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## Editorial: Ever Say Die?

Ned H. Cassem, S.J., M.D.

Three myths seriously obstruct the care of the critically ill. Caught between the crossfire of euthanasia societies and pro-life groups, physicians are often blamed for not accepting oversimplified solutions to complex or insoluble problems. Three of the commonest simplistic shibboleths earmarked for situations of critical illness are the following. (1) *Medical care of the sick has been dehumanized by advanced technology.* Although a convenient misplacement of responsibility, this myth is patently false. Technology never dehumanized anybody. Human beings dehumanize other human beings. The means chosen are irrelevant, even though it is easier to blame the means rather than those who employ [or request] them. (2) *"Natural" death occurs with "dignity."* As reassuring as this maxim might be, it masks the separation, loss, debilitation, anguish, helplessness, organ failure, and pain that are as naturally associated with dying as energy, vitality, and a sense of well being are associated with healthy living. (3) *God gave life; He will determine when it is to be taken away.* God, it seems, was intelligent enough to leave this responsibility to lesser beings. This unthinking maxim apparently assumes that all technology available to prolong life must be used simply because it exists. If one acts according to this principle, technology uses him, not he technology. Although decisions

made according to this reasoning are irresponsible and only intensify the problems of the sick, they follow a deceptively simple process. The welfare of the patient is not considered and he himself, like the physician, is presumed to have no choice in the matter.

Slogans ring hollow in intensive care units, where life and death decisions are no longer theoretical issues. In this issue that decision making process is not only explored historically, legally and ethically, but two authors report on their efforts to expose, guide and observe it as it happens on the spot — in the ICU itself. Dr. Tagge describes a treatment classification system he and others devised for the ICU at New York's Mt. Sinai Hospital. The classification presents four "degrees" of treatment: I. maximum therapy without reservation; II. same as I, but situation to be re-evaluated; III. comfort measures only; IV. life sustaining measures can be stopped. This system forces the treatment team to formulate clearly and to specify openly what the treatment aim is at any given time and why. Communication between physicians, consultants, house staff and nurses was essential and could not be avoided. This was the major purpose of the system. Decisions were no easier but reasons for adding, subtracting or withholding treatment had to be made explicit, so that any member of the

team could weigh them against the best interest of the patient.

Dr. Shoemaker then reports the actual use of the classification system in 1000 consecutive admissions to the ICU. In so doing he provides evidence that such a system can be successfully and flexibly used — two patients in category IV, for example, recovered. The system protects this possibility. Shoemaker, however, pinpoints the most difficult question: what does “hopeless” or “irreversible” mean? More precisely, (1) what is the probability that a given course of treatment will restore the patient’s health, and (2) what will the restored state consist of and will it justify the efforts? Answers, to these two questions, if attainable at all, are the most basic and important “medical” facts in every decision. Unfortunately, this information may not become precise until treatment is well under way.

Fr. McCormick points out that life is not an absolute good nor death an absolute evil. Mere preservation of life for its own sake is therefore not an end compatible with Judaeo-Christian ethics. What means should be taken to preserve it, then? That is, how do we define “extraordinary” means — those which we have no obligation to take in an irreversible illness? Because quality-of-life judgments are involved, a danger lies in using only personal factors to determine ethical norms. Addressing himself to the related issue of abortion ethics, McCormick argues that John Fletcher’s

recent attempt to differentiate fetus from newborn fails because it bases the differences on factors that are not normative — i.e., constitutive of the essential personhood of the individual. He warns that decisions to treat or not, which must take into account personal perceptions, attitudes and desires, cannot stop there. As such, they are insufficient grounds for making normative ethical judgments.

With a lawyer’s sense of the rights of his client, George Annas confronts us with how often the patient is left out of the decision-making about his treatment, and that his is the right to say what should or should not be done to him. To protect the rights of any ICU patient entering a treatment classification system, Annas demands demonstration of four things: proper authority (approval of executive board of the hospital, and directors of the ICU), proper documentation (recording of treatment classification in patient’s permanent chart), adequate prediction criteria (unanimity of medical views about salvageability), and adequate patient representation (patient himself and/or a “patient rights advocate” in the ICU). Annas reminds us that reversal of nature’s downhill course toward death is precisely what intensive care units were established to provide. If there is even a small chance of restored health (how small no one has determined, but he sets the limit at two per cent), responsibility and

honor require an all-out effort on the part of ICU personnel. If any decision-making system deprives the patient of what voice he now has in the process, it should be opposed.

We end where we began — with more questions than answers. Nevertheless, our decisions in individual cases will be improved if we can keep three questions and five checkpoints in mind. (1) What are the chances of this person's restoration to health? (2) Will the patient be sufficiently restored to health to justify the effort, or will the "grave inconvenience" (Pius VII's word) make the means "extraordinary"? Answers to these first two questions should cover five checkpoints: (a) *technological* (what *can* be done and what treatments are available to reverse the downhill course of the illness? how effective will the treatment be?); (b) *socioeconomic* (how limited are the resources of the family, the community, and society?); (c) *moral/ethical* (how is this individual decision justified by criteria and norms that are constitutive of human personhood in general?); (d) *legal* (what does the patient say? are his rights infringed upon?); (e) *psychological* (what irrelevant motives bias the decision — e.g., patient's being disliked, poor, arriving for treatment at 3 a.m., etc?).

Answering the first two questions accounts for almost all the energy expended in arguments about treating the hopelessly ill. One of the strongest incentives to

prolong these disputes is the nearly complete avoidance of the third and final question. (3) Whether the decision is to save or let die, how does one conduct oneself in the face of imminent death? Almost every admission to an ICU requires this encounter for patient and staff. Admission is justified, in fact, by the danger to life present with the patient elsewhere. In treating the critically ill patient, some talk as though making the decision to escalate or limit treatment solves the problem. It is rather then when the task becomes most difficult. How are we to take care of the individual for whom further efforts to save are inappropriate? He may remain fully conscious, or if he is not, his family are. While some treatment efforts are modified or withheld, others must now be intensified. Preparation and support of the family throughout illness are as much a part of our responsibility to them as providing semi-miraculous technologies. Whenever a person lies mortally ill, hopefully he, his physician, family and staff can share the burden and confront together the realities that often dwarf them all. Although there are some heroic measures that need not be used for irreversibly ill patients, some always remain necessary: namely, extraordinary sensitivity, extreme responsibility, heroic compassion. For care itself must continue to the end of life and never cease to be total, even when major facets of it are duly limited or stopped.