal medical interests. Ethicists agree there is no obligation to provide futile therapies, though a variety of definitions of futility are currently being explored.

The proposal that the intellectual construct of "substituted judgment" justified by "respect for autonomy" infinitely empowers a family over a reasoned medical conclusion that a treatment cannot serve the patient's interests defies experience and common sense. Certainly, no practitioner would be thought remiss for declining to provide this woman with a heart transplant even if it would sustain her life. I do not believe that the relative boundaries of professional and family spheres can be precisely demarcated at this time. I do believe that Helga Wanglie, at 87, with endstage pulmonary disease, and irreversibly unconscious, is surely beyond the proper exercise of our most aggressive healing powers. I welcome comments on this case.

Steven H. Miles, M.D.
Associate Professor of Medicine
Hennepin County Medical Center
Minneapolis

## *Linares* Case: In-House Counsel Defended

Dear Editor:

This letter is prompted by the symposium on the *Linares* case in the winter 1990 issue of *Law, Medicine, & Health Care*. I found the content of the various articles concerning the case very interesting but I was disturbed by the tone and extent of some of the comments about how the hospital's attorney, Max Brown, fulfilled his responsibilities. I note that the most critical comments concerning his performance did not come from practicing attorneys. I believe that the lack of a law practice orientation, or not being an attorney, tends to make critics of an attorney's course of action somewhat unrealistic. It is worth noting that Nancy Wynstra's piece–she has a role at the institution she serves very similar to that of Mr. Brown–demonstrates an understanding of the pressures upon the attorney as a counselor.

Whether the attorney counseling a hospital in a complicated situation, such as that involved in the *Linares* case, is a house counsel or is with a law firm, the attorney must always be aware of who his client is. Patients, and physicians on the hospital staff who are not employees, are not clients of the attorney. While I do not ignore the existence of responsibilities owed patients and physicians by the hospital's attorney, the content of the legal guidance is controlled by the attorney-client relationship.

I tend to agree with the critics who gave the opinion that the potential for liability for both the hospital and the physician was minor. However, in dealing with physicians, it has been the experience of many attorneys, myself included, that physicians' fear of involvement in legal proceedings is so great that they often demand a degree of assurance that an attorney, in good conscience, often cannot provide. Thus, to assume that casting the potential for legal involvement in terms of probabilities, rather than possibilities, would ordinarily satisfy physicians, is to be unrealistic in many situations. I have no personal knowledge of the climate within Mr. Brown's institution respecting liability concerns, but I would not underestimate the concern that might be felt, even if it were objectively unwarranted.

In addition, considerations other than legal ones may intrude. Termination of care for a patient without private insurance or personal resources may raise concern in hospital management about misinterpretation of motives by the media. A hospital that facilitates a patient's family obtaining a court order to terminate care may become suspect. Perhaps, ideally, media attention should not be a factor in health care decision-making, but it sometimes is.

Readers of the symposium should look upon the various articles discussing the *Linares* case as a kind of precedent, in the sense that attorneys, physicians and institutional administrators, by reading them, can gain a better understanding of the complexity of the termination of care situation. Mr. Brown felt uncertainty because there was no definitive decision of the Illinois Supreme Court. While some of his critics point to decisions of courts in identical issues, it is necessary to keep in mind that the reason we have those court decisions, which can be used as a source of guidance, is precisely because the attorneys in those situations often felt, because of the concern of their client institutions and physicians, that it was necessary, in one way or another, to prompt or to secure a judicial resolution of the issues. Note that Mr. Brown himself, in the piece he coauthored, indicated he would do things differently based on his experience.

I would like to make two additional points. First, some attorneys, when faced with a situation where they are called upon to assess the nature and extent of the legal risks attendant to a course of action, prefer not to have their clients be the parties that bring



https://doi.org/10.1111/j.1748-720X.1990.tb01159.x Published online by Cambridge University Press