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The President's Page

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To Treat Or Not To Treat

At our recent annual meeting, Richard McCormick, S.J. made some observations relative to the need for therapy in newborn defective children which were first voiced in his article on the same subject in the *Journal of The American Medical Association*, July 8, 1974. It is Father McCormick's opinion that "... life is not a value to be preserved in and for itself ... it is a value to be preserved precisely as a condition for other values. Since these other values cluster around and are rooted in human relationships, it seems to follow that life is a value to be preserved precisely only insofar as it contains some potentiality for human relationships. When in human judgment this potentiality is totally absent or would be utterly submerged and undeveloped in the mere struggle to survive, that life has achieved its potential." The implication being that such an individual because of the quality of his life should not receive life preserving medical therapy. The basis for the judgment whether or not to institute therapy would be the projected nature of this individual's life. In other words, an ethical judgment is called for regarding the existence of a human being based on the value of that individual's life to himself and whether this can be achieved or fulfilled by his continued existence.

Father McCormick has done a distinct service to all who are charged with the care of these seriously ill patients by his careful analysis of the problem before us, particularly by his indication that the traditional guidelines of ordinary-extraordinary means have lost much of their usefulness in modern clinical practice because of the necessity of their application on a situational basis. We must remember, however, that the quality of life ethic applied as a determinant as to whether or not a human being should be treated or sustained exposes the individual and society to a perilous path. One need only remember
the experience of German medicine chronicled by Frederic Wertham in "A Sign for Cain" to recall that the first application of Binding and Hoche's thesis of "The Release of the Destruction of Life Devoid of Value" was in defective pediatric patients, many of whom I am sure were in the same category as that which prompts this discussion.

It would seem to me that the physician facing the therapeutic quandary of the seriously defective newborn must consider the merits of three methods of ethical analysis available.

a) Ordinary-extraordinary means, which has serious defects in practical application because of its situational base.

b) A guideline centered on "the potential for human relationships associated with the infant's condition," suggested by Father McCormick and which I would term a consideration based on an assessment of the individual's prospective quality of life. The application of this principle in clinical practice would require a degree of omniscience quite beyond the limits of any known human agency, including the fallible physician. For example, cerebral palsy victims whose ability to participate in the "goods" of life may not be discernible for many years after their birth. Here we see a common phenomenon in which observers of the medical discipline grant to the physician discriminatory powers which are beyond his abilities.

c) A method restricted to considerations of therapeutic benefit for the patient. How much better is the approach of the physician when faced with the clinical problem as to the wisdom of instituting or continuing medical or surgical therapy for a defective newborn child, or seriously damaged adult for that matter, who makes his decision not on the basis of whether or not his patient can fulfill his potential for human relationship, but rather on the basis that every human life has intrinsic worth, potential or fulfilled, and that the decision for therapy should be based solely on whether this form of medical therapy can be expected to restore the ill or defective child to that state of health for which the therapy was planned. Two examples of this are the anencephalic child with a tracheo-esophageal fistula which I would not treat and the mongoloid child with the tracheoesophageal fistula which I have treated. In the first instance correction of the T-E fistula would not restore the patient to a state of health because the very nature of the anencephaly would result in the child's death from other causes within a short period of time even with surgical intervention. In the second instance the intervention would restore the defective child to a state of health compatible with the pursuit of a life whose quality was ordained by our Creator. The same principle of instituting or discontinuing therapy on the basis of its efficacy in achieving the goals for which it is planned is applicable to decisions regarding therapy for severely damaged cardiac or neuro-surgical patients when we discontinue respirators after it has become evident that their further use cannot possibly restore the patient to health even though the patient may have varying abilities to fulfill his potential for human relationships.

The physician should never be placed or place himself in the position of determining whether his patient should live or die on the basis of his judgment concerning the quality of the patient's life but should properly make his decision on whether or not his therapy will be of benefit to his patient. Physicians are the agents of the patient, not of the
relatives or society. Neither does the physician have the attributes or perquisites of the Creator to determine whether or not this particular human being should exist. The fundamental questions (What are the minimal elements of human personhood? What are the minimal measures necessary for the sustenance of human life?) go unanswered. Certainly the resolution of these questions is mandatory before any broad guidelines can be applicable in clinical practice.

Edward G. Kilroy, M.D.

Editorial

Definition of Death

It has been proposed that the moment of human death be defined as the moment of irreversible cessation of both respiratory and cardiac function, and in the event that these functions are being maintained artificially, the moment of irreversible cessation of cerebral function be defined as the moment of death.

It is my contention that such a definition of death is too narrowly drawn and too rigid in its requirements that the failure of a particular organ system must be present to establish the reality of clinical or legal death. This definition does not conform to the biological reality that death of an organism occurs when that organism’s biological systems undergo an irreversible loss of the ability to maintain vital functions. A pacemaker and/or circulatory assist devices may preserve cardiac functions, and artificial ventilators respiratory function indefinitely with normal cerebral function — a form of “living death.” Conversely, total cessation of brain function may occur and as long as artificial respiration is maintained spontaneous cardiac function can occur and be maintained. If we were to adhere to this definition of death, the practicing physician would be obligated to maintain all efforts to maintain “life” as the New Jersey’s Quinlan case seems to be saying. It is my feeling that such a definition of death would expose the physician to unwarranted malpractice liability if he did not continue all medical therapy until cessation of cerebral function was established and would require extensive clinical and laboratory documentation of cessation of cerebral function in every case, which is clearly not indicated in the majority of clinical situations. Another failing of this type of definition is the inability of such a legal statement to apply to changing events in medical knowledge regarding what bodily functions are truly necessary to maintain life. What is cerebral death this year may not be cerebral death next year, etc.

The patient and physician would be much better served by a much broader definition of death which would leave to the attending physician the employment of all his clinical experience and the most ad-

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