A Demand to Die: Should a Seriously-Injured Patient have the Right to Die?

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by
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Introduction

In May of 1973, Donald Cowart, a 26-year-old single man, had left a tour of duty in the U. A. Air Force as a jet fighter pilot in Viet Nam, and had joined his father in the real estate business while waiting for the employment situation to improve in the commercial air lines. While inspecting some country property one day with his father, they inadvertently parked in an area where gas fumes from a leaking propane transmission line had collected in a creek bed. Attempts to restart their car produced a flash which ignited the leaking gas fumes and produced a massive explosion and fire. Donald’s father was fatally burned and died en route to a local hospital; Donald was severely burned over 67% of his body, to the extent that survival was generally regarded as unprecedented in individuals as severely burned.

Despite his initial protests that he simply wanted to be left to die (or even helped to die), Donald was taken to a local hospital where he was stabilized. His mother and sister were contacted, told of the tragedy, and the mother was asked to assume responsibility for authorizing his care. There began at this point an 11-month battle between Donald and Ada Cowart, she continually authorizing treatment, he continually protesting it.

The burns had cost him the distal finger tips of both hands, and had destroyed the vision in both eyes. During these first months of treatment, contractures had rendered major joints, especially in his arms, “frozen”; surgical efforts to save what was left of his hands had resulted in skin grafts around his bunched fingers and dislocation of hand and wrist joints; and surgical efforts to free up one of his elbows proved unsuccessful.

After many months, his protests brought a halt to surgical intervention; his condition worsened from infections that set into the ungrafted burn areas, and it was felt necessary to transfer him once again, to the burn unit of another hospital, in Galveston. The struggle between Donald and his physicians and mother intensified, with Donald refusing to consent to any additional surgery and threatening legal action if he were not discharged. Physicians became increasingly frustrated and finally turned to a psychiatric consultation, hoping to get Donald declared incompetent so as to be able to proceed with the rest of his scheduled treatment and surgery solely on his mother’s authorization.

The psychiatrist, Dr. Robert White, found Donald to be competent. After several hours of discussion over several days, the psychiatrist and surgeons confronted Donald with the difficulty of the situation legally and morally. Legally, it was unclear whether releasing him without treatment, given that he had expressed a wish to die and sought release for that purpose, would constitute assisting a suicide — an act recently made a felony in Texas. Morally, the surgeons and physicians maintained that not treating him where it was clear that treatment would save his life and non-treatment would end it was tantamount to killing him, and that he had no moral right that any one do that. Further, the psychiatrist observed that Donald’s dependency on
others extended to his intention actively to seek his own death. Donald was adamant, however, that he wanted his right to refuse treatment recognized.

Finally, when the hospital had agreed to assist Donald in obtaining legal counsel and to cooperate in a court proceedings to determine whether he could legally remove himself from the hospital's aggressive treatment plan, Donald suddenly decided to continue the treatment. He was released five months later into his mother's care, able to walk, to operate a ham radio, and willing to see if he could make a life for himself. Despite numerous setbacks and two suicide attempts that were foiled by friends, Donald finally found happiness in an import business and in marriage to an old highschool sweetheart.

Presentations and Discussions of the Case

Two audiovisual productions have been made about this case. One was produced as an instructional aid by the University of Texas Medical Branch at Galveston's audiovisual department for its Library of Psychiatric Disorders, and was intended initially to be used as a case study for teaching on the psychiatric service. The Hastings Center reviewed it in a small publication of film and video reviews in the field of biomedical ethics. On the basis of that review and interpersonal recommendations, many institutions (including SUNY at Buffalo) purchased it for use in biomedical ethics courses. I have used it over 40 times in my undergraduate and graduate courses and in colloquia and grand rounds.

The psychiatrist, Dr. Robert White, was invited to submit the case for publication and commentary in the Hastings Center Report (White, 1975); commentary was by a prominent bioethicist, H. Tristram Engelhardt, Jr., who gave a resounding affirmation of the right of this patient to have treatment stopped (Engelhardt, Jr., 1975). A second commentary, by a Dartmouth College English professor, Michael Platt, written more in the nature of a film review, was published in the Report some months later (Platt, 1975). (Interestingly, Dartmouth adopted the film as a part of its freshman orientation week, with Donald Cowart annually invited to discuss the case with the freshmen.)

In 1985, a film documentary production recreated the case in an hour-long format, titled "Dax's Case" (using the name he adopted after the massive changes in his life), incorporating portions of the video tape as flashback material, but utilizing numerous interviews of Donald, his mother, his attorney, his surgeon, a nurse, a friend, and his physician, and incorporating numerous shots of the accident site, Donald's family home, and his then present home and business location.

It is my purpose today to show this film and to lead a brief discussion of it afterward. I do so to drive home several points, partly psychological, partly pedagogical, and partly philosophical. The psychological point recalls one made by psychologist Richard Bugelski in a colloquium at SUNY at Buffalo some 15 years ago, namely that we entertain concepts through concrete images that we let stand for abstractions, rather than entertain concepts through contemplation of abstract entities themselves. The related pedagogical point is that, in light of the psychological point, we do a much better job as teachers of philosophy if we employ concretions of the abstract concepts and theories to whose study we expose our students, appealing to vivid imagery and detailed examples embodied in the stuff of daily experience.

One philosophical point is that, when we consistently employ the pedagogical point, we remain in touch with the experiential data forming a testing ground for our moral analyses, without the fullness of which data we risk both loss of corroboration and oversimplification.

In illustration of this point, I want to utilize this film to draw into question contemporary bioethics' commitment to an image of what Renée Fox and Judith Swayze have called "the individual seen [essentially] as an autonomous, self-
determining entity rather than [one] in relationship to significant others.” (Fox & Swayze, 1984, p. 339) To put my intended point another way, this case troubles me in the fullness of the detail of its concrete presentation, because I find over simplistic the tendency of bioethicists to analyze it in primary and even sole terms as a question of the rights of the individual patient when confronted with the sort of situation in which Donald Coward finds himself. The richness of the case presentation, so well staged and developed in this film, enable us to extract a host of moral positions and points of view demanding clarification and articulation. Without attention to such detail, ethical analysis risks the tunnel vision of one focused on a theory-selected issue, set of values, and point of view to the exclusion of other points of view, issues, and sets of values: one risks, in short, a selective bias towards data that only confirm.

As a pedagogical aside for those who have seen both the videotape and the film, I invite your reflection of the question of the relative merits of the two as aids to consideration of the fullness of adequate moral deliberation. For I suspect that the videotape, as striking and compelling as it is in its presentation of Donald Coward’s case, is one-sided and fails as a thorough example of the complexity of moral problems in a way in which the film succeeds.)

The second, related, philosophical point is to draw into question, through the examples of the film, the assumption that moral problems admit of consistent resolutions which hold for any individual similarly situated —what has been called the central requirement for an adequate ethical theory. This requirement holds that any moral situation should admit of a “best” solution: one that maximizes utility, or one that achieves a just result, or one that passes the supreme test of morality —so acting that one’s maxim could be at the same time willed as a universal law.

Having been exposed to the videotape version of this case study for years and only recently becoming acquainted with the other characters in the drama as presented in the film, I now find myself increasingly inclined to say that Donald Coward properly insisted on his right to refuse treatment as a patient, but that his physicians were right as well, given their orientation towards the preservation and sustaining of life, doggedly to resist his demands to die, and that his mother, given that she had been designated the representative of her son’s interests, was right in acting as she did.

Yet, standard moral theories seem not to capture my intuitions. That none could know in advance the eventual outcome is clear. This seems to render act consequentialism inconclusive. But that survival in cases comparable to Donald Coward’s extent of injury was unprecedented also makes requires to the rule utilitarian’s strategies equally unproductive. I can imagine the participants each successfully applying Kant’s supreme test of morality to his own maxim successfully. And talk about the just outcome will no doubt provoke the relativizing response, “Just for whom?” What hat is one to make of the situation in which standard theoretical analyses fail to capture strongly-held and highly conflicting moral impressions? The stock answer seems to be: be prepared to regard some subset of your moral intuitions as incorrect; opt for that moral theory that preserves the greatest number of them; and jettison those not preserved by your theoretical commitment as unreliable intuitions. My suspicion, however, is that the problem lies not with just my own moral sensitivities, but that the clash between my intuitions and the theoretical options apparently open to me may be due to the operation of deeper flaws within the approach and presuppositions of contemporary bioethics as a discipline in which those theoretical options find their currency. More on this issue after the film: I want first to invite your sharing of my impressions.

[Here the film is shown.]

Post-screening reflections
Renée Fox and Judith Swayze, two medical sociologists, returned from a visit to China and wrote an article provocatively titled, "Medical Morality is Not Bioethics." There they held that bioethics is characterized by a “cultural myopia” that “generally manifests itself in the form of systematic inattention to the social and cultural sources and implications of its own thought.” (Fox & Swayze, 1984, pp. 337-338) While in China (this is also true of the discipline of sociology) questions of community and social relations are understood to be at the heart of ethics, in American bioethics that heart is seen to involve “the individual seen as an autonomous, self-determining entity rather than [one] in relationship to significant others.” (Fox & Swayze, 1984, p. 338)

They continue their excoriation as follows:

It is in the values and beliefs emphasized and deemphasized by bioethics, and in its cognitive framework and style, that its Western and American orientation is both most evident and most fully articulated . . . . Individualism is the primary value-complex on which the intellectual and moral edifice of bioethics rests . . . . The notion of contract plays a major role in the way relations between autonomous individuals are conceived in bioethics . . . . Little mention is made by bioethicists of what Emile Durkheim termed the “non-contract aspects of contract”: that is, the more implicit and informal commitment, fidelity and trusts aspects of social relations that reciprocally bind persons to live up to their promises and their responsibilities to one another. (Fox & Swayze, 1984, pp. 352-353)

They continue:

The emphasis that bioethics places on individualism and on contractual relations freely entered into by voluntarily consenting adults tends to minimize and obscure the interconnectedness of persons and the social and moral importance of their interrelatedness. Particularly when compared with Chinese medical morality, it is striking how little attention bioethics pays to the web of human relationships of which the individual is a part and to the mutual obligations and interdependence that these relations involve. Concepts like reciprocity, solidarity, and community, which are rooted in a social perspective on our moral life and our humanity, are not often employed . . . . Social and cultural factors are largely seen as external constraints that limit individuals. They are rarely presented as enabling and empowering forces, inside as well as outside of individuals, that are constituent, dynamic elements in making them human persons. The restricted definition of “persons as individuals” and of “persons in relations” that prefaces bioethics makes it difficult to introduce and find an appropriate place for values like decency, kindness, empathy, caring, devotion, service, generosity, altruism, sacrifice, [loyalty, gratitude,] and love. All of these involve recognizing and responding to intimate and non-intimate others in a self-transcending way. Although these principles and qualities are esteemed in bioethics as exemplary and meritorious, they do not fit neatly and logically into its moral framework. There is a real sense in which they fall outside the tight range of variables that are defined as generically “ethical” by this field. For values like these, that center on the bonds between self and others and on community, and that include both “strangers” and “brothers,” and future as well as present generations in their orbit, are categorized in bioethics as sociological, theological, or religious rather than as ethical or moral. (Fox & Swayze, 1984, pp. 354-355)

They conclude:
In the prevailing ethos of bioethics, the value of individualism is defined in such a way, and emphasized to such a degree, that it is virtually severed from social and religious values concerning relationships between individuals; their responsibilities, commitments, and emotional bonds to one another; the significance of the groups and of the societal community to which they belong; and the deep inward as well as outward influence that these have on the individual and his or her sense of the moral. Social dimensions of ethicality are largely compressed into and meted out through a “do good” and “avoid harm” idea of beneficence. To this narrowly gauged conception of individualism, bioethics attaches an inflated and inflationary value. Claims to individual rights phrased in terms of moral entitlements tend to expand and to beget additional claims to still other individual rights. In these respects, the individualism of bioethics constitutes an evolution away from older, less secularized and communal forms of American individualism (Fox & Swayze, 1984, p. 358).

I must apologize for reading such a long quotation to you. I beg your indulgence of it as an example of what it the proper function of quoting others — to provide evidence for a certain point one is trying to make.

It is interesting to see how bioethicists react to such a polemic. Samuel Gorovitz, senior editor of one of the first anthologies in the literature of bioethics and a founder of the discipline, responded to Fox and Swayze in an article titled “Baiting Bioethics.” (Gorovitz, 1986)

He argues that it is not true “that individualism and autonomy have an illegitimate hegemony in bioethical thought,” on the grounds that there are prominent analytic bioethicists, such as Peter Singer and Arthur Caplan, who hold views that recognize that “different principles may be relevant in thinking through a case depending upon the presence or absence of such relationships as friendship, kinship, leadership, etc. . . .” He chides them for misrepresenting his own position on autonomy. They quote him as saying that respect for personal autonomy commits us to the view that “individuals are free to be and do as they see fit, so long as they do not violate the comparable rights of others” (Fox & Swayze, 1984, p. 352), omitting later statements to the effect that “it is obligatory to leave people alone, unless we have powerful reasons for not doing so. Such reasons arise with remarkable frequency, however” (Gorovitz, 1982, p. 36), and include “the existence of special relationships such as those binding a patient with a guardian, brother, spouse, or physician.” (Gorovitz, 1986, p. 367)

At the same time, Gorovitz grudgingly admits to a grain of truth in what Fox and Swayze say. “What apparently needs greater acknowledgment [in bioethics] is that our aspirations are fundamentally interpersonal, as is our character as individuals . . . . What and who we are is itself a product of our connectedness with our backgrounds and with others in our environment . . . . [A]utonomy is a value that enables us to function in a climate of mutual respect, within which each person enjoys wide latitude in the formation and definition of relationships with others . . . . Indeed, perhaps the climate of receptivity that has sustained Nozickian [Robert Nozick] political philosophy, despite its severe foundational problems and the narrow, sterile, moral isolationism it suggests, is due in part to our having paid too little explicit regard to the moral and even political significance of the full range of associations we have, including those spontaneous and affective relationships that Tonnies (1957) called Gemeinschaft—families, friendships, neighborhoods, religious communities—where participation is often either not voluntary at all, or is voluntary not through formal association, but much as Socrates’ Athenian citizenship was voluntary.” (Gorovitz, 1986, p. 368) Perhaps this grain of truth points to the fact that bioethics is yet a young discipline, with much more to be done both by way of articulating the rightness of
values and felt obligations of persons in genuine moral quandaries and by way of placing the discipline's achievements to date in proper perspective.

My point is complete for today. Our discussion of this film, I suggest, should explore the social role-governed responses of Ada Cowart (Donald's mother), of his physicians, of his attorney. Let us not too quickly jump to a solution of the question posed by the sub-titled of this talk, for to do so is to invite another round of bioethics' myopic oversimplification. But, rather than over-determine the discussion by giving my own analysis of the case, let me open the floor to your discussion.

Bibliography


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