

## Ethical Problems of Intensive Care

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THE INTENSIVIST brings to the care of those in critical condition a radically increased power to reverse, retard, or even accelerate the process of death. This greater control over life and death through advanced resuscitative techniques, life-support systems, monitoring equipment, and computers<sup>84</sup> not only transforms all previous limitations of mortality, but also appears to challenge basic ethical principles. We wonder whether there is now an ethical imperative to preserve all patients in life-threatening situations, including those for whom existence seems only a fiction and others for whom it promises to be only short or severely diminished. When, if ever, can treatment be stopped or carried on at any degree less than maximal? Who is to decide these issues, under what circumstances, and by what standards? As more and more people in critical condition undergo prolonged medical intervention,<sup>38,40</sup> these questions surface with even greater intensity, for we are forced to face the inevitable consequence that some who are eligible for admission will have to be denied the scarce finite resources of the intensive care unit.<sup>46</sup> Should the intensivist possibly condemn some to death so that others may have a chance for life? In view of the difficult and often tragic decisions that must be made, it is natural to consider whether old beliefs in the sanctity of all human life, in the duty to prolong life, and in the value of the relief of pain and suffering must be modified or even abandoned.

The recent focus in the literature has been on criteria for the determination of death. Concern about this arose when medical technology became empowered to maintain traditional signs of life beyond the point where a person could be said to exist. Although this focus is of importance, it has left many of the other ethical problems of intensive care untouched. Dilemmas remain about who among the large number of those at various levels of critical illness should be treated and how. The first and only written guidelines specifically directed toward one of these dilemmas were developed by an interdisciplinary committee of the Massachusetts General Hospital.<sup>59</sup> Although it was not within the purview of this committee to provide a philosophical justification for its recommendations, its report does

presume an ethical framework in which basic human rights are recognized. In this paper, after examining the goals of intensive care, I propose to develop briefly a general view of the right to life and then to apply this to four ethical questions that arise for the intensivist. Should all ICU patients be given maximal care? Is it ever morally acceptable to allow a patient to die or to kill a patient? Who is morally empowered to make specific life-and-death decisions? In situations of scarce resources, how is intensive care to be distributed? I do not present specific guidelines for the use of any intensive care unit, regardless of kind, organization, or size, but address the more general ethical questions that logically precede the development of such rules at individual institutions.

The position presented here draws from the Western ethical tradition of human rights that is expressed in the Declaration of Independence, the Nuremberg Code, and the Helsinki Agreement. Its arguments are not supported in ways solely appropriate to medical science, but by means of a rational approach geared to the discussion of non-quantifiable matters of ethics and human values. Its reasoning begins with general ethical principles and then moves to more specific moral judgments for confirmation of these. Moral judgments and ethical principles are justified when they are mutually supportive, when they hold up under sustained rational scrutiny by others, and when they lead to the construction of a selective process for right actions that can be applied consistently to a broad spectrum of ethical situations. The reader is therefore invited to examine the reasons for the basic position presented here, to suggest supporting or conflicting reasons and examples, and to join the effort to work out the resolution of some of the ethical questions that arise within intensive care.

There are many kinds of disciplinary and multidisciplinary ICU's in numerous hospitals which themselves have somewhat varying functions. The ethical questions that arise in these ICU's do not overlap completely, but they are sufficiently similar to allow us to examine them without reference to specialties. The one area that is excluded from consideration is pediatric intensive care, which needs a chapter of its own. There are, in addition, several forms of ICU organization. For this reason, the term "intensivist" will be used to refer to the particular medical professional in charge of the decision. It is

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important that the specialized purposes of ICU's be kept in mind throughout, as it would be a mistake to extrapolate all that is suggested here to general medical care.

Intensive care medicine is designed to treat, diagnose, and maintain patients with immediate, acute, but potentially reversible life-threatening impairments of single or multiple vital organ systems.<sup>70,93,95</sup> It also aims at prophylactic management<sup>18,23</sup> to avoid such catastrophes as cardiac arrest, respiratory arrest, shock, renal failure, and overwhelming sepsis, and thereby attempts to reduce mortality and morbidity. The unit is organized with a concentration of specialized personnel, techniques, and equipment to provide continuous surveillance and coordinated care for potentially salvageable patients.<sup>78</sup> It is not a substitute for an emergency room, which receives and distributes patients with a wider variety of illnesses of differing severities, nor for a recovery room, which focuses on postoperative prophylaxis (although it can be combined with one), nor for a terminal care unit, which is designed for those whose medical courses cannot be reversed by any known therapy.

It follows from this statement of purpose of intensive care medicine that all who are critically ill should not automatically be admitted to the ICU. A necessary condition for admission is that the patient be potentially salvageable, by which it is meant that the patient has a chance of returning to a state in which his or her life is not threatened. Patients who are immediately and irreversibly dying, and for whom it has been carefully determined that there is no known therapy,<sup>61</sup> are not salvageable. They deserve comfort and support within the hospital, but cannot benefit from intensive care.<sup>65,74</sup>

This recommendation does not represent a policy of wilful killing,† as the lives of those who are immediately dying are not directly and intentionally taken by the intensivist who denies them admission. They have been denied by their underlying illness what no intensivist can give them—the indefinite continuance of life.

All too frequently, the conduct of a relatively dignified demise gives way to a horror show, which may culminate in rapid administration of many drugs, some of which may counteract each other. Heroic efforts with simultaneously administered massive doses of multiple agents in the terminal state may suggest the appearance of pharmacologic last rites, rather than that of a well-thought out plan.<sup>85</sup>

† The term "euthanasia" is not used at all in this paper, as it has several variant and mutually contradictory usages which would make its employment confusing and would also vitiate important distinctions.

There appears to be growing belief, both within and without the medical profession, that medical and technologic capabilities should not necessarily be used simply because they exist. Their use should be based on the needs and rights of patients, who cannot be reduced to conglomerations of vital signs that must be maintained at any cost.

The moral necessity of providing maximal ICU care for patients who are terminally or irreparably ill, but who are considered to have a chance to survive their present catastrophes, has been debated. On one view, it is justifiable to moderate the therapy for such patients, even though earlier death will occur, when this will result in relief from pain and suffering.<sup>65</sup> It is considered inhumane to keep alive dying people who are in pain or unable to communicate with others. One urologist points out that for many patients ". . . the problem that . . . has made the thought of death an agonizing one [is]—the fear of artificial prolongation of life when it has already been bereft of all its potentialities."<sup>37</sup> For proponents of this view, there is not an absolute and inviolate right to life that must be maintained under all circumstances.

Those who oppose this believe that "Our training is to preserve life and function wherever possible—not only where it is desirable and convenient, but where it is possible. We are not trained (and should not be!) to decide who 'is better off dead'."<sup>21</sup> On this perspective, there is no dying patient, only dead ones. The patient who is alive has an overriding right to life and deserves the maximum possible therapy. The dead patient is beyond medical aid. The genuine concern that a pattern of neglect will spread from the terminally ill and hopeless to those who are physically or mentally handicapped is also expressed. Shades of neo-Naziism and the terrible possibility that eventually people will be killed for the sake of social convenience are raised.<sup>44</sup>

This conflict does have implications for the care of those who are not terminally ill, but who are potentially salvageable with the chance that survival will be accompanied by devastating physical or mental impairment, or both. It is these difficult cases concerning the level of salvageability, which are relatively few in number, that lead to the widest divergence of opinion about whether intensive care represents exemplary therapy for all salvageable patients. The problems are complicated by the fact that it is often not possible to evaluate the likely outcome of intensive care treatment until the patient has been monitored for a day or two,<sup>24,38</sup> and even then, predictions are open to daily revisions in many

cases. Often the decision to treat or not is made by the very decision to admit and monitor. Although the medical and moral problems are complex, some general ethical principles are needed to prevent us from succumbing to arbitrary choices made according to undefined and *ad hoc* criteria.<sup>15,50</sup>

It is of primary importance, from an ethical perspective, to determine whether the right to life is absolute or whether it can ever be overridden with justification. Only if we come to some conclusion about this will we be able to decide whether it is always morally imperative to extend a patient's life through maximal care. We will also be able to establish whether it is ever ethically permissible to terminate someone's life directly or to allow to die someone who could have been saved. Our conclusions will not apply with absolute finality, like mathematical equations, to all cases of terminal illness with a chance for a brief extension of life or to all cases in which a salvageable patient risks permanent mental or physical impairment, or both, as individuals have very different conceptions of how to exercise their right to the pursuit of happiness within the limits of the ethically possible. Instead, there will be a range of variation in application.

The place of the right to life within the framework of general human rights is important to the resolution of our basic questions. Each of us, solely because we are human, apart from any particular qualities that we may have, has a right to life, and all of us are entitled to claim this right equally. The right to life protects us by limiting the freedom of others to act or to refrain from acting in certain ways with respect to our lives.<sup>30,39</sup> Therefore, with this right are correlated the duties that 1) all others have not to interfere with our exercise of the right to life (or any other human right)<sup>4,39,67,68</sup> and 2) those with the capability and opportunity have to aid us in the exercise of this right (or any other human right).<sup>68</sup> The right to life is one of several interrelated human rights that include, among others, the rights to liberty and the pursuit of happiness.

The claim to a right to life cannot be overridden by others except in fully justified special circumstances. For instance, we are entitled to override the right to life of a violent aggressor to protect our own lives.<sup>54</sup> In situations of war or disaster, society is entitled to forfeit the right to life of some of its citizens in order to ensure its survival<sup>43</sup> as the very guarantor of human rights. The right to life is not of sufficient moral strength to entitle us to violate the rights of others in order to gain what we need to live.<sup>56,69</sup> The rights of others over these needed things

outweigh our right to life. We therefore cannot attribute the right to life to individuals absolutely and unconditionally.<sup>8,39,92</sup> It is a *prima facie* right,<sup>6,28,36</sup> which means that it is a basic right that we have if and when there are no weightier moral considerations that provide warrant for overriding it in special circumstances.

It is not always morally necessary for an individual to exercise the right to life,<sup>10</sup> and so in this sense also it is not absolute. The right can be waived without moral blameworthiness by its holder, for the sake of other rights and values that are taken to have moral precedence. Among these are religious liberty, freedom of thought and action, service to others, and the general well-being. Three aspects of such voluntary acts of waiver are important. First, they are supererogatory,<sup>17</sup> which means that although they are not wrong to do, and indeed are good to do, they are not morally obligatory to do. Further, they are not done in order to bring about one's death, but to achieve some worthy goal whose attainment necessarily annuls the right to life.<sup>3</sup> And finally, they are not based on a denial of the value of life, but on the recognition that life itself is not the highest value.<sup>51</sup>

Not only is the right to life a *prima facie* right, but the two duties of others correlated with the right to life are *prima facie* duties.<sup>74</sup> That is, they are obligatory to carry out unless stronger moral considerations warrant their non-performance. A justification of the suspension of duty 1) was evident in our self-defense example in which the victim was entitled to set aside this duty when his own right to life was unjustly threatened. The duty 2) to aid others in the exercise of their right to life need not be performed when, for instance, a person in good health declines to donate a kidney to a person in danger of death from renal failure. This is because the donation would require the potential donor to accept the possibility of a shortened life span and also to waive the right to bodily integrity. The donation would thus be an act of supererogation that is not morally required, even in the face of duty 2). Therefore, when the second duty comes into conflict with other overriding human rights, that duty can be put aside.

To complete our picture of the right to life, we must outline those conditions under which the right to life cannot be overridden justifiably. Characteristics such as intelligence, skin color, degree of wealth, or technical skill do not provide moral warrant for the annulment of the right to life. This right extends to all human beings because they are of equal worth as human beings, regardless of various qualities by which

they can be graded.<sup>55,61</sup> This precludes the violation of the right to life of those who are under-age, over-age, or mentally or physically handicapped solely because they have these characteristics. These people are not defined out of the human race, but are entitled to the recognition of their basic human rights. Nor can the right to life be overridden for the sake of social utility<sup>52</sup> (apart from the extreme situation already cited). Society's desire for more breadwinners, more Aryans, or more healthy citizens does not entitle it to cancel the right to life, for the human value of a person is not dependent on social worth.

One does not lightly override human rights or breach their corresponding duties. The same consideration that requires us to uphold human rights provides the only acceptable basis for setting them aside in special circumstances.<sup>61</sup> This consideration is the worth of all human beings apart from any particular characteristics that they may have. When the exercise of some human rights unjustifiably impinges on other rights and freedoms of valuable human beings they can be overridden. Similarly, when the fulfillment of the duties correlated with the right to life interferes unjustifiably with other right and duties of valuable human beings these duties can be left undone.

The right to life figures importantly in those intensive care situations in which there is a chance to save a hopelessly or terminally ill patient for a relatively brief time, and also in situations in which there is a strong risk of devastating and irreversible mental or physical impairment, or both, if the patient is saved. In these cases, a conflict can arise between the human rights of one and the same individual. A person's right to life can come into collision with the right to freedom of action, for example, in those cases in which there is a choice of saving a patient, but only at the cost of complete and permanent physical immobility.

Not only can the other human rights of one and the same individual come into conflict with the right to life, but their loss through the circumstances of critical illness can effectively deprive the right to life of its function. For example, when the rights to freedom of thought and action are lost to the permanently comatose patient, the right to life can no longer function as the necessary precondition for the exercise of these two basic human rights. The moral strength of the right to life depends on its potential for the support of other human rights. Life is "a value to be preserved insofar as these other values remain attainable."<sup>61</sup> In those situations in which the right to life conflicts with other human rights of a patient or in which it is deprived of its function

as the necessary precondition for the exercise of other human rights, we cannot simply assume that the right to life must be upheld.

I have argued that the right to life is not an absolute and unconditional right, but a *prima facie* right that does not necessarily have the highest precedence among rights. It can be waived by its holder or overridden without moral blameworthiness for the sake of human rights and values that are of greater moral import. The pressing questions that arise now are which rights take moral precedence over the right to life when rights conflict for one and the same person who is critically ill, and how many and which rights must be rendered ineffective by the course of a critical illness before there is sufficient moral reason to believe that the right to life need not be exercised.

It would be immensely helpful to set up a general calculus of human rights at this point in which the status of the right to life is clearly set forth in relation to all other human rights in all possible circumstances. The intensivist could then translate this calculus of rights into a chart of clinical signs representing various categories and circumstances of critical illness in which the right to life could and could not be set aside. To the intense disappointment of some and to the extreme relief of others, this cannot and will not be done. One reason for this is that we cannot establish a general system of all human rights<sup>1,29,61</sup> that specifies how many of which kinds of rights outweigh the right to life or render it nonfunctional when they are lost. This is because, to an extent, when the rights of one and the same person conflict, the ordering of priorities among rights is a matter of individual choice. Persons of equal worth have different capacities and needs, and so the conditions of the good life (which the right to the pursuit of happiness protects) will not be the same for all.<sup>3</sup> Rights will partially be ordered by individuals on the basis of how best to fulfill the conditions of the good life of which each is capable. A second, related reason for our inability to devise a chart of rights expressed through clinical signs is that human rights cannot be totally correlated with physical functions. The loss of certain physical functions does lead to the loss of the ability to exercise certain human rights but this does not mean that rights are determinable by clinical signs. Different patients with the same clinical signs may have very different conceptions of how their rights should be weighed relative to their capacities for the good life.

The ordering of human rights is not wholly person-relative, however. Some rights take moral precedence over others as a matter of general ethical principle under certain circumstances, as mentioned

in the earlier basic discussion of human rights. There are at least two such human rights in the intensive care cases on which we have been focusing whose combined loss would seem universally to deprive the right to life of its function, regardless of individual conceptions of the good life. These are the rights to freedom of thought and action. The irrevocable loss of both of these rights together would provide sufficient moral justification for setting aside the right to life. Let us examine this contention more closely in two kinds of intensive care situations.

When a critical illness is accompanied by intolerable, indefinite, and uncontrollable pain, the rights to freedom of thought and action are overridden by the underlying disease, for the patient is unable to act in any way that these rights can protect due to the overwhelming quantity and quality of pain. There is considerable debate about whether such extreme and unconquerable pain ever does exist in hospitals.<sup>19,65</sup> However, such possibly hypothetical situations provide a paradigm of those circumstances in which the right to life can justifiably be set aside because it can no longer function as the precondition for the exercise of the rights to freedom of thought and action. A second kind of situation in which the rights to freedom of thought and action are annulled by illness is that of the permanently comatose patient. Here, too, the patient is not able to think or act in any way that the rights to freedom of thought and action can protect. The right to life is thus deprived of its function as the essential precondition for the rights to freedom of thought and action and can be overridden with moral justification in such a situation.

As a general principle, then, when the rights to freedom of thought and action are, in combination, irrevocably annulled by the circumstances of a critical illness, there is no moral necessity to uphold the right to life by providing maximal treatment. This applies to cases of irreparable illness in which a patient can be saved for a relatively short period and to cases in which a salvageable patient will suffer devastating and irreversible mental or physical impairment, or both, if saved. The first consideration related to ethics will be whether the patient faces a future in which he or she will be able to claim the rights to both freedom of thought and action successfully. When the patient will be permanently comatose, in permanent, unrelievable, and intolerable pain, or in some other way permanently incapable of exercising the rights to both freedom of thought and action if saved, there is no ethical imperative to opt for maximal treatment.

Should maximal treatment be instituted when a

critically ill patient faces the annulment of only one human right, such as the right to freedom of action due to the risk of permanent immobility? There is no general ethical principle that can be applied to all such cases that would entitle us to state assertorically that the right to life morally outweighs the right to freedom of action, or vice versa. When the patient is competent and able to communicate,‡ the decision about how to weigh the annulled right against the right to life belongs to the patient. When the decision falls completely to the intensivist in such cases, it is preferable possibly to err on the side of the right to life and to provide maximal therapy.

When a decision is made against maximal treatment, the question naturally arises whether it is ethically permissible to allow the patient to die or even to terminate the patient's life directly. Fletcher<sup>32</sup> believes that both of these are acceptable ethical alternatives, and that under certain circumstances it is morally demanded that we kill a patient and not simply allow that person to die. He considers it more humane to intervene directly by killing rather than to allow the patient to go through an agonizing period of prolonged death. His view is premised on the principle that there is no moral difference between killing someone and letting that person die.<sup>5,32,53,62</sup> Fletcher contends that this can be shown by considering the intentions of those making the decision. The intention in both killing and letting-die is the same, according to Fletcher—to terminate the life of a patient—so that the moral quality of either of these options is the same. If it is ever right to allow someone to die, on his view, then it is equally allowable to kill that person.

Fletcher is mistaken in thinking that the identity of intentions of those acting establishes the moral identity of killing and letting-die in general. It is true that in the sense in which Fletcher uses "intentions," there are some cases about which he is correct. Compare these:

- . . . Frank hates his wife and wants her dead. He puts cleaning fluid in her coffee, thereby killing her.
- . . . George hates his wife and wants her dead. She puts cleaning fluid in her coffee (being muddled, thinking it's cream). George happens to have the antidote to cleaning fluid, but he does not give it to her; he does not save her life and she dies.<sup>69</sup>

Frank's wife is killed out of malice. George's wife is allowed to die out of malice. But the fact that killing and letting-die can thus occur from the same intention does not mean that we can morally equate killing and letting-die in general.

‡ Difficulties peculiar to intensive care in connection with decision-making are discussed in a later section of this paper.

In the following hypothetical situations, what Fletcher terms sameness of intention is not sufficient to allow killing and letting-die to be identified.

(1) We have four patients who could each be saved by a small dose of a new drug and one who needs a massive dose of it to survive. Our supply is limited, so that we can either treat four or one, but not all. We give the drug to the four to save their lives, and, by not treating the fifth, allow him to die.

(2) We have four patients who could each be saved by an organ transplant. We need a total of one liver, two kidneys, and one heart to save them all. We take these organs from a recovered patient, thus killing him, and save the lives of the other four.

It would be morally acceptable to allow the patient in the first example to die, but not to kill the patient in the second example. These particular alternatives of killing or letting-die therefore are not morally equivalent, even though the intention in each is the same—to save four lives. Fletcher is incorrect in suggesting that sameness of intention is sufficient to establish the general moral equivalence of killing and letting-die.

The moral difference between these two alternatives is sometimes said to be grounded in considerations of causality and omission. Killing is unacceptable from this perspective because it involves directly causing a death, whereas allowing to die is permissible because it involves only the omission of life-saving action. I do not believe that these considerations succeed in distinguishing a moral difference between killing and letting-die.<sup>5,12,25,30,33,40,60</sup> Since they are rather complicated for our purposes, I do not include a discussion of them within the scope of this paper.

Instead, I suggest that our foregoing analysis of the duties correlated with the right to life will help us to establish a moral difference between killing and letting-die. Killing involves bringing about someone's death as a result of one's action and so violates the duty 1) not to interfere with another's exercise of the right to life. Allowing someone to die involves not taking action to save another's life when one could do so. This breaches the duty 2) to aid others in the exercise of their right to life when circumstances and capacity permit. Now we must notice that the duties 1) and 2) are not of equal weight.<sup>76</sup> Our duty to avoid injuring others (duty 1) has priority over our duty to aid others (duty 2).<sup>73</sup> We can have a strict duty to aid some people, but cannot choose to do so by harming others.<sup>33</sup> This was apparent in the hypothetical example in which the recovered patient was killed so that his organs could be transplanted into others. There the duty 1)

to refrain from killing was of such greater weight than the duty 2) to aid others that four were allowed to die rather than permit the killing of one. The greater stringency of this negative duty to avoid injury to others is not altered by those special circumstances in which, on grounds of human rights, it is not morally imperative to save a patient. Even then, if death occurs through killing rather than by allowing-to-die, it constitutes an act of injury.

The reason for this is that killing involves more than bringing a quick end to our organic lives. It deprives us of our own transition from life to death.<sup>2,41</sup> We are entitled to this on grounds of self-respect,<sup>70</sup> which involve a sense of our own human worth and also the will to fulfill our plan of life. Killing violates both facets of self-respect. It impinges on our sense of human worth by denying us the opportunity to carry on our own dying. Killing is, in effect, a final act of dehumanization. For these reasons, even in those special circumstances of intensive care in which the right to life is set aside with moral warrant, killing is not an acceptable way in which death can be allowed to come.

This does not mean that a death that is not brought about by killing is somehow guaranteed to be dignified<sup>64</sup> or free from suffering, grief, and anguish.<sup>14</sup> Nor does it mean that one's own dying must be fully experienced, no matter how grim. A person who is suffering or unconscious still is entitled to die his or her own death. When extreme pain may be involved, it is incumbent on the medical profession to live up to its claim to be capable of alleviating pain and also to avoid any treatment that would prolong death. Dying is more than a technical failure of modern medical science<sup>13</sup> that can be compensated for by a quick killing. It is the final event in the life of a valuable human being that no one else is morally empowered to initiate or transact. When a decision has been made that maximal treatment is inappropriate because the right to life has been overridden by other human rights or rendered nonfunctional by illness, it is not an acceptable ethical alternative to kill a patient, but it is permissible to allow that patient to die.

We have become so much more proficient at prolonging life that we are somewhat at a loss to know how to allow someone to die, even when we are convinced that this is the moral course to follow. The ethical teachings of several of the Western religious traditions have reached some general, although not unanimous, agreement<sup>42,58,65</sup> that it is necessary to use "ordinary" but not "extraordinary" means to support and comfort patients in such cases. Kelly<sup>45</sup> defines "ordinary" means as "all medications, treatments, and

operations which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience." "Extraordinary" means are those that do not offer such hope or cannot be obtained or used without these kinds of liabilities. Physicians and lawyers have agreed that intensive care that does not offer reasonable hope of patient benefit and that bears with it the kinds of grave inconveniences mentioned by Kelly constitutes extraordinary care.<sup>49,81</sup> Those measures that fall into the category of "ordinary" vary with the times and with the circumstances of an illness. Kelly states, in the case of a 90-year-old cardiorenal patient comatose for two weeks, "I believe that moralists would generally say that, though the use of glucose and digitalis would be ordinary means if it were a matter of tiding a patient over a temporary crisis, yet in the present case, the actual benefit they confer on the patient is so slight in comparison with the continued cost and difficulty of hospitalization and care that their use should be called an *extraordinary* means of preserving life."<sup>45</sup> It is consistent with this view to suggest that those means that will allow the critically ill patient with no reasonable hope of benefit from intensive care to die in comfort constitute ordinary means and should be the only ones employed.

The decision whether to give maximal treatment or to allow to die belongs to the individual human being involved, both morally and legally. Intensive care units have been chastized for being authoritarian<sup>82</sup> and for overlooking such patient choice.<sup>22</sup> These charges may be made without an awareness that the circumstances under which intensive care must be carried out make it difficult for the intensivist to determine patient preference. Often the patient in critical condition cannot communicate on initial admission. The patient may undergo fluctuating levels of consciousness and delirium related to the illness and may experience further mental disorientation due to the anxiety of being in a life-threatening situation.<sup>47</sup> These problems are exacerbated by the conditions under which intensive care must function. Such factors as lack of sleep (caused by checks for vital signs periodically), the inability to distinguish night from day (since lights are always on and there are often no windows), and the lessened capacity for movement (due to attached monitoring devices and the pain accompanying movement) further diminish the patient's autonomy. The whole ICU experience is extremely stressful physically and mentally to the patient. Even as we recognize these hindrances to informed consent by the critically ill, we must also emphasize that the intensivist has an obligation to

ascertain patient choice about alternatives involving significant risk whenever this is possible without psychological damage. The patient has the responsibility to weigh his or her rights and needs and to accept or decline forms of intensive care.

In those cases in which the patient is not competent or else is unable to communicate and in which the patient when competent and able to communicate never expressed a preference to the primary physician, left no written directions, and never told relatives of his or her wishes, all possible avenues of learning patient preference are closed to the intensivist. In such emergency situations, treatment can be instituted without patient consent.<sup>11,72</sup> Usually, maximal treatment will be initiated, for when there is doubt about patient desires, it is considered best to err on the side of life.<sup>52,72</sup> But we cannot assume that it is best to provide maximal intensive care in all situations. In the case of children, Smith<sup>87</sup> points out ". . . that what follows from the impossibility of consent is not an obligation to maximize length of life but an obligation to act in the best interest of the child." This also is relevant to adults whose wishes cannot be known, but whose rights and interests must be protected. In those special circumstances in which there is reasonable certainty that the patient cannot be returned to a state in which he or she will be able to exercise the rights to freedom of thought and action, the right to life can be set aside with moral justification and the patient allowed to die. In all other circumstances, the ethical presumption must be that it is best to treat.

At some institutions,<sup>14,59,61</sup> the decision-making process for patients unable to consent has been made less vague and diffuse with the help of committees that include some members who are not directly involved in the care of the patient. Such committees can promote a more complete and coherent analysis of the prognosis and treatment alternatives, foster communication among medical personnel and family, maximize support for the physician responsible for the final decision, and encourage a full exploration of the ethical questions that arise.<sup>14</sup> The psychological difficulties associated with ethically justifiable "disconnection" decisions<sup>48</sup> and those of problematic "connection" decisions are lessened by the process of open discussion. In view of growing concern that new legal precedents will be set by claims of "wrongful life" when extraordinary measures are carried out with what is considered insufficient justification,<sup>27,88</sup> such committees can help to develop humane and sensitive institutional guidelines for the care of the critically ill that will, in turn, promote sound legal decisions based on concern for human rights.

As more and more patients stand a chance of surviving due to developments in intensive care, the demand for admission to the ICU from within and without the hospital will gradually outstrip the availability of such resources as personnel, drugs, equipment, and money. With increasing frequency, extreme circumstances will arise in which all admitted critically ill patients are receiving appropriate care in the ICU or through special arrangements elsewhere in the hospital and additional medically salvageable critically ill patients will need intensive care. In such situations, the rights to life of individual human beings will conflict with each other tragically and the dilemma will have to be resolved by some equitable standards.

Rescher<sup>71</sup> has proposed that quasi-utilitarian factors must enter at the point where medical screening ends and there are still too many persons eligible for the utilization of scarce resources. He cites five elements that should enter the criteria of exclusion at this stage: A. the relative likelihood of successful treatment, B. the patient's life expectancy, C. the patient's family responsibilities, D. the potential future contributions of the patient to society, and E. the patient's past services to society. Rescher himself realizes the difficulties involved in applying social criteria C, D, and E. He asks, "How is one to develop sub-criteria for weighing the relative social contributions of (say) an architect or a librarian or a mother of young children?" In his approach to the problem, Rescher formulates principles for selection openly for all to weigh.

No such set of standards was announced by a lay selection committee for a Seattle dialysis unit in which there was limited space available for a large group of medically eligible patients.<sup>1</sup> Decisions to admit or to exclude patients were made *ad hoc* on the basis of such factors as experience in teaching Sunday school and comprehensiveness of life insurance coverage. The decisions of this committee were said to exclude "creative non-conformists who rub the bourgeoisie the wrong way but who historically have contributed so much to the making of America. The Pacific Northwest is no place for a Henry David Thoreau with bad kidneys."<sup>80</sup>

Others contend that in situations where human lives are at stake and not all can be saved, it is unethical to choose some to be saved and not others, as all human beings have an equal right to life. Cahn<sup>9</sup> believes that in such situations, all must die together unless some volunteer to sacrifice their lives to save others. Against this it is argued that it is irresponsible not to make a choice, as even one human life is too valuable to lose. On this opposing view, the only morally acceptable means of deciding is to use a lot-

tery or else a first-come, first-served basis.<sup>7,16,66</sup> In either of these ways, it is ensured that criteria extrinsic to the value of a person as a human being do not enter. Some such system of chance is said to be the only nondiscriminatory means of saving at least some lives.

There are tremendous problems that arise when social worth provides the basis of selection for potentially life-saving care,<sup>20,57,75,83</sup> as the right to life of the individual becomes relativized and subordinated to the fluctuating needs of society. Only when the survival of the society that guarantees human rights is itself at stake, as in wartime, is it justifiable to ground decisions on social worth. In an intensive care setting, however, it is not the survival of society, but that of individuals, that is at stake. Merit criteria, or standards based on particular qualities of individuals that are valuable, are also inappropriate in these situations, as all persons have a right to life regardless of desert. § Criteria of social worth or those of individual merit would, in addition, present an intolerable moral burden to the medical staff.

Yet a choice must be made. To allow all to die together is to make a choice—one that overrides the right to life of all. The equal value that we ascribe to all human beings means that each person has as strong a right to life as the next. To allow some to die so that others may have a chance for life on the basis of the throw of a die is to abrogate our responsibility to make a fair and reasoned choice.

The appropriate ground for the distribution of medical care is ill health,<sup>94</sup> not social worth, individual merit, or lottery. We are all equal in our random susceptibility to health crises.<sup>56</sup> Therefore, a medical criterion should provide the initial basis of selection for any medical care resource. This medical criterion can be refined by considering such factors as the kind and severity of illness, the relationship of the disease to other organic impairments, and the degree of reliability of the prognosis, with the objective of helping all critically ill patients in some way, given the limited resources. In future intensive care circumstances, however, when new discoveries will allow many more people in critical condition to be saved who are not salvageable today, and when intensive care resources will be limited in order to meet some of the equally urgent needs of other branches of health care, the medical criterion will not resolve all treatment questions for the intensivist. Inevitably, not all who would be able to benefit from full intensive care will be able to receive it.

One basic and overriding factor enters the decision

§ I omit considerations of capital punishment from this discussion.



about who is to receive intensive care at this stage. This is the principle cited earlier in relation to the duties following from the right to life, that our duty to aid some people cannot be carried out by harming others. There is a professional and moral relationship entered into with each patient already admitted to the ICU (or to some other hospital service in which special arrangements have been made for intensive care) in which it is understood that the patient will receive appropriate care. Such care cannot be terminated later on the grounds that another patient with a higher potential for survival needs intensive care without violating the original obligation to the admitted patient and without violating the ethical principle that we cannot aid some by harming others. Intensive care should be discontinued for an admitted patient in such future situations of scarcity only when its cessation is consonant with the medical needs of that patient and/or with considerations of human rights. On this recommendation, the basic medical criterion is supplemented by a space-available criterion to provide a fair means of selection.

The basic position running through this discussion of some of the ethical problems of intensive care is that human rights, and the right to life in particular, which provide basic protection for equally valuable human beings, in some special circumstances of critical illness can be best respected and served by foregoing heroic measures and allowing a patient to die. A major implication of this view is that we must reconsider what is meant by "potentially salvageable" when we define the goal of intensive care medicine as the treatment of those with life-threatening impairments who are potentially salvageable. Potential salvageability should involve more than the lack of evidence that survival will be accompanied by severe chronic brain failure. We can broaden our view of potential salvageability by realizing the possibility that under some special circumstances the right to life will be outweighed by other human rights and a patient therefore would be no longer potentially salvageable.

There is legitimate concern about whether intensive care and other expensive forms of medical care that meet a relatively small proportion of our general health needs can justify their continued support. The medical profession must address itself to the question of medical priorities and must be provided with a fair and balanced conception of the value of intensive care. This means that intensive care must be examined both in terms of its contribution to the support of individual lives and rights and also in terms of its necessity for general health care. A strong case can be made for intensive care units if it is clear that their individual guidelines are set within a general ethical framework that takes account of human rights,

and that such guidelines give careful consideration not only to the salvageability of patients, but also to their condition of salvageability. It is difficult to justify the admission and retention in intensive care units of patients whose needs and rights are not served by this care and who diminish the quality and quantity of care available to others. The intensivist has an obligation to ensure that there is no case in which the only "right" that remains to an intensive care patient is the right to utilize medical technology.

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