

Gaggle of OTA 'ethicists' threatens national medical policies

by Linda Everett

Life-sustaining Technologies and the Elderly

Office of Technology Assessment
U.S. Government Printing Office, Washington,
D.C., July 1987
461 pages, clothbound, \$19.00.

The U.S. Congress's Office of Technology Assessment recently released its latest gameplan of assault on what is left of medical care for the elderly, and ultimately, for the rest of Americans. The study aims at effectively eliminating, as "inappropriate treatment for some patients," five life-saving technologies: cardiopulmonary resuscitation; renal dialysis; mechanical ventilation; tube and intravenous feeding and hydration; and antibiotics.

The OTA, the analytical arm of Congress, researched the implications of these "technologies," which can sustain life in patients who are critically or terminally ill, at the request of the House and Senate Committees on Aging. Chairman John Heinz of the Senate Special Committee on Aging, and the chairman of the House Select Committee on Aging, Edward Roybal, "expressed concern about elderly persons whose rights as patients and dignity as citizens are, or feared to be, jeopardized—either by unwanted aggressive medical treatment or, conversely, financial barriers to treatment."

The committees asked for a "thorough review of the ethical dilemmas concerning life and death decisions" facing physicians, patients, and their families, as well as how to resolve the special problems of "cognitively impaired elderly patients unable to make their own health care decisions."

Some three years later, on July 31, 1987, the OTA delivered its 461-page report, *Life-Sustaining Technologies and the Elderly*.

So much for the cover story.

The aim of this study is not cost-containment; the government could achieve that and save billions by throwing out the ethicists who write these reports and gouge huge chunks of the health care dollar every time they do so. No, the intended aim here is a major coup in America's medical system, whereby the treatment you receive will not be governed by what can be medically done to save your life, but by national policies that dictate which categories of patients will receive life-saving procedures, and which will not. Your life sits in

the hands of a pack of self-proclaimed ethicists whose prescription for Nazi euthanasia policies happens to fit the Reagan administration's austerity plans.

The major purpose of the study, according to the OTA, "is to provide an array of options for public policy that will support wiser clinical decisions about the use of these technologies. . . . [It] synthesizes available and new information, from a new perspective, and from this it develops a set of issues and related options for congressional review." Translation: The report strips away American medicine's focus on curing diseases, and offers a "new perspective" which attaches more importance to arbitrary "quality of life" judgments, economic factors, and computer-generated clinical prognoses, than it attaches to life itself.

To sell you this new perspective, you, the patient, are given new rights: the right to discuss each treatment decision with your physician, social worker, nurse, and ethicist; the right to refuse any and all treatment; the right to a "living will" and the right to "die with dignity."

Die you surely will. Behind the "rights" façade, treatment policies are being developed in a compartmentalized, systems analysis approach by which ethics committees will decide if a patient gets *beneficial* treatment. If the chronically ill patient is confused or fussy, extending his life by feeding him would not be beneficial. If a cancer patient develops pneumonia (a "co-morbidity"!) treating him with antibiotics may not be beneficial. The OTA has a "more humanist" medicine, one totally divorced from both the Hippocratic Oath and the scientific thrust traditional to Western culture's treatment of individual human life as sacred.

It adds up to: "We propose to save money by letting people die."

The Office of Technology Assessment, started in 1972 by Sen. Ted Kennedy and his adviser, Club of Rome member Michael Michaelis, is notorious for its brutal depopulation policies and cost-cutting studies. The OTA's advisory panel for this latest study is made up of the most ruthless members of the country's euthanasia mafia. This panel is comparable in its planning of non-treatment categories of patients to Hitler's Reich Commissioner for Health, Karl Brandt, who organized the first waves of euthanasia exterminations.

As with Brandt, it is impossible to exaggerate the evil this panel intends, but *by their deeds, ye shall know them*. Among them is:

- **John J. Paris**, Jesuit "ethicist," Holy Cross College,

Massachusetts. For years, Paris has testified across the country in favor of starving brain-damaged or unconscious patients in lieu of costly care, and in favor of eliminating chronically handicapped children, saying "we can't pull all our resources" and "spend millions of dollars for a baby who feels only pain." For them, Paris says that death is not the enemy. The real issue is, "Who's going to pay for all this?"

● **Daniel J. Callahan**, co-founder and director of the Hastings Institute. He aggressively advocates health care rationing for the elderly to trim their "insatiable" desire to extend their lives. The United States, he says, could do better than throw away its limited resources on those over 65. The Hastings Institute has just completed its own two-year project, coincident with the OTA's, called "Termination of Life-Sustaining Treatment and the Care of the Dying." A half-dozen OTA advisers also worked on the Hastings project with the "Right to Die Society" and the "Concern For Dying."

● **Joanne Lynn**, vice-president, Hastings Institute, associate professor, George Washington University Medical Center; assistant director, President's Commission on Aging. An advocate of patient starvation, Lynn wants to legalize the medical murder (starvation, pulling the plug) of an estimated 15,000 incompetent patients who pass through Washington, D.C.'s health care institutions every year. Her target is both the elderly and AIDS patients. One-third of Washington's hospital patients and two-thirds of its nursing home patients are mentally or physically incapable of making their own health care decisions. Lynn wants to kill them.

● **David Axelrod**, health commissioner of New York State, head of Gov. Mario Cuomo's Life and Law Task Force. He eliminated over 12,000 New York hospital beds, blocked \$7 billion worth of hospital construction and improvements since 1975, and has waged war on "technological idolatry," i.e., use of life support and advanced diagnostic equipment. With the help of Blue Cross/Blue Shield, he established "brain death" and "do not resuscitate" laws, targeting AIDS patients and some 10,000 incompetent nursing home patients for death. Several task force members, including Daniel Callahan, worked directly with the Hastings Institute project.

● **A. Wendt**, Episcopal priest, executive director, the St. Francis Center, Washington, D.C. Wendt, who sells plain pine coffins as coffee tables, so that people may "learn to live with death," once complained that it was difficult to convince black people to support on euthanasia, because they "have too great a will to live."

● **A.-J. Rock-Levinson**, executive director, Concern For Dying. She organizes physicians and attorneys to arrange "negotiated patient deaths," and says that a lot of medical treatment is unwarranted, inappropriate, and not wanted. "Patients have the right to refuse any medical treatment. There are no rights or wrongs."

● **Rose Goldstein**, director of social services, Jewish Home and Hospital for the Aged, Bronx, New York. She likes to prepare families for the inevitable end by discussing

funeral arrangements as soon as they bring a relative to a nursing home.

● **Terrie T. Wetle**, assistant professor of medicine, Division of Health Policy, Harvard Medical School. Anyone, like Wetle, who gives a speech entitled "Death as a Care Option," deserves to be investigated as a Nuremberg criminal.

● **John Rowe**, OTA panel chairman, chief, Gerontology Division, Department of Medicine, Beth Israel Hospital, Harvard Medical School.

● **Nancy Dubler**, director, Division of Legal and Ethical Issues in Health Care, Montefiore Medical Center, New York.

● **Victor W. Sidel**, professor of Social Medicine, Montefiore Medical Center, New York.

● **Anne A. Scitovsky**, chief of the Health Economics Department, Research Institute, Palo Alto Medical Foundation, President's Commission on Aging.

● **A. Edward Doudera**, Harmon, Jones and Sanford, Camden, Maine, American Society of Law and Medicine.

'Strong convergence' on Nazi plan

The panel expressed a "strong convergence of opinion," on a number of "principles," among them:

● Patients have the right to refuse any treatment or intervention; however, "an individual does not necessarily have a right to unlimited medical treatment or intervention."

● "Diagnosis alone is a poor criterion for life-sustaining treatment." Whether a patient is saved should depend on the severity of illness, the patient's functional impairment, and cognitive function. Also, "age may be a legitimate modifier."

● More medical education in "appropriate use" of life-saving procedures, better methods of predicting the probability of patient survival, functional status, and subsequent quality of life—meaning, "We do not intend to save those with poor prognosis."

While the report focuses on elderly patients over the age of 65, it reiterates that policymakers must not dismiss all elderly persons as candidates for life-sustaining technologies based on chronological age alone. They suggest that "life-threatened elderly should be seen as individuals with widely varying physical and mental status." But the OTA assessment severely undermines care for the elderly by voicing every rationale imaginable for eliminating it, including the overtly Nazi argument that "too much money" is spent on patients who are elderly, and too much of this on patients "who die anyway."

The OTA cites such facts on the "high cost of dying" as: Health care expenditures for the nation's 29 million elderly persons account for about one-third of all health care expenditures, although the elderly constitute only 11% of Americans. In 1982, 1% of Medicare enrollees over age 65 accounted for 20% of all Medicare expenditures, and the 5% of Medicare enrollees over the age of 65 accounted for more than 50% of expenditures. The 5.9% of Medicare enrollees who died in 1978 accounted for 27.9% of all Medicare ex-

penditures; 30% of this was spent on the last 30 days of life, 46% on the last 60 days of life, and 77% on the last six months; 3% of Medicare enrollees who died in 1978 had Medicare expenditures of over \$20,000, and 1% over \$30,000.

Confusion can get you starved

One major gripe of the OTA panel is that the sick and chronically ill elderly eat. The study details the "controversial," "emotionally burdened" issues surrounding the current Nazi practice of starving conscious and unconscious patients who are unable to take food or fluids by mouth, or are unable to digest and absorb them. Food and water can be delivered through small tubes into the digestive tract (enteral) or intravenously, where the nourishment is delivered via catheter into the blood stream (parenteral). Total parenteral nutrition (TPN) provides intravenous nourishment that best maintains weight indefinitely.

The OTA authors carefully couch their views with the "some say" method. "Some people also believe that nutritional support can be withheld or withdrawn from severely debilitated or confused patients when the burden of treatment outweighs its benefits." "Some nutritional support specialists" do not think patients should get nutritional support at home if the patient has "no meaningful existence." Nutritional support, because of its cost, "should not 'be like dialysis,'

that is, used on patients for whom it is futile or inappropriate."

The authors suggest that money can be saved by using APACHE II, a clinical assessment instrument developed to classify severity of illness and predict a patient's survival chances with certain treatments. It predicted with 100% certainty that eight TPN patients would die in hospital, and they did. The OTA proposal: Starving the TPN patients predicted to die "would have reduced the annual cost of TPN to the hospital by 28%." The researchers conclude: "One way to improve cost-effectiveness is to examine critically the ways we prescribe expensive therapies. By not treating [not feeding] patients who will not benefit, cost-effectiveness is increased, with a simultaneous reduction in the total cost. The ethical problem is to identify these patients accurately."

Fundamentally, the report is a fraud. Studies are cited showing horrible malnourishment of patients in hospitals and nursing homes: 43% in one home, 57% in another, 57% in yet another. While hospital dietitians were the first to be sacrificed in the Medicare reimbursement cuts, the authors say more studies of the elderly's nutritional requirements and metabolism are needed, and better skilled hospital personnel, to develop proper diets and recognize malnutrition. Actually, the only thing needed is education of hospital personnel to recognize that 600 calories a day is a concentration camp diet.

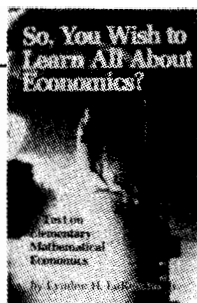
The unspoken policy is that patients too feeble to feed themselves will not get fed because of staff shortages.

The OTA authors contrast geriatricians' "more realistic" and "more holistic perspective" with traditional medicine. "The traits, habits, and mental sets characteristically nurtured by medical education perpetuate a perspective that tends to . . . view all problems, including death, as *treatable* [emphasis in original]. Death is construed as a biosystem going awry. . . . This human condition is inadvertently taken out of the realm of social meaning and put in a framework of normal versus pathological functioning. Here, death becomes viewed as a chronic resistance to life."

These panelists are the people who have for years demanded court decisions and laws in favor of starving patients because feeding them is an "extraordinary" or "inappropriate" medical treatment that does not cure the underlying disease. But then, does breathing cure your disease? The authors might as well advocate putting pillows over patients' faces. (You may be sure they will, when the atmosphere is right.)

Although nutritional support specialists state that Medicare limits patients' access to nutritional support (both enteral or parenteral) in the hospital, home, or nursing home, the OTA states, "Despite financial incentives to limit expensive care, however, there is no evidence to date that PPS [Medicare's prospective payment system] has reduced access to *life-sustaining* treatment [emphasis in original]."

Who are they kidding? In one typical, recent case, a Michigan surgeon and two cardiologists needed permission



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to implant a permanent pacemaker to save the life of a 65-year-old patient who became dependent on an external pacemaker during surgery. With the patient's life hanging in the balance, the doctors were repeatedly refused permission by the Medicare reviewer, a cardiologist, who said the patient was not sick enough. (*Chicago Tribune*, June 15, 1987).

The OTA also fails to mention the myriad of incentives for a "natural death" built into the system. Frequently, nursing homes "discuss" choosing death over treatment with patients, writing out details of all the possible burdens of all those "invasive, painful procedures that leave you dying in a sterile hospital hooked up to machines."

'This bias to treat'

While persons 65 and older comprise about 11% of the total U.S. population, they comprise over 30% of all patients receiving dialysis, nutritional support, and mechanical ventilation. In hospitals, an average of 55% of all patients who are resuscitated are elderly, and it is likely that they are a large portion of patients receiving life-sustaining antibiotic therapy. Life-saving interventions are expensive, but the OTA says that keeping a patient alive afterward may be exorbitant. Their recommendation is for more information on "the need for, or criteria to be used in, rationing of access to health care."

"The traditional bias of medical education and practice places the cure of acute illness above all other goals. When cure is not a realistic goal, this approach often leads to inappropriate treatment decisions." "This bias to treat appears to prevail." So, withholding treatment is resisted by medical personnel, and "pulling the plug" even more so, because "grief, guilt, and health professionals' feelings of failure at times prevent rational decision-making."

As a remedy, "some propose the greater moral imperative" of withdrawing "treatment that proves futile or unwanted," or "time-limited trials," giving a patient a week on a ventilator, or a few months on a dialysis machine, and then re-evaluating the case. The fact that the patient is still alive is not reason enough to continue treatment. The OTA wants "innovative" curricula for physicians and health personnel that focuses "on achievable goals, such as maximization of the patient's functional capacity . . . the quality of life . . . medical ethics, humanities, and death and dying." These treatment questions would be solved, OTA says, if more people signed their lives away with living wills, durable power of attorney documents in which relatives make your treatment decisions if you become unable to express them, and "substituted judgments," in which someone else decides if you live or die.

The creeping 'prognostic uncertainty'

For a human being, or a doctor who happens to have taken the Hippocratic Oath, things ought to be simple. Here is the ailing patient, so provide treatment. But the OTA says, rather, here is the ailing patient, so let us now engage in

"decision-making processes" concerning whether or not to initiate treatments when you do not know "in advance whether or not a patient would survive, for how long, and in what condition."

OTA figures show that "one-third to one-half of all in-hospital resuscitation attempts succeed; and only one-half of the patients who are successfully resuscitated survive long enough to be discharged from the hospital. Adults in acute respiratory failure have a 50% chance of survival with a mechanical ventilation; for acute renal failure, only 20% of those over 70 survive. Patients receiving antibiotic therapy or nutritional support have a relatively high, but not necessarily predictable chance of survival."

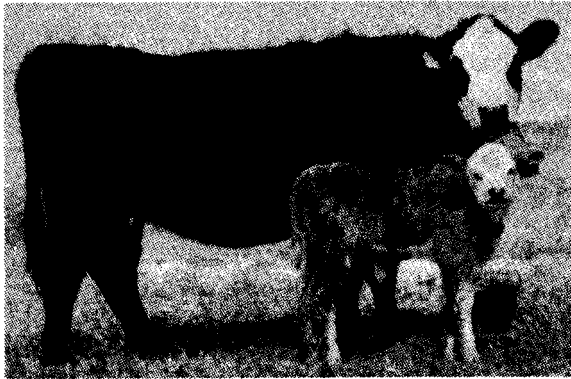
To halt "pervasive prognostic uncertainty," doctors are to become actuaries, taking up forecasting by using clinical research on "the physiological and psychological responses of elderly patients to particular treatments as well as information about the outcomes *without* treatments [emphasis in original]." Diagnostic and treatment data will be combined into statistical categories associated with "known probabilities of survival." These will then be disseminated through education and training of health care professionals.

The result? Treatment is not up to you or your doctor, but to a computer printout that quantifies your chances. Applied to another area, such a ludicrous mind-set would have meant that none of the extraordinary advances witnessed in the last five years in saving premature babies could have occurred; all would have been allowed to die because they were born below a birthweight X pounds or a gestation age of Y weeks, which would not have been judged a viable or statistically "known probability." (Tell this to the parent or physician holding a living miracle weighing less than three pounds in the palm of their hand.)

For patients receiving renal dialysis therapy, the OTA wants you to know that "some people" think "dialysis is being overused, that is, public resources are being misallocated, and/or dialysis is being wasted on some patients for whom the benefits are questionable." Because of the growth of dialysis, the U.S. experience "is frequently cited by those who . . . warn against excessive growth of other disease-specific benefit programs or overuse of life-sustaining technologies." The OTA points approvingly to the national health care pogrom in the United Kingdom, where health care rationing is routine and based on your employability and age. "This rationing seems 'not only sensible, but necessary—in a patently obvious way'. . . . Patients in the U.K. are not entitled to treatment. The fact that a reliable life-saving treatment exists does not mean that a person who will die without it has a right to receive it."

While we cannot review all the medical treachery planned in this report, let us say this: The overbearing element throughout the report is a total acquiescence to the doctrine of "scarce resources." Perhaps more frightening, however, the OTA is already preparing a followup study with specific killing policy guidelines for use in hospitals.

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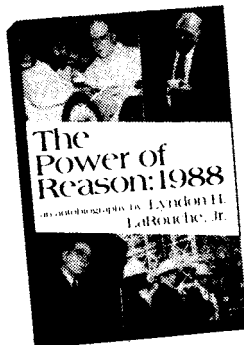
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