Special Section: First Voices

Harmless Error and Other Forays into Bioethics

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How does a self-described "simple teacher of religion" at the College of the Holy Cross get involved in bioethics? Nothing in my training or experience had prepared me for involvement in medicine. Much like that of my moral theology professor and then mentor, Richard McCormick, my training was in moral theology and social ethics. I also had an abiding interest in the courts and constitutional law. That interest led to a doctoral dissertation at the University of Southern California's Program in Social Ethics on "The Supreme Court's Understanding of Religion in Conscientious Objector Cases."[1] Interestingly, doctoral work in the late 1960s on the ethical dimension of war was the starting point for other ethicists such as Leroy Walters and James Childress who subsequently became early voices in bioethics.

Discussions and debate on the ethics of the Vietnam War revivified applied ethics, which for generations had been dismissed by the serious academic philosophers as beneath interest. At that time, linguistic analysis ruled the day in the philosophy departments of elite institutions such as Harvard and Yale. I well recall spending a 2-hour graduate seminar in 1960 at Harvard with Prof. Israel Scheffler discussing such issues as "Is it raining between the drops?" or discerning the difference, within the proposition "We carried her home *in* tears *in* a sedan chair," of the meaning of the word "in." Bill Clinton, it seems, was not the first to pose the question of what the meaning of "is" is. During that era applied ethics was relegated to Jesuit colleges or Catholic and Protestant seminaries, institutions that clung to the quaint notion that moral theory ought to govern social as well as personal behavior.

My early research interest was in politics, particularly that of Congress and the courts. The summer after doctoral studies, which was spent with Ralph Nader's Congress Project in Washington, D.C., led to publications on "The Politics of Public Broadcasting"[2] and a chapter in Nader's book *The Commerce Committees*, on the organization and politics of the communications subcommittees of the House and Senate.[3]

Teaching classes on "Religion, Politics, and Society" and a seminar on "The Supreme Court and Human Values" led to publications such as "Compulsory Medical Treatment and Religious Freedom: Whose Law Prevails,"[4] a law review article on the First Amendment's freedom of religion clause and its implication for the right of Jehovah's Witnesses to decline unwanted blood transfusions. Physicians and hospital administrators, it appears, thought it imperative for doctors to do everything possible to save a life. The Jehovah's Witnesses insisted that their obligations did not extend to submitting to

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medical procedures they believed violated God's commands. In typical American fashion, these issues were brought to court for resolution.

An interest in the role of courts in the conflict between deeply held personal values and medical decisionmaking led to an article on how decisions are made by courts for the never-competent patient. The case, *Superintendent of Belchertown State School v. Saikewicz*,[5] involved a profoundly retarded man who had been institutionalized all his life. At age 67 he was diagnosed with leukemia. The dilemma facing the physicians at the University of Massachusetts Medical School was whether or not to attempt chemotherapy treatments on this patient who had a 30% chance of a 3–13 months' remission of his cancer. The difficulty was that Mr. Saikewicz violently resisted any attempts to insert the IV lines that would be needed to administer the chemotherapy. Almost all competent patients in this situation elect treatment. Should Mr. Saikewicz, because of his limited mental status, be denied similar care? Wouldn't such action devalue the life of the cognitively impaired and thus constitute discrimination against the retarded?

The Massachusetts Supreme Judicial Court in its landmark *Saikewicz* decision ruled that by the process of "substituted judgment" the court could "don the mental mantle of the incompetent" and discern what the never-competent Joseph Saikewicz would want. The Court determined that, because he would experience the pain of treatment without any of the hope that leads competent patients to elect to receive the burdensome treatments, Joseph Saikewicz would not want the treatment. The Court went further and ruled that in every case of withholding or withdrawing life-sustaining treatment from a now-incompetent patient—including those who were once competent—a probate court must make a judicial finding through the substituted judgment process of what it is that the patient would want before treatment could be withdrawn.

That intrusion of the judiciary into the daily practice of medicine occasioned an article on "Withholding Life Support Treatment for the Mentally Incompetent."[6] The essay, which was focused on the untoward consequences of courts being thrust into end-of-life decisionmaking, was read by an attorney in Worcester, Massachusetts, the home of both The College of the Holy Cross, where I was teaching in the Religious Studies Department, and the University of Massachusetts Medical School. The attorney showed it to her husband, Ed Landau, who was a gastroenterologist at the medical school. Dr. Landau was intrigued by the question of decisionmaking for the never-competent and invited me to discuss the topic with the house staff. I did. Apparently, Dr. Landau found the talk of broader interest because several weeks later he called and asked if I would give grand rounds on the topic to the some 200 physicians at the Medical School.

I demurred. I told him that such a lecture would be exactly what I had been criticizing judges for doing: speaking in areas in which they had no expertise. Dr. Landau then asked a question that radically altered my life: "How would you like to learn some medicine?" He volunteered that his program did teaching rounds on Tuesdays from 1:00 to 3:00 and I'd be welcome to join. Thereby began my involvement with medicine. Those rounds soon led to meetings with the oncology and palliative-care teams and then an encounter with an incredibly thoughtful and caring surgeon, Garry Fitzpatrick. Dr. Fitzpatrick had me accompany him to all his meetings with his patients so I'd see medicine from the patient's perspective. The hopes, fears, successes, and failures—all must be experienced, he explained, if one is to comment on "what

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should be done." For Dr. Fitzpatrick, medical ethics was not an abstract theory; it was the practical involvement of the physician with the patient in some of life's most demanding choices.

For several months my "education" continued, until one day during regular gastroenterology rounds I was asked my opinion on whether or not an elderly woman in hepatorenal failure who had now contracted pneumonia should be treated with antibiotics. I protested that I was just there to "learn." "The learning cycle is over," intoned the Chief of Gastroenterology, Greg Eastwood. One physician questioned the wisdom of prolonging the dying. Another replied that antibiotics were "ordinary" means and could never be withdrawn. I was supposed to play Solomon and provide the wisdom that would resolve the dispute. Rather than turn to Aristotle or Kant, I turned to my Irish Catholic tradition for insight and guidance. I asked, "What will happen if we give the patient, an elderly Irish Catholic woman, five-star treatment?" Dr. Eastwood replied she would, at best, survive a couple more weeks in her comatose status.

I then projected the discussion into the future. Two weeks from now she will be "laid out" at Callahan Brothers Funeral Home. What will be the response of the family and friends who come to the wake? The comments will be: "Doesn't she look wonderful. Just like herself." Then, "It is a blessing. At last she is at peace. Thank God, her suffering is over."

I then asked what the woman's two middle-aged daughters would reply if Dr. Eastwood informed them at the wake that there was a new miracle drug that could restore their mother to exactly the way she was 2 weeks ago? They would think he had gone mad. Of course, they would not propose bringing their mother back to reexperience those final 2 weeks of suffering. My query then to the assembled team of physicians was, "If it is crazy 2 weeks from now to restore the person to her present status, why do we think it an ethical imperative to utilize antibiotics to produce the same result today?"

Thus began my career in medical ethics. It began not with great theoretical insights from philosophy, theology, or the law but with the caring concern for the human dimension of living and dying I learned from my grandmother. I had learned those lessons at an early age as I witnessed her caring for her elderly sisters through the end of life's journey.

Narrative ethics, not abstract theories, legal fantasies, or philosophical distinctions provide the basic insight. The rest can be filled in as needed. Those insights likewise guided my initial foray into the courts, that area which for woe or weal, we Americans use to resolve our moral dilemmas. That tendency, which was first noted by Alexis de Tocqueville in the 1830s,[7] transforms moral dilemmas into legal disputes as if somehow judges, unlike the rest of us mere mortals, can resolve the mysteries of life and death dispassionately and definitively.

The first of what are now over 50 court cases in which I've been involved concerned a 21-year-old woman, Melanie Bacchiochi, who had suffered an anesthesia accident in the dentist office while undergoing the extraction of her wisdom teeth. The diagnosis at the hospital in Stafford Springs, Connecticut, was "brain death." The husband requested the ventilator be removed, but the treating physician, in the absence of a statue recognizing brain death, would not do so without a court order or a grant of immunity. During some several hours of testimony before a judge who questioned me directly for over 2 hours, I noted that if we were to transport the patient some 10 miles across the border

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into Massachusetts the patient would be "dead." Would putting the ambulance in reverse at the border, I asked, produce her resurrection?

That inquiry forced us to realize that the primary question in ethics ought not be "What should we do?" but "What is going on? What is the status of the patient? How will our involvement alter that status? To what end?" The judge in that case ruled that under the Uniform Anatomical Gift Act, had Melanie Bacchiochi checked "organ donor" on her driver's license, she would have waived her common law "right" to death by irreversible cessation of heart and lungs and her vital organs could be harvested. But, he ruled, because she had not, she could not be considered dead in Connecticut.

That finding, bizarre in itself, did not resolve the issue of withdrawal of the ventilator. The resolution occurred only when the judge was persuaded that he should not order the removal of the ventilator, thereby transferring a medical decision into a legal one, nor should he grant immunity for the doctor's action, thereby encouraging physicians to petition the court for a protective order every time a difficult decision arises. Rather, he should return the issue to the treating physician for a decision that was consistent with the appropriate care of one in the patient's condition. If the primary care physician did not know the proper "care" for a brain-dead individual, there were many physicians in the state who did. They are called neurologists. That evening, with the husband present at his wife's side, the treating physician disconnected the ventilator from the brain-dead woman. Moments later, when the heart monitor produced a flat line, the physician pronounced the patient dead.

The role of the ethicist in court hearings is proving problematic for bioethicists. The danger is that they will be nothing more than hired guns—the moral equivalent of the psychiatrist who can be found to defend any side of an issue for a sufficiently high fee. One federal court in Pennsylvania dismissed the testimony of a physician-bioethicist in a pharmaceutical case involving the drug Fen-Phen on the grounds that the physician lacked any training or expertise in the subject of the trial.[8] Training in ethics, the court noted, does not by itself qualify one to discourse any ethical issue.

The Second District Court of Appeal of Florida ruled that a trial judge erred in allowing a jury to hear the videotaped deposition that I had given in a case involving a newborn infant who had been declared dead and 10 minutes later was found gasping for breath and crying. That court ruled in *Hall v. Anwar*[9] that in the state of Florida no expert can testify on the standard of care unless the expert is qualified in the same specialization as the physician who is being charged. The appellate court ruled, however, that because my testimony was very abstract and involved "such things the 'metaphysical' and 'epistemological' issues associated with the 'post-Kantian world,' " none of which was cited by the attorneys in the closing arguments, it was "harmless error." As such it did not require a new trial. ("Harmless Error" could be the title of the eulogy given at my funeral.)

My practice when approached by attorneys seeking my testimony as an expert in bioethics is to tell them I'll do three things: look over the materials to see if there is an ethical issue, let them know if I think an ethicist would be helpful to their side, and let them know if I am willing to be the expert. Cases that interest me are those in which there is a significant public policy issue.

That was surely true of the early cases of withdrawal of nutrition and fluids. In the first of those, *Barber v. Superior Court*,[10] two physicians were indicted by

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the Los Angeles District Attorney for first degree murder for, at the family's request, removing an IV from a patient diagnosed as irreversibly comatose. That issue was resolved when a California court of appeals found that artificial nutrition and hydration were medical treatments to be assessed as any other medical intervention—on the basis of proportionate benefit/burden experienced by the patient. If the patient does not want them, the physician has no obligation to provide them, nor the court a duty to order them. By the time that standard had been recognized not only in *Barber* in California but implemented in *Brophy*[11] in Massachusetts, *Jobes*[12] in New Jersey, and *McConnell*[13] in Connecticut, I had no further desire to testify on the topic and so declined to appear in the Rhode Island federal district court in *Gray*[14] or in any subsequent court hearings on that topic.

More importantly, there are multiple issues in which I've declined to testify, such as the Fen-Phen case, a case involving Norplant, a physician seeking a defense for sexual involvement with a patient "to save her from suicide," or a case in which the treating physician wanted a court order to remove a feeding tube over family protests. I did so because I thought that in those instances the party seeking my testimony did not have a legitimate ethical foundation for what was being requested.

Perhaps the most bizarre case I've turned down was the defense of a cardiovascular surgeon who identified me as the expert he wished to support his actions in a phalloplasty procedure. At the time I naively had to inquire what phalloplasty was. On learning that it involved penile enlargement and girth enhancement, I immediately replied, "*No*." I could see the tabloid headlines: "Jesuit Testifies Longer Is Better."

When pressed by the defense lawyer to assess the plaintiff's claim that a $750 nonrefundable down payment before gaining an appointment with the surgeon—where the patient would learn that the procedure involved not only the cutting of the suspensory ligaments but the wearing of two-pound weights 4–6 hours a day for 4 months to assure that the "enhanced length" was not lost to surgical contractions—violated the voluntereity of the contract, I, once I regained enough composure to respond, told the defense lawyer that I agreed with the plaintiff. There ended my involvement in that case.

The journey into bioethics has involved deeply satisfying opportunities to help patients and families wrestle with and resolve moments of deep crisis. Being present in the NICU to baptize a 420-g newborn whose life was destined to be measured in minutes not years, to guide parents though the maze of issues to a decision on whether or not to undertake a Norwood procedure on their child born with hypoplastic left heart, or to convince a physician of the truth of poet John Milton's insight that "They also serve who only stand and wait"—at a time when God is summoning a dying person home—is a priestly calling of the highest order.

The opportunity to meet, interact with, challenge, and be challenged by such marvelous and thought-provoking people as Dick McCormick, Dan and Sydney Callahan, Ed Pellegrino, David Thomasma, Margaret Farley, Jay Katz, Art Caplan, and Mark Siegler is to have been graced beyond the gift given to most academics. The Hastings Center, The Kennedy Institute of Ethics, The Center for Clinical Ethics at Georgetown Medical School, Yale Law School, The University of Pennsylvania Center for Bioethics, and especially The MacLean Center for Clinical Ethics at The University of Chicago, where I now spend

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every fourth semester doing clinical research, have all proven to be a home as well as a resource.

The world of theory and of practice, of law and of medicine, of the practical and the problematic—death and dying, genetics, managed care, the human genome project, and new forms of reproduction—all are material for articles, lectures, conferences, and policy formulations. What a grace it has been to have been given the opportunity to explore, to examine, and to participate in such topics.

The Book of Acts tells us that Paul of Tarsus was struck by a bolt of lightning and fell to the ground before his conversion. Fortunately, my journey into bioethics involved nothing more than responding "yes" to Dr. Landau's inquiry, "Would you like to learn some medicine?" That "yes" has added unexpected and wonderful worldwide adventures to the task of being a "simple teacher of religion."

Notes

1. Paris JJ. Toward an understanding of the Supreme Court's approach to religion in conscientious objector cases. *Suffolk Law Review* 1973;7:449–515.
2. Paris JJ. The politics of public broadcasting. *Commonwealth* 1972;97:179–81.
3. Paris JJ. The communications subcommittees of the House and Senate. In: Nader R, ed. *The Commerce Committees*. New York: Viking Press, 1975:212–251.
4. Paris JJ. Compulsory medical treatment and religious freedom: whose law prevails. *University of San Francisco Law Review* 1976;20:1–46.
5. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass 728, 370 N.E. 2d 417 (1977).
6. Paris JJ. Withholding life support treatment from the mentally incompetent. *Linacre Quarterly* 1978;45:237–48.
7. de Tocqueville A. *Democracy in America*. New York: Oxford University Press, 1947.
8. *In re Diet Drugs*, WL 45486, E.D. Pa. (2001).
9. *Hall v. Anwar*, 774 So. 2d 41 (2000).
10. *Barber v. Superior Court*, 147 Cal. App. 3rd 1006 (1983).
11. *Brophy v. New England Sinai Hospital*, 398 Mass. 417 (1986).
12. *In re Jobes*, 529 A. 2d 434 N.J. (1987).
13. *McConnell v. Beverly Enterprises–Connecticut, Inc.*, 209 Conn. 692, 553 A. 2d 596 (1989).
14. *Gray v. Romeo*, 697 F. Sup. 580 R.I. (1988).

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