WHO WOKE THE SLEEPING FIREFIGHTER?*

*by Rory R. Olsen***

Introductory comment: Part One of this paper comes from a seminar on Guardianship Law sponsored by the Houston Bar Association in 2006 edited to make the paper more relevant. Part Two deals with changes that have occurred in our world since January 2006.

I. PART ONE

A. A True to Life Rip Van Winkle

On the third day of May 2005, a Buffalo, New York firefighter named Donald Herbert managed to make the news because he talked to his wife

* Thanks to Susan Fillion, Harris County Attorney's Office, for her able assistance in the initial writing of the paper. Additional thanks are given to James Conrad, Probate Court Number Three, for his editing and advice in the preparation of this paper. Additional gratitude is due to Mr. Allen Blakemore; Hon. Jack Cagle; my wife, Patricia Olsen; Douglas Samuels, MD; and James Wyckoff, Esq. for their comments and concerns.

** Judge, Probate Court Number Three, Harris County, Texas, Seventh Floor, Civil Courts Building, 201 Caroline Street, Houston, Texas 77002, Voice: 713/368-6730; Website: http://www.co.harris.tx.us/probate/Ct3/INDEX.HTM.

and four sons.[1] This event was newsworthy—not because Mr. Herbert was a man of few words—but because he had been in a coma for most of the previous decade.[2]

Herbert's family was overjoyed and medical science was surprised.[3] One medical doctor said, "It's almost unheard of after 10 years, but sometimes things do happen and people suddenly improve and we don't understand why."[4]

B. Welcome to the World of the DNR

The Herbert case illustrates many of the difficulties faced by both judges and practitioners forced to deal with DNR questions.[5]

1. Definition of Terms

Originally "DNR" stood for Do Not Resuscitate orders.[6] Over time, DNR has come to include more than actual orders not to resuscitate a patient.[7] The term DNR, in the context of this paper, refers to the limited circumstances in which the Harris County Guardianship Program files a motion seeking permission to either withdraw or withhold some form of medical treatment from one of its wards. Notwithstanding the broad grant of authority given to a guardian of the person under the Texas Probate Code section 767, the Harris County Guardianship Program is wise to seek judicial approval in these cases and is required to do so by law.[8]

The term DNR may also be used in this article to refer to those circumstances in which a guardianship is sought for someone having a severe medical condition, the facts and circumstances of which raise an end-of-life question. In addition, even if a guardianship is in place, sometimes a suit is brought to enjoin a guardian from withholding certain kinds of treatments or to remove the guardian because of these medical

---

1. CTV.ca News Staff, *Brain-Injured Fireman Breaks 10-Year Silence,* CTV NEWS, May 3, 2005, http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/1115133868434_110543068/?hub=TopStories.

2. *Id*.

3. *Id*.

4. *Id*. (quoting Dr. Rose Lynn Sherr of New York University Medical Center).

5. Edward F. McArdle, *New York's Do-Not-Resuscitate Law: Groundbreaking Protection of Patient Autonomy or a Physician's Right to Make Medical Futility Determinations?*, 6 DEPAUL J. HEALTH CARE L. 55, 57 (2002) (noting a current debate in states over whether to withdraw or withhold treatment when patient's wishes are unknown).

6. *Id*. at 56.

7. *Id*. DNR also includes "the power to consent to the withholding or withdrawal of the life-sustaining treatment." *Id*.

8. TEX. PROB. CODE ANN. § 767 (Vernon Supp. 2005).

decisions.[9] Litigation of these two types is not uncommon for judges exercising probate jurisdiction, wherever the judge is located.[10] Therefore the issues treated in this paper have wide applicability.

If a decision must be made on whether to withhold or withdraw treatment for a ward—who should make that decision?

Ideally, the incapacitated person should have a medical power of attorney or other sort of directive to his or her physician and other caregivers.[11] Unfortunately, not everyone does that.

If the patient fails to give clear directives, the family and friends of the patient are the next logical sources of information as to what the patient would want—and express—if the patient were able to speak.[12] Unfortunately, oftentimes no family or friends present themselves to provide information.[13] Or, if they come forward, they may express conflicting viewpoints.[14] In these situations, judges are asked to make the decisions.[15]

In the instance where the patient is a ward under a public guardianship program, should a nameless, unelected, public employee make these decisions in private? Or should an elected judicial officer make the decision in open court, after notice and hearing, in which competent counsel vigorously asserts the rights of the ward? To ask the question is to answer it. The public's confidence in our governmental institutions will be enhanced—or at least not damaged—if these decisions are made in open court with all the procedural protections afforded to the patient under the law.

2. First, the Good News

If you receive an appointment from Probate Court Number Three (or in any other court) to serve as an attorney *ad litem* in a DNR case, you should pat yourself on the back. If you receive a court appointment in a DNR case, rest assured that the court has seen you enough times to be comfortable with your abilities as a trial lawyer. You have also

---

9. *See, e.g., In re* Martin, 538 N.W.2d 399, 402 (Mich. 1995) (seeking to enjoin a guardian); American Bar Association, *Rights in Residential Facilities*, 19 MENTAL & PHYSICAL DISABILITY L. REP. 721, 723 (1995) (seeking removal of a guardian).

10. *See, e.g., In re* Guardianship of Barry, 445 So. 2d 365, 368 (Fla. Dist. Ct. App. 1984); *In re* Guardianship of Schiavo, 851 So. 2d 182, 183-86 (Fla. Dist. Ct. App. 2003).

11. Sebastian v. Grass Jr., *Estate Planning for a Family with a Special Needs Child*, 23 PROB. & PROP. 14, 16 (Aug. 2009).

12. *See, e.g.*, *Martin*, 538 N.W.2d at 402.

13. *See* Halderman v. Pennhurst State Sch. & Hosp., No. Civ. A. 74-1345, 1997 WL 835412, at *1 (E.D. Pa. 1997).

14. *See, e.g.*, *In re* Schiavo, 916 So. 2d 814, 815 (Fla. Dist. Ct. App. 2005).

15. *See, e.g.*, Conservatorship of Wendland, 26 Cal. 4th 519, 555 (Cal. 2001).

demonstrated to the court that you possess maturity, diligence, and tenacity sufficient to be entrusted with a matter of life and death—literally.

3. Now, the Bad News

If you receive an appointment from Probate Court Number Three (or another court) to serve as an attorney *ad litem* in a DNR case, you may also rest assured that the court expects you to give the DNR your highest priority because DNR motions need to be disposed of quickly—one way or another.

In preparing your case, you must remember that you may be the only thing standing between your client and the graveyard. While most DNR motions are granted, not all are. If you remember the case of Donald Herbert, the firefighter from Buffalo, New York cited above, you can understand better the awesome responsibility that is placed upon your shoulders.[16]

Not all lawyers are able to deal adequately with the pressures of a DNR case. If you receive an appointment in a DNR case and you do not feel comfortable with the area, please just let the court know. It will not be held against you. Over the years, the court has seen lawyers, who normally are as tenacious as Inspector Jaubert, fall apart in DNR cases. Others have dumped the file into the lap of an associate. If you decide that you are not up to taking a case of this sort, the court will respect your honesty and character in refusing to take the assignment.

4. The Court

Judges, rumors to the contrary notwithstanding, are often human beings. Like other human beings, judges like certain parts of the job much better than others. Judges rarely look forward to DNR cases. They are unpleasant matters that cause judges to have many sleepless nights. So, when you come to court on a DNR matter, the judge may not be in the best of moods. This is understandable. You can make your judge's life a little easier if you zealously represent your client's interests within the bounds of the law.

5. Imprecision of Medical Science

Medicine, as we all know, is part science and part art. "In fact, medicine remains more of an art than a science."[17] In DNR cases, medical practitioners are asked to render opinions that involve a certain degree of

16. *See supra* notes 1-6 and accompanying text.

17. ALAIN ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COSTS OF HEALTH CARE 4 (1980).

subjectivity.[18] As human beings, medical doctors occasionally make mistakes. Or sometimes, they fail to predict the future correctly as in the case of Don Herbert cited above.[19] This is understandable since physicians are not fortune tellers or psychics.

Another case which illustrates the inability of the medical profession to predict the future is the story of Dr. Mark Ragucci, who at the very young age of thirty-one was left paralyzed by a major stroke.[20] His doctor, who was the director of neurointensive care at Columbia, thought that there was no hope that he would ever recover, doomed to a life of total disability—if he survived at all.[21] A year later and much to the surprise of his doctors, Dr. Ragucci—except for speaking in a monotone voice and with limited use of his hands—had fully recovered.[22]

In DNR cases, an attorney *ad litem* should approach medical testimony with a healthy dose of skepticism, particularly when the testimony involves predicting the future.

Skepticism is also important in dealing with medical testimony that cloaks itself in the language of scientific certainty. The inherent imprecision of medical science is one of the factors that makes DNR hearings so difficult and painful for all involved.

C. Confusion About the Meaning of "Death"

Texas law reflects our society's overall confusion and discomfort with defining death as something other than the common sense definition: when the lungs stop breathing, the heart stops beating, and the body becomes very still and cold.[23]

For instance, section 671.001(a) of the Texas Health and Safety Code defines death to be "[W]hen, according to ordinary standards of medical practice, there is irreversible cessation of the person's spontaneous respiratory and circulatory functions."[24] This general rule seems simple enough. But, as with most things in the law, further complications await.

Section 671.001(b) of the Health and Safety Code changes the general rule to address the definition of death in a situation in which a person is receiving artificial life support:

---

18. *See* M. Elizabeth Breslin Stachura, *The Rhode Island Health Care Power of Attorney and the Living Will: A Comparative Overview*, 43 R.I. B.J. 15, 15 (May 1995).

19. *See supra* notes 1-6 and accompanying text.

20. Thomas M. Burton, *In a Stroke Patient, Doctor Sees Power of Brain to Recover*, WALL ST. J., Nov. 23, 2005, at A1.

21. *Id.*

22. *Id.*

23. *See* TEX. HEALTH & SAFETY CODE ANN. § 671.001(a)-(b) (Vernon 2003).

24. *Id.* at § 671.001(a).

> If artificial means of support preclude a determination that a person's spontaneous respiratory and circulatory functions have ceased, the person is dead when, in the announced opinion of a physician, according to ordinary standards of medical practice, there is irreversible cessation of all spontaneous brain function. Death occurs when the relevant functions cease.[25]

This definition of death fails to address the Karen Ann Quinlan situation, where the body keeps on going after the machines are turned off.[26] For those who cannot remember the decade of the 1970s, her situation was as follows:

> Karen Ann Quinlan was the first modern icon of the right-to-die debate. The 21-year-old Quinlan collapsed at a party after swallowing alcohol and the tranquilizer Valium on 14 April 1975. Doctors saved her life, but she suffered brain damage and lapsed into a "persistent vegetative state." Her family waged a much-publicized legal battle for the right to remove her life support machinery. They succeeded, but in a final twist, Quinlan kept breathing after the respirator was unplugged. She remained in a coma for almost 10 years in a New Jersey nursing home until her 1985 death.[27]

What exactly are we to do with a breathing human body that meets the definition of being dead? One student of the subject raises a truly awful problem with using the brain death definition:

> Another factor which could be advanced against a "cerebral" death criterion is a very practical and frightening one. It is the general and understandable revulsion at the prospect of burying or cremating a body in which respiration and circulation continue, even though cerebral function has irreversibly ceased. To do so would, at the very least, be an act of grave disrespect towards the body and the memory of the person concerned.[28]

The long-drawn-out death of the late Terri Schiavo is another example of the confusion caused by not knowing what really constitutes death.[29] If the late Mrs. Schiavo was truly brain dead and therefore legally dead under Florida law, why was her body kept locked up and guarded? If she was legally dead, what was the fuss about?

---

25. *Id*. at § 671.001(b).

26. M.L. Tina Stevens, *The Quinlan Case Revisited: A History of the Cultural Politics of Medicine and the Law*, 21 J. HEALTH POL. POL'Y & L. 347, 347 (1996).

27. Who 2, *Karen Ann Quinlan Biography*, http://www.who2.com/karenannquinlan.html (last visited Jan. 25, 2010).

28. Edward W. Keyserlingk, *The Quality of Life and Death*, *in* QUALITY OF LIFE: THE NEW MEDICAL DILEMMA 45 (James J. Walter & Thomas A. Shannon eds., 1990).

29. *See In re* Schiavo, 916 So. 2d 814, 815 (Fla. Dist. Ct. App. 2005).

We all know what the fuss was about. Statutes and judicial rulings notwithstanding, the notion of sending a breathing body to be buried or cremated is very jarring to most people. The concept seems more appropriate for the literary universes created in the writings of Edgar Allen Poe or Stephen King. As a society, we are truly uncomfortable and uncertain as to when and how death *really* occurs.

D. Medical Ethics in Transition

Adding to the already murky situation surrounding end-of-life issues, medical ethics have been in transition for some time.[30] For example, consider the classical rendition of the Hippocratic Oath:

> I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:
> To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art — if they desire to learn it — without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.
> I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.
> I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.
> I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.
> Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.
> What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.
> If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.[31]

---

30. *See* Edmund D. Pellegrino, *The Metamorphosis of Medical Ethics: A 30-Year Retrospective*, 269 J. AM. MED. ASS'N 1158 (1993).

31. THE HIPPOCRATIC OATH: TEXT, TRANSLATION, AND INTERPRETATION (Ludwig Edelstein trans., Johns Hopkins Press 1943), *available at* http://www.pbs.org/wgbh/nova/doctors/oath_classical.

Now consider the more recent version propounded by Dr. Louis Lasagna, Academic Dean of Tufts Medical School, in 1964:

> I swear to fulfill, to the best of my ability and judgment, this covenant:
> I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.
> I will apply, for the benefit of the sick, all measures [which] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.
> I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.
> I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
> I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.
> I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
> I will prevent disease whenever I can, for prevention is preferable to cure.
> I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.
> If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.[32]

While a detailed textual analysis of these two versions of the oath is far beyond the scope of this paper, please notice the difference in tone between the two versions. The classical version very clearly sets forth things to be done and things to be avoided.[33] The modern version is more humble and less certain, favoring ethical goals over definite things to be done and not done.[34] This transition in medical ethics reflects society's ethical confusions and uncertainty, particularly with respect to end-of-life issues.

---

html.

32. Louis Lasagna, *The Hippocratic Oath: Modern Version*, NOVA, June 8, 2005, http://www.pbs.org/wgbh/nova/doctors/oath_modern.html.

33. THE HIPPOCRATIC OATH: TEXT, TRANSLATION, AND INTERPRETATION, *supra* note 31.

34. Lasagna, *supra* note 32.

One medical doctor has described the situation as follows:

> [The traditional Western ethic] has always placed great emphasis on the intrinsic worth and equal value of every human life regardless of its stage or condition. . . . This traditional ethic is still clearly dominant, but there is much to suggest that *it is being eroded* at its core and may eventually be abandoned . . . . there is *quite new emphasis* on something which is beginning to be called the quality of life . . . It will become *necessary and acceptable* to place relative rather than absolute values on such things as human lives, the use of scarce resources and the various elements which are to make up the quality of life or of living which is to be sought.[35]

1. Philosophical Confusion

Dr. Lasagna's version of the Hippocratic Oath mentions both overtreatment and therapeutic nihilism, suggesting that these matters are to be avoided.[36]

Overtreatment, also known in academic circles as "vitalism," holds that human life is to be preserved at any cost.[37] The parents of the late Terri Schiavo and their supporters would fall into this camp.[38] This position is both emotionally appealing and intellectually clear and simple.

The opposite approach, known to academics as therapeutic nihilism, or medical pessimism, has a very long philosophical pedigree.[39] Originally, therapeutic nihilism referred to the 19th century European notion that aggressive medical treatment of most ailments was a waste of time and money, preferring instead to let nature run its course.[40]

Nihilism, as a philosophical approach to the universe, is often credited to Friedrich Nietzsche.[41] Nihilism is the belief that all values are baseless and that nothing can be known or communicated.[42]

With respect to the ill, Friedrich Nietzsche wrote:

> The *sickly* constitute the greatest danger to man: *not* the evil, *not* the 'predators'. Those who are from the outset victims, downtrodden, broken —they are the ones, the *weakest* are the ones who most undermine life

35. Keyserlingk, *supra* note 28, at 37.

36. *See* Lasagna, *supra* note 32.

37. Richard A. McCormick, *To Save or Let Die*, *in* QUALITY OF LIFE: THE NEW MEDICAL DILEMMA 30 (James J. Walter & Thomas A. Shannon eds., 1990).

38. *See In re* Schiavo, 916 So. 2d 814, 818 (Fla. Dist. Ct. App. 2005).

39. *See* McCormick, *supra* note 37, at 30.

40. Peter Morrell, *Therapeutic Nihilism*, Dec. 7, 2005, http://www.homeoint.org/morrell/articles/nihilism.htm.

41. *See* Alan Pratt, *Nihilism*, May 3, 2005, http://www.iep.utm.edu/nihilism/.

42. *Id.*

> among men, who most dangerously poison and question our trust in life, in man.[43]

Friedrich Nietzsche greatly influenced the thinking of the Nationalist Socialist Party in Germany in the previous century.[44] For instance, Adolph Hitler directed that Nietzsche's *Thus Spoke Zarathustra* be issued to every soldier in the Wehrmacht.[45] In 1959, William L. Shirer described Nietzsche's influence on the Third Reich:

> Yet I think no one who lived in the Third Reich could have failed to be impressed by Nietzsche's influence on it. His books might be full, as Santayana said, of "genial imbecility" and "boyish blasphemies." Yet Nazi scribblers never tired of extolling him. Hitler often visited the Nietzsche museum in Weimar and publicized his veneration for the philosopher by posing for photographs of himself staring in rapture at the bust of the great man.[46]

The Nazis acted upon Nietzsche's disdain for the sick:

> At the end of October, 1939, an order was officially promulgated by Hitler that "persons who, according to human judgment, are incurably ill may, upon the most serious evaluation of their medical condition, be accorded a mercy death" (Nürnberg, 1949-53). Six units were set up in which medical personnel carried out what came to be known as the "Euthanasia Program." This was, in effect, a program of mass murder, in which accurate medical diagnoses and humane considerations played no part (Dawidowicz, 1975, pp. 834-844). The killings, which had begun earlier in secrecy with mentally and physically impaired children, now engulfed adults who were ill or disabled. Ultimately, they consumed a wider range of people including those who were "*useless eaters,*" [emphasis added] Jews, Gypsies, foreigners, "deviants" of a conscientious nature, and those simply labeled as "undesirable" (Mitscherlich and Mielke, 1949; Krausnick, 1965; Gorlitz, 1960). Untold numbers of human beings were murdered before the termination of the Third Reich. They were killed on grounds that they were "devoid of value" and *unlebenswertig* or "unworthy of life" (Broszat, 1960).[47]

---

43. FRIEDRICH NIETZSCHE, ON THE GENEALOGY OF MORALS (Douglas Smith trans., Oxford University Press 1998) (1996).

44. *See The Influence of Nietzshe*, http://www.wsu.edu/~brians/hum_303/nietzsche.html (last visited Jan. 25, 2010.)

45. *Id*.

46. WILLIAM L. SHIRER, THE RISE AND FALL OF THE THIRD REICH: A HISTORY OF NAZI GERMANY 100 (Simon & Schuster, Inc. 1990) (1959).

47. Cynthia B. Cohen, "*Quality of Life" and the Analogy with the Nazis, in* QUALITY OF LIFE: THE NEW MEDICAL DILEMMA 62 (James J. Walter & Thomas A. Shannon eds., 1990).

Another source describes the Nazi euthanasia program thusly:

> The T4 Euthanasia Program was a Nazi German effort—framed as a euthanasia program—to kill incurably ill, physically or mentally disabled, emotionally distraught, and elderly people. Adolf Hitler initiated this program in 1939, and, while it was officially discontinued in 1941, killings continued covertly until the military defeat of Nazi Germany in 1945.
>
> In October 1939, Adolf Hitler empowered his personal physician and the chief of the Chancellery of the Führer to kill people considered unsuited to live. He backdated his order to September 1, 1939, the day World War II began, to give it the appearance of a wartime measure. In this directive, Dr. Karl Brandt and Chancellery chief Philipp Bouhler were "charged with responsibility for expanding the authority of physicians. . .so that patients considered incurable, according to the best available human judgment of their state of health, can be granted a mercy killing."
>
> Within a few months, the T4 Program--named for the Chancellery offices that directed it from the Berlin address Tiergartenstrasse 4—involved virtually the entire German psychiatric community. A new bureaucracy, headed by physicians, was established with a mandate to kill anyone deemed to have a "life unworthy of living." Some physicians active in the study of eugenics, who saw Nazism as "applied biology," enthusiastically endorsed this program. However, the criteria for inclusion in this program were not exclusively genetic, nor were they necessarily based on infirmity. An important criterion was economic. Nazi officials assigned people to this program largely based on their economic productivity. The Nazis referred to the program's victims as "burdensome lives" and "useless eaters."
>
> The program's directors ordered a survey of all psychiatric institutions, hospitals, and homes for chronically ill patients. At Tiergartenstrasse 4, medical experts reviewed forms sent by institutions throughout Germany but did not examine patients or read their medical records. Nevertheless, they had the power to decide life or death.
>
> While the program's personnel killed people at first by starvation and lethal injection, they later chose asphyxiation by poison gas as the preferred killing technique. Physicians oversaw gassings in chambers disguised as showers, using lethal gas provided by chemists. Program administrators established gas chambers at six killing centres in Germany and Austria: Hartheim, Sonnenstein, Grafeneck, Bernburg, Hadamar, and Brandenburg. The SS (Nazi paramilitary corps) staff in charge of the transports donned white coats to keep up the charade of a medical procedure. Program staff informed victims' families of the transfer to the killing centres. Visits, however, were not possible. The relatives then received condolence letters, falsified death certificates signed by physicians, and urns containing ashes.
>
> A few doctors protested. Some refused to fill out the requisite forms. The Roman Catholic church, which had not taken a stand on the "Jewish question," protested the "mercy killings." Count Clemens August von

> Galen, the bishop of Münster, openly challenged the regime, arguing that it was the duty of Christians to oppose the taking of human life even if this cost them their own lives.
>
> The transformation of physicians into killers took time and required the appearance of scientific justification. Soon after the Nazis came to power, the Bavarian minister of health proposed that psychopaths, the mentally retarded, and other "inferior" people be isolated and killed. "This policy has already been initiated at our concentration camps," he noted. A year later, authorities instructed mental institutions throughout the Reich to "neglect" their patients by withholding food and medical treatment.
>
> Pseudoscientific rationalizations for the killing of the "unworthy" were bolstered by economic considerations. According to bureaucratic calculations, the state could put funds that went to the care of criminals and the insane to better use[,] for example, in loans to newly married couples. Proponents for the program saw incurably sick children as a burden on the healthy body of the Volk, the German people. "Wartime is the best time for the elimination of the incurably ill," Hitler said.
>
> The murder of the handicapped was a precursor to the Holocaust. The killing centres to which the handicapped were transported were the antecedents of the extermination camps, and their organized transportation foreshadowed mass deportation. Some of the physicians who became specialists in the technology of cold-blooded murder in the late 1930s later staffed the death camps. They had long since lost all their moral, professional, and ethical inhibitions.
>
> Like the Judenrat ("Jewish Council") leaders during the Holocaust, psychiatrists were able to save some patients during the T4 Program, at least temporarily, but only if they cooperated in sending others to their death. The handicapped killing centres developed gas chambers like those later used at extermination camps. As the extermination camps did later, the handicapped killing centres installed ovens to dispose of dead bodies. The death camps that followed took the technology to a new level. The extermination camps could kill thousands at one time and burn their bodies within hours.
>
> On August 24, 1941, almost two years after the T4 Program was initiated, it appeared to cease. In fact, it had gone underground and continued covertly during the war years. While the program claimed over 70,000 victims during its two years of open operation, the killing centres murdered even more victims between the official conclusion of the program and the fall of the Nazi regime in 1945. The total number killed under the T4 Program, including this covert phase, may have reached 200,000 or more. The official conclusion of the T4 Program in 1941 also coincided with the escalation of the Holocaust, the culmination of Nazi programs to eliminate those deemed an embarrassment to the "master race." [48]

48. Michael Berenbaum, *T4 Euthanasia Program*, http://isurvived.org/t4-program.html (last visited Jan. 25, 2010).

In addition to killing those that it deemed to be unworthy of life, the Third Reich also involuntarily sterilized many other people that did not meet its criteria: including, but not limited to, those with mental deficiency, schizophrenics, depressed, deaf, blind, and alcoholic individuals.[49] A projected 410,000 people were sterilized.[50]

After World War II, twenty-three physicians and medical administrators were tried in the case of *U.S.A. v. Karl Brandt, et al*. for various medical misdeeds, including those described above.[51] The case is more commonly referred to as the "Doctors' Case."[52] The Harvard Law School Library, in its Nuremberg Trials Project, digitized and put documents from the various trials online.[53] In its summary of the indictments in the Doctors' Case, it describes part of what was alleged as follows:

> **Euthanasia**. September 1939 - April 1945. Involved the secret killing of the aged, insane, incurably ill, deformed children, and others, beginning at asylums in Germany and later in the camps and occupied territories. Charged against Blome, Brack, K. Brandt, and Hoven. Blome was acquitted; Brack, K. Brandt, and Hoven were convicted.[54]

Clearly, the concept of certain people being unlebenswertig is alien to the traditions of Western society, being a toxic mixture of therapeutic nihilism and philosophical nihilism.[55]

Between the Scylla of overtreatment and the Charybdis of therapeutic nihilism there is a middle course.[56] As one author describes the situation, traditional Judeo-Christian thought is that life is indeed a basic and precious good, but a good to be preserved to allow other goods to be attained.[57] Therefore, life is a relative good and the duty to preserve it must be weighed against the costs—both direct and opportunity—incurred in preserving it.[58] This position holds that while valuable, human life, in and

---

49. ROBERT J. LIFTON, THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE 25 (1986).

50. *Id*.

51. United Nations War Crimes Commission Reports, Case 1, tried by the United States Military Tribunal No. 1. Volume IV at 91-93 and Volume VII at 49-53, *available at* http://www.mazal.org/NMT-HOME.htm.

52. JEREMY BLACK, THE SECOND WORLD WAR: ALLIANCE POLITICS AND GRAND STRATEGY 403 (Ashgate Publ'g 2007).

53. Harvard Law School Library, *Introduction to NMT 1 U.S.A. v. Karl Brandt, et al.*, http://nuremberg.law.harvard.edu/php/docs_swi.php?DI=1&text=medical (last visited Jan. 25, 2010).

54. *Id*.

55. RICHARD A. MCCORMICK, TO SAVE OR LET DIE, QUALITY OF LIFE: THE NEW MEDICAL DILEMMA 30 (James J. Walter & Thomas A. Shannon eds., 1990).

56. *Id*.

57. *Id*.

58. *Id*.

of itself, is not the be all and end all of human existence.[59] This traditional position is well demonstrated in this excerpt from the Catechism of the Catholic Church:

> **Euthanasia**
>
> 2276 Those whose lives are diminished or weakened deserve special respect. Sick or handicapped persons should be helped to lead lives as normal as possible.
>
> 2277 Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. It is morally unacceptable . . . .
>
> 2278 Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.
>
> 2279 Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.[60]

Has our society abandoned the traditional approach to these questions? Until our society decides whether it has abandoned the traditional middle approach to health care and adopted therapeutic nihilism as its standard, everyone involved in making health care decisions for the incapacitated will be forced to operate in the midst of philosophical and ethical confusion. Until the broader question is resolved—if ever—for society as a whole, in DNR cases, lawyers and judges will be forced to operate in the "kultursmog" of the times, further confusing and complicating our professional lives.[61] Since these cases are personally troubling to the

---

59. McCormick, *supra* at 37.

60. THE CATHOLIC CHURCH, CATECHISM OF THE CATHOLIC CHURCH, 608 (U.S. Catholic Conference Edition, 1994).

61. *See* R. Emmett Tyrrell, *Global Warmists Caught Red-Handed*, THE AMERICAN SPECTATOR, Nov. 25, 2009, http://spectator.org/archives/2009/11/25/global-warmists-caught-red-han (defining kultursmog).

participants in the decision making process, confusion as to the accepted standards to be applied makes the situation more difficult for all involved.

E. Reality Check

One of the more beneficial aspects of the DNR process is that by having to come to court and explain his or her thinking to someone not sharing the common assumptions and language of the medical community, a physician is forced to undergo a reality check. [62] If you are unable to explain adequately your position to someone out of your area of expertise, it may be because of linguistic difficulties. It may be because of the jargon of your profession masks confused thinking. For example, a physician might be able to tell a colleague with a straight face that performing a life-saving procedure on a dying patient would not be in the patient's best interests, but a statement like that will not go unchallenged in court. There may be reasons why the procedure should not be performed that need to be weighed against the benefits of the procedure, but saying that death is in someone's best interest will not—and should not—pass unchallenged.

F. Quality of Life

The concept of quality of life originated as an attempt to quantify and evaluate proposed public policy decisions.[63] For example, if an island nation located near the United States were to contemplate legalizing gambling as a way of bringing additional tourist revenue, the anticipated economic benefits and costs could be quantified readily. However, the intangible costs, such as the loss of a peaceful existence, additional traffic, and crime would also need to be considered. By assigning a numerical value to the intangible costs, an analyst could add these factors into the calculations. Of necessity, any numerical value assigned to intangible costs or benefits must be subjective—and therefore subject to dispute.[64]

From these humble beginnings, the phrase, quality of life, has caught on and become very popular in our culture, even though it has a subjective meaning. For example, "In the Windy City, administrative tribunals that Chicago's mayor refers to as 'quality of life' courts handle city nuisance cases . . . ."[65]

---

62. Probate Court Number Three's official position is that seeking to end a person's life is such an important matter that it calls for live (non-telephonic) expert testimony.

63. Personal conversation with Dr. Marianne Constable, Dep't of Rhetoric Chair, Univ. of Cal., Berkeley.

64. *See Calvert-Henderson Quality of Life Indicators,* http://www.calvert-henderson.com (website describing the use of quality of life as a policy analysis tool) (last visited Mar. 21, 2010).

65. Geoffrey Gagnon, *City of Blight: Detroit's New Weapon in Its War on Eyesores*, LEGAL AFFAIRS, July-Aug. 2005 at 8, 9.

Medical science is also interested in this area.[66] However, the methodologies currently available to clinicians to assess quality of life are all highly subjective.[67] Further, there does not seem to be a generally recognized test to measure quality of life. Consequently, any medical testimony that concerns the withholding or withdrawing of treatment based upon a poor quality of life is highly suspect. So, if counsel performs an adequate job of cross-examining a medical expert on the subject of quality of life, they will likely discover that the expert's quality of life assessment is nothing more than the doctor's personal views hidden behind a veil of science.

To illustrate this point, this author heard a DNR application concerning a ward in a guardianship proceeding on the court's docket. The case is illustrative of the extremes to which some will take the notion of withholding treatment.

The ward was in his early twenties. Life had not been kind to the young man, since he was mildly retarded and also suffered from a mental disorder that was treated with psychotropic medication. In addition to his retardation and mental illness, the young man also suffered from a congenital medical condition that made him susceptible to pneumonia. Several bouts of pneumonia hospitalized the young man the year before the hearing. The application requested permission to deny him antibiotics when he had his next bout of pneumonia.

The driving force behind the application was the physician who was treating him, an internist in her early thirties. On direct examination, the doctor testified that upon the ward's next hospitalization for pneumonia it would be best to deny him antibiotics. The doctor wanted the patient to receive palliative care only. When asked why the doctor wanted this authority, the young physician testified curtly that her patient had an insufficient quality of life to justify further treatment.

Needless to say, the cross-examination of this young doctor was not a pretty thing to watch. The doctor was shocked to discover that lawyers can play rough on cross-examination. Still, despite a strenuous cross-examination, she stuck to her desire to deny her patient antibiotics the next time the patient was suffering from pneumonia.

The denial of the application surprised the physician even more. Had the doctor been paying attention to the social dynamics of the courtroom, particularly the expression on the faces of the court reporter, the bailiff, the

66. *See* American Thoracic Society, http://www.thoracic.org (last visited Feb. 11, 2010). The American Thoracic Society maintains a very useful website that explains patient oriented quality of life measurements. *Id.* Additionally, the Health Measurement Research Group sets forth a questionnaire to be used by clinicians in evaluating the quality of life of patients affected by various breathing related disorders, and how proposed courses of treatment will impact upon the perceived quality of life. Health Measurement Research Group, QWB-SA, http://healthmeasurement.org/pub_pdfs/_QUESTIONNAIRE_QWB-SA,%20version%201.04.pdf (last visited Jan. 25, 2010).

67. *See Calvert-Henderson Quality of Life Indicators*, *supra* note 64.

clerk, the staff attorney, and the several law student interns in court, she might have guessed that she had not managed to persuade anyone that it was necessary to deny the ward antibiotics in the future.

The author's personal reaction to her testimony, although hidden behind his usual poker face, was quite strong. As she was reiterating her position on cross-examination, the author started to get the mental image of the Herr Major Strasser and his fellow officers in the movie, *Casablanca*, standing together by a piano singing the old Prussian song, *Die Wacht am Rhein*, because the physician's attitude was redolent of the Third Reich, not the United States of America.[68]

The author's second reaction was that he did not want this physician anywhere near him or near anyone dear to him under any circumstances, but particularly under any medical circumstances.

The author's third reaction was wonderment that someone with these beliefs managed to make it through medical school. That idea did not last long when the author remembered how poorly law schools screen their students for tendencies towards unlawful or unethical behavior. The legal profession has its set of problems and the medical community has its own.

The author's final reaction that afternoon was one of indignity. It would seem that the young physician thought either that the court system was not too bright or held human life in low esteem. Whatever the explanation, indignity was an appropriate response.

 [69]

That night the author had more trouble going to sleep than usual. He tossed and turned for a while and finally got up and went outside on the patio to think about the day's events. After a while he decided that the

68. CASABLANCA (Warner Bros. 1942); *see* CASABLANCA: ORIGINAL MOTION PICTURE SOUNDTRACK, *Die Wacht am Rhein/La Marseillaise* (Rhino/WEA) (Oct. 14, 1997).

69. CASABLANCA, *supra* note 68.

physician was probably neither insane nor evil. Rather, she was probably just attempting to act upon the prevailing ethos of the practice of medicine that she was taught during medical school and her residency.

The author was saddened to think about how the practice of medicine has degenerated during his lifetime. His late mother was a physician—a very dedicated one. If she lost a patient on the operating table, she would be very sad for days or weeks. Anyone who knew her knew that she cared deeply about her patients and tried to keep them alive and well as long as medical science would permit her to do so.

As he sat on the patio, he decided that if young physicians are being taught nowadays that it is permissible to advocate for the death of their patients—not because the patient was in intense agony and at death's door—but because the patient did not meet their criteria for having a quality life—it might be just as well that his mother was no longer alive. This change in the practice of medicine would have broken her heart because when she studied medicine, the physician was oftentimes the patient's last best friend.

Ever since *Daubert*, trial judges have been called upon to act as gatekeepers, by keeping junk science out of cases.[70] Is the testimony of a physician with respect to a patient's quality of life admissible? Or, is the testimony junk science?

It would seem that a physician's testimony regarding the quality of life of an individual exceeds their expertise. Why? Such testimony does not meet any of the three criteria for an expert as set forth in Texas Rule of Evidence 702.[71] The rule states:

> If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.[72]

So to pass muster as being expert in nature, testimony must be either: (1) scientific; (2) technical; or (3) specialized.[73]

---

70. Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579 (1993); Kumho Tire Co. v. Carmichael, 526 U.S. 137 (1999); E.I. du Pont de Nemours & Co. v. Robinson, 923 S.W.2d 549 (Tex.1995); Merrell Dow Pharm., Inc. v. Havner, 953 S.W.2d 706 (Tex. 1997); Gammill v. Jack Williams Chevrolet, Inc., 972 S.W.2d 713 (Tex. 1998); Volkswagen of Am., Inc. v. Ramirez, 159 S.W.3d 897 (Tex. 2004); Allison v. Fire Ins. Exch., 98 S.W.3d 227 (Tex. App.—Austin 2002); Dudley v. State, 58 S.W.3d 296 (Tex. App.—Beaumont 2001); Franco v. State, 25 S.W.3d 26 (Tex. App.—El Paso 2000).

71. *See* TEX. R. EVID. 702.

72. *Id.*

73. *See id.*

Testimony with respect to a patient's quality of life is neither. It is not scientific because, broadly defined, the testimony of a practitioner, while learned, is not science, *per se*:

> **Scientific method** refers to a body of techniques for investigating phenomena, acquiring new knowledge, or correcting and integrating previous knowledge. To be termed scientific, a method of inquiry must be based on gathering observable, empirical and measurable evidence subject to specific principles of reasoning. A scientific method consists of the collection of data through observation and experimentation, and the formulation and testing of hypotheses.[74]

According to Karl Popper, the well regarded philosopher of science, something is "scientific" if it is falsifiable, that is, if someone can prove an idea wrong through further observation or experimentation.[75] Clearly, something as inherently subjective as a measurement of "quality of life" is not falsifiable, since there is no objective standard upon which to base a decision.

Is it technical? Based upon the common usage of the term technical, it would appear not.[76] There is no art, science, specialized body of learning, or technique that makes one person more adept at judging the quality of another human being's life than any other person. Actuaries, bakers, butchers, candle stick makers, lawyers, medical doctors, poets, rodeo clowns, sociologists, and street sweepers all have the same abilities in that regard.

Is "quality of life" testimony by a physician specialized? It would seem that the correct answer is in the negative, because as used in this context, specialized is used as the antonym of "particular."[77]

I submit until there is a scientific, validated test for quality of life—or at least a generally accepted test for measuring it—medical testimony with respect to a patient's quality of life is beyond the expertise of a medical practitioner, or anyone else for that matter. If and when a test is developed and accepted, who should apply it? There is nothing unique in the education, training, or professional experiences of a physician that would

---

74. Wikipedia, *Scientific Method*, http://en.wikipedia.org/wiki/Scientific_method (last visited Jan. 25, 2010) (citing to ISAAC NEWTON, PHILOSOPHIAE NATURALIS PRINCIPIA MATHEMATICA 794-96 (I. Bernard Cohen & Anne Whitman, eds., University of California Press 1999) (1726)); MERRIAM – WEBSTER'S DICTIONARY, *available at* http://www.merriam-webster.com/dictionary/scientific% 20method).

75. *See generally* KARL POPPER, THE LOGIC OF SCIENTIFIC DISCOVERY 56 (Basic Books 1959) (setting forth the premise of falsification).

76. *See* Dictionary.com, *Technical*, http://dictionary.reference.com/browse/technical (last visited Jan. 25, 2010).

77. *See* Dictionary.com, *Specialized*, http://dictionary.reference.com/browse/specialized (last visited Jan. 25, 2010).

make a physician any more or less able to testify about the quality of someone's life than any other sane, competent adult.

The biggest problem with these subjective determinations of quality of life is that no one has either the right or the ability to judge the quality of another's life. For example, early members of the baby boom generation can remember the Simon & Garfunkel song, *Richard Cory*, which was based on the poem of the same name by Edward Arlington Robinson:

RICHARD CORY
WHENEVER Richard Cory went down town,
We people on the pavement looked at him:
He was a gentleman from sole to crown,
Clean favored, and imperially slim.

And he was always quietly arrayed,
And he was always human when he talked;
But still he fluttered pulses when he said,
"Good-morning," and he glittered when he walked.

And he was rich—yes, richer than a king—
And admirably schooled in every grace:
In fine, we thought that he was everything
To make us wish that we were in his place.
So on we worked, and waited for the light,
And went without the meat, and cursed the bread;
And Richard Cory, one calm summer night,
Went home and put a bullet through his head.[78]

If someone unfamiliar with the apparent personal agony that the character in the poem *Richard Cory* suffered from was asked to assess Richard Cory's quality of life, all the objective indices would suggest a very satisfying quality of life, as was assessed by the narrator of the poem. That assessment would be both subjective and wrong.

Consider another example: A young man was born into a poor household. His father, an alcoholic, beat him mercilessly. His mother died when he was a teenager. His father died a few years later. The young man supported his siblings through various musical activities—mostly piano playing. In his early thirties, his hearing began to fail. Shortly afterwards, he began to show signs of what we now call a mood disorder—most likely bipolar disorder.[79] He engaged in bitter legal disputes with family

78. EDWARD ARLINGTON ROBINSON, *Richard Cory*, *in* COLLECTED POEMS (1921), *available at* http://www.bartleby.com/233/211.html (last visited Jan. 25, 2010).

79. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 345-46 (4th ed. text rev. 2000).

members, causing him to be socially isolated from his family. Although involved with numerous women, the man was never able to marry. By the end of his career at age fifty-three, he was totally deaf. He died a few years later from liver disease caused by his heavy drinking.

By any objective assessment, the musician described in the previous paragraph had a very low quality of life at the end of his career. Yet at age fifty-three, though he may have been deaf and half-mad, Ludwig von Beethoven, having overcome his many trials and tribulations, triumphed to see the performance of his Ninth Symphony:

> Despite his deafness, Beethoven insisted on conducting, but unknown to him the real conductor sat out of his sight beating time. As the last movement ended, Beethoven, unaware even that the music had ceased, was also unaware of the tremendous burst of applause that greeted it. One of the singers took him by the arm and turned him around so that he might actually see the ovation.[80]

Please remember these two examples the next time you hear someone telling you that someone else has no quality of life. The response to the Ninth Symphony must have been the highlight of Beethoven's life, his many personal problems notwithstanding.

II. PART TWO

A. Health Care Reform

As this paper is being written, the debate concerning President Obama's healthcare proposals is ongoing.[81] Lacking a crystal ball, the author is writing under the assumption that a drastically scaled back proposal will eventually be passed. However, the debate over the various proposals has had several salutary effects, regardless of the final outcome of the various bills.[82]

The first and greatest salutary effect of the discussions of the healthcare proposals is a strong statement by a large segment of the population that it does not want the federal government to have the power—either directly or indirectly—to decide who lives and who dies.[83]

---

80. Beethoven: The Immortal, http://www.lucare.com/immortal/after.html (last visited Jan. 25, 2010).

81. *See, e.g.*, The White House, http://www.whitehouse.gov/issues/health-care. *See also* Health Reform.gov, http://www.health reform.gov (showing government sponsored website displaying information on the health care debates).

82. *See infra* notes 83-92 and accompanying text.

83. *See* Sarah Palin, *Obama and the Bureaucratization of Health Care*, WALL ST. J., Sept. 8, 2009, at A23, *available at* http://online.wsj.com/article/SB10001424052970203440104574400581157986024.html.

Remember the infamous "death panels"? The fear of government control over our lives was in my opinion, the motivating factor behind the controversy.[84] Anyone who has ever dealt with the I.R.S. or the U.S. Postal Service must feel more than a twinge of discomfort at the thought of federal bureaucrats deciding who will live and who will die—either directly or through budgetary decisions that will determine what drugs, treatments, and procedures will be available versus those that will not be cost effective.[85] Giving the federal government control over what resources will be expended upon the sick gives the federal government life and death power over us all.[86]

The judgment as to whether fears of federal budgetary control over healthcare are grounded in reality—or not—seems to reflect one's view of the federal government and its role in modern society. If you disagree with President Reagan that the nine most feared words in the English language are "I'm from the government and I'm here to help," you should have no problem with a low level federal bureaucrat determining whether you or an ailing loved one receives a modern, expensive treatment.[87] If you think that President Reagan was right, then you are apt to be more skeptical of claims that government run health care will improve your life.

The second salutary effect of the discussion of health care engendered by the Obama health care proposals is that it has made it more acceptable to talk about certain things that previously were removed from polite discussion.[88] One of these previously taboo topics is quality of life.[89]

While the debate about the Obama health care plans was raging during the summer of 2009, someone raised a question as to whether the federal government was already engaged in "death counseling" in U.S. Department of Veterans Affairs (V.A.) run hospitals.[90] A booklet allegedly distributed to patients at V.A. hospitals, entitled *Your Life, Your Choices* became the subject of public scrutiny for a few days in August, 2009.[91] The media's

---

84. *See id*.

85. *See id*.

86. Michelle Malkin, *Death Panels? What Death Panels? Oh, those death panels*, MICHELLE MALKIN, August. 9, 2009, http://michellemalkin.com/2009/08/09/death-panels-what-death-panels-oh-those-death-panels/. This internet article displays links to other web pages that detail what life is like under single payor systems in other countries. *Id*.

87. Daniel Kurtzman, *Ronald Reagan Quotes*, ABOUT.COM, http://politicalhumor.about.com/cs/quotethis/a/reaganquotes.htm (last visited Jan. 25, 2010).

88. *See, e.g.*, Jonathan Cohn, *Obama Starts a Grown-up Discussion of Health Care*, THE NEW REPUBLIC, Apr. 29, 2009, http://www.tnr.com/blog/the-treatment/obama-starts-grown-discussion-health-care (describing a discussion between President Obama and New York Times writer, Leonhardt, about new topics in health care, including end-of-life care and quality of life).

89. *See id*.

90. *See, e.g.*, *Fox News Sunday with Chris Wallace: 'Death Book' Debate* (Fox News Broadcase Aug. 23, 2009), transcript *available at* http://www.foxnews.com/story/0,2933,541820,00.html (explaining the controversial pamphlet and its use in V.A. hospitals).

91. *See id*.

description of a "death book for veterans" piqued the author's interest.[92] The author found the booklet online at a V.A. hospital's web site. He was able to download and save the PDF file of the booklet; however, the booklet was no longer made available at the V.A. hospital's URL. The author did find another website, as of October 2009, where the booklet could be downloaded.[93]

One Saturday afternoon the author read the booklet carefully. He found it unsettling for a number of reasons.

First, the author, who was set to turn sixty in a few weeks, discovered that as he has begun to age, the subjects of death, disability, or serious illness are much less abstractions and much more real. The author confesses that he is only human and that the subjects treated in the booklet might have only been of an academic interest to him a decade or so ago.

Second, the full title of the booklet is *Your Life, Your Choices.*[94] The subtitle of the document is *Planning for Future Medical Decisions: How to Prepare a Personalized Living Will*.[95] The authors of the booklet, in the order that they are listed on the title page of the booklet, are: Robert Pearlman, MD, MPH; Helene Starks, MPH; Kevin Cain, PhD; William Cole, PhD; David Rosengren, PhD; and Donald Patrick, PhD, MSPH.[96] The absence of the initials, JD, after the names of any of the authors of the booklet is disturbing because the booklet deals with a legal subject and it ignores the legal aspects of making end-of-life decisions.[97]

Third, this author could see the booklet leading to more harm than good for some patients. A patient's psychological condition is a major determinant of how rapidly the patient will heal after surgery.[98] Can you think of anything less calculated to uplift a patient's mood and convince him or her that the ultimate outcome of the treatment or procedure will be favorable and that he or she will return back home to his or her normal life and routine than a turgid booklet talking about such cheery topics as:

---

92. "Your Life, Your Choices" Death Book for Veterans by Any Other Name, http://paxalles.blogs.com/paxalles/2009/08/your-life-your-choices-death-book-for-veterans-by-any-other-name.html (Aug. 23, 2009).

93. ROBERT PEARLMAN ET AL., YOUR LIFE YOUR CHOICES (2009), http://www.rihlp.org/pubs/Your_life_your_choices.pdf.

94. *Id*.

95. *Id*.

96. *Id*.

97. *Id*.

98. Phillip T. Marucha et al., *Mucosal Wound Healing is Impaired by Examination Stress*, 60 J. BIOETHICAL MED. 362, 364 (1998) *available at* http://www.psychosomaticmedicine.org/cgi/content/abstract/60/3/362; *see also* Marie Johnston and Claus Vögele, *Benefits of Psychological Preparation for Surgery: A Meta-Analysis*, Annals Behav. Med., 1993, 245, 250, *available at* http://www.abdn.ac.uk/healthpsychology/publications/MJohnston_pubs/journal_articles/1993AnnalsofBehavioralMedicine.pdf (showing that patients who prepared for surgery benefited during recovery).

1. What makes my life worth living?
2. How would you like to spend your last days?
3. Organ donation and autopsy.
4. Burial arrangements.
5. Funeral or memorial services.
6. Coma.
7. Dementia.
8. Serious stroke.
9. Terminal illness.
10. Kidney dialysis.
11. CPR—Cardiopulmonary Resuscitation.
12. Feeding tubes.
13. Mechanical ventilators (breathing machines).
14. Hospice and palliative care.[99]

As far as the author knows, right now, he is as healthy as a horse, feeling well and in good spirits—until he just finished reciting the topics above which seem to be a modern day analog to the sufferings of Job in the Old Testament. Can you imagine the profoundly negative effect that reading a booklet of this nature would have on an older, unsophisticated patient in pain, on medication and awaiting surgery—or the patient's family? All these topics deserve serious, sober consideration by all of us, but not when we are ill or awaiting surgery.

Why would the VA have prepared and distributed this booklet? I do not know, but I am sure that if the booklet is only distributed to the very sick, the reason for doing so would not be to raise the spirits and enhance the chances of recovery of the patient.

Fourth, the most disturbing aspect of the booklet is the "What Makes Your Life Worth Living?" questionnaire on page 21.[100] Those filling out the questionnaire on page 21 are asked to put a check in one of four columns for each of the disabilities enumerated below.[101] The four columns are labeled as follows:

1. difficult, but acceptable;
2. worth living, but just barely;
3. not worth living; and,
4. can't answer now.[102]

99. *See* Pearlman, *supra* note 93, at 3-4.
100. *Id.* at 21.
101. *Id.*
102. *Id.*

The disabilities listed on the questionnaire are:

a. I can no longer walk but get around in a wheelchair.
b. I can no longer get outside—I spend all day at home.
c. I can no longer contribute to my family's well being.
d. I am in severe pain most of the time.
e. I have severe discomfort most of the time (such as nausea, diarrhea, or shortness of breath).
f. I rely on a feeding tube to keep me alive.
g. I rely on a kidney dialysis machine to keep me alive.
h. I rely on a breathing machine to keep me alive.
i. I need someone to help take care of me all of [the] time.
j. I can no longer control my bladder.
k. I can no longer control my bowels.
l. I live in a nursing home.
m. I can no longer think clearly—I am confused all the time.
n. I can no longer recognize family/friends[.]
o. I can no longer talk and be understood by others.
p. My situation causes severe emotional burden for my family (such as feeling worried or stressed all the time).
q. I am a severe financial burden on my family.
r. I cannot seem to "shake the blues."
s. Other (write in).[103]

These issues should be discussed with a trained professional. Reading about them in a booklet while you are ill and not thinking clearly could open the door to depressed feelings and thoughts of suicide. Regardless of the authors' intentions, the questionnaire could have a negative effect on many people who are either in the hospital or suffering from a critical health condition. It is likely that reading the questionnaire will not elevate a patient's mood, due to the depressing list of ailments, with no counter-balancing optimism.

The author does not like the booklet, nor does he like the philosophical outlook behind the booklet. The implicit message contained in the booklet —particularly the questionnaire—is that if you are old and sick, it is okay to give up on life, since life is not worth living. The message is morbid and pessimistic.

The final salutary effect of the discussion of the various health care proposals is that the public was given an opportunity to learn about changes in medical thinking. For most non-medical types—to the extent that we even begin to think about medical ethics and the philosophies underlying the practice of medicine—all we know is "*primum non nocere*" which

103. *Id.*

translates as "first do no harm."[104] However, sometimes simple maxims fail to fully express the complexities of the subject.

Former Congressman Rahm Emanuel is the current chief of staff for President Obama.[105] His older brother, Ezekiel Emanuel, is a man of many accomplishments, including an M.D. and a Ph.D. from Harvard.[106] Dr. Emanuel is regarded as a leading bioethicist, having written a book entitled, *The Ends of Human Life: Medical Ethics in a Liberal Polity*.[107] He is also a member of the Obama administration and serves as a "special adviser to the budget director, Peter R. Orszag."[108]

Over the summer of 2009, Dr. Emanuel became part of the controversy surrounding the Obama healthcare plans when Columbia Ph.D. and former Lieutenant Governor of the Empire State, Betsy McCaughey, wrote a piece which appeared in *The Wall Street Journal*, attacking Dr. Emanuel and his influence on the health care plans of the administration.[109] Governor McCaughey did not pull any punches in her article.[110] The first paragraph sums up her theme quite well:

> Dr. Ezekiel Emanuel, health adviser to President Barack Obama, is under scrutiny. As a bioethicist, he has written extensively about who should get medical care, who should decide, and whose life is worth saving. Dr. Emanuel is part of a school of thought that redefines a physician's duty, insisting that it includes working for the greater good of society instead of focusing only on a patient's needs. Many physicians find that view dangerous, and most Americans are likely to agree.[111]

Further in the article, she writes the following:

> True reform, he argues, must include redefining doctors' ethical obligations. In the June 18, 2008, issue of JAMA, Dr. Emanuel blames the Hippocratic Oath for the "overuse" of medical care: "Medical school education and post graduate education emphasize thoroughness," he writes. "This culture is further reinforced by a unique understanding of professional obligations, specifically the Hippocratic Oath's admonition to 'use my power to help the sick to the best of my ability and judgment' as

---

104. Medicinenet.com, http://www.medterms.com/script/main/art.asp?articlekey=6110 (last visited Jan. 25, 2010).

105. Robert Pear, *A Hard-Charging Doctor on Obama's Team*, N.Y. TIMES, April 18, 2009, at A14, *available at* http://www.nytimes.com/2009/04/18/us/politics/18zeke.html.

106. *Id*.

107. National Institutes of Health, The Department of Bioethics, Our People, http://www.bioethics.nih.gov/people/emanuel-bio.shtml (last visited Jan. 23, 2010).

108. *See* Pear, *supra* note 105.

109. *See* Betsy McCaughey, *Obama's Health Rationer-in-Chief*, WALL ST. J., Aug. 27, 2009, at A15, *available at* http://online.wsj.com/article/SB10001424052970203706604574374463280098676.html.

110. *See id*.

111. *Id*.

> an imperative to do everything for the patient regardless of cost or effect on others."
>
> In numerous writings, Dr. Emanuel chastises physicians for thinking only about their own patient's needs. He describes it as an intractable problem: "Patients were to receive whatever services they needed, regardless of its cost. Reasoning based on cost has been strenuously resisted; it violated the Hippocratic Oath, was associated with rationing, and derided as putting a price on life. . . . Indeed, many physicians were willing to lie to get patients what they needed from insurance companies that were trying to hold down costs."
>
> Of course, patients hope their doctors will have that single-minded devotion. But Dr. Emanuel believes doctors should serve two masters, the patient and society, and that medical students should be trained "to provide socially sustainable, cost-effective care." One sign of progress he sees: "the progression in end-of-life care mentality from 'do everything' to more palliative care shows that change in physician norms and practices is possible."[112]

Unsurprisingly, Dr. Emanuel does not agree with Dr. McCaughey's assessment of his work and his philosophical positions.[113]

Refereeing an intellectual dispute between two Ivy League Ph.D. holders is beyond the author's pay grade, so he will let others ascertain whether Dr. McCaughey's analysis of Dr. Emanuel's writings is fair and accurate or not.

What is relevant to the discussion at hand is a comment that was made in a very pro-Dr. Emanuel piece in *Time* magazine by Michael Scherer:

> But in a country where trust is in short supply, Emanuel has become a proxy for all the worst fears of government efforts to rein in costs by denying care. "The fundamental danger is that the American people are being asked to delegate all these life-influencing decisions," explains Betsy McCaughey, the conservative scholar who wrote the New York *Post* attack on Emanuel. "There is a lack of transparency here."[114]

III. CONCLUSION

While no sane person—and certainly not this author—is suggesting that the federal government is proposing anything like euthanasia or a revival of the T4 program, there are legitimate issues that need to be discussed, such as the following:

---

112. *Id.*

113. Michael Scherer, *Ezekiel Emanuel, Obama's 'Deadly Doctor,' Strikes Back,* TIME, Aug. 23, 2009, http://www.time.com/time/nation/article/0,8599,1915835,00.html.

114. *Id.*

1. Is the physician's responsibility only to his or her patient, or should the physician also look to the overall social good?
2. If we give the federal government the power to decide who receives certain kinds of medical treatments and how much can be spent on treating them, are we not delegating life and death decisions to the federal government? If the federal government holds the ultimate power of life and death over the citizenry, will we have ceased to be free people?
3. Who should make the decisions concerning the allocation (rationing) of health care resources—bureaucrats, elected officials, judges?

In a free society, such subjects need to be debated freely and openly with no arbitrary time limits imposed upon the debate. If given sufficient time, maybe a consensus will develop; or maybe it will not. Whatever happens, these issues are now under discussion at levels of society, which is how it should be!

IV. APPENDIX "A"

GUIDELINES FOR ATTORNEYS AD LITEM IN DNR CASES.

1. As the Attorney Ad Litem you are appointed to represent and advocate on behalf of the ward. TEX. PROB. CODE ANN. § 601 (Vernon Supp. 2005).
2. Upon appointment, review the Order appointing you as the Attorney Ad Litem. The Order should authorize that you have access to all of the relevant medical records of your client in accordance with the Health Insurance Portability and Accountability Act. Typical language is:

   > IT IS ORDERED that the Attorney Ad Litem is to be given access to all of the Proposed Ward's financial, medical, psychological and intellectual testing records. This Order is issued pursuant to 45 CFR 164.512(e)(1)(i) Health Insurance Portability and Accountability Act which authorizes covered entities to disclose protected health information in the course of any judicial or administrative proceeding when responding to an order of the Court.

   If this language is not in your Order, immediately bring this omission to the Court's attention.
3. Things to do before the hearing:
   a. Review Court filings:
      i. Review the Motion for instructions and supporting medical reports;
      ii. Review the citation and advise the court if your client has not been served in accordance with TEX. PROB. CODE ANN. § 633 (Vernon Supp. 2005) (The requirement of service varies among the different courts.).
   b. Ascertain your client's wishes:
      i. TEX. HEALTH & SAFETY CODE ANN. § 166.039(c) (Vernon Supp. 2005) provides that treatment decisions "must be based on the knowledge of what [your client] would desire, if known." Accordingly, you need to perform your own investigation to ascertain your client's wishes, as you will be representing those wishes at the hearing. You may accomplish this task by:
         1. Interviewing your client in order to ascertain his or her wishes in this type of situation. If your client is unable to verbally communicate his or her choices, consider non-verbal means of communication such as

your client blinking his or her eyes and/or squeezing your hand in response to your questions;

2. Reviewing current and previous medical records to ascertain whether your client has previously issued instructions setting forth his or her wishes in this situation. If an advance directive or other written instruction is located, determine whether such document was ever revoked, TEX. HEALTH & SAFETY CODE ANN. § 166.042 (Vernon Supp. 2005); and,
3. Interviewing family members, friends, neighbors, or anyone else who might provide you with a clue as to what your client's wishes and desires were when your client was still competent.

c. File an answer and other responsive pleadings prior to the hearing.

4. The hearing:
   a. Advocate strongly on behalf of your client's position, if known, keeping in mind the sage advice of the Poet of the Yukon, Robert W. Service that "[a] pal's last need is a thing to heed."[115]
   b. Remember, the fact that your client has not executed a directive "does not create a presumption that the patient does not want a treatment decision to be made to withhold or withdraw life-sustaining treatment." TEX. HEALTH & SAFETY CODE ANN. § 166.039(f) (Vernon Supp. 2005).
   c. Advocate that the burden of proof should be based on a clear and convincing standard pursuant to *Cruzan v. Missouri Dep. of Health*, 497 U.S. 261, (1990), as Texas does not have an established standard at this time.
   d. Familiarize yourself with the definitions of terminal condition, irreversible condition, and life-sustaining treatment. TEX. HEALTH & SAFETY CODE ANN. § 166.002 (Vernon Supp. 2005).
      i. "Irreversible condition" means a condition, injury, or illness: (A) that may be treated but is never cured or eliminated; (B) that leaves a person unable to care for or make decisions for the person's own self; and (C) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal. TEX. HEALTH & SAFETY CODE ANN. § 166.002(9) (Vernon Supp. 2005).
      ii. "Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes

115. Robert W. Service, *The Cremation of Sam McGee*, http://www.robertwservice.com/modules/smartsection/item.php?itemid=95&keywords=Cremation (last visited Jan. 25, 2010).

both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificial nutrition and hydration. The term does not include the administration of pain management medication or the performance of a medical procedure considered to be necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain. TEX. HEALTH & SAFETY CODE ANN. § 166.002(10) (Vernon Supp. 2005).

iii. "Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care. A patient who has been admitted to a program under which the person receives hospice services provided by a home and community support services agency licensed under Chapter 142 is presumed to have a terminal condition for purposes of this chapter. TEX. HEALTH & SAFETY CODE ANN. § 166.002(13) (Vernon Supp. 2005).

e. On cross examination, be prepared to:
   i. Attack the physician's qualifications if you believe the physician is not qualified to testify as to the underlying nature of your client's condition;
   ii. Attack the physician's testimony if you believe the physician has a personal interest in the case;
   iii. Attack the physician's conclusion, if any, that your client's condition is either terminal and/or irreversible; and,
   iv. Attack the physician's recommendation, if any, that the treatment sought to be withheld or withdrawn comports with the definition of "life sustaining treatment."

f. Know the rules of evidence.

5. After the hearing, if you think that the best interests of justice would be so served, go to a higher court. *See, e.g.*, *Cahill v. Lyda*, 826 S.W.2d 932 (Tex. 1996).