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by George J. Annas, J.D., M.P.H.

Movie critic David Denby has asserted that American theatergoers are a "professional avant-garde audience" who "cannot be shocked by what others would find unintelligible . . . [and] have lost the capacity for outrage."[1] This analysis of American theater can be aptly applied to clinical medical education.

I assume almost every nonmedical professional reading "Death at a New York Hospital" will be horrified and outraged at the "treatment" Ms. Hewitt was subjected to in the hospital. Many physicians will too; but it is likely that more will be as understanding of the actions of the intern and residents as was Dr. A, the senior staff member who explained to Prof. Schucking that these doctors in training who ignored Ms. Hewitt's wishes were simply "erring on the side of life." Why wasn't Dr. A as outraged as we are, and what did Drs. X (the intern), Y (the first-year resident), and Z (the senior resident) learn from their experience with Dr. A, Ms. Hewitt, and Prof. Schucking? This is not a story about emergency medical care; it is a parable of clinical education.

Dr. X learned that his instructors would back him up if he ignored the prior stated wishes of his patient, as stated in writing and by her closest friend. He also learned that his clinical superiors expected him to take advantage of the opportunity presented by a unsalvageable patient to practice major surgery: dying patients, it seems, are fair game for use as teaching material. Since their dying is seen as having no intrinsic value to them or their loved ones, it is easy to conclude that it is appropriate to use their bodies for teaching purposes. Thus it was perfectly acceptable, from the medical staff's point of view, to perform a pericardiocentesis without either consent or the likelihood of patient benefit. Drs. Y and Z had apparently learned this lesson from their own training and were now teaching it to Dr. X in the time-honored teaching methodology of medicine: "See one, do one, teach one."

There is no room for thoughtfulness, no room for the intrusion of human values, and no room for discussion with the patient or family in such a system. The only values are technological; the imperative is to use all available medical technologies possible—for practice, if not for the patient.

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The hospital in which this intentional degradation of what could have been a dignified and peaceful death took place is not, unfortunately, unique among teaching hospitals. Perhaps the only unusual thing was the belated appearance of the "Messenger of Death," the "salesman in a business suit" who introduced himself as a "patient representative." This was too little too late. The attitude of the "patient representative" (who should have described himself as a "hospital representative"), as betrayed by his own words, was focused on protecting the hospital: "Let's not get involved in what happened yesterday."

The case of Ms. Hewitt "happened yesterday." There was no justification for treating her worse than we would permit a dog or a horse to be treated. It was outrageous, and Prof. Schucking's reaction to this horror is a perfectly appropriate one. Indeed, his is probably a relatively typical reaction to a cruelly common occurrence. Literature from across the world informs us that many hospital physicians cannot understand why patients seem to take autonomy so seriously, when the physicians *know* that fighting death and teaching others to fight death is so much more important.

In Aleksandr Solzhenitsyn's *The Cancer Ward*, for example, a patient, Oleg Kostoglotov, discovers he has been receiving hormone therapy for cancer without his knowledge:

> By some right—it doesn't occur to them to question the right—they are deciding for me, without me, on a terrible treatment, hormone therapy. This is like a red-hot iron which, once it touches you, leaves

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you maimed for life. *But it appears so ordinary in the ordinary life of the hospital!*[2]

Oleg understands fully that his physicians believe the treatment is absolutely necessary if he is to survive.

Does it really have to be like this? Must doctors continue to train doctors to ignore the person and concentrate exclusively on the body?

But he also understands much more fully than they that there are fates worse than death:

> What, after all, is the highest price one should pay for life? *How much should one pay, how much is too much?* . . . The camps helped many of us to reach the conclusion that betrayal, the ruin of good and helpless people, is too high a price. Life isn't worth it. . . . But what about this price—to save one's life at the cost of surrendering everything that gives it color, flavor and sparkle. To get a life of digestion, breathing, muscular and mental activity, and nothing more? To become a walking husk of a man—isn't that an exorbitant price?[3]

Most Americans believe that we and our loved ones should be involved in medical treatment decisions and at least retain the right to refuse *any* medical intervention. Nonetheless, we do not realistically expect this to happen in the hospital setting. Larry McMurtry's description of Emma's feelings on being hospitalized for cancer in his *Terms of Endearment* conveys an almost universal resignation:

> From that day, that moment almost, she felt her life pass from her own hands and the erring but personal hands of those who loved her into the hands of strangers—and not even doctors, really, but technicians: nurses, attendants, laboratories, chemicals, machines.[4]

This is powerful imagery, powerful primarily because of its accuracy: "not even doctors, really, but technicians: nurses, attendants, laboratories, chemicals, machines." It is a line Prof. Schucking could have written, having himself delivered Ms. Hewitt "into the hands of strangers."

Does it really have to be like this? Must doctors continue to train doctors to ignore the person and concentrate exclusively on the body? Must we really choose between expert technicians and humane caregivers?

These questions are not new, and "Death at a New York Hospital" assures us they have not yet been satisfactorily answered. What can we do?

We could—as Prof. Schucking tells us he would, given another chance—simply keep ourselves and our loved ones out of the hospital. Dying at home is not always either pleasant or easy, but given the option of the type of "care" Ms. Hewitt received in the hospital, it certainly has much to commend it. Hospice care, which has developed as a compromise alternative to overaggression in hospitals and undertreatment in home care, can be a humane option.

We could encourage people like Prof. Schucking to bring legal actions against physicians like Drs. X, Y, and Z, who insist on using dying patients as teaching props, for assault and battery, mayhem, and intentional infliction of emotional distress. As long as physicians perceive themselves as beyond the law in such behavior, they seem to have no incentive to change.

We could develop an effective system of patient advocates, with professional advocates trained, hired, and employed by independent agencies (such as a coalition of health insurance companies, local departments of health, or state departments of public health or consumer protection). These advocates could be on call seven days a week, twenty-four hours a day, to help patients (and their proxies, when the patients are incompetent) to exercise their legal rights.[5] Prof. Schucking needed a patient advocate immediately. Going through the Yellow Pages to find an attorney was no substitute and, as it turned out, a futile exercise.

We could encourage legislation aimed at giving real meaning to advance directives, by legally requiring physicians either to follow them or to transfer the patient to a physician who will, and by designating a proxy to enforce one's wishes. A model "Right to Refuse Treatment Act" that would accomplish these objectives has been drafted by the Legal Advisers Committee of Concern for Dying.[6]

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In the long run, we can use education to gradually change the attitudes of doctors, nurses, and allied health professionals. "Death at a New York Hospital" should be widely circulated in the teaching hospitals in this country for use as a case to provoke discussion in teaching rounds, for use by ethics committees and other educators as an example of what should not happen, and as an impetus to develop policies to prevent it from happening again.

A United States Army recruiting advertisement insists that "Technology Is Taking Over the World." The army implies that this is a good thing. But as

"Death at a New York Hospital" touchingly teaches, technology may make a wonderful servant, but it is a mindless and insensitive master. We need to recapture control of modern medical technology and put it to work for useful human purposes. This will require developing a new respect for the patient as person and taking the right of self-determination seriously. The challenge is to channel our outrage engendered by "Death at a New York Hospital" into constructive steps to humanize the hospital.

References

1. David Denby, *Stranger in a Strange Land: A Moviegoer at the Theater*, ATLANTIC MONTHLY 255(1): 37, 48 (January 1985).
2. ALEKSANDR SOLZHENITSYN, THE CANCER WARD (Dell, New York, 1968), at 346 (emphasis added).
3. *Id.* (emphasis added).
4. LARRY MCMURTRY, TERMS OF ENDEARMENT (Simon & Schuster, New York, 1975), at 394.
5. GEORGE J. ANNAS, THE RIGHTS OF HOSPITAL PATIENTS (Avon, New York, 1975), at 209; GEORGE J. ANNAS AND J. HEALEY, *The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context*, VANDERBILT LAW REVIEW 27(2): 243 (March 1974).
6. Legal Advisers Committee, Concern for Dying, *The Right to Refuse Treatment: A Model Act*, AMERICAN JOURNAL OF PUBLIC HEALTH 73(8): 918, 921 (August 1983).

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References

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1. Anne Sexton, *August 17th*, in WORDS FOR DR. Y (ed. L. G. Sexton) (Houghton-Mifflin, Boston, 1978), at 77.
2. *See* M. Anbar, *The Penalties of Excessive Inquisitiveness*, in THE MACHINE AT THE BEDSIDE (ed. S. J. Reiser and M. Anbar) (Cambridge University Press, New York, 1984), at 279.
3. Sexton, *supra* note 1, at 77.
4. IVAN ILLICH, MEDICAL NEMESIS (Random House, New York, 1976), at 205.
5. *Id.* at 207.