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The Physician's Responsibility Toward Sacred Human Life

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A recent article in the *New England Journal of Medicine* on "The Physician's Responsibility Toward Hopelessly Ill Patients"[1] 1) encourages non-treatment of patients, 2) confuses the right of privacy with a patient's decision to refuse a treatment gravely burdensome to himself, 3) encourages "living will" statutes which lack the prerequisites for informed consent and are otherwise objectionable, and 4) states that a physician cannot participate in suicide because "...this is contrary to the law." However, it omits noting the inherent immorality of assisted suicide and the fundamental obligations of physicians entrusted with recommending therapy to protect and promote physical, mental, and emotional health. Physicians have had, and will continue to have, professional obligations, moral duties, and ethical responsibilities when treating each and every patient. For many physicians, these responsibilities are rooted in religious principles, yet other doctors lacking formal religious affiliations or beliefs affirm them as well. The history of their broad acceptance is reflected in the Oath of Hippocrates, the Declaration of Geneva, the Nuremberg Code, and elsewhere. It is under the guidance of their standards that medicine has achieved its greatest advancements.

The *NEJM* article states "[t]he patient's right to make decisions about his or her medical care is clear. That right, grounded in both common law and the constitutional right to privacy, includes the right to refuse life sustaining treatment...". While the Constitution expressly protects certain specified privacy interests such as the Fourth Amendment's guarantee against unreasonable searches and seizures, it recognizes no general, all-encompassing right to privacy. In our system of jurisprudence, it is proper for the courts to interpret the Constitution in accordance with the values and principles rooted in its language and history. However, when new constitutional "rights" are created without regard to any value or principle that is fairly discoverable in the Constitution, those "rights" are illegitimate.[2]

Roe v. Wade,[3] the 1973 decision of the Supreme Court that recognized a "right" of privacy sufficiently broad to legalize abortion-on-demand from fertilization through birth, is a definitive example of illegitimate judicial review.[4] This decision, which serves as the cornerstone for extending the "right" of privacy to other life issues at other stages of human development,

is an unprincipled and unconstitutional display of "raw judicial power."[5] While the rule of law requires our recognition of *Roe's* "legal" force, our consciences and professional integrity compel rejection of its moral force.

Upholding Sanctity of Life

Moreover, the common law right of a *competent* patient to refuse medical treatment does not diminish the duty of the physician to uphold the sanctity of life when advising the patient as to the appropriate course of treatment. Neither does it diminish the physician's responsibility to the incompetent patient. Indeed, the physician's primary obligation is to preserve life and "do no harm."

Human life is special. For Jews, Christians, Moslems and other monotheists, human life is sacred because every human being is created in the image and likeness of God. The imperatives of personal and societal survival, the desire for civilization, and the universal relevance of the Golden Rule dictate respect for human life for all, including those who believe neither in religion nor in God. Reverence and care must be given to each and every human being, regardless of sex, race, color, creed, or whether he or she is in the womb or in a nursing home, handicapped or nondisabled, comatose or communicative, young or old, because each human being is unique and irreplaceable.

What effects does this awareness of the specialness of every human life and the uniqueness of each human being have on a physician? Let us begin by briefly reviewing the routine in which a physician practices when a patient comes into his care. He obtains a history, does a physical exam, then laboratory studies, perhaps images of internal structures through the use of X-rays, ultra-sound, or radio-isotope studies and biopsy when needed. Data is collected. Relative to training, experience, and knowledge of medical literature, as well as support through appropriate consultation, the physician makes a diagnosis. Therapy is then recommended based on that diagnosis.

Awareness of Limitations

The physician must always be aware of the limitations of the expertise he possesses. These limitations are individualized in terms of one's knowledge, intelligence, and reasoning ability. Further, these limitations are intrinsically related to the basic sciences underlying the practice of medicine: biochemistry, physics, etc. Identification of these limitations helps the physician to be conscious of the degree of certitude, or lack of certitude, which exists for the diagnosis, treatment and prognosis for this particular patient.

Once a diagnosis is made, other factors must be considered. Should a patient have more than one serious pathologic process, therapy needs to be altered accordingly. For example, a patient with disseminated oat-cell carcinoma of the lung can suffer a myocardial infarction. The likelihood of such malignancy being fatal and even interfering with healing generally

would alter the therapy recommended for simply the heart disease. Or for another patient who has already had extensive treatment but remains ill, perhaps with complications from therapy already used, decisions regarding further treatment may be altered. For example, should the further treatment be intravenous medication which is toxic to a vein, and all the more readily accessible veins have been used, the discomfort and potential risk for using a deeper vein may influence recommendations by the doctor and decisions of the patient. In all such instances, the sole variable is efficacy of medical treatment and never any quality-of-life consideration.

Decisions to use or not use a treatment are often considered according to "ordinary" and "extraordinary" means. "Ordinary" and "extraordinary" means represent constructs by some ethicists enabling an understanding of the decision by the *patient himself* who elects to use or not use a particular treatment. "Ordinary" means include any treatment, medication, or operation which offers a reasonable hope of benefit without requiring heroic virtue or causing excessive pain, expense, or other grave burden to the patient himself. The patient must use all available "ordinary" means to preserve his life. Included in the category of "ordinary" means are keeping the patient on a suitable mattress, maintaining an appropriate thermal environment, keeping the airway patent, providing water and nutrition, providing an exit for stool and urine, and using other readily available efficacious therapies.

Heroic Virtue Required

"Extraordinary" means include any treatment, medication or operation that would require heroic virtue, or be gravely burdensome. While ordinarily the patient is not obligated to employ "extraordinary" means, he may decide to do so. Such a course could constitute an act of heroic virtue. "Extraordinary" means cannot be foregone in order to kill the patient or to advance other immoral ends. Moreover, medical progress renders today's "extraordinary" means tomorrow's "ordinary" means.

In the religious context in which "ordinary" and "extraordinary" means originated, they are limited to particular criteria that *may* (not *must*) be employed by the *patient himself* to ascertain his moral duty to utilize specific medical treatments. In secular and legal parlance, however, they have come to provide a pretext for coercive persuasion to accept the imposition of yet another euthanasia subterfuge - i.e., "passive" euthanasia and, failing that, for its involuntary application.

When the patient is unable to speak for himself, the decision regarding treatment becomes more complicated. Then the physician must obtain a proxy-type consent. This should be as close as possible to the instruction the patient himself, if able, would state. Almost always the patient has a close family tie with a spouse, a parent, or a child. As a result of these bonds, when the patient is unable to communicate for himself, the physician has an obligation to communicate with the family. Pertinent

information from relatives and close friends is extremely helpful at these times. Communication with loved ones offers the best chance for personalized care for the patient unable to speak for himself. In no instance should the patient's right to life be violated in favor of any proxy's directives, nor should any proxy be permitted to deny the patient life-preserving treatment.

Orders Must Be Precise

Decisions and written orders to use or not use a treatment for a patient must be as precise as possible. A decision to perform or not perform an operation, to administer or not administer a blood transfusion, to use or not use a particular antibiotic, can be made only after the facts and details have been obtained through a thorough and complete medical evaluation of the patient.

Generalizations or non-specific terms such as surgery, antibiotics, or blood products are classifications which are too broad for application to a particular patient. "No-code" is a prime example of an ambiguous order accepted by physicians and courts. But we question if this lack of precision of thought resulting in multiple variations of non-treatment has a place in medical practice. Does it mean no maintenance of an airway, or no intubation, or no ventilatory support, or no cardiac resuscitation, as well as no new or additional therapy? Such broad, non-specific orders are not acceptable on other occasions of standard medical practice. Why are they here? Furthermore, realizing the weakness of human nature, once the course has been plotted by a "no-code," "slow code," or a DNR (Do not resuscitate) order, there is a tendency to preclude, eliminate, or reduce other kinds of "ordinary" treatment, such as visits by physicians and care given by nurses.

The privilege to treat our fellow man includes responsibilities, obligations and duties. There is a duty to help patients obtain the morally licit medical treatment they require. There is a responsibility to understand that the concept of "extraordinary" means is neither universal nor open-ended. There is an obligation to preserve life when the physician cannot yet cure. Those who deliver medical and nursing care must never kill the patient either intentionally or through culpable negligence. If this occurs, the responsibility or duty associated with the privilege of treating our fellow man is violated.

According to a letter by Pless[6], not only was the Bloomington, Indiana "Baby Doe," who had esophageal atresia and Down's syndrome, denied medically indicated surgery, but also he ". . . was given phenobarbital (5 mg) and morphine (2.5 mg) as needed for pain and restlessness." While the administration of these and other drugs can be morally and medically acceptable to relieve pain, when given at 5-10 times the dose ordinarily needed for this, the question is "Why such a high dose?" Did thirst and starvation cause this infant to be so very uncomfortable? Or was this high

dose intended to depress ventilation and hasten death? The behavior of these physicians was professionally unacceptable.

Withdrawing or withholding essential means of sustaining life, such as food, water and protection from exposure is morally – if not always "legally"—tantamount to murder, and professionally unacceptable for one who is privileged to help the sick. Prior to the death of Karen Quinlan, to have stopped feeding her, to have failed to treat life-threatening infections with antibiotics, or not to have kept her room warm, would have resulted in hastening her death. It would have been the moral equivalent of murder.

Physician Responsible for Best Medical Care

The physician has a responsibility to provide the best possible medical care for the patient. Yet, he must also understand the emotional changes that accompany physical illness and provide support and hope when the situation is interpreted by the patient or family to be overwhelming.

Even though the ultimate responsibility for the decision regarding medical treatment generally lies with the patient himself, commonly the physician is asked to provide guidance and direction. At these times the physician must be mindful of the privilege and obligation he has to safeguard the life of the patient, as well as the lives of others who may be endangered as a result of such decisions.

The physician-patient relationship has may attributes, any of which can be abused by either the physician or the patient. One that can be abused easily by the physician revolves around the position the powerful physician holds in comparison to the weak and ill patient. He must be mindful of this as he makes decisions and recommends treatments for a patient. The potential for abuse increases when the patient is unresponsive, unconscious, unable to communicate, or at the ebbing of life when the patient is so very defenseless.

When the patient deems a specific treatment "extraordinary" and directs that it not be used, that directive applies solely to that specific treatment and in all cases the patient must continue to receive all "ordinary" care. At *all* times, including when dying, the patient must be treated as a human person who has rights. When a treatment is contraindicated or no longer indicated, we must realize that we are not "letting him or her die;" rather, we realize that that particular treatment is of no use in the struggle against death. Death may occur despite our best efforts to preserve life, but we shall never be death's expediters.

The *NEJM* article lists four categories for "The Incompetent Patient":

1. "Patients with brain death." The lack of scientific validation for "brain death" criteria and the questionable morality of what is occurring in this area have been discussed in depth in recent publications[7,8]. Be it sufficient here to point out how the authors of the *NEJM* article are willing to call a patient "dead" when there is "irreversible cessation of all *functions* of the brain . . ." in contrast to their following category of "persistent vegetative state," when the ". . . neocortex is largely and irreversibly *destroyed*." (Emphasis added).

Needless to say, none of the brain-related criteria for death are adequate for the diagnosis of destruction of the brain, much less death of the person.

2. "Patients in a persistent vegetative state." Cranford, and very likely all the authors of the *NEJM* article, are familiar with Sgt. David Mack of Minneapolis[9], who was diagnosed as being in such condition. After 22 months of being unresponsive, those taking care of him noticed eye movement, only then to find out from Sgt. Mack that he had been aware of those around him for at lease six months before anyone knew that he was anything other than in "a persistent vegetative state." Would they now agree that it would have been acceptable to have withheld nutrition and hydration from Sgt. Mack?
3. "Severely and irreversibly demented patients." The word "severely" was not defined by the authors and therefore is subject to excessively wide interpretation. "Irreversibly" cannot be empirically determined.[10] It is not appropriate to apply such adverbs categorizing patients. While the authors speak to making the patient comfortable, where are the studies showing the patient dying of dehydration and starvation is comfortable? Nor is comfort a substitute for life, much less a rationale for death.
4. "Elderly patients with permanent mild impairment of competence." To be in such a state does not require attainment of age. Furthermore, "elderly" in itself is not a precise term. In fact, one dictionary defines it as "beyond middle age." Medicine should not accept such vacuous philosophical speculations.

The difficulties are compounded when an individual has previously executed a "living will", indicating an approach to non-therapy. A major deficiency in a "living will" is that it is executed without the information and data needed to make such a decision and accordingly, violates the fundamental principles of informed consent. The "living will" decreases the possibility of adequate testing and treating diseases that would otherwise be diagnosed and treated. Furthermore, while attempting to "simplify" proxy directives, it does this only in a death-embracing manner.

Physicians must exclude their own narrow self-interest when making decisions or when asking the patient or the person whose consent is legally required for a particular treatment. One can readily appreciate that personal advantages or disadvantages regarding legal liability, prolonged or inconvenient hours required to treat, or compromised compensation from a Medicare-Medicaid-welfare patient, can influence a physician's decisions. The physician must always keep the rights and responsibilities of the patient in compliance with sound medical ethics foremost in the decision-making process.

Member of Health Care Team

A physician does not carry out his duties and responsibilities in a vacuum. The physician is a member of a health care team including nurses, respiratory therapists, administrators, physical therapists, social workers, pastoral care personnel, secretaries, and others working in the hospital or treatment setting. Each and every one of these is a human being with his own values, privileges and responsibilities in terms of delivering medical care to another human being. Each one has power and strength in relation to his own intentions, training, and personality. Each one has deficiencies and frailties. Each one must understand the strengths, weaknesses and

limitations of the ill patient, especially when the patient is unresponsive, comatose, or otherwise unable to communicate through spoken or written language or when he or she happens to be at an ebb in his or her own life.

That human life is sacred must be foremost as medical and nursing care is administered. Human life is a basic good. The right to life is a fundamental God-given right. Without life there are no other rights or goods for a human being. When medical and nursing care are delivered without identifying the sacredness of human life and the right to live, the priorities are radically different. When society establishes that human life is not sacred and man has dominion over life and death, such as the case in abortion, infanticide, and euthanasia, then not only is the physician-patient relationship altered, but so are all other relationships between human beings.

There is a large and growing number in society, including physicians, who regard life as sacred because it is a gift from Almighty God. For each person, there is a life span on earth determined by God. Human beings have obligations toward themselves and each other to respect this life-span. The basis for these obligations are the Judeo-Christian beliefs which were included in the very foundation of our country. Slipping away from them has seriously injured "the land of the free, and the home of the brave." There is a way to practice medicine and to live together, still maintaining respect for human life, without the weak being the victims of the strong.

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2. "The Judiciary, including this Court, is the most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or even the design of the Constitution." *Moore v. City of East Cleveland*, 431 U.S. 494, 544 (1977) (White, J., dissenting). See also *Dronenburg v. Zech*, 741 F.2d 1388, 1396-97 (D.C. Cir. 1984) (refusing to recognize a right of privacy protecting private consensual homosexual activity).

3. 410 U.S. 113 (1973).

4. Dean John Hart Ely of Stanford Law School, one of the leading scholars of constitutional law and the Supreme Court, found the jurisprudence of *Roe v. Wade* "frightening:" "What is frightening about *Roe* is that this super-protected right is not inferable from the language of the Constitution, the framers' thinking respecting the specific problem in issue, any general value derivable from the provisions they included, or the nation's governmental structure." Ely, "The Wages of Crying Wolf: A Comment on Roe v. Wade," 82 *Yale L.J.* 920, 935-36 (1973). Dean Ely is not alone in his condemnation of *Roe v. Wade*. As a leading law school textbook on the subject of law and medicine points out, the reaction of legal scholars to *Roe v. Wade* "has been overwhelmingly negative, a fact which is especially impressive because some of the critics share the Court's policy preference reading abortion." W. Wadlington, J. Waltz & R. Dworkin, *Cases and Materials on Law and Medicine* 726 (1980).

5. See *Doe v. Bolton*, 410 U.S. 179, 222 (White, J., dissenting).

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9. *Minneapolis Tribune*, "Rip Van Winkle" Mack, April 25, 1982, p. 1.
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