

May 1993

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Recommended Citation

Hilgers, Thomas W. (1993) "Life ... the (Significant) other Side of the Coin," *The Linacre Quarterly*: Vol. 60: No. 2, Article 11.
Available at: <http://epublications.marquette.edu/lnq/vol60/iss2/11>

Life . . . the (Significant) other Side of the Coin

by

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We will call her Mrs. Chibusinsky (Mrs. C. for short). She was an 82-year-old woman of eastern European ancestry when I first came into contact with her. I'll never forget that evening as the events unfolded.

I was an intern rotating through the medical service at a hospital in Rochester, New York. It was my night to be on call. At the end of the day, all the interns and residents got together, as they usually did, for their "check out" rounds. We heard about the patients in the hospital who might need care during the course of the evening. We especially heard about those patients in the intensive care unit who may need our assistance. Having this kind of "check out" was important to all of us so that there would be a good continuity of care 24 hours a day.

At this particular "check out," one of the interns mentioned that Mrs. C. was on 2 South and not doing well at all. She had been admitted with upper GI bleeding and was incoherent, occasionally agitated, but mostly moribund with a hemoglobin about 6.0. She had an NG tube in place and, while she was stable now, she was expected to die that evening.

I was told at the "check out" rounds that I didn't have to worry about Mrs. C. because, since she was going to die anyway, there was nothing more that could be done. More specifically, I was told that "if the nurses from 2 South call me about Mrs. C., don't worry about it, just tell them that there's nothing more than can be done and leave it at that."

When "check out" was over, I went about my duties. I told myself rather consciously that I hoped that I wouldn't have to deal with the situation on 2 South. First of all, I felt poorly prepared to deal with the decisions that I might be forced to make. No so much from an emotional point of view, but rather from a medical one. Secondly, I really didn't know Mrs. C. as a person or as a patient I was only covering for another physician. That made me feel uncomfortable since the personal, caring side of medicine has always been important to me.

Well, as one would have it, I got a call about 4 a.m. saying that Mrs. C. was not doing well. Her blood pressure had dropped and she had become more agitated and incoherent. Would I please come down and see her?

I would, I said. When I got there I found this rather petite, elderly woman, agitated and incoherent, her blood pressure was about 90/70, her pulse 120, an NG tube in place with coffee ground material coming from it. I asked for a recent hemoglobin/hematocrit but it hadn't been done for about six hours so it was ordered. There were no signs of an acute abdomen or any other major problems.

She didn't communicate very well. She spoke no English, only her eastern European tongue. One couldn't understand a word she said and it made her more difficult to deal with.

Her hemoglobin/hematocrit came back even lower than before. In *my* evaluation of the patient, I didn't see any other alternative but to give her blood. This was contrary to our discussions at the "check out" rounds but I ordered two units of packed red blood cells to be given anyway. Upon receiving the blood, her blood pressure normalized, her agitation decreased and she stabilized. She still couldn't speak English and we couldn't understand a word she said.

The next morning, her attending physician came to see her and she was seen by a general surgeon. I wasn't around for a lot of that interaction, but the decision was made to take her to surgery to see whether or not the source of the upper GI bleeding could be resolved. As it turned out, she had a small arterial bleeder coming from a stomach ulcer which was ligated at a surgical procedure which lasted about 30 to 45 minutes.

I happened to see Mrs. C. several hours later in the Intensive Care Unit (where she was placed, mostly because of her age). *She was like a totally different person!* Her English was excellent (although broken), she had a sensational sense of humor, the entire staff grew immediately attached to her . . . this, the woman *they were going to let die.*

I learned a big lesson that night. The lesson was that it's difficult to predict, as a physician, what the outcome of a course of action is going to be. I also learned that some physicians take it upon themselves to make judgments which can be lethal to others.

In this day and age of suicide machines and prescribing barbiturate overdoses to assist in suicide (all couched in the most compassionate of terms), we need to be reminded that we physicians are not nearly so great as maybe we think. It might just be that our judgment can become clouded. It might just be that we are capable of prejudice like everybody else. This is what I learned that evening. I learned that we physicians can be immensely prejudiced in our attitudes towards others. In fact, it was Mrs. C's language problem, agitation and difficulty communicating that led the doctor to assume that her life was no longer worth living.

We hold negative attitudes towards people whether they're black, white, red, or yellow. We hold negative attitudes towards people if they don't speak the right language or have the same value system. We hold negative attitudes towards people if they are unable to pay their bills. We hold negative attitudes towards old people and sometimes toward young people. We hold negative attitudes

towards the infirm and the handicapped. There is nothing unique to medical education or to the practice of medicine that keeps us from these prejudices, except perhaps the *life protecting* oaths we used to take and have tried to live out.

As I have practiced medicine now over the many years, I have seen these prejudices and their accompanying emotional immaturities surface time and again.

I remember the time when a physician went into the labor room, and he used to do this routinely, to talk all of the women who had five or more children into having their tubes tied. I remember the time when a baby was born with a cleft palate and the attending physician who delivered the baby was emotionally and intellectually paralyzed in his inability to converse or to convey this problem to the parents.

I remember the times in our own community when physicians, as a routine practice would turn away patients who are on medicaid partly because they don't pay as well as private paying patients and partly because of their lower social status. I remember seeing patients who have been told that if they get pregnant another time, "You will die!" They'd been told this after a relatively simple episode of pregnancy induced hypertension which, while a recognized medical complication of pregnancy, is not one that usually threatens death.

It might just be that suicide, has *never* been viewed as a dignified way of death. And, it might just be that our assisting in suicide *brings even less dignity* to these situations. It might even be that our own prejudices might cloud our judgments as we administer the death toxins.

Are Doctors Kevorkian and Quill going to be our leaders and role models as we move into a new era of medicine? Do we as a profession want to accept their level of emotional maturity as guidelines for how we, too, are to act? Are we going to look at our patients as disposable pieces of property and ourselves as technicians for the disposal of that property? Or, are we going to take a good hard look at the one supreme value that has made medicine what it is . . . *the respect for human life* from the beginning through its natural end . . . *the one value that protects both the profession and the patient* from the inherent prejudices, discriminatory attitudes, and emotional immaturity of some members of the profession.

We physicians are weak! Our medical schools and residency programs haven't prepared us to be emotionally and spiritually strong. We are, however, intelligent. But emotional immaturity and intelligence sometimes spells disaster. The intelligent man who thinks nothing of discriminating against his/her fellow man spells monumental problems for the profession and leaves the public unprotected. Assisted suicide for a close friend can easily become assisted suicide for individuals who become socially unwanted.

After World War II, the World Medical Association looked long and hard at some of the major issues that confronted medicine and society. The major question confronting the world at that time was the question "Why Auschwitz?" To this end, the Declaration of Geneva and the Declaration of Oslo were formulated . . . "I will have the utmost respect for human life, from the moment of conception." But now *we have proven* that we are *not yet willing* to accept the ethical system

necessary to prevent another holocaust. So men of good will *must* rise up within medicine to prevent turning this once noble and respected profession into the "killers for the social good."

The lesson that we can learn from the care given Mrs. C. is that *we are not always right* and at the end of our decisions often lies another person's life. There are, indeed, two sides of the coin and *the (significant) other is LIFE*, the place where our profession and our patients are best protected. The place where we can best work to rid the profession of prejudice, discrimination and emotional immaturity. The place where perseverance, caring and commitment stand.
