The Paul Brophy Case

D. John Doyle

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[*Brophy v. New England Sinai Hospital, Inc.* 298 Mass. 417, 497 N.E.2d 626 (1986).]

Paul Brophy was an energetic middle-aged fireman in Massachusetts who sustained a devastating basilar artery aneurysm rupture with tragic consequences. Following the rupture he entered a persistent vegetative state with no chance of recovery. As he was unable to chew or swallow, a gastrostomy tube was placed. When it was obvious that there was no hope for even a modest degree of recovery, his family requested that his gastrostomy feedings be terminated. This request was based on the fact that Mr. Brophy had verbally indicated that he would not want to exist in such a state. However, this request was refused by the hospital, leading to legal actions which landed in the Massachusetts Supreme Court. The Court agreed that Mr. Brophy would have wanted the gastrostomy tube removed but refused to authorize its removal as he was not terminally ill. However, when the case went further on to the Supreme Court, transfer of Mr. Brophy to another facility that was agreeable to removal of the gastrostomy tube was authorized. Mr. Brophy died not long after.

What sort of evidence is necessary in order for us to be satisfied that Brophy, the person who existed pre injury, would not want to continue as Brophy post injury?

I believe that it is sufficient that Mr. Brophy had clearly indicated his wishes to one or more individuals in the course of ordinary conversation. While a formal advance directive would be ideal in removing any uncertainty, in the real world hospitals and courts must often deal with far less certain situations. Provided Mr. Brophy had clearly and unambiguously indicated his wishes to one or more unbiased and credible individuals, and provided no one came forward with reports of conversations or other evidence to the contrary, I believe that Mr. Brophy's verbal statements would be sufficient in this case. I do not feel that only a signed, dated and witnessed advance directive would be good enough for us to reasonably ascertain his wishes.

Why would we appeal to someone's interests, someone who no longer exists, in order to justify present action?

Many conservative bioethicists would take issue with the notion that Mr. Brophy "no longer exists" merely because he is in a persistent vegetative state. After all, Mr. Brophy is not brain dead. Still, I would admit that many bioethicists (for instance, Princeton's Peter Singer) would maintain that Mr. Brophy no longer meets the criteria for "personhood".

However, even if Mr. Brophy "no longer exists" or is no longer considered to a person, this is still no reason to ignore his clearly expressed wishes. Indeed, the notion of a legal will (last will

and testament) exists exactly for that purpose – to indicate what wishes we want to be carried out after our death.

It is simply respect for Mr. Brophy's wishes and respect for his prior autonomy that leads us to justify our action.

Should society be able to weigh in on the choice to keep such individuals alive indefinitely?

Society already does "weigh in" on such matters to the extent that care givers, hospitals and courts already make decisions and establish policies on such matters. Two reasons for this arrangement exist. The first reason is to ensure that perceived legal and ethical obligations to the individual are met. The second reason is to ensure that perceived legal and ethical obligations to the society at large are met, particularly in any public health-care setting with resource limitations.

Central to this matter is the question whether or not there is an ethical obligation to prolong life in settings such as this. I would argue that if there is no reasonable chance of an individual recovering consciousness following such a clinical insult, then we do not have an ethical obligation to prolong life. This is because there is no benefit - physical or spiritual - to be gained from delaying death, and we should discontinue artificial measures to sustain bodily existence.

A more complex issue concerns the situations where relatives, hoping for a miracle, want to keep such individuals alive despite there is no chance of recovery. The most extreme instance is that

of the brain-dead individual where family members refuse to allow discontinuation of artificial ventilation in hopes that their prayers for Divine intervention are successful.

Should a feeding tube be viewed as somehow different from other medical interventions?

Feeding tubes are just one of many possible medical interventions in a spectrum of clinical procedures ranging from the very simple (like insertion of an oropharyngeal airway) to the very complex (like the use of extracorporeal membrane oxygenation). As we ascend the scale of complexity for these interventions we increase the degree to which these interventions are considered to be medical measures that are "extraordinary", "superhuman", "unusual" or "aggressive". Despite feeding tubes provide life-sustaining hydration and nutrition, I do not see them as being fundamentally different from other medical interventions – I would maintain that any differences are differences of degree, not substantial differences.

I would argue that if nasogastric feeding tubes are substantially or fundamentally different from other medical interventions merely because they provide life-sustaining hydration and nutrition, would not feeding by a gastrostomy tube also be fundamentally different, as well as feeding and hydration by total parenteral (intravenous) nutrition? I would maintain that these medical interventions may be different in degree, but not in their substance or fundamental nature, from other medical interventions. For instance, I would ask how feeding tubes providing life-sustaining hydration and nutrition are different from mechanical ventilators providing life-sustaining oxygenation and ventilation. In my view these interventions are all different only in matters of degree.

What sort of moral theory might be used to help sort out the issues raised by this case?

Both the dominant moral theories of consequentialism and deontology have been advanced as the basis for ethical decision making. Of these, I see the deontological ethical model as the more helpful in this particular instance. This is because it emphasizes our duty to respect the valid wishes of our patients. In particular, I would argue that respect for patient autonomy, one of the four guiding principles of the "Georgetown School" of bioethics (principlism), provides an important moral foundation for exploring the issues raised by this case.

Further Reading

Stoddard, Jim. 1987. "The Brophy Case: Courts Support Self-Determination." Midwest Medical Ethics 3(1).

Cranford RE. Brophy and Beresford: More Questions Than Answers. Neurology 1987;37:1359-1360.