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Current Medical-Moral Comment

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ment and the cardiac catheterization unit. We have not found that the program requires expensive items of equipment, but that much of the equipment used in a specialized referral community hospital can double very adequately in a clinical research program.

Future support of clinical research programs is necessary in order to maintain the development of good ideas in clinical medicine that benefit many patients. Support is also necessary to maintain an inquisitive attitude on the part of the house staff and attending staff in a large teaching program, and it is very important in augmenting the training program in postgraduate medicine that is becoming an everyday responsibility of the community teaching hospital.

SUMMARY

The community hospital affiliated with a university is growing into a major teaching and clinical research activity. The development of a cancer program serves as an example of one facet of this growth emphasizing the contributions to medical care, scientific advancement, and the medical profession. Support of growth in research activities to the large community teaching hospitals must be considered to maintain good programs.

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Medical Missionaries in Peru and Bolivia Organize

English-speaking missionary doctors, nurses, and medical personnel from seventeen different religious organizations, the Papal Volunteers and Catholic Families from Latin America working in Peru and Bolivia recently met in Cusco, Puno, Peru, to discuss their problems, exchange experiences, and meet those who work in the health field. This religious assembly gathering brought together missionaries from the arid coast of the high Andean sierras—the "altiplano" of Peru and Bolivia, from the dense jungle of the Peruvian Amazon and the tropics. They work in or staff parish clinics, government health posts, public and private hospitals, and nursing schools.

Several papers were read and panel discussions held. Representatives from the WHO, the Peruvian health ministry, the Peruvian Red Cross, and members of the clergy spoke before a group of health workers, social and economic factors affecting the health apostolate, nursing education, and the role of the medical professionals in the missions today.

A result of this meeting is the formation of an organization, the Conference of Health Service Personnel—for the mutual education, renewal and development of the apostolic spirit of its members; for the deepening of their understanding of the people for whom they labor, and for the opportunity to plan together to better develop the Christian Apostolate.

Due to the success of this meeting, plans are being made for another in October of this year, to be held in Arequipa, Peru. Those interested in this meeting and this organization can contact:

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CURRENT
Medical–Moral
COMMENT*

Thomas J. O'Donnell, S.J.*

The question of prolongation of life in terminal illness comes up constantly in the current medical literature. While individual cases are not always easy to assess, the basic principles to be considered are reasonably clear. In any human context, whether it be religious, civil or medical (and these are the three areas which become involved in this problem) as long as the phrase "under God" rises naturally to men's lips, it is readily recognized that man is not the absolute Lord and master of human life. Man rather carries with him, both as a right and as a duty, the wise stewardship of his human life — toward the fulfillment of his human personality, his participation in the brotherhood of men, and his love and service of God.

Out of these concepts arise the obvious that man is not free to arbitrarily terminate human life, either his own or another's; that he must, moreover, take ordinary care of his life and health; but that since ultimate dissolution on the brink of eternity is a part and parcel of our common clay, he need not go to extraordinary and exotic lengths to stave off the moment of approaching death.

In our times of advancing medical and surgical techniques the question of what is ordinary and what is extraordinary has become more difficult to decide. A hundred years ago no one doubted that a purge was a quite ordinary therapeutic procedure, and that the amputation of a leg (without anesthesia and with the likelihood of lethal complications) was more than the concept of stewardship of one's life demanded.

But with the advent of modern medicine, of antibiotics and intravenous feeding, of the iron lung and cardiac surgery, colostomies and home dialysis, the distinction between ordinary and extraordinary becomes more difficult to discern.

The modern techniques cannot be judged as ordinary or extraordinary in themselves. They must be considered in relation to the proportion between what is to be hoped for in human values and the cost in terms of human resources, both personal and material. Hence, it would seem that while the use of a resuscitator is most vital at a critical moment, its continued use after very extensive and irreversible brain damage is

*By arrangement with the Editor of Georgetown Medical Bulletin, Father O'Donnell's column in that journal appears concurrently in THE LINACRE QUARTERLY.

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The Jehovah's Witnesses owe their origin to Charles Taze Russell, a native of Pittsburgh, who was influenced by the Second Adventists (an offshoot of the New England Mormons). He presented himself as God's Witness, predicting the coming of the Lord and interpreted the scriptures according to what he claimed to be personal divine inspiration. Russell died in 1916 and his place was taken by "Judge" Rutherford until his retirement. Russell opposed both Catholic and Protestant Churches as being under the supervision and control of the devil. For this reason, the sect has opposed participation in politics, jury duty, military service, salute to the flag, vaccination and blood transfusion as being contrary to various injunctions of scripture.

The first case is the case of the adult patient who is seriously ill and in grave need of the transfusion. The patient is conscious and refuses permission for the transfusion. The patient is unconscious but previously refused the transfusion on religious grounds, the situation is essentially the same. In this case, it is either a violation of human rights either to give the transfusion or to seek a court order whereby a transfusion would be effected. In some cases such court orders have been granted. In other cases they have been denied.

This is the easiest of the three cases, and the reasons in my opinion are as follows. While one is obliged to use ordinary means to prolong his life, one is not obliged to use extraordinary means. Theologians agree that which, in itself, an ordinary means can be considered subjectively extraordinary if the patient has a grave subjective abhorrence, antipathy, repugnance or aversion to its use. This is a subjective state of mind on the part of the patient which de facto can exist whether the considerations which give rise to it are reasonable or not. This is certainly vested in the Jehovah’s Witness with regard to transfusion. Therefore, since the transfusion is a subjectively extraordinary means of prolonging life for this patient, the patient has no obligation to resort to it. Hence, the patient has the right to refuse it. And no matter what the consequences to this patient, that right must be respected.

The second case is more difficult. What is to be done if the patient is an infant in need of transfusion as a life saving therapy, and the parents or the next of kin refuse permission? In this case, the more usual disposition of the courts has been to declare the infant a ward of the state and to order the transfusion. The situation is usually approached under the juvenile court law of the various jurisdictions which provides, in some degree, for the protection of "dependent and neglected children." The procedure is ultimately based on the common law concept of the state "parents patriae."

This, I believe, is a morally sound approach to the problem. While the state recognizes the right of the individual to freedom of conscience, this does not include the right to act on such convictions in violation of the rights of others. In this apparent conflict the state is correct in assuming the custody of the child to ensure that the child receives ordinary care. Moreover, it should be noted that the transfusion remains an ordinary means for preserving the infant life, since the child does not experience that personal abhorrence which made the transfusion subjectively extraordinary in the previous case.

The third and most difficult case is that of the mother who is in need of life saving transfusion, and who is carrying her unborn child in her womb.

Such a case came before the Supreme Court of the State of New Jersey June 17, 1964 in regard to a patient at Fitkin Memorial Hospital. The court recognized the fact that the pregnancy was beyond the thirty-second week and that the mother was in danger of hemorrhage which would be fatal to both herself and the unborn child. After the Chancery Division of the Superior Court had held that the judiciary could not intervene, the Supreme Court on appeal did not hesitate to order the transfusion for the protection of the unborn child.

Here, I believe, we have the unusual situation of the court being right in principle, but wrong in its application of the principle. Theologians would certainly agree with the court's insistence on the right of the unborn child to the protection of the law. Moreover, it is interesting to note that in the last twenty years there has been a healthy legal trend away from the view established by a decision of Justice Holmes in 1884. Justice Holmes refused to recognize the legal existence of an unborn child.

Likewise, I would agree with the view that the mother certainly has...
an objective obligation to provide ordinary care for her unborn child. If she refuses to do this for whatever reason, the state, *parens patriae*, has a right to step in.

However, under the circumstances of this kind of case, I believe that the state should not exercise that right. Even if both the mother and the child will otherwise die — and this for two reasons:

1. To force a conscious Jehovah's Witness, on the point of death, to submit to a blood transfusion to save the life of her unborn child might well bring her human and religious feelings into such deep and confused conflict as to endanger her own spiritual welfare at this uncertain and critical moment. Hence, if the obligation for her to accept the transfusion is verified, it should not be urged under these circumstances at risk of her eternal salvation.

2. I am inclined to believe that the precedent of the state physically invading the human person contrary to her conscience is so dangerous to the common good as to outweigh the individual good of the unborn child.

Finally, by way of a recent development in this general problem, it might be noted that although there has been some discussion as to whether or not blood may be collected in advance from, and reserved for, a Jehovah's Witness for autotransfusion, the use of, a particular procedure to be acceptable to a Jehovah's Witness has been rejected by *The Watchtower* Bible and Tract Society (New York) which is an official organ of the Jehovah's Witnesses.6

**Two Forces, One Goal**

**REVEREND DR. PAUL B. MCCLEAN**

Man is a whole being. It is impossible to divide him into separate areas or categories. His vocational life affects his mental attitude, his social well-being can create strength or weakness in his physical being. Though all men may not recognize it, each individual's faith gives confidence, certainty, and hope for whatever he does. In the art of healing we seek then to bring together the spiritual, medical, mental, and social factors to be applied to the patient or the parishioner that his health might be strengthened.

The physician and the clergyman, deep within their hearts, have a sincere and vital interest in the patient or the parishioner. In a sense each is called to his profession, a calling that underlying all of our front is a calling of compassion, tenderness, and concern. The cry of the needy is heeded by each one of us. As men of concern, we should strive then to make possible in times of illness to use all of the facilities that are at hand to bring about total health. It is not a matter that each patient that is seen requires consultation by colleagues of the medical profession or referrals to a clergyman. Nor is it true that each parishioner who seeks counsel from his clergyman requires consultation by other colleagues or referrals to doctors. But, there are times and there are areas involving the life of the patient and the parishioner in which the two professions could be of help one to the other in making possible the complete healing rather than partial healing.

Throughout all America, there is a new recognition on the part of many of the concept that man is a whole being. He is physical, he is spiritual, he is mental, and he is social in his total health. It is widely recognized that a weakness in any one of the four factors of his health can and does militate toward ill health in any one or all three of the other factors. We recognize immediately that all illness is not organic. The parents of the retarded child in some cases are more ill than is the child. Moments of shock, fear, hysteria, and grief are moments of serious illness and these illnesses can affect the whole being of the patient.

The faith of the individual patient is a vital factor in total health. The patient must be treated and cared for within the scope of that faith. There may be times that the physician would disagree and not approve of the concept or attitude that a faith group presents to his patient, but the fact still remains that it is the patient's faith and every physician knows that he must treat within that faith. There needs to be greater

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