

DEATH WITH DIGNITY

An Inquiry Into Related Public Issues

HEARINGS
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
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PART 1—WASHINGTON, D.C.

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¹Senator Winston Prouty, Vermont, served as ranking minority member of the committee from September 1969, until his death, September 10, 1971. Senator Robert T. Stafford, Vermont, was appointed to fill the vacancy on September 17, 1971.

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DEATH WITH DIGNITY

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MONDAY, AUGUST 7, 1972

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met at 10 a.m., pursuant to call, in room 1224, New Senate Office Building, Senator Frank Church (chairman) presiding.

Present: Senators Church, Fong, and Percy.

Staff members present: William E. Oriol, staff director; Patricia Callahan, professional staff member; John G. Miller, minority staff director; Gerald D. Strickler, printing assistant; and Pam Phillips, clerk.

OPENING STATEMENT BY SENATOR FRANK CHURCH, CHAIRMAN

Senator CHURCH. The hearing will please come to order.

Today the Senate Special Committee on Aging begins a frankly exploratory inquiry into public issues related to a subject which is sometimes called "Death With Dignity," or "The Right To Die," or by other titles which question the right to prolong life by extraordinary means when all hope for recovery—or in some cases, even for consciousness or lucidity—has vanished.

Several points should be made at the very outset of these hearings.

One is that the committee has no preconceived conclusions, nor are we floating trial balloons on proposals for governmental action. We realize that we have a long way to go before we can even begin to think about changes in public policy, if indeed such changes should prove to be desirable.

Second, this inquiry is not a hearing on euthanasia. As one of our witnesses will make clear, there is a great difference between what he and others envision as "death with dignity" and what others call "mercy deaths."

Let me emphasize again that this hearing has nothing to do with euthanasia.

Third, several of our witnesses will necessarily deal with ethical and even spiritual questions. But the committee must, of equal necessity, deal primarily with public issues. We will not invade matters that should remain the exclusive domain of family, clergy, and physician.

Fourth, the committee hearing records will remain open until a valid sampling of opinion and data have been assembled.

From what I have said thus far, it should be clear that the committee is taking a cautious and—I would hope—a tactful approach to our subject.

Part of our concern is caused by the very title of our committee: the Senate Committee on Aging. Members of that committee have done everything within their power to make the lives of older Americans as secure and as satisfying as possible. We want to take no action that will in any way suggest that we regard any person as expendable, whether that person is 1 year old or 100 years old.

But we must face the fact that the "Right To Die" issue has its greatest impact upon our elderly population. Chronic illness and terminal illness will increase as our population of older, and very old, Americans continues to increase. Today's unresolved questions related to our subject are likely to intensify unless, finally, they are faced squarely.

What, then, are those issues? From what I have already said, it should be clear that one of the functions of these hearings should be to define those issues. They cannot be spelled out in an introductory statement.

But they should at least be described in outline. And that outline should begin with this fact: at least 80 percent of the population of this Nation now dies in institutions—hospitals, nursing homes, and other facilities of one kind or another.

Yet, not very long ago, the largest percentage of Americans died in their own homes, quite often with other generations of their own families in residence or nearby. Lingering illnesses, of course, occurred with some frequency, but more often than not there was no practical way of keeping persons alive after they had lost conscious relationship to the world around them.

Today, the very institutions and medical talent that have triumphed over many illnesses are also coming under criticism because of the way in which they deal with the terminally ill, or apparently terminally ill, patient.

To the author of the classic, "On Death and Dying," it appears that the machinery of the modern medical institution sometimes crushes the dignity and the comfort of a patient even while it works to save his life.

Her basic point is that the patient may be treated like a thing rather than a person. Decisions are frequently made without his opinion, even on major questions of treatment. He becomes, as the book says, an object of great concern and great financial investment.

Furthermore:

"He may cry for rest, peace, and dignity, but he will get infusions, transfusions, a heart machine, or tracheotomy if necessary. He may want one single person to stop for one single minute so that he can ask one single question, but he will get a dozen people around the clock, all busily preoccupied with his heart rate, pulse, electrocardiogram, or pulmonary functions, his secretions or excretions, but not with him as a human being.

"He may wish to fight it all, but it is going to be a useless fight since all this is done in the fight for his life, and if they can save his life they can consider the person afterward. Those who consider the person first may lose precious time to save his life!"

Dr. Elisabeth Kubler-Ross, who wrote the book, is one of our witnesses this morning, and we will want to hear more about her conclusions, many of which were reached after interviews with terminally ill patients. We will also invite testimony from others who may not share her conclusions about the way in which our institutions work.

But for Members of Congress, her indictment has special meaning because so many actions taken by Congress within recent years are directly related to the type of institutions available to most Americans.

It has been said, and I am sure it will be said at these hearings, that medicare puts entirely too much emphasis upon institutionalization of patients, thereby increasing costs of treatment and anxiety among patients. That criticism is being acknowledged by the Department of Health, Education, and Welfare at least to the extent that many statements are made about the need for alternatives to institutionalization.

But at the same time we see much evidence that actual practices fall short of public pronouncements. Recently, for example, the Senate Committee on Aging issued a report which disclosed that the number of home health agencies in the United States has actually *declined*, despite all the talk, within the last 2 years. The report cites Medicare regulations and practices which have contributed to the decline of such agencies.

Another cluster of complaints centers around Medicaid and reimbursement of long-term care facilities. Too often, the Committee on Aging has been told, Federal funds are used simply for minimal maintenance of chronically ill persons when, with more understanding and skill, they could be better served, possibly at lower cost.

I am sure that many administrators of institutions are already struggling to provide humane and sensible treatment to the terminally ill and everyone else who comes to them for care.

But, as will be explained by at least two of our witnesses, a fundamental difficulty in serving a dying patient is that our present health care system may simply not be geared to provide appropriate services and surroundings for such patients.

One of those witnesses will describe efforts to establish a "hospice" which will involve patients and families in an effort to—as the sponsors of this proposal describe it—"face with dignity and meaning that part of life we call 'death.'"

This brief introductory statement would be incomplete if I did not at least acknowledge awareness of the fundamental question: when is an illness truly so hopeless that no fight should be made against it?

To the patient, exhausted and tormented by pain, the will to resist may seem to be merely a way of prolonging agony.

To the family, conflicting emotions of guilt and concern may make their judgments invalid.

To the physician, the disciplined determination to maintain life may overcome all other judgments.

One of our witnesses, a physician, will say, however, that such judgments must be made when the alternative is prolongation of life without meaning or satisfaction.

Another witness, also a physician, will say that incurability must not be equated with hopelessness, and that there is no certainty that the apparently terminal case will always result in death.

That difference of opinion sums up, in my view, the sensitiveness and the importance of the hearings which now will begin.

Clearly, there are no easy answers. But there should be public discussion and greater public understanding of issues related to death and dying in the United States today. Unwillingness to face such issues is probably rooted in our reluctance to think about our own mortality. But life can have more meaning if we make the end of it as worthy as the span of it. We are here today with that purpose very much in mind.

Senator FONG. Mr. Chairman.

Senator CHURCH. Senator Fong is the senior ranking Republican member of our committee.

STATEMENT OF SENATOR HIRAM L. FONG

Senator FONG. Mr. Chairman, the hearings of the Special Committee on Aging which begin today on the subject of "Death With Dignity" deserve our careful attention. The issues involved are most important.

It is my understanding that witnesses today, tomorrow, and Wednesday will offer different points of view regarding the right of an individual or an individual's family to reject life-sustaining medical services when an illness appears to be hopeless, but the controversy on this question in itself shows that answers are not easy.

I presume that questions which will be explored include: When is an illness hopeless? Are there values more important to an individual than life? Who ultimately should have the power of decision—the sick person, the family, his physician?

I will listen with great interest to the various answers which will be advanced today to these and equally intense questions. It is my sincere hope that the witnesses will be able to provide new insights into a problem that becomes more critical as the medical profession expands its ability to prolong life. Does there come a time when such prolongation is inappropriate? Does there come a time when there is no hope?

Mr. Chairman, I am pleased that you have scheduled these hearings. I know they will help in giving us a little more knowledge on the subject of "Death With Dignity."

Thank you.

Senator CHURCH. Thank you very much, Senator Fong, and I want to say that before the committee undertook to set up these hearings we discussed the matter with all members of the committee who felt that the time had come to open up a public inquiry into a subject that heretofore had been regarded as taboo; and we are doing this, as I have previously stated, without any preconceived conclusions. We are merely seeking information from qualified witnesses.

Our first witness is Dr. Arthur E. Morgan. He is accompanied by David Bishop, a student. Dr. Morgan comes from Yellow Springs, Ohio; he is a former president of Antioch College and is presently at the ripe young age of 94.

I would like to say also that Dr. Morgan served as the first chairman of the Tennessee Valley Authority. He is a very distinguished citizen of this country and we are very pleased, Dr. Morgan, to welcome you to the committee this morning and we would like very much to hear your testimony.

**STATEMENT OF DR. ARTHUR E. MORGAN, YELLOW SPRINGS, OHIO,
FORMER PRESIDENT OF ANTIOCH COLLEGE, ACCOMPANIED BY
DAVID BISHOP, STUDENT**

Dr. MORGAN. More than 50 years ago, my then wife Lucy was moved to express her opinion on death. She called that expression "On Drinking the Hemlock." Perhaps 20 or 30 years ago I published it and it has been somewhat widely read.

I am here today to enlarge upon her statements and to try to see relationships involved in them.

Until two or three decades ago, the suggestion that a right existed to discontinue life would have been vigorously opposed by persons holding contrary convictions, even when life had lost all evidence of value and had become only a tragic and negative experience.

However, during the past three decades in both Europe and America there has been a loosening of old doctrines greater than has occurred since the days following the lives of Copernicus and Galileo 400 years ago.

The present change is taking the form not so much of a formal surrender of doctrines as of avoiding or ignoring them. The plain word "suicide" may be shunned for half a century longer, while we yet give attention to the desire to cease to live when all the experiences of life have become strongly negative.

RELIGIOUS BODIES ACTING TOGETHER

It is becoming increasingly customary for the several religious bodies to give less attention to their differences and to act together in meeting the current demands of life, recognizing their shared purposes. A widespread, informal, and largely unpublicized habit of planning and working together as a single organization is becoming the active practice of a range of religious affiliations in Europe and America: Jews Catholics, Methodists, Lutherans, Quakers, Episcopalians, and others.

Opposition in thought and action will not suddenly cease, but there is opened a broad area of cooperation without definite boundaries. Thus there are emerging united practical efforts to find solutions to problems which only a few generations ago would have seemed insoluble.

This new spirit of cooperation seems to provide a promising atmosphere for finding realistic answers to a persistent and acute problem and holds hope for your undertaking.

You face a great and tragic field of human need. But it is in just such emerging areas that sound, careful judgment is most necessary. In planning legislation, the aim should be to insure overall appraisal in accord with the greatly varying conditions requiring consideration.

Legislation bearing upon the right to live should be as effective in protecting life, where circumstances indicate that course as desirable, as in providing for the ending of life where that conclusion is called for.

Selfishness, indifference, and cravings for material advantages are common human traits, and the elderly or disadvantaged may be peculiarly susceptible to neglect or exploitation, sometimes without friends or resources for protection. Arbitrary powers of action or of influence in such instances are especially in need of regulation in regard to the vulnerabilities of age or circumstance.

LEGAL CONSIDERATIONS

In many cases, continued living is an unalloyed liability, giving none of the values of life to the person involved. However, the decision to cease living should have legal consideration before action. Even the decision of the person himself may have been induced against his own judgment, simply by acquiescence.

Should it not be social custom in matters of life and death that a legal verdict be required? Quite commonly the issues will be so clear that legal determination will be little more than a form. Furthermore, in cases where the person chiefly involved may be largely without self-determination, a legal and social judgment would seem to be sound public policy.

Quite obviously, the real burdens sometimes placed upon others by the necessity of caring for persons for whom life has lost all meaning, or for the hopelessly aged or infirm, must also be considered.

There are diseases and disabilities characterized by disorganization of the brain, especially congenital anomalies and vascular diseases of the brain, including those referred to as presenile dementia and encephalitis, which lead to permanent and irrecoverable and complete loss of intelligence and awareness which lasts through life, sometimes 20 or 30 years or more.

In many instances the care of such cases through the years monopolizes family activities and attention with no relaxation and the certain prospect of no recovery. The necessary continuance of life in such cases often represents unrelieved tragedy for the responsible individuals or families, or the waste of institutional facilities.

Experienced and representative physicians hold that this class of totally incurable disability has called long and loudly for relief which up to the present has been denied. I have known cases where the presence of a near idiot in the family was taken as a family obligation, and where the life plans and prospects of one or more family members were consumed in the custodianship of such a person.

In some cases the wholly irresponsible person has remained a useless, unproductive, and uncooperative individual, depleting common resources and diminishing useful occupation, with no capacity for participation in reducing this burden. Sometimes the keeping of a totally disabled person who is getting very little but misery from his remaining years takes up almost the entire family income. Outside judgment would seem to be appropriate in such cases.

On the other hand, many persons are disposed of by their guardians in institutions. Sometimes people with possible productive and enjoyable years left are simply assigned to an oblivion which may be worse than death.

And sometimes concern for the aging or otherwise dependent person calls for legal considerations which go beyond a decision as to life or death, such as public support for the disabled person whose life is, on balance, worth continuing, but for whom resources for essential care are lacking.

At the present time, provision for such cases is very inadequate, and the need for legislation is imperative.

Senator CHURCH. Thank you very much, Dr. Morgan, for your statement. I have two or three questions I would like to put to you.

First of all, you warn that the elderly may be particularly vulnerable if arbitrary powers of action or influence are imposed when suspension of treatment is considered. I would appreciate your discussing this further, and particularly, I would appreciate any further details you might give on how a legal verdict in such cases could be arrived at.

Dr. MORGAN. I think it must be partly by a spirit of understanding. My late wife spent 3 years in a nursing home. We found it impossible to give satisfactory care in our home, as much as we tried to, and I personally had to be away for an operation, and she went to the home while I was away.

I observed in that home a great range of conditions. The proprietor of the home took the position it was their business to keep people alive just as long as they could. In Mrs. Morgan's case, she had fallen on a pavement and cracked her skull, and her mental condition was modified; there came a time when she had lost sight and speech and hearing and much motion, and she was just staying there. For a good while the affection between us was enough to give joy and cooperation.

The time came when she could scarcely express herself, and she opposed having the nurses pry her mouth open to put food in it, and I tried to have them change the policy in that case, and toward the end she was allowed either not to eat and so forth and her last days were not disturbed as they might have been otherwise.

I observed in that same institution one woman who had an injury in midlife which prevented her being active in work and so forth. She had to be wheeled around, but her mind was alert. She was quite a person, but her husband just put her in the nursing home and left her there. She was living out her life with very little interest, and I believe she was entitled to some human concern.

And I saw in that place a great range of lack of care of people with capacity for interest, and on the other hand, the people who had lost all power of discretion and so forth.

I think that we must accept appraisal of cases by competent persons to see that mistaken choices are not made and that the law can further that discretion.

Senator CHURCH. Dr. Morgan, your testimony flatly says that some diseases cause irrecoverable changes in awareness, and yet some physicians say that no illness should be regarded as hopeless. They argue that a new treatment may change the picture entirely.

What do you say to that?

Dr. MORGAN. I would say that the probabilities must be judged by experience, but in cases where the record has been that there is no recovery, and there are such cases where the deterioration of the brain has gone a good ways and there is no record of recovery, in such cases, that the life of the person involved is not the only issue; the family and friends who must give up their lives to take care of an insensible person who just continues to live because he can't help himself is probably just as important an issue.

For 10 or 20 years for several family members to be giving up their normal life to take care of an insensible person is too great a price to pay for keeping an unbroken record of no cure, and I think with the diagnosis today we can have some judgment of brain deterioration which never does heal.

Senator CHURCH. We are going to pursue these questions further with other witnesses today, tomorrow, and the next day.

There is one final question I would like to put to you, Dr. Morgan, and that is this. As you said, your wife wrote an article in which she raised the question of the right to "Drink the Hemlock." It has been reprinted in the Washington Post and in the United Methodist and other publications.

I think for purposes of the record I would like to insert the text of the article in the record at this point.

Dr. MORGAN. All right.

(The article referred to follows:)

ON DRINKING THE HEMLOCK

(By Lucy Griscom Morgan)

The average duration of life in America has increased greatly in the past half century. This change is usually referred to as an unmixed blessing. But is it?

So far as the added years are a result of a lowered infant mortality, there can be no question of the benefit, and the same is true of the lives saved by modern control of disease. Where I question its value is in the prolongation of helpless old age.

My father and mother both died on the farm at about sixty. Until their last illnesses, they were active and vigorous, and life seemed good to them in spite of the lack of modern sanitation or lighting in the house. All of their brothers and sisters went to the city, lived in modern houses and openly pitied my mother's lot of farmer's wife. In their protected environments, they have gone on living, until their average age is eighty. One is blind, one is terribly crippled with rheumatism, the keen mind of another is entirely faded, and the oldest, though he lives as a cherished possession in his son's beautiful home, is cared for by a paid attendant. With his contemporaries all scattered. I hardly wonder that he longs to die.

They still say to me, "If only your mother could have led an easier life, she might be with us still." But there has never been a question in my mind that her fate was kinder.

As I look about in my husband's family and in the family of my friends, I see many similar situations. Our little York State village is full of very old people who left the farm, and came to modern houses where, unexposed to the weather and carefully fed, they find trouble in dying even when their bodies are too worn out to give them much pleasure.

One case in particular has made the problem a very real one for me. An old lady of eighty-eight, a childless widow for over fifty years, had been living during most of that time in comfort on her income. All who knew her in the past tell of her wit and charm and joy in life. As her health failed, she lived at a sanatorium. The doctor was good to her and though her means lessened with the decreased buying power of the dollar, he still allowed her to remain. With his death and a new regime, she could not afford to stay, and thought of the pleasant village where she had lived as a bride. She heard of a gentlewoman there who took boarders, and arranged to go to her. Childishly ignoring the facts, she wrote that she could attend to all her own wants. When she arrived, it appeared that she could not even go up and down stairs alone, and that her sight was nearly gone. She was exacting beyond all reason and querulous when not pleased.

After two years she was asked to leave and I, even though an outsider, was drawn into the hunt for a refuge for her. Children of her friends, mindful of their parents' old affection for her, forgave her peevishness and attempted to get her settled. In vain we tried hospitals large and small, old ladies' homes, private homes. No one would take her.

Practical nurses came and went. She disliked them all and her tongue alone of all her members remained active. Finally her heart apparently ceased to beat and the doctor was summoned to give the situation its legal status. Unfortunately, he felt it his duty to revive her if possible. With the help of modern science, he finally stirred up her poor old heart so that it went on more or less spasmodically, and with terrible suffering to her, for eight months longer.

Her friends' children rallied financially and saw that her hostess was paid in money; but as I look at this woman's worn face, I realize that she can never be recompensed for those months of nursing. I see as I never did before that one element of the increase in average age is largely a prolongation of senility, and that it must be heavily paid for by the rest of society. The money and effort expended on that old woman during those last four years would have been enough to happily care for at least three children during that time, and they might now be an asset to the community and to themselves. She never was.

One of my friends who had the care of a senile mother-in-law sadly counted up its cost to her little children. I could not but rejoice for her when she lost her burden.

Having become interested in the subject, I have sounded out a number of my friends. I find an almost unanimous feeling that we will never suffer ourselves to be such a burden to our children or children-in-law. We are none of us afraid of the grave, and have no feeling of desire for life when usefulness is over.

We do not want to give up our present comfort in order that exposure might bring us to a timely end, and we do not want to disgrace our families by anything spectacular. We do wish we might help to bring about a change in public opinion so that it would be recognized as honorable and proper for a person who has done a good life's work and is honestly weary from the burden, to so signify. We feel that after mature consideration, such a one should be allowed to drink the hemlock in some dignified and simple way.¹

We also feel it no longer should be a professional duty in a physician to needlessly prolong suffering in a very old person. This, I think, should apply also to people about to die from any hopeless and terrible disease.

Many people object, saying, "Oh, such a policy would lead to great abuse." Probably there would be cases in which the younger generation would encourage the wish to die, in order that it might get an inheritance sooner. A very suitable policy would be for the parents to arrange to receive a reasonable annuity, calculated on buying power and not merely dollars, and let the children have the bulk of the estate when their children are young and when they need it most.

No one realizes more than I do that some people can be young and worthwhile at eighty or even at ninety as was Dr. Charles W. Eliot. Just so, some people can do with very little sleep, but I do not feel that they should keep the rest of us out of bed when we are too weary to work, or need paid help to prop our eyes open.

I dearly love my elderly relatives. None of their burdens fall on me and I shall miss them when they are gone. Nevertheless it is the duty of those who observe this growing tragedy of senility, to express the need of a new attitude in the public that will allow people to pass on voluntarily.

Senator CHURCH. You spoke of your wife's last illness, and the only question I would like to ask you is: did her views change at all as she approached death?

Dr. MORGAN. I don't think so, except that the value of friendship and affection was a reality to her and life seemed good to her quite a way through her illness. She had brain injury and this deterioration never recovered, but for a couple of years, although her nursing home was 8 miles from home, I used to visit her every day, and she once said to me, "I wish there were somebody I could talk to; I would like to tell them how much your visits mean to me."

Her expression was imperfect, but she would sometimes speak a little and say, "This means so much to me."

Later, her responses were largely ended and life was mostly a burden. And she was trying to keep from being fed, and they were prying her mouth open to feed her. I insisted that they should not compel her to eat if she didn't want to eat, and they shouldn't inject medicine into her body.

¹I have a suspicion that the aged Socrates refused to make the concessions that would save his life, partly because he realized his work was done, and that years of senility loomed ahead.

Senator CHURCH. Senator Fong, do you have any questions?

Senator FONG. I have no questions. Thank you.

Senator CHURCH. Dr. Morgan, we have three other witnesses—all of them are M.D.'s—listed this morning. I would like to call them up for testimony and then to call you back to sit on the panel with the others as time permits.

I don't want to keep you up here at the witness table during that time; I would like you to be more comfortable. Then when we have the panel, if you would like to come back you would be most welcome.

I want to thank you very much for your testimony.

Senator CHURCH. Our next witness is Dr. Elisabeth Kubler-Ross, an M.D., from Flossmoor, Ill., who is the author of "On Death and Dying."

Dr. Ross, we appreciate your testimony this morning.

If you have a prepared statement you would like to make, why don't you proceed to make it, and then we will have questions.

STATEMENT OF ELISABETH KUBLER-ROSS, M.D., FLOSSMOOR, ILL.

Dr. Ross. Senator Church, Members of the Senate, I have been asked to share my experiences in the case of the dying patient, with special emphasis on dying with dignity.

I do not like to talk about dying with dignity, but I would like to talk about living with dignity, and I think that makes a difference.

I have interviewed over 500 terminally ill patients and asked them to share with us what it is like to be dying, what kind of needs, fears, and fantasies those patients have, and, perhaps most important, it tells what kind of things can we do, by which I mean family members and members of the helping professions, to be more helpful.

We started this project not as a research project or anything planned, but as a chance happening. I think it became important that I was born and raised in Switzerland. In the old country—and I guess in the old times in this country, also—death was part of life, like birth is.

When I was a child, people used to be born at home and often died at home. Dying patients were not very often institutionalized. This did not make dying easier for the dying patient, but I think most important of all, it helped the children and grandchildren to learn that death is part of life.

When I came to this country, I was very impressed that the children are not allowed to visit patients in hospitals or the mental institutions. Very seldom you hear the laughter of children in nursing homes. And I have seen hundreds of people in this country who have never experienced a death in the family. What we have learned from interviewing over 500 dying patients—and I am not talking about dying children, who, by the way, die much easier than grownups—the majority of our patients want to die very badly at home. Yet, close to 80 percent of all patients interviewed died in an institution. Patients who can prepare themselves early and in a familiar comfortable environment for their impending death are better able to finish their unfinished business, to put their house in order, as they pass through the stages of dying, as I have outlined in my book, "On Death and Dying".

Family members still now believe that it is better "not to tell" the patient. We found the opposite to be true. If we will listen to the patient and talk with them about their illness, they will proceed much quicker to the stage of acceptance, and not resignation. Eighty per cent of our patients in nursing homes want to die very badly, but they are not in the stage of acceptance. They are in a stage of resignation, which is kind of a feeling of defeat, "what's the use, I am tired of living."

NEED OF THE PATIENT FOR HOPE

Patients have two basic essential needs when they are informed that they have a potentially fatal illness: The biggest need is always allow for hope. Hope is not the same as hope for cure treatment or prolongation of life. When a patient is dying, this hope will change to something that is not associated with cure treatment or prolongation of life.

To give you a practical example of how hope changes, like hope from the living to the hope of the dying, I visited a young mother with small children who had cancer. Each time I saw her, she said, "I hope those research laboratories work hard and I can get one of their new miracle drugs, and I get well." Naturally, I shared those hopes with her, though the probability was extremely slim.

One day I visited her, and she looked very different. She said, "Dr. Ross, a miracle happened." I said, "Did you get the new drugs?" She said, "No, I know now that these miracle drugs are not forthcoming, and I am no longer afraid." I asked her, "What is your hope now?" She said, "I hope my children are going to make it."

If we are not afraid to face and talk about dying, we would then say, "Do you feel like talking about it?"

As long as a patient is alive, he needs hope, but not the projection of our hope, which is usually a prolongation of life.

Besides the need for hope, patients need a reassurance that they will not be deserted, yet most of our patients who become beyond medical help feel deserted.

To give you a brief clinical example of what I mean by the loneliness of dying, I had a 28-year-old mother of three small children with liver disease. Because of her liver disease, she was going in and out of hepatic comas, and became frequently confused and psychotic.

Her husband could not take it any more. He had spent all his savings on doctor and hospital bills. He had these three little children. He had no homemaker, no help whatsoever. He was heavily in debt, and he never knew when he came home from work whether his wife was still functioning.

One day he said, "It would be better if you would live one single day and function as a housewife and a mother, rather than to prolong this misery any longer."

Unfortunately nobody helped this desperate husband and father, who tried unsuccessfully to provide for his family, The patient herself desperately looked for hope, which nobody gave her. She went to the hospital, where a young resident told her, "There is nothing else I can do for you."

She then went home, and in her desperation went to a faith healer, who told her that she was cured. She believed this, and stopped taking

the medication, stopped taking the diet, and she again slipped into a coma.

Nobody helped this family. She was again admitted to the hospital. By then, the family had it. They just could not cope with it any more.

In the hospital, the same tragedy: The medical ward wanted to transfer her to the psychiatric ward and the latter did not want a dying patient and insisted that she be kept on a medical floor. They could not tolerate this woman who walked up and down the hallway talking about God's miracles, of the faith healer who cured her.

It become like a ping-pong game, and this is the tragedy of hospitalized patients who cause all these anxieties in us. We don't know what to say or do with them.

I told this woman that I would never talk with her about her illness or dying, and I would not desert her. "Let's only talk about the present." She became the best patient I ever had, but she was put in the last room at the end of a long hallway, farthest away from the nursing station.

Not one door closed, but two doors. She never had a visitor.

This woman, when I visited with her one day, sat on the edge of the bed with the telephone off the hook in her hands. I said, "What in the world are you doing?" She said, "Oh, just to hear a sound"! This is the loneliness of the dying patients that I am talking about.

Another time, she was lying on her bed smiling, with her arms stiff down the side of her body and I asked her, "What in the world are you smiling about?" She looked at me and said, "Don't you see these beautiful flowers that my husband surrounded me with?" Needless to say, there were no flowers.

It took me a while to appreciate that this woman realized that she just could not live without some expression of love and care, hopefully coming from her husband. In order to live, this woman had to develop a delusion of flowers, sent to her by her husband after her death.

SUPPORTIVE HOME AIDS

This is the loneliness I am talking about. And these things would be preventable if we would not hospitalize all these patients, but if we could give the family some help at the beginning, if we could occasionally relieve them with homemakers, if we could send physicians and caseworkers to their homes, so that this last hospitalization can be prevented, and the dying patient can at least die in his own home, surrounded by the children, and also in the familiar environment that they have lived, and where they have been loved. But in order to do this, we have to give help not only to the dying patient but to such desperate husbands who try to make ends meet and just cannot make it alone.

A DEATH-DENYING SOCIETY

We live in a very peculiar, death-denying society. We isolate both the dying and the old, and it serves a purpose, I guess. They are reminders of our own mortality.

If I am allowed, I would like to read Joseph Matthews' description of the death of his own father, a classical description of a death denying society:

My father, I say, was 92. In his latter years he had wonderfully chiseled wrinkles. I had helped to put them there. His cheeks were deeply sunken; his lips pale. He was an old man. There is a kind of glory in the face of an old man. Not so with the stranger laying there. They had my Papa looking like he was 52. Cotton stuffed in his cheeks had erased the best wrinkles. Makeup powder and rouge plastered his face way up into his hair and around his neck and ears. His lips were painted. He looked ready to step before the footlights of the matinee performance.

I fiercely wanted to pluck out the cotton but was afraid. At least the makeup could come off. I called for alcohol and linens. A very reluctant mortician brought them to me. And I began the restoration. As the powder, the rouge, the lipstick disappeared, the stranger grew older. He never recovered the look of his 92 years but in the end the man in the coffin became my Papa.

Not only the needy lonely old people are isolated, not only the dying patients are getting lipstick on their lips in order to make them look younger, the young dying patient suffers perhaps the most because he is rarely allowed to die without heroic efforts to prolong his life—which often results in a prolongation of suffering.

And I thought as an example I would use this patient that some of you will remember, she was a 21-year-old girl with acute leukemia. She was young and full of life. When we interviewed her in our hospital, she said very loud and clear that although her chances were one in a million that her big dream was still that she could graduate in June from college, that she could get married in July.

Her bargain was that she would not have any children for 5 years, and if she would still be alive, she would then have lots of children and live happily ever after. But she also said she knew that her chances were one in a million.

She came back into the hospital 5 weeks later, again because the family could not get enough home care for her. Her biggest dream was to live at home, and possibly to die at home.

She was put into an intensive care unit. When I visited her on New Year's Eve, she was a picture of utter isolation, loneliness, and anguish. I came into the intensive care unit. She was lying there with tubes hanging out of her mouth, her lips cut, the infusion bottles going, a tracheostomy and the respirator, and she was desperately holding my hand.

I covered her with a bed sheet. (She was not even covered.) A nurse came and says, "Don't bother. She is going to push it off anyway." I walked toward her, and she grabbed my hands pointing her fingers to the ceiling. I looked up and said, "Susie, I think this light bothers you. You are lying on your back and must stare into this light." She grabbed my hands and kissed them obviously conveying "You are understanding me". I went to ask if these lights could be turned down, only to get a nice lecture about the rules and regulations of the intensive care unit.

I also asked for two chairs for the mother and father to sit down when they visit, because I cannot comprehend why patients have to die alone in an intensive care unit and their families sit alone outside in a waiting room. I was told the mother cannot get a chair because she stayed more than 5 minutes last time."

CHANGES NEEDED

This happened in my own institution, where I have been teaching the care of the dying patient for four and a half years. The reason I am using these examples, not to be judgmental, but because we have to face this together and do something about it! Nurses who work on cancer wards or intensive care units, have an extremely depleting and exhausting kind of work if they dare to get involved.

I am supposed to be a specialist, but I cannot do this work more than 4 hours at any given time. Then I need to switch gears or recharge my battery. But the nurses are supposed to do this 8 or 9 hours every day. This is inhuman and emotionally impossible.

If I could change the administration, I would ask these people to work 4 hours a day, so that they can look at a patient as a human being and don't have to depersonalize him, so that they can get involved. You can only do this a limited amount of time. If you are asking too much of them, they have to depersonalize, mechanize the care and in the process of it, the care must become dehumanized.

The physicians looked at this specific girl and called both parents at 7 p.m., telling them that it was a question of hours. Then they went home. They informed them, not in the hallway, not over the telephone, but in a private room. But then they went home. This is the tragedy. They accepted academically that this girl was dying, but inside there was no degree of acceptance.

If they had really accepted that there is a time to live, and a time to die, they would have taken this young girl out of intensive care unit at 7 p.m., put her in a private room, and had two chairs for the mother and father to sit with their child during the last hours of her life.

This is a question of reeducation of the public, not only physicians and nurses and social workers, but also families, who sooner or later have to be faced with a dying patient.

EDUCATION THROUGH EXPERIENCE

Why do I bring up all these specific examples? I think we can do something about it. I think we have to put much more emphasis on education, on teaching even small children that death is part of life, or inviting old people who perhaps don't have a family any more in our homes, to take them in as grandmothers and grandfathers, not only to give them the final care, but to allow our children to have an experience of having old and sick people in our house.

We should not institutionalize people. We can give the families much more help with home care, visiting nurses, giving the families and the patient spiritual, emotional, and financial help in order to facilitate the final care at home.

We very badly need alternative living situations like smaller housing units in hometowns which are financially accessible, and I am not going to talk only about the dying patient. We need retirement villages, not isolated from the center of life, in a community for the healthy old people.

We need much more homemaker services, shopping services, delivery services, and much better medical services. Indeed, transportation to physicians, and encourage more physicians who make house calls.

Nursing homes should be part of other facilities, not dead ends. Every nursing home in my opinion, should have a day care center on the premises, where the elderly, lonely person can become a grandparent to a lonely, needy child. It would take much less staff, it would cost less money, and it would also teach the young child that old age can be a source of wisdom and love, even when the eyesight fails and the steps slow down.

Children should be allowed and encouraged to visit mental institutions, old age homes, and hospitals, so that they grow up knowing that old age and death is part of life, just like birth is. Thank you.

Senator CHURCH. Thank you very much for your very moving testimony, Dr. Ross.

I understand you are a psychiatrist, and that your observations are based upon interviews with 500 or more dying patients. Is that correct?

Dr. Ross. Right.

Senator CHURCH. As I understand your testimony, would it be accurate to say that your theme really is that we live today in a death-denying society?

Dr. Ross. Yes.

Senator CHURCH. And we pay heavily for this in nearly every way. There has been so much criticism, much of it self-criticism, of our contemporary society on the grounds that it is becoming increasingly dehumanized. Many young people have felt this. And surely it is in the way that we approach death and deal with death that this particular weakness in our society is most dramatically revealed.

I was interested in your observation that whereas in earlier generations families tended to live together, and several generations sometimes in the same home—in fact, that was typical, so that even young children became familiar with death as a part of life, but this increasingly has disappeared in America.

Your recommendations deal mainly with ways for changing the method of dealing with dying patients in institutions, do they not?

Dr. Ross. Yes.

CHANGING BASIC ATTITUDES

Senator CHURCH. What can be done about changing basic attitudes that living people have, who, faced with the imminence of death within the family, will insist that the dying person is not dying, and doctors who will refuse to disclose to the patient, or who are reluctant to disclose to the patient that death is inevitable, or sometimes even to the family? How do we reach and change these attitudes that in their accumulative effect really only make it all more agonizing for everyone concerned?

Dr. Ross. You can change these attitudes, and some of this is already beginning to happen. If you try not to be judgmental, if you would try to understand why these things are happening, then I think you can change something about it.

We train physicians basically in the science of medicine, that is, the cure, to treat, to prolong life. I think we should also add a few lectures on the art of medicine, and that is how to take care of the dying patient, and some old people who are not living and not dying.

If we can reach the medical students—we have been teaching medical students for the last 7 years—if you get to them as students, you

have a 95-percent batting average. If you get to them as externs it is easier than interns. Interns can be taught better than residents and after about 2 years of residency it becomes almost hopeless.

What I am trying to say is that we have to reeducate, and the earlier we start, the better we can help them.

The same thing goes for children. We have to include children in this experience. If a person dies at home, you should give the children a choice, if they want to come to the funeral. Don't send them away to relatives and exclude them! Those children will then grow up and learn to regard death as part of life. They will remember these shared experiences and hopefully not view death as such a horrible happening.

It is a question of reeducating the whole public. Nursing schools, social work schools, and medical schools have now started to include the care of the dying patient in their curriculum. Seven years ago, I was totally alone, and now there are about 75 institutions in the United States and Canada who have included the care of the dying patient in the curriculum. So as far as I am concerned, there is a lot of hope.

All of these young people will go out to teach other people the same thing.

Senator CHURCH. Do you know of any hospitals that follow your recommendations and have made special provisions for dying patients to better enable at least the closest members of the family to be present?

Dr. Ross. Yale University has now applied for grants to start such a hospital. It is similar to the St. Christopher's Hospital in London, which is exclusively for terminally ill patients.

Senator CHURCH. But this is just really in the beginning stages, is it not, as far as hospitals are concerned?

Dr. Ross. I think you cannot bring about real, meaningful change by revolution. It requires a slow-moving evolution and education.

Senator CHURCH. What, in your opinion, has been the effect of Medicare and Medicaid upon the problems that you have discussed this morning?

Dr. Ross. I am not very good in money matters, but I know that both Medicare and Medicaid tend to enhance institutionalization. The very first response is, "Let's hospitalize the patient."

I think many of these patients could be taken care of on an outpatient basis, if the financial and other necessary help would be forthcoming.

Medicare and Medicaid is, to me, not the total answer. I think if half of the money could be spent in helping to do preliminary workups and final care away from the hospital, preferably on an outpatient basis, we would not only help the patient to cope with it better but also help the family to come to grips with it and go through the stages which is best done in the home, not in an institution.

Senator CHURCH. In other words, if the program were modified in such a way that the financial help that is now given to pay for the hospitalization, or the nursing care and treatment, if in the alternative money could be available to promote care in the home, that this would be a great step forward?

Dr. Ross. A tremendous step, not only to the patient but also to the family. You see, the patient and the family have to go through the

stages of denial: The "No, not me" stage; the anger; the "Why me?" stage; the bargaining "Yes me but" stage; and finally the depression and final acceptance. The family also has to go through those stages, and it is very hard to go through these stages when a patient is in the hospital, and separated from the family.

If the patient and family can reach the stage of acceptance, the patient dies very peaceful, and the family who is left has no grief work to do afterwards. You can only do this if you have time to come to grips with it together.

FACILITIES FOR THE TERMINALLY ILL?

Senator CHURCH. There is one suggestion here, and I will ask it for the record. I have strong misgivings about this kind of approach, myself, but perhaps you have a different view.

Do you think a brick and mortar program should be launched to provide entirely any kind of facility for the terminally ill, or should we adapt our hospitals, nursing homes, and other institutions in conjunction with other kinds of care given at those facilities?

I think perhaps you have already answered that question, but what about the notion of setting up separate facilities for the terminally ill?

Dr. Ross. I would be very leery if the care of the dying patient would become another subspecialty. I would be opposed if we have some modern death houses which are institutions just for the dying.

Senator CHURCH. In other words, this would make a bad situation worse, would it not?

Dr. Ross. Yes, there is this danger.

It depends, naturally, on the atmosphere of the institution. Basically, St. Christopher's Hospice in London is a hospital for dying patients exclusively, but the atmosphere there is one of love, care, and acceptance, so it is a beautiful place to be, and I think if I would be dying, I would love to be in a place like this.

But this is something we really cannot duplicate in the United States. In England, it does not cost the patient a penny, because of the British system, and they can give them drugs (like heroin) so that they are totally awake and without pain to the very last moment before they die.

Those things are not duplicable in this country. I would be much more in favor that we train nurses, physicians, and social workers here who love to work with old and dying patients. Then you will not need special institutions for the care of the dying patient, and the majority would be allowed, at least for the final care, to be at home.

Senator CHURCH. How much of this education you have spoken of, education for nurses and for doctors to change the present practices in our institutions and to make some better provisions for dying patients—what about reaching out to the general public?

What I mean by that is that there is presently a feeling in this country that if a member of the family is fatally stricken, even if the family is aware of and fully told about the condition of the patient, there is a feeling of compulsion because of the mores of our society that the family should place that person in an institution, in a hospital, for example, where every facility is available to prolong the life as long as

possible, and where, inevitably, we will see in the progression of events the very kind of indignity about which you have testified.

Yet the typical family would feel constrained by the general compulsion, the general attitude that prevails in this country today, to do just this. It might not even occur to them, or they might think that there was something morally wrong or sinful in keeping that person at home, where the latest devices of science were not available to prolong life, so it seems to me it is an educational problem, if it is a problem, one that is not limited to the physician and the nurses in the institutions, but maybe one that extends to the entire country, the whole population.

Dr. Ross. When you talk to these families, it is sometimes very little things that prevent them from even considering taking the patient home. I have, every day, requests to help with making such a decision.

If these families had somebody they could talk to and consider the alternatives, if you can teach a wife how to give injections for pain for her husband, then she might consider taking him home, but somebody has to bring up the issue, "What is the problem? Why can't you take him home, if that is his biggest need?" And she may say, "Well, he is in so much pain and needs injections around the clock."

All it takes is to teach somebody to give injections. If you can teach it to diabetics, you can teach it to members of the dying person's family, too.

COUNSELING BY THE CLERGY

Senator CHURCH. And now, at the present time, that kind of counseling is almost unavailable, is it not?

Dr. Ross. Yes, except from the clergy. The clergy have been the only ones, but until recently they have not been trained in the needs of the dying patient.

Senator CHURCH. That was going to be my next question. Why have the churches so refrained from entering into this area, which seems to be the most natural one for them, and seems to be central to their whole purpose? Why, in your opinion, have churches and clergymen really failed to concern themselves about this problem, as much as one would think they would?

Dr. Ross. I don't know if they have really failed. I think they have been the only ones who at least face death once in a while. You appreciate that it is very hard to admit that people are so petrified to die, because if you are really a true Christian, for example, you are not supposed to be afraid to die. You are supposed to look forward to a better life after death, and it is very hard, then, for a normal human being to admit that he is scared, does not want to die, or might even have some doubts about the hereafter, so there is also a lot of conflict from what the church is teaching.

Senator CHURCH. You would think if our society as a whole is a death-denying society, at least the churches are not; and, therefore, is there not a larger role that the churches could play in adding greater dignity and comfort to the process of dying in this country?

Dr. Ross. I think they have made probably one of the greatest contributions in the last few years. I have seminaries of all denominations to teach the seminarians how to be more effective with a dying person, and that is true of priests, Protestant ministers, and rabbis.

Senator CHURCH. Senator Fong.

Senator FONG. Dr. Ross, how do you go about counseling people to accept dying? Should there be a person in each institution that is knowledgeable about this subject? Should there be somebody in the community, some agency whose sole purpose is to see that people are educated to accept dying? Should there be something like that?

Dr. Ross. It is very hard to tell. I don't think you can have one specialist in an institution who does all the counseling. That would again lead to a subspecialty of the sciences, the "thanatologist," so the physician would not get involved with a dying patient. The physician would take care of a patient as long as he could help him medically, and there is a chance of recovery. He would desert that patient when he becomes "beyond medical help" and call in the thanatologist—like a priest is called now—in the last moment to give the last rites.

Senator FONG. So we cannot look to the physicians?

Dr. Ross. Not exclusively. I think we have to include the needs and the care of the dying patient in social work schools, seminary schools, and medical schools, and there will always be a few who love to work with either old people or dying patients, and those are, then, the ones who will visit these people.

It is like in medical school—you always find a handful of medical students who are absolutely great for research. They make terrible clinicians, but they do well in research.

Senator FONG. Is there a movement now to have such a subject in the social work schools—

Dr. Ross. Yes.

Senator FONG (continuing). To counsel people to accept dying?

Dr. Ross. Yes.

Senator FONG. There is?

Dr. Ross. Yes. I have been teaching many, many schools of social work every year.

Senator FONG. And are the social workers equipped now to handle the subject?

Dr. Ross. More and more. It is still a tiny drop.

Senator FONG. Now, how do you approach the dying patient? Who makes the move to tell him, or to try to educate him? How does it come about?

Dr. Ross. You see, it is not that you go into the room of a terminal patient and say, "You are dying. Let's talk about it."

I think if he can go visit these patients, and if they look miserable or grouchy or bitter, somebody, whoever feels comfortable doing this kind of work, simply sits with them and says, "Do you feel like talking?" It is like opening floodgates.

Senator FONG. I come to that next subject.

DYING PATIENTS NEGLECTED

You feel that many of these people who are dying are being neglected?

Dr. Ross. Yes.

Senator FONG. Nobody comes to see them, or if somebody comes to see them, then certain things are not being done for them. You

mentioned this girl. She was looking into the light, and the light was very, very bright.

Now, how do we get nurses to show a little more solicitude? How do we get hospital aides and the people who are paramedical to help in this field, and how can we get the community to help?

For example, to get more people to do visiting; to visit the hospital? I know there are certain groups of people, ladies who volunteer to go to hospitals, but they sit at the desk and tell you what room a patient is in, but do you have a group that goes out and visits older people, people who are dying, people who need to be comforted? Can we increase that group of people to get into that act?

Dr. Ross. We have had the seminar on death and dying, where we interviewed hundreds of terminal patients in a screened room which was observed by social workers, nurses, hospital volunteers, medical and theology students.

These dying patients shared with us the most beautiful human doctrines of faith, hope, love, their anguish, and their needs.

You can have classes like this, and you don't stand up behind a desk and lecture to them. That is where the people who work with these patients can listen to what the dying patient himself has to teach; it is one of the most moving human experiences. I have seen very few of the hundreds and hundreds of members of the helping profession who have not become much more humanly involved with those patients, and this is something we have to include in the curriculum, and it is happening now.

There are many volunteers who sit with dying children whose parents live 3, maybe 4 hours away from the hospital. Their mothers may be pregnant or they have other children or they just have to be home with the children, so we ask volunteers to become substitute parents. They sit in the recovery room with them, they listen to their needs and help these children tremendously.

Those volunteers are marvelous, and we have many, many volunteers to do this work, and there will be more every year.

Senator FONG. Dr. Ross, do I understand that you are in favor of prolonging life as long as there is life? Would that be interpreting your thoughts correctly?

Dr. Ross. Our basic role should be to relieve suffering and not to prolong life.

I am against any form or shape of mercy killing. I want to make this very clear.

But I am very, very much in favor of allowing patients to die with dignity; the patient's own death. I am very opposed to artificial prolongation of life when it becomes meaningless.

I would first wait and discuss who is going to be put on a respirator. I would not put the patient on a respirator and then afterward decide who shall pull the plug.

To me, this is again a question of education. Resuscitation is another example. I have seen patients full of cancer who were hoping that they could die soon, and when they die, the resuscitation machine goes on, and they are brought back to life for a few more hours, a few more days. To me, this is inhuman. This is prolongation of suffering and not even prolongation of life.

Senator FONG. While the patient is living, you feel that we should give them every care and make them comfortable, to make them feel relieved of pain?

Dr. Ross. Yes; loving nursing care, and a human being who can sit with them and love them and care for them. If you have a patient who has no chance to live on any level of real functioning, I would not use those machines.

I hope you appreciate the difference. For example, if he has any chance to make it again, I would use all the treatment available, but if the patient is full of cancer, is hoping to die, and in the stage of acceptance, and wants to die, I think you should let him. That, to me, means he dies with dignity.

Senator FONG. Thank you.

Senator CHURCH. I think that is a very important distinction to make, and that is why I emphasize in these hearings these are not hearings on euthanasia.

The distinction between any form of so-called mercy killing and a refusal in cases of terminal, hopeless terminal illness to simply prolong life a little longer when it prolongs the misery and agony, and when it really is not conducive to the patient himself or the family, this is the question, and I think you have made that distinction very clear.

Dr. Ross. The tragedy is a tragedy of words. You see, the word "euthanasia" means "a good death" and I am very much in favor of euthanasia, of a good death for the patient's own death, hopefully at home, surrounded with good care and love, but euthanasia tragically is also used for mercy killing, and I am opposed to that.

I think we have to find different words. Otherwise, people are confused.

Senator CHURCH. Yes; in the latter sense that the term has come to be understood.

Dr. Ross. This is why I said living with dignity, and not dying with dignity.

Senator CHURCH. Yes.

Senator Percy, do you have any questions?

Senator PERCY. No; I have not.

I would just simply like to welcome my distinguished constituent and say that I am sorry I could not get down earlier to hear you, but I will very carefully go over the record, and I appreciate your being with us this morning.

Senator CHURCH. Thank you very much, Doctor.

Our next witness is Laurance V. Foye, Jr., also an M.D., from Bethesda, Md., Director of Education Service, Veterans' Administration. He was formerly with the National Cancer Institute.

Doctor, before you begin your testimony, I would like to announce the presence this morning of Prof. and Mrs. Kiyoshi Ikegawa from Japan, who is a professor of social work at Kobe College and a student of the problems of older people, in the company of Mr. Rudolph Danstedt, representing the National Council of Senior Citizens.

We just want to welcome you and your wife this morning, and we appreciate the fact that you have come to witness these hearings.

Dr. Foye, I apologize for interrupting further, but I am a very absentminded man, and if I don't put this in the record now, I may

forget to put it in, so before you begin your testimony, I previously made reference to the fact that home services, rather than increasing in number in this country, are also diminishing in number and are being curtailed. That fact which is an astonishing one in view of the generally recognized need for more home services in connection with terminal illness and other illness, is contained in a report of this committee which was published in April, 1972,¹ and for purposes of the record, I would like to read into the record from page 14 of the report the actual statistics.

There has been a decrease in the number of home health agencies participating in the Medicare insurance system: there were 2,350 participating home health agencies in June of 1970 and in June of 1971, there were 2,256 participating home health agencies.

I make that for purposes of the record. We want to inquire further into it as these hearings progress.

Now, once again, Doctor.

**STATEMENT OF LAURANCE V. FOYE, JR., M.D., BETHESDA, MD.,
DIRECTOR OF EDUCATION SERVICE, VETERANS' ADMINISTRATION**

Dr. FOYE. Thank you.

A number of complex problems are encompassed by the popular but obscure phrase, death with dignity. These include: the hopeless case, prolongation of suffering, active and passive euthanasia, the "right to die," and the "living will."

Essentially, these are all medical problems relating directly to the responsibilities and decisions of the physician in his relationship with his patient. Rational consideration of these questions is unfortunately and customarily confused by opinions based upon misconceptions and emotion.

A recent newspaper article on this problem clearly demonstrated and contributed to the confusion by quoting priests, rabbis, theologians, the Pope, a State Governor, a poet, and several physicians. It is a disturbing observation that, to my knowledge, every religious spokesman on this subject has come out in favor of passive and occasionally active euthanasia in hopeless cases.

A discussion of the "hopeless case" will bring up most of the problems mentioned above.

First, we must not equate incurability with hopelessness. Diabetes, emphysema, practically all heart disease, baldness, and flat feet are incurable but rarely hopeless. While approximately one-third of cancer patients can be cured of their disease, the remaining two-thirds are today incurable. The incurable cancer patient may live 3 months, or 3 years, or 30 years with his disease; possibly earning a living, raising a family, and enjoying life during this period. He may or may not require treatment along the way and he may or may not die of this incurable disease.

These statements are generally true of all incurable diseases. With cancer, as with other incurable diseases, there are spontaneous remissions, when the disease lies dormant, and even rare spontaneous cures.

¹ "Home Health Services in the United States," U.S. Senate Special Committee on Aging, April 1972.

Typically, in incurable diseases, the future course of the disease in a specific patient is not predictable except in a statistical sense. Thus, if, of 100 patients with similar disease, 20 die in 5 years, a specific patient may be said to have a 20 percent chance of dying in 5 years.

Therefore, while our prediction or "prognosis" in the individual case is based upon experiences with many different patients, usually treated differently by different doctors, the decision regarding euthanasia or "hopelessness" always relates to a specific patient whose course is not specifically and accurately predictable.

Every physician can, as a result, describe a number of patients for whom he predicted a rapidly fatal outcome—saying, "I knew they were going to die"—and was wrong. The patient who was told by his doctor that he had 6 months to live but is alive years later is legendary.

Thus, since the practice of any form of euthanasia, active or passive, can only be justified by certainty of outcome, and we can't be certain for any specific patient, we dare not authorize or practice euthanasia.

If a physician withholds maximum effort from patients he considers hopelessly ill, he will unavoidably withhold maximum effort from an occasional patient who could have been saved. Patients will die because of the physician's decision not to treat actively. This approach and concern cannot be fostered or condoned, legally or otherwise.

Typically, at this point in the discussion, the proponent of euthanasia then describes in detail a patient being kept alive "uselessly" with tubes and machines, and urges that the machines be turned off and the tubes removed "so the patient can die peacefully and with dignity."

Neither I nor anyone else knows how to decide when being alive becomes "useless"; I can only point out that "tubes and machines" are used because they save lives, relieve symptoms, and permit many patients to survive critical stages of an illness.

Since it is usually a serious life-threatening problem that calls for these measures, they don't always work, and in spite of these efforts some patients will die. One cannot then say, because such a patient dies, that these measures were a waste of time and shouldn't have been used, since when they are initiated it is not known in which patient they will be successful.

The statement made by noted clerics that the physician is not obligated to use "heroic or extraordinary" means in a "hopeless" case now becomes meaningless, since we can't be certain the case is hopeless, and it is precisely in such critical cases that "extraordinary" measures must be considered and may be effective.

Hippocrates was a safer guide when he said, "Extreme remedies are appropriate for extreme diseases."

It has also been pointed out that the extraordinary measures of today are the routine procedures of tomorrow.

THE LIVING WILL

The "living will," a document in which the patient permits and instructs his physician to let him die if his condition is hopeless, really solves nothing but does create problems of its own. The danger is that relatives, deciding for any number of reasons that active treatment should be stopped, will attempt, with or without legal support, to

prevent the doctor from continuing his life-saving efforts, or that the doctor will find that the existence of such a document will be one "reason" to terminate his active treatment.

In any case, the complex and difficult decisions faced during the care of the critically, and possibly terminally, ill patient are in no way going to be simplified by "the living will," which would merely convert a possibly fatal outcome into a certainly fatal one.

The "right to die" concept implies that, if our death is certain and immediate we have the "right" to make it even more immediate. The now obvious fallacy is that the patient or the doctor can know when death is certain. This is the "hopeless case" problem in human rights clothing except that the "right to die" is the one "right" we are all absolutely guaranteed at the moment of our conception.

We must never forget that on occasion patients, their families, and their physicians will conclude that a disease has reached the hopeless stage and death is imminent—and be wrong. If they can stop treatment on the basis of their hopelessness, the prophecy becomes self-fulfilling.

Whether the patient was going to die or not, their action ensures his death and the physician's confidence is his ability to predict death is dangerously enhanced. We must keep in mind that all medical therapy, curative or palliative, only prolongs life and hopefully improves its quality, or what we call its "health."

Finally, what many laymen fear is that the doctor, in a pointless attempt to postpone death, will keep them in agony for long periods of time—the prolongation of suffering problem. A number of studies have shown, and this corresponds to my experience, that the majority of critically or terminally ill patients do not have pain and that those who do can be controlled by the judicious use of pain-killing medicines.

It is essential that everybody understand that while a physician strives to cure a patient or to bring his incurable disease under control, suffering can be prevented and severe pain need not occur.

We can now see that such approaches as legalized euthanasia and "the living will" are based upon the misconception that the point of hopelessness can be known with accuracy and that the physician may uselessly prolong suffering beyond that point unless forbidden by law or similarly excused from his obligation.

I fear that, unless people understand the false reasoning behind these concepts, the physician's hands may be tied in just those cases where his skill and modern technology can make the greatest contribution to the saving of lives and the control of disease.

Thank you.

Senator CHURCH. Dr. Foye, I, by coincidence, just happen to be one of those legendary cases you mentioned in your testimony. I was once told I had only 6 months to live. It turned out later that the medical diagnosis had been wrong. I have a reason to appreciate your observation that it is extremely hard to be certain about the imminence of death, and it is, I suppose, a statistical matter in that there are rare occasions when a seemingly hopeless case, even at the last stages, turns out not to be.

We base our legal system on an assumption that it is better to observe procedures that might let 10 guilty men go free rather than send

one innocent man to the death chamber. Does it follow that we might adopt a similar attitude toward death in apparently terminal cases at the very last stages upon the theory that it is better that 100 people who are on the verge of death should be allowed to die as they wish, than to require treatment under the appropriate conditions and to save the one that might prove saveable?

That is a philosophical question, I suppose, but it is one that we face in society all the time.

Dr. FOYE. Well, I think I would apply the "letting 10 guilty men go free rather than let one innocent man die" as being strongly in support of just what I have said.

Senator CHURCH. But it is a statistical judgment, isn't it?

Dr. FOYE. I think this is not a statistical judgment essentially, nor a legal one. It is the basis of medicine in this country and in many countries that the physician is responsible only to his patient and his responsibility is to do everything he can to cure his patient, to control his disease, to control his discomfort, and to make his life as pleasant as possible.

Senator CHURCH. Let me ask you this. Do you think that a patient is obliged to seek a doctor if he doesn't want one?

Dr. FOYE. No.

Senator CHURCH. Then if he does seek a doctor, is he obliged to accept the doctor's prescriptions if he desires not to?

Dr. FOYE. No.

Senator CHURCH. Then if as he approaches death he no longer wishes the kind of treatment because of his own suffering, perhaps, because he may be very old and recognizes that he has very little time to live anyway, he is prepared mentally and spiritually to accept this as the moment of death, do you think he has a right to say to his doctor, "Stop treating me"?

Dr. FOYE. Oh, I think he has the perfect right at any instant to say: "I am going home. I am leaving the hospital. I am discharging you from the case. I am refusing the next form of treatment you offer." I mean absolute, individual—

Senator CHURCH. That is his right?

Dr. FOYE. That is absolutely essential in this medical relationship. My experience, however, with hundreds of incurable cancer patients over a period of 9 years is that I have never had one single patient refuse treatment or request that I let him die. I have never had it happen.

Every patient, of course, knew what was going on, knew what we could do and what we couldn't do, knew what the risks were, knew that he was a totally free agent to say at any point, "I am leaving," or "I don't want any more," or "Stop now." And this was made very clear to them repeatedly. Every patient understood that.

Senator CHURCH. I am just probing to see how much you really do agree or disagree with this concept, and you have made it clear that it is always the absolute right of the patient himself to refuse the treatment at any point.

Dr. FOYE. It must be.

Senator CHURCH. Well, I agree with you on that. I am completely in agreement on that score. Otherwise, hospitalization could become a form of imprisonment, couldn't it?

Dr. FOYE. Absolutely.

Senator CHURCH. Well, now, suppose a patient is in a critical stage, a final stage or what appears to be a final stage in a terminal case, and he loses his capacity, obviously has lost by medical diagnosis his capacity to make any further rational decisions, but the family can see that the patient is in pain or in anguish, and the doctors are convinced that the patient cannot live, then it is at this point where you, I suppose, take issue that the family ought not to have any right to say to the doctors, "Call off the treatment"—or do you?

I mean, I know I projected your answer, but just from your testimony I think that is where you draw the line; is that correct?

Dr. FOYE. Yes; I think in the first place you have to realize that if others can dictate the treatment of the patient, many factors may enter the decision besides the welfare of the patient, and you cannot always be sure that the welfare of the patient is uppermost in the minds of those who are dictating their treatment.

Senator CHURCH. Doesn't that assume, Doctor, if I follow you, you are saying that at this point if the patient himself cannot decide, has lost the capacity to decide, then the welfare of the patient is and must be left to the judgment of the doctor and the practices of the hospital, rather than to the judgment of his immediate family? Isn't that necessarily implied in what you said?

Dr. FOYE. Let's say I have never known it to be otherwise, but I admit of the possibility. I have never known of an instance where the judgment of a well-informed family in this matter was different from the physician's. In other words, if the patient was in pain, both the doctor and the family wanted the pain relieved. If the patient appeared to be thirsty, appeared to be restless, appeared to have any number of different symptoms, both the family and the doctor wanted any discomfort controlled.

So I think the critical factor in achieving this kind of harmony of desire and interest in the patient's welfare is very thorough education of the patient and the family. I think they both must thoroughly understand what can be done, what is going on with the patient, what he is suffering, and what given manifestations mean; I just have not experienced a conflict in this matter between the well-informed family and myself.

Senator CHURCH. Well, I wonder if that might not be partly due to other factors that we discussed earlier with Dr. Ross. Again, a personal experience must suffice as an example. We have a doctor in the family, close in the family, who took care of my father-in-law at the time of his death. He was a very old man when he died, and the doctor knew from the beginning that the judge could not recover—that was his professional judgment—and because he was partially paralyzed and unable to communicate, having suffered a severe stroke, we were not able to be certain of his own wishes.

We have often thought since that he was trying to tell us that he wanted to go home, sensing that he was not. The doctor afterward cursed himself for having prolonged the medication. He did it because he felt that we expected him to, and we took no issue with him because we couldn't be sure if there was any chance of recovery or we couldn't quite interpret what it was that the judge seemed to want of us.

And so all of us, I guess, conformed with established practice, the doctor in his discipline continuing against his own better judgment and afterward to his own great regret, continuing to apply the medication, while we continue to accept it because it seemed to be the accepted thing to do.

I mean, isn't it possible that these factors often condition the reaction of a family at the very end; where there might be a different judgment reached, it just isn't reached; the question just doesn't come up? The doctor assumes that the family feels that what he is doing is right; the family assumes the same, that what the doctor is doing must be right; and no one pays enough attention to what the patient himself might be trying to indicate.

Dr. FOYE. I think it is quite possible, obviously. I think the type of situation one deals with is that at each point in the path one has to make a decision—do we go on; do we try some new form of treatment to try to control the disease; something more "heroic," as the term is; or is this the point where the patient might consider going home and when we can say that we have tried everything that offers any chance?

I am not advocating using every machine in the building because it is there, but I am advocating using those forms of treatment that offer any hope of success.

After discussion between the wife, the patient, and myself, we may have decided that the best next move is that the patient go home, and then if his condition suddenly deteriorates, he can always come back. In other words, the decision to go home must in no way make it more difficult to return. One maintains a two-way street very easily traveled back into the institution and back out to the home. I think this is the ideal situation.

There was nothing wrong with care at home, let's say, dying at home or birth at home, when there was no better care available anywhere else. There was no point in going to the hospital for these conditions because nothing more could be done there than at home. Today, birth at home would not be the safest form of birth if you have a complication, if you are not where the modern techniques for handling severe complications exist.

The same thing may apply to the seriously ill patient, the incurable patient, the "hopeless" patient. He, for certain reasons, may need to be in an institution, and, at other times, may be better off at home, and he should have, I believe, the freedom to move back and forth as his condition and needs change.

Senator CHURCH. Senator Fong?

Senator FONG. Doctor, do you feel that a physician faced with a "living will" of the patient should follow it or shouldn't follow it?

Dr. FOYE. I think I would have to know what the will said, I would have to have discussed this with the patient: "What was your intent," one would then have to, say, discuss with the patient what he wanted to do next about a given problem—just as if there were no "will."

Senator FONG. But if the patient is lucid, he could decide for himself, he could refuse treatment. But if he is not lucid, then what should the physician do?

Dr. FOYE. Well, let's assume that you are unconscious as the result of an automobile accident and that, if I can bring you to consciousness,

you will end up with a stiff knee for the rest of your life. Now, if you read a "living will," it says that "if there is no reasonable expectation of my recovery from physical or mental disability, I request I be allowed to die."

Now, does that mean—since after all, a stiff knee is a physical disability, that I should let you die?

My point is that it is difficult to imagine how a "living will" might be written so that it would cover rationally those circumstances which arise when this kind of decision must be made.

Senator FONG. If the physician has never said—and there are legendary occasions in which physicians have been wrong—

Dr. FOYE. Many. At least as many as there are physicians.

Senator FONG. Applying that principle, then, the physician should never follow the "living will."

Dr. FOYE. I am not sure what the "will" does for the critical situation. In other words, the concept of the "right to die" or the right to determine your own death, in a sense, implies duties. "Rights" imply "duties." I question that one can legally make it my duty or the duty of a loved one to kill a patient or to do those things that would fall in this category—withhold proper care or withhold optimum care.

I certainly would have no intention of engaging in active or passive euthanasia on the basis of a "living will," nor do I think it is enforceable.

Senator FONG. In other words, you would let nature take its course rather than hasten death?

Dr. FOYE. I would try to do all those things that I consider best for that patient, controlling his discomfort and making his last hours, if they are his last, as comfortable as possible. That is the whole purpose of the medical profession.

Senator FONG. And that adage that a man is never too young to die nor too old to live, still should be a good adage?

Dr. FOYE. Yes.

Senator FONG. Because we just can't tell when death is coming. We are never certain.

Dr. FOYE. No. All treatment at best only prolongs life, even curative therapy.

Senator FONG. Thank you.

Senator CHURCH. Senator Percy?

Senator PERCY. I would only like to comment, Mr. Chairman, that yesterday and the day before in Chicago, Mrs. Percy and I continued our practice of many months of visiting at least two or three nursing homes on a weekend.

Yesterday, I was at the 4600 South, in one of the most hopeless nursing homes I have seen. There were 54 patients who seemed to be in the most hopeless condition. A number of them were deeply disturbed mentally but had been moved from mental institutions into the nursing home. When I left, I must say, both my wife and I were somewhat depressed. I asked Susan Atkins, the nurse who took us around, "Do you get discouraged?" And she said, "No, really, not at all. It is amazing what a little love and kindness and affection means to some of these people, how quickly they respond to it, and how it affects them more than even the medicine we give to them." So the human spirit is a very difficult thing to destroy.

I commend the chairman and our ranking minority member for holding these hearings, which are on as difficult and delicate a subject as I imagine any senatorial committee has ever tried to approach. But I approach it with a totally open mind and appreciate the very valuable substance that we are going to get from these hearings. And I am most grateful for your testimony.

Senator CHURCH. Thank you very much.

Our next witness is Dr. Walter W. Sackett, who comes from Miami, Fla., a member of the Florida House of Representatives, author of the "Death With Dignity" bill since 1967.

STATEMENT OF WALTER W. SACKETT, M.D., MEMBER OF THE HOUSE OF REPRESENTATIVES OF THE STATE OF FLORIDA

Dr. SACKETT. It goes without saying, Mr. Chairman, that I appreciate this opportunity to come to a higher legislative body than that of which I am a member, to present this case. I was going to open with a definition of euthanasia to distinguish it from death with dignity and mercy killing, but inasmuch as Senator Church has already clarified the issue, I will just simply say that euthanasia is more closely akin to death with dignity than it is to mercy killing. Euthanasia by translation means happy death. It goes without saying that this philosophy is almost unanimously accepted by the general population.

I have asked for a referendum on it, I have asked for a constitutional amendment, and I have no doubt that it would pass overwhelmingly.

In support of this general agreement, I offer the evidence that I am now running for my fourth term in the legislature. I am one of two of today's delegation in Dade County of 22 members who is unopposed, and I have been identified with this piece of legislation, so I have a feeling that the population is willing for it and ready for it.

Senator FONG. How do you get people not to oppose you?

Dr. SACKETT. Well, one time I had 11 opponents. Another time I had seven. You just give them a good trouncing a couple of times.

Senator CHURCH. Discourage them.

Dr. SACKETT. Yes.

The reason I think this does not appear in any of our legislation is the fact that when the Federal and State Constitutions were written, this was not a question. When people became very ill, they either died or recovered, and had a purpose in life. Nature was a wonderful thing and the Lord was a wonderful being. I have been accused by a few rattlebrains, I think, of being inhuman and trying to act like God. Now, when I keep a person such as we have been describing alive, I feel then I am acting like God, and I am being very inhumane to that person by continuing his suffering. Many of these people suffer. They can't say anything, but you can tell by their actions that they are suffering.

There were no nursing homes on every street corner when I came out of medical school. People have asked me what is my interest in this subject. Facetiously, I say this, that I am at the point that I have to face this issue within a matter of a few years.

I no longer fear death. When I was your age, I didn't want to die. I don't want to die now, as long as I can be useful. There were no institutions such as we have in Florida for the severely retarded mentally and physically individuals in 1938 when I graduated. They just didn't exist. We were taught that a mongoloid would die of pneumonia by the time he was 12 or 13 years of age. They are very susceptible to pneumonia.

We have training institutions for the less severely retarded who are trainable. I am all for those, but in these two institutions for the severely retarded in Florida, we have 1,500 residents, some with heads as big as buckets, some small as oranges, grotesque and drawn up in contracture. According to present-day cost and the fact that you can keep these individuals alive artificially to between 50 and 60, it's going to cost the State of Florida for 50 years \$5 billion.

COST-BENEFIT QUESTION

Translated roughly this means it's going to cost the various States over this same period \$100 billion, and when one thinks of what one could do with this money in other fields, the less severely retarded, the mentally ill, our jails, in our homes for delinquents, it is most revealing and yet in a hearing in one of my committees the Secretary of Health and Rehabilitative Services made a statement that I just couldn't swallow. The kidney dialysis group was asking for \$500,000, and when he said the State doesn't have it, this meant that we are going to have to let 125 people, half of the people who had treatable kidney disease in Florida had to be allowed to die, and the arguer for the bill said: "Then we have to decide who is going to live and who is going to die." The Secretary replied, yes, it amounts to that. It is a question of cost benefit.

Now, where is the benefit in these 1,500 severely retarded, who never had a rational thought, and still we are going to let 125 people whose lives could be prolonged in a useful state—kidney transplant is the most successful example of the transplantation field, and yet we are going to let 125 of these people die because we are putting all this money into these huge institutions.

I asked the medical director of one of these hospitals what percentage of these individuals should be allowed to die. He is a very humane man, and he said, "Dr. Sackett, I think 90 percent of them should be allowed to die." I said, "Why don't you let them die?" Then he answered me, "Do you think I am nuts?"

I said, "Well, why?"

"Well, little Suzy, hasn't been visited in a year or two. Uncle Joe comes down from New York. Where is little Suzy? Well, she died last year. Well, let's look at the medical record and see what happened." High fever, no antibiotic, and then he is on the legal pan. He is subject to suit.

Lawyers are getting smart enough. Work is getting scarce, and lawyers are getting so that they don't want to see this happen where doctors would get off the hook.

Now, what evidence do I have that this is an important subject, one that should be acted on?

Senator FONG. You are talking about those that are being kept alive by artificial means?

Dr. SACKETT. Oh, yes. A third of those people have had major surgery with a tube inserted in their stomach. It's major surgery to feed them. This is ridiculous, but the director of that hospital, when he was put on the pan for putting all these tubes in, because I thought as long as the philosophy of keeping them alive no matter, I thought he was justified in putting those tubes in. And the minute it became otherwise, he seeks legal protection and I don't think he will put the number of tubes in them.

I have a series of reasons here, why I think people are ready for this. Every time I get a little publicity, I get hundreds of letters and mostly from old folks. My greatest support lies in St. Petersburg. These people are not afraid to die, but they are afraid of the artificial prolongation of the death process.

They have gone to see their loved ones, or checkerboard mate, or card-playing mate, and watched him die, and they don't want that to happen to them in that fashion with tubes, exposing themselves, et cetera.

I walk down a hall in the hospital once in a while, and I see a man all uncovered. He may have messed himself up before the nurse can get to him. Tubes, machines. I said who is he? Looks very familiar. They will name some very dignified person who was very prominent in our life in Miami, and it's appalling and shocking.

I don't want him to be lying there open to view. I want him to be allowed to die. So I get these thousands of letters, and I have only had a dozen letters of protesting, calling me a Hitler and calling me a killer, and those are always written in pencil, misspelled, underlined in red, and not signed.

Why would four State legislatures be willing—including Hawaii—to undertake this, and I have a copy of the Hawaii bill here. I will be glad to show it to you.

Why would Governor McCall request of his legislature that they take this under consideration, and he recently had a symposium on the subject. He must think it is that important.

Why would you folks here think it is important enough to discuss in the Senate? Why would such prominent TV programs make this a subject for half-hour or 2-hour national programs? They must think it has some merit. And several I have listed here on my copy.

The courts want guidance, I am sure. We have had two cases in Miami in the last 5 years. I believe it was the year before this that a woman was dying of aplastic anemia, and she didn't want any more of the transfusions, but the doctor said no, and he had to give them to her. They had become very painful. He said he had to give them to her.

I would have had no trouble making this decision. This was a Cuban doctor. They come by their license the hard way, and I am sure he didn't want to jeopardize his license in any way. The circuit judge did not say she should be allowed to die. He said she has a right not to be subjected to further torment and suffering. She died within a few days. And yet a few years previously, a circuit judge decreed that a protesting woman must undergo a leg amputation which was done.

Senator CHURCH. Doctor, do you have any doubt as to the present state of the law? I can speak not only as a lawyer, but under the

present state of the law, I have no doubt that a person has the perfect right at any time in his life in any stage in the particular illness to refuse treatment.

Dr. SACKETT. This may be true of the competent person, but witness the two just cited conflicting judicial opinions.

But what about the incompetent, those 1,500. Or, if I should have a massive stroke here and now, after all the ballyhoo I have carried on over the years, I think it is very evident that I want to die, but there are cases when you don't know.

I have a rich person, Senator Percy, from Illinois who has a lot of money. Her husband is dead, she has no relatives whatsoever, and she is in the nicest nursing home in Miami with nurses around the clock, and all we have to go on is what she told her friend, that she wanted to die. She didn't ever want to—

Senator PERCY. She was mentally incompetent?

Dr. SACKETT. Yes, very much so.

Senator PERCY. Well, if she were mentally competent, she could refuse all assistance and help.

Dr. SACKETT. If she were, but she is not. Who could make that decision?

Senator PERCY. But I wonder if the chairman is addressing himself to the first provision of your legislation that you are offering which says a person can —

Dr. SACKETT. Create a document—you can create one now, and I would just like to make that document legal. That is all. Just like a will or a deed.

Senator PERCY. Isn't the question, though, is whether or not a document is necessary when, under existing law, a person has a perfect right, if mentally competent, to refuse all of the medications?

Dr. SACKETT. This is true, but what if you should become incompetent? Who is going to determine it?

Senator PERCY. Well, that is the second point.

Dr. SACKETT. And that is probably the greatest need, and the second point of the bill, where the person is incompetent, relatives of the first degree, the majority of brothers and sisters, shall make the decision, and I would hope my surviving relatives would make that decision.

Senator PERCY. How do you answer the question, though, of a conflict of interest? What if the immediate relatives of my rich constituent will directly benefit as a result of her earlier death?

Dr. SACKETT. What was that?

Senator PERCY. Well, in the case that you have taken of a rich Illinois constituent who is mentally incompetent, who, then, should sign her death warrant—close relatives, all of whom might benefit financially?

Dr. SACKETT. This comes in the third portion of the bill.

Senator CHURCH. Why don't you review for us the portions of the bill?

Dr. SACKETT. Well, I think we have the first two.

Senator CHURCH. Yes, but in your own words explain the whole bill.

Dr. SACKETT. Well, I think we have the first two.

Senator CHURCH. Yes, but in your own words explain the whole bill.

Dr. SACKETT. It's a very simple bill. You have a copy of it, I believe.

Senator CHURCH. Without objection, a copy of the bill will be inserted at this point in the record, but would you explain this provision. (The bill follows:)

Proposed legislation for next session of the Florida Legislature, by Representative Walter W. Sackett, Jr., M. D., Miami, Florida.

A BILL to be entitled: An Act relating to medical treatment; providing for termination of sustaining treatment of terminally ill or injured patient in certain circumstances; providing immunity for physicians; exempting persons complying with this act from the provisions of section 782.08, Florida Statutes; providing for revocation of a document authorizing the termination of sustaining medical treatment; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

SECTION 1. As used in this act terminal illness or injury means any illness or injury that would result in natural expiration of life regardless of the use or discontinuance of medical treatment to sustain the life processes. Any person eighteen (18) years of age or older and competent may at any time execute a document directing that medical treatment designed solely to sustain the life processes be discontinued. However, said document shall not take effect until said person has been declared terminally ill or injured by two (2) licensed physicians and attested to by written statement.

SECTION 2. In the event any terminally ill or injured person has failed to comply with section 1 above because he is unable to make such a decision due to mental or physical incapacity, as determined by two (2) licensed physicians, a spouse or person of the first degree of kinship shall be allowed to make such a decision, provided written consent is obtained from a majority of all persons of the first degree of kinship.

SECTION 3. In the event the terminally ill or injured person is incompetent and the procedure authorized by section 2 cannot be complied with because no person of the first degree of kinship can be located within thirty (30) days, then the decision to terminate medical procedures solely to sustain the life processes may be ordered by three (3) licensed physicians and attested to by a written statement.

SECTION 4. A physician who relies on a document authorized by section 1 to refuse medical treatment or who makes a determination of terminal illness or injury shall be presumed to be acting in good faith and, unless negligent, shall be immune from civil or criminal liability that otherwise might be incurred.

SECTION 5. No person participating in good faith in the execution of a statement or document required by the provisions of this act shall be deemed to be in violation of section 782.08, Florida Statutes.

SECTION 6. A person who has executed a document to refuse medical treatment shall have the power to revoke said document at any time by oral or written statement; provided however, that such revocation must be witnessed by two (2) persons.

SECTION 7. This act shall take effect upon becoming law.

Dr. SACKETT. The first part would say that if the person creates such a document, it would have legal impact, would be notarized and registered if necessary, I don't care, but it would have legal meaning. And the second part, when a person was incompetent, those relatives of the first degree would make the decision.

The spouse. Now, where a couple who were married 33 years, and the man has a stroke, if his life has meaning to her, that she goes in and bathes his face every day, tries to feed him, I'd keep such a person alive with no doubt in my mind. And I have this facing me often. I have let hundreds of people die. And what I do, I have one question I ask. Say a father who's had a stroke. The kids are there, and I say, "Now we have got to make a decision right now. What's that? I say we have got to make the decision. Are we going to keep dad alive artificially or are we just going to keep him comfortable?" And oftentimes they will say, "Oh, doctor, we don't think we should take this responsibility. We don't think we have the right to do this."

I have one question I ask them. If that were you lying there, what would you want? And it never has failed me. They say, "Doctor, let's do that. Keep dad comfortable." Supposing I am the child of a parent. My other brothers and sisters are somewhere else, and I make this decision. I have taken care of dad for the last 10 years of his life. I make this decision for him. Then the other brothers and sisters come down for the funeral. Well, what happened? Well, he had a very high fever, and we just didn't give him any antibiotics. I mean that I individually imagine I would be open to suit. Certainly the doctor would be. So that we need this law.

Now, in the third portion of the bill this provides where there are no relatives or the individual does not have a guardian, anybody responsible or who has legal authority, then three doctors on the staff agreeing unanimously shall make this decision, and I hope that this would happen to me. Three of my colleagues. I have no doubt that their judgment will be 99.99 percent correct.

You talk about there are no diseases that are actually incurable. You maintain one can't say 100 percent, incurable. There are. When the central nervous system is injured, that is permanent. That is forever. When the brain tissue, spinal cord tissue, is injured, that is it. It will never get any better. That is final. There is no return from it.

If you are lying there with such a condition, the brain has been damaged by a stroke after 2 or 3 weeks. I don't care what you want to say.

DEFINITION OF DEATH

Interestingly enough, I think we are going to have to change our criteria. Today death is defined to medical students as a cessation of breathing and the heartbeat.

I believe one of the Dakotas has already passed a law. You may use that criterion or use the criterion of three flat negative brain waves, and that means that portion which distinguishes us. No activity when that is gone. Canada was considering the bill. I don't know what they ever did about it.

Now, for instance, in our big charity hospital in Miami County Hospital I spoke to a group of junior students on this subject a little over a year ago, and when I came out, one of the students turned and said, "Doctor, come with me and I will show you two wards full of these people. The surgeon has done his beautiful work; the internal medicine man has made the miraculous pushoff on death; and he passes the case on to his resident."

Well, his resident isn't interested in this case. He passes it on to the intern. The intern, he wants to learn things, not just watch a person die with nothing in his head, so he passes it on to the student.

He says, "Who am I to say let these people die?" So we probably have 100 of them in our Memorial Hospital in Miami.

Senator CHURCH. Well, now, Doctor Sackett, you have said—and you are a very forthright man—you have said that in your practice of medicine you have let patients die.

Dr. SACKETT. Hundreds of them.

Senator CHURCH. Hundreds of them. Is it your judgment that other doctors do likewise, that this is actually a widespread practice that simply isn't talked about or acknowledged?

Dr. SACKETT. Yes; 75 percent of the doctors. That is a rough estimate. There is no way you can tell.

Senator CHURCH. That is your own estimate?

Dr. SACKETT. Yes; based on my own experience. I came down the hall of our hospital one day shortly after one of these introductions of this bill, and the director of the hospital threw his arm around my shoulder and said, "Dr. Sackett, I love your bill." "Which bill are you talking about?"

"Your death with dignity."

"Oh," I said, "We don't have to worry about it in our hospital."

He said, "Don't kid yourself. We have got men on our staff who will keep them alive until the last gong is rung." And he said, "We need such legislation."

Senator CHURCH. Well, what is the state of the present law as you understand it?

Dr. SACKETT. Well, there is nothing in any law that speaks to it.

Senator CHURCH. But do you think it could be in a given case that a doctor is satisfied by all the indications that a patient was in the last stages of life, certainly, didn't take those actions, those extreme actions that might prolong the life for a few more days, do you think he might be made liable? Do you think that he would be liable under the law for a damage suit?

Dr. SACKETT. For keeping a person alive?

Senator CHURCH. No, for failing to.

Dr. SACKETT. Oh, legally I think he is, yes, if your definition of death is cessation of the heartbeat and breathing.

Senator CHURCH. Do you think he might be subject, if this could be proven, to action by his fellow doctors to deny him the right to practice any further?

Dr. SACKETT. Well, the only case I can remember was a case in New Hampshire or Vermont where a doctor actually put air into a woman's vein, and she had money, and one of the heirs instigated action—he didn't lose his license, but he was put on probation for a long period.

Senator CHURCH. That is a very different case, isn't it? That is a case where one could argue that he was murdering his patient or attempting to murder his patient.

Dr. SACKETT. This was the case.

Senator CHURCH. I am not talking about this at all. I am talking about, let's say it is proved that the doctor in a given case, having persuaded himself that there is no more chance of life and feeling that the patient was in agony and wanted no longer to live, just decided not to take those extreme measures that would prolong the life for a little while, but had no reason or no hope at all within the state of the art, at least within the state of expectation of saving the man, so he just didn't take those measures in order that death might come a little sooner.

Suppose that were proven on a doctor today, what would be the consequences under the present law as you understand it and under the code of ethics as far as doctors with their organizations are concerned?

Dr. SACKETT. He could lose his license. I can see where, by a far stretch of the imagination, he could be tried for murder. I think you can see this. When two lawyers get eager or hungry, I can see this case

being entered by the legal profession. When I came out in practice, nobody was ever sued for malpractice.

Senator CHURCH. I think he might be sued for malpractice under the state of the law. I don't think, given the facts I gave you, that he could ever be indicted for murder; but I think he might be sued for malpractice and might very well be denied his license by the medical association if this could be established under the existing law.

That is why you feel a bill of the character that you presented to the Legislature of Florida is necessary, is that right?

MALPRACTICE INSURANCE

Dr. SACKETT. Yes; and I think you can see this as lawyers have found new ways to get to doctors. I have never been sued for malpractice, never threatened with a suit. My insurance has risen—from 1941 to the present time—from \$35 to \$2,500 a year. Not one case. Break this field open to the law and you will see malpracticing out of sight.

Senator PERCY. Mr. Chairman, I am bothered about trying to understand step two here, which is section 2 in your Florida bill.

Certainly when we come to doctors, there is no conflict of interest ordinarily presumed. But when you get down to the point where to sign a death warrant in this kind of a case all you need are any two licensed physicians—and you can find two unscrupulous people in almost any group, including the clergy—and all you need is a next-of-kin or a majority of the relatives who might well benefit financially and substantially and who might consider a person mentally incompetent because he wants to give all his money to charity and not to them, couldn't you have a real problem with this legislation?

You say in your testimony you have very few letters of objection. I am surprised you say that they are all kooks or cranks. I hope I am not, but I raise questions as to what problems this kind of legislation will open up.

What kind of a Pandora's box would be if it would make it that easy to shut off medical care to an individual under intensive treatment?

Dr. SACKETT. Well, one of the first programs—it probably was the original talk program on the radio. I was invited, and Allen Courtney in Miami. He said, "Doctor, I want you to understand before we go on the air that I am violently opposed to this bill."

I said, "How can an intelligent man be opposed to it?"

He said, "Well, too many people, doctors, lawyers, relatives, can get together and do evil things," but I said, "If those relatives have evil in their heart and they are going to kill him, they are going to kill him with something. It could be a gun, a knife, medicine. You know that, you are not so naive that you think there is only one way of killing a person." It's more irrevocable when you shoot them or stab them.

Senator PERCY. No; but if a person is in a nursing home and has a limited amount of assets, let's say \$100,000, and the bill is \$750 a month, and relatives can figure out how long that is going to last, I think if it is easier to shut off the tubes or whatever it may be and make legal provision for it, it raises some real questions.

Dr. SACKETT. You think that I as a doctor should keep this woman alive, one of your constituents, just because she has a million dollars and, well, it's going to run out in so many years and I am going to keep her alive no matter what until then?

I don't think that is being humane.

Senator PERCY. Well, sir, suppose among doctors you have great difference of opinion as to whether or not a case is hopeless. You can always find two doctors who take the most pessimistic view of life and say anything is hopeless, but you will find just as many doctors who will say there is always some hope, and I say, this wealthy constituent I have, this nameless constituent, has all this money.

I don't know if it's up to her relatives to say that is a waste of money.

Dr. SACKETT. Nobody knows how much money she has except the bank in Chicago, and who knows, you may get her back as a charity patient, an indigent patient. I don't know when it's going to run out. They haven't told me. They haven't said, "Go easy," or "Pour a little more on." I send my bill up there. I see her twice a month. For what, I don't know.

I can just as easily take care of her by telephone, which I often do. They will call me and tell me this or that. I want to keep her comfortable.

Now to finish that story about the radio announcer, he admitted in breaks in the program that he had been involved newswise with cases of this kind where there was dirty work. Lawyers, doctors, and relatives got together and did evil things. But later in the program I said, "Now that is you lying there, Alan, and you are in a coma, you are being given oxygen and IV's, and I, as a doctor, tell your wife we are convinced after consultation that that is the best you will ever be, and we can keep you alive endlessly. What would you want her to say?"

He said, "Well, I hope she'd say to let me go."

I said, "This is what we are talking about. You are not against my bill. You are actually for it."

And when a person projects themselves into the situation, they don't want to put it on themselves.

Senator PERCY. I wonder. You indicate, Doctor, that you have been on the Mike Wallace, Dick Cavett, Allen Douglas, Phil Donahue shows which are widespread shows.

Dr. SACKETT. I was on "Panorama" 2 days ago.

Senator PERCY. I have been on several of them and on less controversial subjects than this, and I am amazed at the amount of diversity of response I get and the number of letters.

I always dread one of these programs for fear it's going to tie up my office the next week acknowledging receipt of these letters. But you say you have in your files only a scant dozen or less letters objecting to your legislation, usually in pencil, misspelled, underlined in red, and ending up with derogatory remarks, "Hitler, you killer."

In other words, the implication is that only a kook would be against your legislation, or no one else is really interested in it.

I wonder. I want to be sure of the full impact of this testimony. Do you keep all letters you receive in your files?

Dr. SACKETT. Yes.

Senator PERCY. Have you kept in your files every letter that you have ever received against your legislation?

Dr. SACKETT. Yes; yes.

Senator PERCY. And you have no derogatory letters from anyone other than what you consider sort of a kook?

Dr. SACKETT. That is correct. I have had some very brilliant people write. Only one on the Phil Donahue show disagreed with me. Strangely enough the first time I ever heard a nurse speaking against it, but later on she got into the field of abortions, and she was Catholic. The Catholic Church—probably not the people, the hierarchy, are the greatest opponents of my bill. Yet the Pope, in an official encyclical in 1957, Pope Pius XII, said you don't have to do these heroic things and he went a step further in that statement, that you can give the discomfort and the pain-relieving medicines even though you know they may hasten the end. So what do you do? Give one shot of morphine and relieve the pain, or give them a handful of morphine? He didn't define how much medicine.

Senator PERCY. I don't want to imply by my questioning that I have made a decision. I approach these hearings with an open mind, and I just want to be certain that for the record, if you are proposing legislation of this type that we be sure we don't have any big loopholes in it. I just wondered whether as a father of this legislation in Florida you have felt that there were adequate safeguards or if there are loopholes—

Dr. SACKETT. There may be.

Senator PERCY (continuing). Because I am concerned that it is so broadly drawn and so easy to meet these standards, and knowing human nature and having seen it, and we all know the way human nature works, we have got to guard against the unpleasant side of it.

Aren't there any other types of tightening up that should be considered?

Dr. SACKETT. I have had this bill in many forms, different wordings, using the word "meaningful," which is not in there now. I said if that lady about to be widowed gets a joy out of bathing the face of her husband, I would like it in there for her, so these terms are hard to apply, and I think you are aware in your legislative activities that every law has a loophole. You can't discover these loopholes until you enact the law. You do the best you can, and this bill is a composite of all my previous bills and written by staff, and even the lawyer for the various dioceses of the Catholic Churches of Florida, who represents the Bishops, he has said this bill takes most of the objections that I have had to it away.

"You have taken the word 'meaningful' out. It is not in there." He won't be as strenuous an objector now.

Senator PERCY. Mr. Chairman, I very much appreciate this challenging testimony this morning. It's very provocative, indeed, and I might only ask: This constituent of mine from Illinois, does she have a voting residence in my native State of Florida or my acquired State of Illinois?

Dr. SACKETT. I might say the outlook for the bill is very much better this year. I have had a great deal of trouble getting Senators to sponsor a comparison bill. You know, when the bill comes from both sides, it has a much greater chance, but I have two Senators who have

volunteered, and previously when I asked them, Senator or Representative, they had said we believe in this but—they don't know about public opinion. And I always ask Senator Beth Johnson from Coco Beach: "Well, you believe in it. Why won't you introduce it?"

"I am just a little afraid what it is going to do to my votes down there."

Senator CHURCH. Well, I think that Senator Percy raises a very important consideration. It is a question of how much of a hazard this might be.

Dr. SACKETT. Well, I think your gun law has—

Senator CHURCH. I mean as far as relatives are concerned. I think that Senator Percy's point is well taken, but our purpose here is not to examine in detail your particular bill. We are trying to look at this subject very broadly. We are groping for guidelines, and I might say that your testimony has been most helpful.

I do think that we should draw one distinction here in view of your testimony. That has to do with the issue raised about the 1,500 individuals who are retarded and institutionalized, and were being kept alive at the large expense to the State, the mongoloids and others.

Our hearings are concerned primarily, but not exclusively, with people who, though they may have been healthy and intelligent all their lives, become helpless as death approaches, and your reference to retarded persons raises some very hard questions, but they do fall beyond the scope of the inquiry.

I just wanted to make that clear because I think that the committee wants to avoid any public confusion about the purpose of this hearing and what it is we are striving to achieve, but that is why I thought I should make that distinction.

Dr. SACKETT. I think this is true with the bill in general. I think the first part is going to be much easier to pass. I think that is going to be relatively simple in contrast to the other.

Senator CHURCH. Yes.

Well now, we are running overtime this morning. I had planned that there might be a panel at this point. I wonder if we could run until 1 o'clock. That gives us 10 additional minutes, and I would like to call our witnesses who have testified. Are they still here?

PANEL DISCUSSION

Senator CHURCH. The reason I am calling you back for this final 10 minutes is to ask you who have heard one another testify if you would not explore the extent of your differences.

I mean are you really in basic disagreement, and if so, what are the points of difference between you?

You have heard one another testify, and I think the panel discussion might address itself to that particular question.

Dr. SACKETT. I don't think our basic philosophies are different. I mean it is just the way you approach them. Maybe Dr. Foye is a little far off of them, but I think Dr. Ross is with me.

I cannot see actually psychoanalyzing a person who is dying. I have never had a person ask me, "Am I going to die now?" When they are in good health, they say, "Doctor, I want you to tell me when I get an incurable condition I am going to die," but I never tell them unless they

ask me, and I cannot recall one single person who did want to know he was going to die. Possibly old folks are ready for it.

Senator CHURCH. Well, it seems to me there is a conflict between your testimony and Dr. Foye's, because as I recall, Dr. Foye, you said that you don't recall in your experience any patient who did not want all of the treatment that could be given in order to prolong his life, regardless of how hopeless his case might be.

Is this a point of disagreement between the two of you?

Dr. FOYE. I think the major concern I have is that the patient's decisions be informed decisions.

The average patient does not know a lot about the different pathways a disease may follow.

Many doctors, including myself, argue that patients should be told if they have cancer, and others say, "Oh, this would be terribly cruel."

There have been studies on this question and it has been found that a large percentage of cancer patients know they have cancer even if they have never been told. There are very few diseases in this world where the patient has a lump taken off and is not told what it is: that sequence tells him what disease he has. Then there is something that is tritely and famously known as the conspiracy of silence.

The doctor comes in the room and does not tell the patient what he has found. If the patient starts to ask, the doctor quickly says, "My it is a nice day outside. Do you think it might rain?", thereby informing the patient he is not to ask about his diagnosis. From that point on, the patient cannot discuss the disease with which he is dying. He is treated as if he did not understand anything about what was going on—

Senator CHURCH. Don't you think that is a serious mistake in the way the probability of death is treated? Don't you think that a doctor has a real obligation to tell the patient, give him the best assessment he can of his actual illness and what in all probability is likely to happen?

Dr. FOYE. I think that is absolutely critical. The only disease where we question this is cancer. If a person has diabetes, we say the education of the patient is essential. but here you are dealing with an incurable disease. If nothing else kills that patient, that disease will.

When you tell a patient he has cancer, however, you have to explain it to him. You have to say that one-third of all cancer is curable. You have to explain to him that the majority of patients with incurable cancer do not have severe pain, and of those that do have pain, the majority can be controlled with aspirin. Of those that cannot be controlled with aspirin, all can be controlled by other medications, so that there is no such thing as having to die with excruciating pain. You have to explain to the patient that there are things you can do for him, there are medicines that will control the disease in a certain percentage of patients, and would he like to try them? When the treatment is dangerous or risky, we explain what we will do to try to avoid the dangers and risks.

You have to inform the patient thoroughly so he can make the necessary decisions.

Senator CHURCH. I don't think there will be any argument about the fact that the patient should be educated about the nature of his

illness. I certainly think that is the case, and would apply it to cancer as well as any other disease.

It happened to me. I am a cancer patient. I had a cancer removed, and I was at the university years ago, in 1947, and it was explained to me in that way at the time.

So I really think that ought to be the practice, but I take it from what you say that it often is not the practice. In fact, it might not even be the prevailing practice.

Dr. Foye. I think in the majority of cases it is not done. It takes a lot of time, a lot of understanding on the part of the physician about the disease, cancer, and it takes his willingness to go into the sometimes complicated forms of treatment that offer a certain percentage of responses.

In a large number of cases I have been asked to see patients where the doctor says the patient does not know what he has. Yet when you walk in the room, the wife says, "I would like to talk to you in the hall, Doctor, he does not know what he has." I then say, "How many diseases do you ask to talk to the doctor in the hall about? What do you think he think he has?"

Of course, the patient knows he has something terribly serious and he is just scaring himself to death with ignorance. I have yet to have a patient who was unable to handle the knowledge in an emotionally stable way.

Senator CHURCH. If we are all agreed that it ought to be the obligation of the doctor to give such an education to his patient in every case—

Dr. SACKETT. I disagree.

Senator CHURCH. Oh, well, then we cannot proceed on this assumption.

Dr. SACKETT. Well, I have been taken out in the hall many times where the wife will call after we do surgery.

We just did a man who had cancer of the stomach, and the cure rate is practically nil. She demanded that we not tell him. As the family doctor, I scrubbed in on the surgery with the surgeon, and she got both of us together, she does not want him to know.

Senator CHURCH. And in that case you think that the wife's wishes should be complied with?

Dr. SACKETT. No, if he should ask, I certainly would tell him, but I will not go in there bluntly and say, "Your wife did not want us to tell you this, but you have cancer and are going to die. The cure rate of cancer of the stomach is 5 percent, something like that."

Senator CHURCH. One final question: The real disagreement, as I see it, among the witnesses this morning, has to do with the case where a patient appears to be in terminal illness, no longer has the lucidity with which to make a judgment as to his own wishes in the matter of treatment, and here there seems to be very real disagreement as to what the law or what the custom and practice should be.

Is there any final comment that any of you would like to make in connection with that question?

PHYSICIAN'S RESPONSIBILITY TO PATIENT

Dr. FOYE. I think Judge Cardozo said something very pertinent to this question: that there is no law of human jettison. I think that the responsibility of the physician to his patient is that he do everything he can for that patient's welfare, for that patient's comfort, for that patient's life, and when death defeats him, so be it, but I don't believe he should give the game away by default. I think death should be the failure point, not the goal.

Senator CHURCH. Dr. Ross, do you have any observation on that?

Dr. ROSS. I cannot really respond to this in 1 minute.

I think what Dr. Foye says is right theoretically, but in practice it just does not happen this way.

My own mother wanted to die very badly. She is kept now alive 2 years in the hospital, and cannot possibly sign herself out. She is totally paralyzed. She cannot say one word. She lies there like a body, and stares at you, fully conscious, and would very much love to die, but she is kept alive with tubes through her nose, and begging you (with her eyes) to let her die, and you cannot find a place that would let her die with peace and dignity, and she lies there for 2 years like that.

I don't have the answer, except that we educate our people not to artificially prolong suffering.

Senator CHURCH. In your mother's case, since it is very personal I really hesitate to ask the question, but given your strong feeling in the matter, suppose you were to simply withdraw her from the hospital. Do you think it is within your legal right under these circumstances. to take her from the hospital, or do you think the hospital would refuse? Is your problem one of assuming the responsibility, or is it one of fearing the legal consequences?

Dr. ROSS. No, I would not be afraid of the responsibility and the legal consequences at all. My mother is thousands of miles away, and the only remaining family she has are two young couples, both of whom are working. She cannot move 1 inch of her body, so you need nursing care around the clock. And it is very, very hard to do in the home. It is impossible. Those are the patients who need institutions for their physical care, but it is very hard to find an institution who cares for their need and does not use respirators and other means of artificial prolongation of life.

The only thing that I was able to do is to move her from the large teaching hospital to a very small Catholic hospital (and I am not Catholic, so I am not prejudiced) where they have sisters who give her devoted loving nursing care and I know they will not put her on a respirator.

Senator CHURCH. That is one question I wanted to ask you earlier. In your experience you have criticized the hospitals for their failure, for the dehumanization of death, and for their failure to make even minimal arrangements to make a death easier both for the dying patient and for the family.

But do you notice a difference between a municipal hospital, for example, and a Catholic hospital on that score?

Dr. ROSS. It is a gross generalization, but I think the worst place to die would be a large teaching hospital.

Senator CHURCH. That would be the worst type?

Dr. ROSS. Yes. A small community hospital, perhaps, would be my choice if I had to die in an institution.

Senator CHURCH. Any other final comments from anyone on the panel?

Dr. ROSS. I would like to go on the record "that I am not one of the nuts of the 12" Dr. Sackett described, but I am also very leery of that bill.

Senator CHURCH. You are very leery of the action?

Dr. ROSS. Yes; I am afraid to legalize bills like this because I am afraid of the loopholes which would make it possible to "eliminate" people's life when they become too costly or too much of a burden to us.

Dr. MORGAN. I have a final comment.

We get ready to die when we have not yet come to realize what a complex human life is. There are many elements that bear on living which commonly we do not consider.

Half a century ago, up in Minnesota, before we got the element iodine in our salt, goiter was so common that a painter, on painting a portrait of women frequently added a goiter as being a proper part of the physical body. There is an element of good health that we just had not discovered yet.

And down in western North Carolina there is an area that was never prosperous. People were very poor. I arranged to have a road built there, and the neighbors undertook the labor. They were physically unable to do that labor. The necessary food elements and body elements did not exist in their soil. In one place I entertained a friend from this area at a meeting in a region of fertile soil. On observing those in attendance he commented, "Oh, this is a limestone audience." There are elements of development there which were absent in his native area.

There are numerous factors in living necessary to health and vitality which often are actually missing. Men often do not consider there are many such elements within the food we eat, and in our nutrition, and the amount of sleep we take. Add the fact of exercise—we have hardly discovered this human life is not just a habit.

There is an achievement there that seldom is approached, because not many people ever realize those elements, and if we would give attention to those many factors, the picture of death would be very different.

The factors that enter into a good life are not one element. They cover a large range, and if we should consider the fact, the process of life and death would be very different. We give so much time to death.

Businessmen in the United States tend to drop off in the sixties, when they ought to be just in their prime, and we don't give attention to that, or pay attention to the causes of vigor and health and vitality and long life which have not been thoroughly approached. I don't know when old age should come. It should not come in the sixties. A person ought to be in full health in his sixties. Just when it should come I don't know, but man has a right to live to be a hundred, and the art of living is not pursued to the degree that it might be if we should change our whole civilization.

The approach to living is an enormous field.

Senator CHURCH. Well, I certainly do agree with you, Dr. Morgan, that the art of living is certainly the most important consideration of all.

Dr. MORGAN. I started out in early life as a victim of cerebral meningitis, and my physical life was limited. I was surprised that I grew up, but even with such a poor start, I got on a while. If it should become a major life purpose to see what the elements in life are, I think you will add more than 70 years of life as well as a vast amount of light on the makeup of the human body and mind in its elements. We have a whole world to discover and work in, and that should control our interest as well as consideration of the time of death.

Senator CHURCH. Thank you very much, Dr. Morgan.

Dr. SACKETT. Could I answer?

Senator CHURCH. Yes, certainly.

Dr. SACKETT. Just a brief statement that some day a law is going to have to face up to the situation that today is a huge problem, emotional bankruptcy of individual families, the bankruptcy of private estate, bankruptcy of government, because it is mighty hard to die—if they can get you to the hospital alive it is going to be a hard job to die, and I can foresee the problem becoming bigger and bigger every year, with medicine, we say improved, I am not always sure, but I can see those problems become overwhelming, to the point there may be more people in the kept state with some degree of incapacity than there are people and money enough to take care of them, and I think we are going to have to face up to it, and I think instead of stressing the prolongation of life, I think medicine ought to stop that and increase the quality of the expected life today, which is not always the case.

Senator CHURCH. Well, thank you very much.

I think in concluding, it is clear that we have two approaches to this subject presented this morning, one like yours, Doctor, stressing the need to change the laws dealing with this question, and the other being the need to foster education and to try to change the practices in the hospitals and to increase the opportunities for home care of dying patients, so that with that, I thank you for coming, for being witnesses this morning in the first of 3 days of hearings on this very delicate question. We appreciate your testimony very much.

Dr. SACKETT. Might I just say one thing I would like to see done, just inserted in the Constitution three little words, “* * * right to life, liberty, pursuit of happiness, and death with dignity.”

Senator CHURCH. Thank you very much.

The hearing is adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 1:20 p.m., the committee adjourned, to reconvene at 10 a.m., Tuesday, August 8, 1972.)