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Letters...

Catholic Physicians' Guild

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Help Sought

To the Editor:

Two of us physicians work in a rural hospital near Quezaltenango City in Guatemala, Central America. We heard about your association from reading *Linacre Quarterly*, an excellent review for ethics in medical practice.

We serve an indigenous population and we hope you might send us, if possible, aid for improving our health service. This aid can be surgical or laboratory equipment, medicines and drugs, or recent articles and books referring to infectious diseases, tropical medicine, malnutrition, epidemiology or public health.

Thank you. God bless you.

— **Dr. Edgar Domingues**
Sanatorio Pasac I
Cantel, Quezaltenango
Guatemala, Central America

Editor's Note: We suggest that anyone able to respond to this plea send medicine or supplies directly to Doctor Domingues at the address given.

Re: Cerebral Death

To the Editor:

The rather odd fact is that certain sections of the medical and legal professions *et al.* have taken it upon themselves to manufacture a new type of death which goes by the name of "brain death" and which is utterly different from the somatic death which has been recognized throughout the ages. This innovation is not based upon any new discovery with regard to death but is of much more ordinary parentage and owes its being to nothing more substantial than present fancy.

Up until about 20 years ago, when a person's heart stopped beating for more than a few minutes, he was dead. He was dead then because there was, then, no means of substituting for the function of the heart. Life was thought to be dependent upon the function of the heart. Understandably enough it was not recognized then that it was not the heart that was important but the circulation. Once it became possible to substitute mechanical apparatus for the function of the heart, the definition of death, then extant, became outmoded.

Life is an active process, dependent upon circulation for it is circulation which binds the person into one being, that unites the body in a whole. When circulation ceases, the body disappears. It has been replaced by a disintegrated collection of separate organs. That is death: that lack of integration. Absence of brain function is not death. If it were, the child who is conceived would be conceived "dead." But, often, the woman who has conceived the child is desperately afraid of it. She would not be afraid of a dead child. No! The newly conceived child is very much alive and yet that child has no brain function as yet.

There is an extremely significant difference between the brain and circulation. The former is fixed and stationary and is only an organ of the child while circulation is in constant movement and life is that movement. When that movement ceases for a significant period of time, so does life cease. The presence or absence of cerebral function may determine whether further treatment is warranted; it does not determine whether the child is alive or dead. That obvious fact appears to have escaped attention. The heart is an organ even as the brain is an organ, but neither the one nor the other is the organ of life. A person with no brain function is unconscious, but he is not dead. But let there be no circulation for more than a few minutes (when the body is at normal temperatures) and he is dead forever. It is circulation which brings into functional unity the various parts of the living body. It is the absence of

circulation which is corruption, which is death.

The medical and legal fraternities in their wisdom or lack of it, have overlooked that obvious fact and decided to manufacture a new form of death — a form in which the person does not die but instead is maintained in a perpetual state of unconsciousness for whatever purposes his attendants have in mind.

Until relatively recently, it was thought that if a patient were treated in a hospital, that treatment was given for his benefit and for his alone. Sheila Taub, writing in *Connecticut Medicine* ("Brain Death: A Re-Evaluation of the Harvard Criteria," vol. 45, no. 9 [Sept., 1981]) cites the following three reasons for treating the irreversibly unconscious patient.

(1) The patient's organs become available for transplantation while they are still in the optimum condition.

(2) The patient's relatives are spared the emotional and financial burdens of treating the patient as if he or she were still alive for several additional weeks when death is inevitable.

(3) Society is spared the use of scarce and expensive resources which can more profitably be used on other patients.

In other words, in no way will the patient be the beneficiary of the treatment he is receiving. He has been conveniently eliminated by the definition of his own death. Now the whole purpose of brain death legislation becomes obvious. It would be a simple matter to discontinue the obviously futile treatment if that were the object of the exercise. But it is not. The object is to obtain the patient's organs before he is properly finished with them because they "can, more profitably, be used on other patients."

If the declaration of "brain death" were only the means by which the termination of treatment could be brought about, this would not matter too much, for the treatment of the cerebrally dead is an exercise in futility. But that is not the end of brain death legislation; it is only the beginning, for once it is enacted it will become possible to obtain living bodies in a better and better state of preservation by declaring them "dead" at an earlier and earlier stage of their terminal illness.

What do a few residual reflexes matter if the patient can neither think or feel? Why not declare him "dead" now and put him on life support? The finding of "brain death" is not a conclusion drawn from an examination of the patient; it is a predicate of the examination. That it has no real existence is evident from the fact that the time of death can be moved about at will; it is not fixed by the nature of things. Thus the "brain dead" person is given two examinations about 24 hours apart. If his condition is unchanged between them, he will be declared to have died before the first. But the very fact that he was given two examinations proves conclusively that it was not certain that he was dead at the time of the first and it proves also that the physician cannot distinguish between a live person and a dead one. Who, in his right mind, would re-examine a person whom he knew to be dead already?

The concept of "brain death" is unbelievably naive. It is the product of the expert mind and it receives slavish acceptance because that is so. The general practitioner is only too conversant with the meaning of "dead" from his own practical experience. He would not think to question its meaning. The specialist is too far removed from the realities of life and death to come to grips with them. To him, "dead" does not denote the existential condition of a person, but the availability of his still living body for transplant material or experimentation. The opportunity to experiment on the living body of the "dead" person is too good to be missed.

Let us try to see what the future holds if "brain death" legislation is enacted. If nothing else, it will be a heyday for the legal profession.

At the moment, when a patient is

close to death, all treatment other than that aimed at making him as comfortable as possible, even at the expense of rendering him unconscious, is abandoned. Any hope of curative treatment has long since been lost.

But in the event that the actual time of death becomes very important and it will become important from time to time, the whole situation which previously existed, will be altered. The poor patient is thrust into the impersonal and uncaring maw of scientism.

In all circumstances, except, perhaps, brain death, the person and his brain die together. In no circumstance does the person die first and his brain die afterwards. If brain death legislation is enacted, there will be an implied duty on the physician to continue with supportive therapy at least until death. This will be so in all instances of death. No patient may be allowed to die without the fear that the physician who so allowed him will be found derelict in his duty to the patient. Once one physician has been successfully sued for not having used every weapon in his armamentarium to keep his patient alive, every physician will be afraid to discontinue treatment, however futile it may be. In the Quinlan case, the court ruled, "He (the physician) must do *all* in his human power to favour life against death." "All." There is no choice. There are no exceptions.

The fact is that the decision as to whether further medical treatment is medically warranted can be made, reasonably, only by a person who is an expert in the practice of medicine, not by the court and not by both. What the court has failed to realize is that the physician is obliged to care for the patient's health, not his life. If the court would have it otherwise, then the court should be burdened with the problem of means; of how to care for the patient's life other than by caring for his health.

Please excuse the length.

— Colin P. Harrison, M.B., B.S.
Vancouver, B.C.
