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The "Hopeless" Case

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**DR. LAFORET WINS INTERNATIONAL PRIZE
FOR MEDICAL ETHICS**

AWARDED POPE JOHN XXI MEDAL

Dr. Eugene G. Laforet of Chestnut Hill, Massachusetts was honored by the International Congress of Catholic Doctors for his paper "The 'Hopeless' Case" read at its tenth triennial meeting held in London during early July. As the report of the Congress appearing elsewhere in this issue indicates, the Pope John XXI International Prize for Medical Ethics was instituted by the Association of Portuguese Doctors in 1952 and it is awarded every third year.

Dr. Laforet edits our Abstracts section each quarter and has contributed a number of excellent articles to LINACRE QUARTERLY. We value his assistance to our Editorial Board and congratulate him most sincerely on receiving this International Award. We are very happy to include the prize-winning paper in this August issue. It is published with the kind permission of the International Federation of Catholic Medical Associations from the Acts. (Proceedings of the Congress.)

THE "HOPELESS" CASE

O God, Who has doomed all men to die, but has concealed from all the hour of our death, grant that we may pass our days in the practice of holiness and justice

~ Prayer for a Happy Death

INTRODUCTION

When, in a given patient, there has been established a firm diagnosis of a relatively chronic condition that may be expected to terminate fatally because curative treatment is either not known or not applicable, the case may properly be considered "hopeless." Under these circumstances medico-moral problems are almost inevitable; they are accentuated when the pathogenesis is obscure, when remission is rare, and when the general health of the patient is apparently good. Almost by common acceptance the prototype "hopeless case" is the patient with incurable malignancy. Unfortunately there are many other diseases,

such as central nervous system neuropathies, that may readily be included in this baleful category. It is evident, but nevertheless of considerable significance, that the term "hopeless" in this context is relative — its limits are defined by the current state of medical knowledge. Scientific progress has narrowed these boundaries in some areas and expanded them in others. Pernicious anemia, for example, was stricken from the list by Mintot and Murphy, and diabetes mellitus by Banting and Best. On the other hand, Wegener's granulomatosis and idiopathic pulmonary hemosiderosis are but two of the potentially "hopeless" diseases that have been added to nosology in recent

years. Indeed, to modern science we owe the example *par excellence* of the "hopeless case" — the individual who has accidentally received a lethal dose of ionizing radiation, whose early doom is sealed beyond doubt, but who, for the moment, remains completely asymptomatic.

And yet even the stark term "hopeless" can perhaps be mitigated to some extent . . . while many diseases may be "hopeless" in terms of ultimate survival, they may be far from so in terms of effective palliation and worthwhile existence.

What specific medico-moral difficulties may be engendered by the "hopeless" patient? Primarily, of course, there may be problems associated with *therapy* — for example, whether to employ vigorous treatment or, indeed, whether to treat at all. A second important facet concerns the *imparting of pertinent medical information* — to the patient, to relatives, and to other interested parties. Further, the "hopeless" aspect almost necessarily invites a consideration of human experimentation, either related or unrelated to the disease at hand and aimed either at immediate benefit to the subject or at remote benefit to others. Finally, associated intimately with these topics but worthy of separate consideration, certain *spiritual aspects* of the "hopeless" patient merit comment. In the following pages these medico-moral features will be discussed individually and an attempt will be made to draw conclusions that are consonant with

Christian ethics and accepted medical practice.

THERAPY

Every physician, whether or not "psychosomatically oriented," appreciates that the dichotomy between the psyche and the soma, between the spiritual and the physical, is artificial and arbitrary. It is, however, a convenient distinction, and one that permits a certain analytic approach not otherwise possible. In spite of the foregoing, the physician has traditionally been concerned more with the outward aspects of disease than with its subtler features, and the following discussion of "therapy" specifically excludes such modalities as are primarily spiritual, psychiatric, or sociologic.

What norms, then, does one employ in the *physical* treatment of the "hopeless case"? The spectrum varies widely; it ranges from the deliberate and direct extinction of life to vigorous efforts at maintaining a semblance of vitality in a moribund patient. Certainly between these extremes, but not always susceptible of precise definition, lies the Christian attitude.

Euthanasia: The directly intended and procured death of a patient in order to terminate suffering has been designated "euthanasia." It is probably coeval with the history of mankind. Regardless of motive, it constitutes an intrinsically evil act and as such is not licit. "Thou shalt not kill" permits of no other interpretation.

May not a physician, however, act with propriety and as a mere

agent in ending the life of a patient who desires and consents to euthanasia? Because man exercises only custodial privileges in this matter, such consent cannot validly be granted.

Fundamental to any consideration of euthanasia is the fact that pain and suffering, while *physical* evils, are *morally* indeterminate, neither good nor evil *per se*. Consequently any argument based upon the premise that pain and suffering are intrinsically evil is fallacious.

Prescinding from moral considerations, Kamisar¹ has presented virtually unassailable arguments against euthanasia. In brief, he holds that the risk of error and abuse is so large that permissive legislation regarding euthanasia would be impracticable.

Unconscionable Prolongation of Vital Functions: Technologic advances have made it possible to maintain for a considerable interval a semblance of vitality in a moribund, or actually dead, patient. Respiratory movements can be induced extrinsically, as with a respirator, and cardiac function similarly, as with electrical stimulation or mechanical support. Under these conditions, however, one is dealing not with a living human being but with a functioning human heart-lung preparation. Such measures hardly seem warranted in the case of a chronically ill patient in whom cessation of respiratory or cardiac activity is but the final outward manifestation of death. Undue prolongation of vital functions, therefore, may or

may not be licit, depending upon the intent of the physician. Additional elements to be considered include charity to the patient and justice to the relatives. Because even unreasonable prolongation of vital functions, unlike euthanasia, is not intrinsically evil, it is obvious that a firm and unqualified statement regarding its morality is not possible.

The Middle Ground: Ordinary versus "Extraordinary" Means:

Thou shalt not kill but need not strive

Officiously to keep alive

In the present context the temptation to quote this Shavian couplet is well-nigh insuperable, particularly since it seems to state so succinctly the crux of the problem. Like so many other felicitous expressions, however, it risks oversimplification. What, for example, is "officious" striving? In the succeeding paragraphs this and related topics will be discussed.

As a guide to the solution of difficulties involved in the present subject the Church makes a distinction between "ordinary" and "extraordinary" means. Thus, there is a moral obligation to take all "ordinary" means to preserve life and health, but resort to "extraordinary" means is optional.² It is obvious that a universal definition of these terms is impossible, since such circumstances as time, place, and person may constitute the final determinants. Once the principle has been enunciated, therefore, the Church wisely defers to the judgment of the interested

parties. It is at this level of "practical ethics" that the major difficulties arise.

While not necessarily confined to the "hopeless case," the problem of ultra-radical surgery requires consideration here because of the implicit suggestion that without such means a potentially curable patient may become "hopeless," or a "hopeless" patient may be denied palliation. A classic contribution in this matter has been made by Ford and Drew,³ who list the following factors that must be weighed by the physician-counselor:

1. The patient's spiritual well-being: While not a prime responsibility of the physician, this element must be considered when advising radical surgery. "Is the patient prepared to die?" and "Would he be prepared, or better prepared, if his life were prolonged?" are queries of importance.
2. The patient's own desire to continue his life by extraordinary means: The *balanced* judgment of the patient must be considered.
3. The expected length of survival and the degree of comfort expected: These should be commensurate with the drastic procedure contemplated.
4. The effect of the patient's survival on his associates: This includes such elements as stress and strain on the members of the family and the cost of continuous medical care.
5. The advancement of science: This is considered an important

reason for advising radical surgery only when the patient wishes to contribute to science in this manner, or when it does not conflict in any way with his personal interest.

In medically evaluating the justification of radical cancer surgery Whipple⁴ has cited the following factors as important: 1. threat of the disease, 2. operative risk, 3. the probability of cure and long term survival, 4. the assurance of relief of symptoms, even though palliative or temporary, and 5. the ability of the patient to adapt to the dysfunction or deformity that may result. In a similar vein, Stone^{5, 6} has contended that the feasibility of technical success in ultra-radical surgery does not *per se* justify these operations and that such factors as patient comfort and expense must be considered. In short, then, extraordinary *surgical* means may be employed in a given patient but only when all of several factors have been conscientiously evaluated.

What norms govern the use of extraordinary *non-surgical* means in the "hopeless" patient? According to Collins,⁷ "No physician is obligated to institute extraordinary measures to save life, especially under impossible circumstances." In support of this view, he refers to the reply of Pope Pius XII⁸ to a question asked by delegates to the International Congress of Anesthetists in 1957. The query concerned the right, or obligation, of the anesthetist to use modern techniques of artificial respiration in all cases of deep unconsciousness,

"even in those that are considered completely hopeless." To this the Pope replied, "Since these forms of treatment go beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them."

It is the management of the "hopeless" patient who actually is dying of the underlying disease that has stimulated so much recent discussion. In this situation, intensive efforts to maintain life have been stigmatized, perhaps rightly, as a "prolongation of dying" rather than of living. There is no dispute that a prime aim is to assure the comfort of the patient, even if such therapy results in a shortening of life-expectancy. Certainly the use of expensive and painful means of adding a few hours of life to a dying patient is not in keeping with Christian charity. There has been considerable discussion about the "quantity" versus "quality" of life, about "fruitless longevity."^{9, 10, 11} Obviously it is not wise to increase quantity of life at the expense of quality, or to strive for fruitless longevity. But however nicely such phrases may describe the problem, they do not contribute significantly to its solution. Who, for example, is to determine how much "quality" exists in a given life, or when longevity is "fruitless"? While mere preservation of life should not be considered an end in itself, there is reason to believe that recent writers accord too liberal an interpretation to "extraordinary means." In the "hopeless" patient who is dying but not moribund, vigorous and considerate therapy aimed at

increasing both the "quantity" and the "quality" of life certainly requires no defence. If a decision need be made, it would seem wiser for the physician to err on the side of active treatment rather than *laissez faire*. Cogent reasons for this opinion may be adduced as follows:

1. The physician is fallible and the case may not be medically "hopeless."
2. The physician by tradition has been committed to active contention with disease.
3. The physician is not competent to determine fully the "quality" of a given life or whether longevity is "fruitless."
4. Even if without positive act, the physician who advocates to himself the prerogative of determining whether life shall continue or terminate by default is in an uncomfortable moral position.
5. The imminent discovery of new curative agents is an ever-present possibility.*
6. Spontaneous regression of malignancies in apparently "hopeless" patients has been documented.¹²
7. Miraculous intervention is possible.
8. The physician may find that self-recrimination at errors of omission is harsher than at errors of commission.
9. Even a brief moment of mental lucidity in a moribund patient

* As an outstanding example, the advent of methotrexate has radically altered the outlook in metastatic choriocarcinoma, previously uniformly fatal.

may be all-important for his spiritual welfare.

10. "Extraordinary" means of treatment may result in cure.

Management of Pain and Other Distressing Symptoms in the "Hopeless Case"; Use of Drugs: Because long-continued pain is such a basic element in much of the preceding discussion, particularly with respect to euthanasia, it may be well here to consider this aspect of the "hopeless case." According to Perese,¹³ patients with malignant disease ordinarily do not have severe pain corresponding in intensity to that of renal colic, thermal burn of the skin, or facial neuralgia. The pain of malignant disease, however, differs from that of benign conditions in one important feature, its duration. The mild, dull, aching, persistent pain of the cancer patient erodes physical and mental reserves alike. By individualizing the approach it was found possible to effect substantial and long-term relief of pain in the majority of patients without resort to marked obtundation by narcotics. Medical, surgical, or radiation therapy was employed, alone or in combination.

Similar conclusions have been reported by Exton-Smith,¹⁴ who found that only a quarter of 33 patients terminally ill with cancer had moderate or severe pain and that this could be controlled by judicious use of narcotics. Further, of the 220 terminally ill patients comprising the entire study, other distressing symptoms such as nausea, vomiting, dyspnea, and dysphagia occurred in only 17 (7.7%).

What of the small minority of "hopeless" patients who do have persistent, severe, and distressing symptoms? This problem is particularized in a recent monograph¹⁵ as follows: "In the face of severe life threatening hemorrhage from the bronchi in the incurable patient, heavy sedation and the liberal use of narcotics is not only justified but mandatory to allay the patient's apprehension even though their use may hasten death." This attitude is fully consonant with Christian ethics and susceptible of formal defence by the principle of the double effect. It might also be argued that *failure* to use narcotics in this situation would constitute an extraordinary means of preserving life.

In summary, euthanasia is intrinsically evil and is not licit. Unreasonable attempts to maintain a semblance of vitality in a moribund or actually dead patient may offend the virtues of charity or justice. There is a moral obligation to take all "ordinary" means to preserve life and health, but resort to "extraordinary" means is optional. There is no universal definition of what constitutes "ordinary" or "extraordinary" means since circumstances constitute the final determinants. In general, it is wiser for the physician to err on the side of active therapy. Pain in the patient with "hopeless" malignancy is usually not severe and responds readily to thoughtful treatment.

IMPARTING INFORMATION

A major problem in managing the "hopeless case" concerns the imparting of pertinent diagnostic

and prognostic information to the patient and to other interested persons. Because this facet of the "hopeless case" is so intimately related to psychologic and sociologic management, these aspects are also considered in this section. While equally applicable to all "hopeless" diseases, the discussion will be concerned primarily with malignancy, since it is this disease that evokes the greatest emotional response.

"Resolved: That the Patient Should Always Be Told 'the Truth'": Considerable debate, some of it producing more heat than light, has centered about this subject. Attitudes range from an uncompromising negative to an unyielding affirmative. Most opinions, however, while favoring one approach, admit of exceptions.

In point of fact, the entire emotion-charged difficulty rests upon an untenable premise, viz., that "the truth" in any given instance can be known to the physician. What is "the truth"? That the patient will live 3 months? Or 3 years? That there will be pain? That radiation therapy will not effect marked palliation? That a curative chemotherapeutic agent will not be found? That the patient will not die of an unrelated myocardial infarct tomorrow? It is a little paradoxical that the medical profession, usually so circumspect, conservative, and cautious, should assume this aura of omniscience in the precise disease-category where reliable information is most lacking, neoplasia. As a result one conceivably could make short shrift

of the entire problem by maintaining that the patient cannot be told "the truth" because this simply cannot be determined. To do so, however, would be to ignore the numerous complexities associated with this subject.

It must not be concluded, therefore, that "the truth" in this context has no meaning, but rather that it requires definition. What, then, is "the truth"? Essentially it is the best clinical judgment of the physician concerning the expected course of events in a given patient with a given diagnosis. It is a statistic applied to a person and as such is intrinsically inaccurate. A survival table indicating that an octogenarian has exceeded his life expectancy do not prove that he is dead.

Telling the Truth — Legal Aspects: Relating as it does to property rights, the making of a will, and other forensic matters, it is not surprising that a considerable body of legal opinion is available on the question of whether to tell the patient the truth. Is there a legal obligation to inform the hopelessly ill patient of his diagnosis and prognosis? While an unqualified answer is not possible, the gist of most opinions is that such an onus does exist.¹⁶

According to Regan,¹⁷

It is extremely doubtful that a physician has a therapeutic privilege to withhold a specific diagnosis from a patient who is sick with serious or fatal illness. To the contrary, the confidential relationship requires in ordinary circumstances that the physician make a frank and full disclosure of all the pertinent facts to any adult and mentally competent patient.

While the precise amount of detail required to constitute "the

truth" is usually conceded to be debatable, the legal principle seems clear. In his pertinent review Taylor¹⁶ states,

The patient has a right to know the truth. All lawyers will agree that a doctor may not breach his duty to his patient through deceit or a lie. The doctor's duty to tell the patient of his critical condition so he can put his worldly and spiritual affairs in order does not require the doctor to disclose all of the diagnostic data in detail, or to tell him the precise nature of his illness. A doctor may reasonably presume that a patient does not desire knowledge which would injure rather than help, but the doctor may not rely upon this presumption contrary to the patient's known desire for full knowledge.

In the legal sphere, then, which codifies man's behavior as a social animal, there appear to exist no permissive opinions by which the physician may justify a course of deliberate deceit. Precisely what constitutes deceit, however, remains moot.

Telling the Truth — Psychologic Aspects: Despite the fact that there are many diseases more unpredictable, disabling, and lethal, no diagnosis imparts the emotional or psychologic impact of "cancer." The very derivation of the word suggests fear and horror. Under these circumstances, therefore, informing the patient of this diagnosis may evoke grave psychological stresses. It is likely, however, that these stresses may actually be greater if such information is withheld.

A major source of difficulty for the "hopeless" cancer patient is the sense of isolation that is foisted upon him. As Rothenberg¹⁸ states:

Communication is characteristically disrupted in terminal cancer to a greater extent than in almost any other illness. Patients are frequently not told that they

have cancer or that they are dying . . . Although withholding this information may seem justified in a particular case, it must be borne in mind that this inevitably results in disrupted communication on all sides and creates other problems. For one thing, an almost unavoidable effect of a disruption of communication is an increase in the patient's isolation and loneliness.

In some cases the physician may feel that information about the patient's disease should be withheld from him in spite of the potential danger of isolation. The important principle in management is simply to be aware of the trouble spots, not to take a dogmatically rigid position on them. . . . The temptation to support processes such as denial, magical thinking, and the avoidance of issues stimulating unrealistic guilt may be dictated by the physician's inner conviction that death cannot be faced realistically by patient or by himself. This is not a necessary assumption.

A reason frequently advanced for not informing a patient is the possibility of a cataclysmic psychiatric response, perhaps leading to suicide. The ability of the average patient to cope with the truth, however is often underestimated by the physician. After the initial shock there is usually successful adaptation and adjustment. Adequate statistics are not available but suicide as a direct consequence of learning the truth seems rare.^{19,20}

In most cases, therefore, there appear to be compelling psychological reasons for adequately informing the patient of his diagnosis and prognosis.

Telling the Truth — Medical Aspects: Do specifically medical reasons exist for making a patient privy to his diagnosis and prognosis? Certainly when disfiguring or disabling palliative surgery is indicated the patient will wish to be informed of the reason for such

measures. And when potentially hazardous drugs are employed he should be told both of their risk and indication. Furthermore, a patient whose symptoms prove refractory to therapy may frequently be dissuaded from vain and expensive recourse to other physicians or clinics only by disclosure of the nature of his disease.

Although these medical reasons in favor of informing the patient may seem weak and inconclusive, it should be indicated that purely medical reasons for *not* doing so are virtually non-existent.

What are the attitudes of the laity and of the profession toward this issue? In most studies based upon patient response there has been a marked preference for being told the truth,^{21,22} and serious problems resulting from this policy have not been frequent. Physicians, on the other hand, show a decided preference for *not* telling the truth. Fitts and Ravdin,²³ in a study based on 444 physicians, found that 70 per cent either never informed the patient or usually did not, while only 30 per cent always or usually did so. Ninety per cent of physicians in a more recent survey²⁴ indicated a preference for not telling. According to this investigation:

Although clinical experience was cited by three-quarters (of physicians) as the major policy determinant, the data bear no relation to experience or age. Instead, inconsistencies, opinionatedness, and resistance to change and to research were found which indicated emotion-laden *a priori* personal judgments as the real determinants. Feared reactions to telling (e.g., suicide) could rarely be substantiated. Equally undocumented assumptions were given as justifications for telling.

Underlying were feelings of pessimism and futility about cancer. The strong feelings mobilized by our deep and serious concern for cancer patients, and our difficulties in helping them, stimulate emotional mechanisms. These responses, unfortunately, operate as interferences to progress in cancer therapy.

In 1946, Lund²⁵ concluded

The doctor is bound in his duty to his patient to do whatever is best for his patient and to avoid doing him harm. In discussing his patient's condition the doctor realizes that there are some circumstances when he cannot, for the patient's own good, tell him the whole truth." However, there are other frequent circumstances in which friends and relatives want the "whole truth" (unpleasant) kept from the patient when it is much better for the patient for the doctor to be quite frank.

In brief, we seem to be faced with the startling paradox that as patients more and more indicate a preference for being informed, physicians are becoming more and more reluctant to do so. Speculation on the reason for this is vain, but it may be that preoccupation with sophisticated diagnosis and advanced instrumentation has exerted a dehumanizing influence on the modern physician who, having less intimate knowledge of the spiritual resources of his patient, is apt grossly to underestimate them.

Telling the Truth — Practical Aspects: Certain practical factors influence the decision to inform the patient, and to do so truthfully. If the physician imparts a distorted version of the actual state of affairs, he may experience difficulty in repeating it accurately at a later date. "A liar," said Quintilian, "should have a good memory." The problem is further compounded if more than one physician is involved.

In point of fact, there are probably few "hopeless" cancer patients who do not realize the diagnosis and prognosis, even though they may be unwilling to verbalize it to themselves. What intelligent patient can go daily to a Cancer Institute for radiation therapy and not suspect the diagnosis? What patient can report for inordinately frequent follow-up examinations and not suspect? What patient can undergo extensive extirpative surgery and not suspect? As a corollary to this, patients have occasionally stated that the really insurmountable burden was not the knowledge of the disease but the difficulty of trying to satisfy family or physician by *pretending* not to know.

In addition, the patient who learns that he has been deliberately misled will find it impossible to repose any future confidence in his medical advisor. This will often occur at a juncture in the patient's illness when such confidence is necessary for adequate treatment.

Finally, a patient with financial or family obligations may be spared imprudent or disastrous decisions only by receiving full prognostic information.

Telling the Truth — Moral (Ethical) and Spiritual Aspects: In response to a patient's direct question a direct lie is never morally justifiable. "Thou shalt not bear false witness . . ." But apart from this explicit prohibitive dictum, human dignity demands that the patient have opportunity of knowing the truth.^{26,27} This does not always involve a detailed explana-

tion of *all* medical facets of the case, but it does require a practical and honest presentation of what is necessary and suitable for the patient to know.

A patient's dignity as a Christian, too, demands that he have access to the truth. "To retard by silence," said Pope Pius XII, "a sick person's preparation for the grand passage to eternity can be a grave fault." Directive 7 of *Ethical and Religious Directives for Catholic Hospitals*²⁸ is quite specific on this point:

Everyone has the right and the duty to prepare for the solemn moment of death. Unless it is clear, therefore, that a dying patient is already well-prepared for death, as regards both temporal and spiritual affairs, it is the physician's duty to inform, or to have some responsible person impart this information.

There are, therefore, explicit prohibitions against lying to a patient, as well as cogent reasons for actively informing him of the truth. An unqualified statement of obligation, however, is not possible.

As a guide in these circumstances, Lynch²⁹ states:

. . . a doctor's strict moral duty to inform the patient would seem to include only 1. information necessary to the patient in order to insure successful therapy, and 2. foreknowledge in proper time of approaching death . . . The moral principle involved is altogether clear: act always in the best interests of the patient.

Speaking as a psychiatrist, Meyer³⁰ similarly suggests that there is a hierarchy of obligations and that the precept to "do no harm" may take precedence over "the process that is quaintly called telling the truth."

Telling the Family and Others: In general there would seem to be

an obligation in justice, and probably in charity, to inform at least one responsible member of the patient's family in pertinent diagnostic and prognostic matters. This is particularly so if the patient is unaware of the facts, and in this situation the obligation would appear to have legal roots as well. How far does this onus extend? Certainly not beyond the immediate family, unless there are others whose social or business connections with the patient are such that a valid claim to information may be made.

In keeping with the growing belief that the patient should be suitably informed is the tendency to inform the family as well. Westberg³¹ has presented a considered Christian exposition of why this approach is desirable and how best to accomplish it.

One of the difficulties that may arise when pertinent information is not available to all interested parties has been stated by Kline and Sobin:³²

In some cases, when the family has knowledge and the patient has not, the patient himself exerts much pressure to find out "what the doctor said." At times, strong guilt feelings may be created in the family if they have to tell deliberate lies, and sometimes the situation can be helped if the statement to the family is worded in an equivocal manner; however, it should still be clear.

Christopher,³³ a strong proponent of the "do not tell" school, indicates that he has, on a rare occasion when he had decided to inform the patient, refrained from doing so at the behest of the family. Although the advice of the family in this matter should certainly be

carefully weighed, there should be no infringement on the direct patient-physician relationship which, in its own sphere, is as intimate as that of patient with family. Although considerable pressure can be brought to bear on the physician by the family, strictly speaking the latter would seem to have no moral or legal right to interfere in this matter. Conversely, and fully in keeping with the relationship of patient with physician, the patient may insist that the family not be informed, a stricture that the physician is bound to respect.

How to Tell the Truth: As has been intimated, "telling the truth" is not synonymous with a brutally frank, concise, clinical recitation of diagnostic and prognostic facts. It should always be done gently, compassionately, and sincerely. Hope should not be dashed but positively encouraged, a position easy to assume in these days of rapid medical progress. Realism should be tempered with optimism, veracity with charity. ("A little thought will make it clear to you that charity and veracity, both being commended by God, cannot possibly be in real conflict ever."³⁴)

A practical norm in this matter is never to volunteer information or gratuitously to expand on available data. In general, the patient will make obvious how much he wishes to know. For example, in response to his query regarding what was found at operation one might reply, "A tumor." Many patients will not pursue the matter further. For those who do, information in response to direct questioning might

include the fact that the tumor was malignant, but of low grade, and that all gross disease was removed. It is usually simple and expedient to be guided by the patient.

For the patient who must undergo surgery, a full preoperative discussion of the possibilities will go far toward obviating later difficulties. Certainly, when the surgeon must recommend a serious operation for malignancy, this possibility should be mentioned to any patient who might otherwise be inclined to temporize dangerously. In general, however, the surgeon can honestly adopt an attitude of uncertainty concerning the precise diagnosis. With specific reference to lung tumors, for example, the patient may be told that much will depend on the findings at operation — that some tumors are best treated by resection and that this will be done if indicated; that others respond better to radiation and this will be learned from biopsy of the lesion; and that for some a combination of excision and radiation is indicated. Thus the ground-work is laid for an acceptable explanation to the patient if the lesion is non-resectable, or if there is an indication for post-operative radiation therapy. "Telling the patient," then, is a gradual process, not an abrupt revelation.

Semantics play a great role in this matter, with the word "cancer" being accorded entirely unwarranted connotations by physician and patient alike. It is therefore important, if the patient asks, "Is it cancer?", to explain that "cancer" means many things of diverse im-

port and that it is not really a meaningful word. It may be helpful to make an analogy with the word "infection," explaining that etiologies, prognoses, and manifestations of infections are so varied that the unqualified noun is almost meaningless. And so it is with "cancer."

To conclude, there are pertinent legal, psychologic, medical, practical, moral, and spiritual reasons for informing the patient. Secondly, there are strong indications for informing the patient's family. In this context, however, "the truth" is not an absolute entity but merely a matter of clinical judgment. The patient should be informed gently, compassionately, sincerely, and gradually. While the arguments in favor of adequately and suitably informing the patient are almost incontrovertible, the fundamental moral principle remains: Act always in the best interests of the patient.

HUMAN EXPERIMENTATION

General Principles: A consideration of human experimentation is unavoidable in any discussion of the patient who is hopelessly ill with a chronic disease. The mere fact of hopelessness suggests itself as a circumstance that might mitigate the ethical obligations surrounding such experimentation. In the case of the hopeless patient these studies might be directly related to the disease at hand or entirely unrelated to it. Further, the objective might be either immediate benefit to the subject or remote benefit to others.

Regardless of the scope or intent, however, the medico-moral conditions that must be met before proceeding with human experimentation on the "hopeless case" differ in no respect from those obtaining when the subject is healthy. The enlightened consent and desire of the subject is imperative, the risk must not be inordinate, and the cause must be proportionately grave. The attitude of the Church has been fully and explicitly presented by Pope Pius XII in a now-famous allocution.³⁵ Ladimer^{36, 37} and Beecher³⁸ have reviewed the problem comprehensively from medical, legal, and moral aspects.

Experimentation on the "Hopeless Case": With specific reference to the topic at hand, Beecher³⁸ has assumed a firm attitude:

... the use of the "hopelessly incurable" as experimental subjects has developed recently. I have already stated the reasons for my deep conviction that those who are in imminent danger of death should not be subjected to experimentation, except as part of the therapeutic effort for the benefit of the subject himself. Occasionally, reports are found wherein use of the "hopelessly incurable" seems to justify dangerous experimentation. The error in this appears evident. It is not the physician's prerogative to make or to profit from such dubious judgments.

Human experimentation on the "hopeless case" has also been discussed extensively by Guttentag:³⁹

This question illustrates the chaos that results when the two aspects of the patient-physician relationship are not recognized, and no conscious attempt is made to separate the two. All—the science of medicine, the suffering patient, the physician-experimenter, and the physician-friend—lose by this confusion. The literature suggests that the classification of persons as "hopelessly sick" is not intended to be merely a presentation of fact in the objective sense on the part of the experimenter, but, by its character-

ization as "hopeless," is intended to justify an experimenter's self-permit for greater boldness. It is an apparent attempt to express a conscious effort of restraint on his part when, in performing experiments that endanger the lives of the experimented-on sick, the experimenter restricts himself to those "marked by death." It is meant to be noble in the democratic spirit, yet it unconsciously challenges this spirit more subtly but no less than the use of force, because it violates the concept of equality or brotherhood in violating the principle of the original patient-physician relationship. From the experimenter's point of view, the description "hopelessly incurable" is not germane to his purpose. The designation is inadequate, because it does not specify the time element—hopeless within hours, days, months, or years? And, if months or years are concerned, do all experts agree on the status of their respective sciences and deny the possibility of discovering effective agents within such a period? . . . From the standpoint of the physician-friend, the assertion is not germane to his purpose, either. To him it is an expression of detachment between physician and patient. The announcement of a scale of partnership vs. domination quite contrary to its original spirit. As a matter of fact, it creates the paradox that the healthier the patient, the more he should be the concern of his physician; the sicker, the less.

Claude Bernard, too, has wrestled with this problem:⁴⁰

Others have made analogous experiments on patients with phthisis doomed to an early death . . . As experiments of this kind are of great interest to science and can be conclusive only on man, they seem to be wholly permissible when they involve no suffering or harm to the subject of the experiment. For we must not deceive ourselves, morals do not forbid making experiments on one's neighbor or on one's self; in everyday life men do nothing but experiment on one another. Christian morals forbid only one thing, doing ill to one's neighbor. So, among the experiments that may be tried on man, those that can only harm are forbidden, those that are innocent are permissible, and those that may do good are obligatory.

It would appear evident from the foregoing, therefore, that human experimentation involving the

hopelessly ill is not of itself forbidden, provided the ethical strictures surrounding any human experimentation are observed. It is also evident, however, that this specific form of human experimentation is fraught with the danger of self-deceit for the experimenter and of injustice to the subject.

Donations of Tissues or Organs:

Somewhat related to the problem of human experimentation is that of tissue or organ donation. Realization of the imminence of death and the acquiring of a sense of true values may impel the "hopeless" patient to arrange for the post mortem donation of such tissues or organs as may be of value to the living. Donation of eyes for corneal grafts would be a case in point. This is an entirely acceptable and commendable act of Christian charity, and in no way conflicting with medico-moral standards.⁴¹ Donation *inter vivos*, however, raises difficulties that are less easily resolved.⁴² This is largely due to the fact that only recently have tissue and organ transplantations of this type emerged from the realm of philosophical speculation to that of medical fact, and there has not been opportunity for a considerable body of theological opinion to accumulate. However, certain statements of pertinent norms are available,⁴³ indication that transplantation *inter vivos* is licit if the operation does not gravely endanger the life of the donor or impair his functional integrity. In general, it seems certain that the same ethical considerations obtain when the

prospective donor is a "hopeless case" as when he is healthy. At present, much of this discussion is theoretical because patients with malignant disease are not usually considered medically acceptable as tissue donors.

To conclude, human experimentation upon the hopelessly ill patient is permissible provided established ethical norms are respected. The matter, however, is one of great sensitivity and difficulty. Tissue or organ donation by the "hopeless case" is licit if moral safeguards are observed; the ethical problems are greater with transplantations *inter vivos* than with post mortem donations.

SPIRITUAL ASPECTS

As one whose perception of eternal values is sharpened by the evident proximity of death, the hopelessly ill patient may pose problems of a unique spiritual nature. In addition, it is with respect to the "hopeless case" that miraculous intervention assumes its greatest pertinence.

The Last Sacraments: These include Penance, Holy Eucharist received as Viaticum, and Extreme Unction.^{44, 45} The importance to the Catholic patient of their worthy reception cannot be overstated.⁴⁶ Arrangements to this end should be made well before the patient is moribund or comatose, because an adequate mental status is mandatory for the unconditional reception of Penance and for the ordinary reception of the Eucharist. In this connection a recent study⁴⁷ lends support to the contention

that there are few medical contraindications to the reception of Holy Communion by the ill, except for mental incompetence, defective sensorium, and intractable vomiting.

The question of informing the patient of his prognosis, treated in the preceding section, has a particular relevance here. In the first place, full knowledge of the true medical outlook would more likely prompt the patient to set his spiritual house in order than if pertinent information were withheld. Secondly, it is difficult to believe that a knowledgeable Catholic patient could receive the Last Sacraments without being cognizant of the prognostic implication.

Miracles: A physical miracle involving the supernatural cure of a hopelessly ill patient is an extraordinary occurrence almost by definition. Instances have been documented, however, beginning with the miracles of Christ and extending even to our own day. In an autobiographical note Alexis Carrel⁴⁸ has described the miraculous cure at Lourdes in 1903 of a young girl "hopelessly ill" with tuberculous peritonitis. Miracles in general, and modern miraculous cures in particular, have been ably discussed by Dr. François Leuret, former President of the Lourdes Medical Bureau, and Dr. Henri Bon.⁴⁹ Since, as mentioned previously,¹² spontaneous regression of malignancy has occasionally been recorded, the supernatural origin of miracles manifest in this fashion might be called into doubt. However, there are two marks that

serve to distinguish miraculous cures of this nature:⁴⁹ 1. the cure must be instantaneous, and 2. there must be complete absence of any convalescence. In none of the spontaneously regressing cancers collected by Everson and Cole¹² were these criteria fulfilled.

SUMMARY AND CONCLUSIONS

A case may be termed "hopeless" when there has been established a firm diagnosis of a relatively chronic condition that may be expected to terminate fatally because curative treatment is either not known or not applicable. Complex medico-moral problems are inevitable when this subject is considered.

Difficulties associated with therapy range from euthanasia, which is not licit, to unconscionable prolongation of vital functions, which is not desirable. The physician is bound to employ "ordinary means" to preserve life but need not resort to "extraordinary means." In general, it is wiser to err on the side of active therapy.

Imparting pertinent diagnostic and prognostic information is another sensitive area. While there can be no absolute rule in this matter, there are forceful legal, psychological, medical, practical, ethical, and spiritual arguments in favor of suitably and adequately informing the patient and the family. The fundamental moral principle remains: Act always in the best interests of the patient.

Human experimentation involving the hopelessly ill is not of itself forbidden, provided the ethical

strictures surrounding any human experimentation are observed. It is noted, however, that this form of human experimentation is fraught with the danger of self-deceit for the experimenter and of injustice to the subject.

The most important spiritual aspect of the problem is concerned with the proper reception of the Last Sacraments by a Catholic patient, or with appropriate preparation for death by a non-Catholic patient.

EPILOGUE

It must by now be apparent that "hopeless case" is a misnomer applied to a patient for whom the physician has little hope. It does not, however, represent the judgment of the patient. For there are no "hopeless" patients, only hopeless doctors. Even the suicide dies hoping for something better. With this in mind, then, it would seem desirable to expunge this term from the lexicon of medicine, since it introduces unwarranted emotional elements and serves as an obstruction not only to the care of the patient but also to the progress of medicine.

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