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Robert J. White

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# The Moral Dilemma of the Catholic Neurosurgeon

ROBERT J. WHITE, M.D., PH.D.

My thesis is that the moral posture of the Catholic neurosurgeon at the present juncture of scientific knowledge of the brain-mind-soul continuum is tenuous and in serious need of updating and revision by the moral theologian. Few physicians, regardless of their area of clinical competency, are fully cognizant of the overwhelming moral responsibilities that transcend the clinical area designated as neurological surgery. Indeed, it can be further stated that many neurosurgeons themselves are ignorant of or unconcerned with the moral implications of their clinical work.

To a large degree these difficulties stem from our continued lack of knowledge of brain, especially with reference to how it, as a tissue substrate, subserves the psychological concept of mind and the theological concept of soul. The neurosurgeon alone must decide on a positive form of treatment (intracranial surgery) which will have profound and far reaching effects on this cellular aggregate which is responsible for human intellectual performance, moral judgment and all contiguous relations to external environment.

While admitting significant scientific ignorance of the brain on one hand and the absolute necessity on the other of performing surgery on this organ when life is threatened, we must acknowledge an additional problem wherein the life of the patient may be saved or prolonged

but the individual so utterly changed from a personality and moral standpoint that he may be unrecognizable to his family and, indeed, to himself. Now it is true that modern techniques utilized in cerebral surgery, e.g., hypothermia, hyperventilation, dehydrating agents, reduce considerably the direct trauma to brain in the course of an intracranial operation thereby minimizing unfortunate psychological, behavioral and neurological complications. In spite of idealization of neurosurgical techniques, complications in these categories may develop and are to a large degree unpredictable.

By way of example, the neurosurgeon may successfully clip an anterior communicating artery aneurysm and protect the patient from further catastrophic intracranial hemorrhage (which most assuredly would result in his demise), yet because of the aneurysm's pernicious location on the circulation at the base of the brain and the requirement of cerebral tissue retraction for its exposure, the patient may be fundamentally altered in intelligence and behavior so that he is no longer the "same person" to his family or his friends.

The clinical problem of the cerebral aneurysm can be used in another frame of reference, for here the neurosurgeon faces a situation (and all too frequently) where in spite of his skilled efforts he may

lose the patient on the operating table as a result of fatal cerebral hemorrhage or vascular occlusion.

It would appear that surgeons operating on the brain and the heart, as opposed to other surgical specialties, share an unhappy common denominator in that their patient may die as a direct result of their surgical intervention regardless of excellence of surgical skill and optimization of instrumentation. This is due primarily to the intrinsic irreversibility of function in these organs if they are sufficiently damaged. While it is true that all physicians face this therapeutic possibility it would appear that only in these two specific surgical areas is the probability of immediate death so easily equated directly with the operative technique itself.

This state of affairs was poignantly described recently in an excerpt from a book entitled, "Diary of a Russian Surgeon" written by N. M. Amosoff, a Soviet cardiac surgeon, published in the December issue of *Harper's Magazine*.<sup>1</sup> In this article we are party to a moving description of the emotions of a surgeon during his failure to salvage a patient in the operating room. We read of the confusion, the errors in judgment; indeed, the child-like behavior reflected in the surgeon's actions in the course of a surgical procedure in which he knows all is lost. We do not see here the popular image of the cool, detached, efficient surgeon but rather a human being overwhelmed by feelings and emotions that all neurosurgeons have unfortunately endured under similar circumstances.

The practicing neurosurgeon must

be honest in admitting that during the course of many of his surgical procedures there have been moments of doubt as well as confusion; best expressed by the thought: "Just where am I and what should I do?" Yet at each of these junctures, the surgeon is faced with a choice, which if incorrect, may render his patient an intellectual cripple for the rest of his life. Certainly many of the most famous and, indeed, most capable neurosurgeons do not consider the moral implications of neurosurgery but rather prefer to carry out intracranial procedures feeling that they are being performed to the best of their ability and judgment and that whatever may occur would occur under any circumstances.

Recently an excellent neurosurgeon, Dr. Bland W. Cannon of Memphis, has raised the question as to whether neurosurgeons' *pace* are different from their medical colleagues. In an article entitled "A Neurosurgeon's Identification: 'Queer Breed' or 'Happy Breed'?" published in the autumn issue of *Perspectives in Biology and Medicine*,<sup>2</sup> Dr. Cannon, using a chance remark of Dr. Wilder Penfield, the world famous brain surgeon, examines the relationship of the modern day neurosurgeon to his professional colleagues, to his patients and to society in general. While the author draws no specific conclusions regarding these relationships or for that matter the uniqueness of the neurosurgeon in modern day society, he himself feels that he would be far more comfortable with medicine as it was practiced forty years ago than with the present day elec-

tronic uniformity. While this particular neurosurgeon may have been happier with his personal and professional relationships of that time, he unfortunately has not come to grips with the central problem of intracranial surgery of any age—that is, our continuing lack of fundamental information regarding the effects of surgical intervention on the brain.

To put it in a more clinical setting, what does or what should the brain surgeon tell the referring physician, the family, and indeed, the patient himself regarding the prospects of success in removing tumors, hemorrhages and repairing the circulation of the brain when he is not sure that he may not intrinsically alter the highest processes of cerebral function in an attempt to correct these life threatening conditions? The added tragedy here for the Catholic neurosurgeon is that there are no well-established moral guidelines covering the therapeutic approaches to the various pathophysiological states he is called upon to treat.

While it is true that the overall moral "rule of thumb" regarding primary and secondary effects may be invoked, it would appear that even the most up-to-date publications in the field of medical and moral theology are devoid of any reference to these overwhelming neurosurgical problems. Admitting the great preoccupation of the present day Catholic theologian with obstetrical morality, one must still seriously question the persistence of discussion of such rapidly disappearing techniques as frontal lobotomy when this represents the

extent of theological concentration dealing with brain surgery in modern day textbooks of moral theology.

Were it only the well established and accepted operations of neurosurgery that require review by the moral theologian the implications of these procedures might or might not present major areas of moral decision. But now with the availability of techniques to artificially supply and control the environment of brain in the isolated state for neurovascular surgery where the classical physiological definitions of death are meaningless, when now in the experimental laboratory the brains of highly developed animals may be permanently separated from their bodies and maintained in a viable state for hours with machines—a situation which could be easily duplicated for the human brain—and when even the overall problem of the definition of death, which after all must in its final analysis be a definition of the death of the brain, is rapidly pushing its way to the front because of its relevancy to the problems of organ transplantation, it would appear to me that not only the neurosurgeon but the entire medical profession is in need of overwhelming assistance from the moralists.

Recently the French Academy of Medicine has ruled that when the brain is gone a patient may be considered dead even though other organs may be kept alive by artificial means. This is obviously an attempt to encourage the availability of living organs for transplantation. Even though these problems, specifically related to transplantation, were discussed at the most recent

International Congress of Medical Ethics pointing up the moral dilemmas resulting from the availability of instrumentation for prolonging body function, as yet the necessity of reassessing the relationship of brain function to death has had little or no serious commitment on the part of the Catholic theological community.

While I would agree that the Catholic neurosurgeon can continue to practice his medical specialty according to the traditional moral code, my plea is that we are in need of a new and bold approach to our problems from moral theologians. They must weigh anew and carefully the relationship of

the brain-mind-soul continuum to modern day brain surgery and in broader sense, to the eternal problem of life and death.

#### REFERENCES

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[DR. WHITE is Director, Department of Neurosurgery, Cleveland Metropolitan General Hospital and Professor of Neurosurgery, Western Reserve University School of Medicine.]