Is the medical profession always justified in saving lives?

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Keywords: medical profession; saving lives

Abstract

Background: The aims and objective of this paper are to address controversial and contentious issues in Medical Practice which should be of universal interest to family practitioners.

Topics: The author reviews the Hippocratic Oath and its relevance to end-of-life decisions, abortion, renal dialysis and euthanasia.

Conclusion: The opinions expressed in the article are based on evidence and the author's opinion and will encourage lively emotional response from the readers in a multicultural South Africa

SA Fam Pract 2009;51(1):36-38

Introduction

Most of the sentiments expressed in this paper appeared in an address to members of the medical profession at the Adler Museum of History of Medicine in Johannesburg 35 years ago. They are still pertinent today.

Although the doctor's vocation is to relieve suffering and save and preserve lives, his responsibilities are being complicated by the great advances in medical science which, more than ever before, place the power of life and death in his hands.

Should our aim be to prolong every life as long as possible with the use of all possible means, including extensive use of drugs, operations, organ transplantation, artificial organs, respirators, haemodialysers, pacemakers and defibrillation, irrespective of whether such prolongation leads to happiness, or to great physical or mental suffering, or both, of the individual as well as others? Should we force patients to continue to live, even when they would prefer to die, particularly when they face marked mental or physical disability, or both, and if their continuing to live causes social, economic and other problems for society? In essence, our problem is to choose which patients should be revived, and which should be allowed to die in peace.

The orthodox teaching is quite clear. The Hippocratic Oath or its modern version, the "Hippocratic Oath updated" by Eugene D Robin, reminds the doctor of his duty to "maintain the utmost respect for human life", to concern himself with the "health of the patient" – not to use his medical knowledge in any way "contrary to the laws of humanity". Robin also suggests that physicians should be bound by the wishes of their patients or, when the patient is incompetent to decide, by the decision of the family members.[1]

Professor Calne writes: "It is common for a patient with cardiac arrest occurring in hospital to have the heart beat restored by cardiac massage. If there is evidence of severe brain damage, then it is customary not to attempt further cardiac massage should another cardiac arrest occur"; and "if there is no evidence of brain recovery after a given period of time, it is customary to disconnect the machine and allow the patient to die".[2] But, has a doctor, bound by the Hippocratic Oath, the right to 'allow the patient to die?' And when is a patient actually dead? Pompously asked by a magistrate, "When, precisely, did you realise the man was dead?" a well-known old Natal doctor is reputed to have replied, "When I slit him from his belly-button to his gullet and he made no complaint."[3] This sarcastic reply, made years ago, might well be uncalled for in an age in which scientific advances have made the medical and legal professions realise that the definition of death is not the simple matter it was once thought to be.

Before the 1950s, end-of-life decisions were simpler than they are today. Most people died in their homes, surrounded by family and loved ones. Medical science had not yet learned how to keep patients with chronic diseases such as heart disease and cancer alive. Nature, not medicine, controlled the timing of one's death. This began to change in the 1950s, as medical technology increasingly became able to thwart death through an array of technical tools. Now, when the end comes it is usually in a hospital room, unlike in the past, when only one third of patients died in medical institutions. Four out of five patients now die in hospitals or nursing homes.

Since it is desirable to obtain organs for transplantation when they are viable, 'brain death' is diagnosed on the basis of the electroencephalogram tracings of the brain's electrical activity. People are considered dead when the electrical activity in the brain ceases.[4] Much more difficulty is encountered in designating the moment of death when brain death is used as the criterion. Lack of sufficient oxygenation is the major cause of nerve-cell death. The need for oxygenation in different portions of the brain is inversely related to the phylogenetic development of the brain, thus the cortical portion is the first area to suffer, whereas the respiratory centre and the vasomotor centre tend to be the last ones to cease activity. The public at large find it very difficult to consider death when the subject's heart continues to beat and when he continues to breathe. Today, however, these functions are often perpetuated by

artificial respiration and by artificial stimulation of the heart with an internal pacemaker; without either the patient will soon be 'totally dead'. Even with these aids, the brain has been found to be extensively necrotic and largely liquefied.

"Thou shalt not kill" has prompted a vast amount of discussion as to when life begins. Many have justified abortion as long as it is performed before 'life begins' or before there is a soul. The question is: When does life begin? Is it, according to the Bible (Genesis 2:7), at the moment of conception? Or is it as stated by the Common Law of South Africa: "A foetus is not a person in law and therefore does not have legal rights and obligations". If the court were to rule that a foetus had a right to live, the right would not be absolute. The constitution also guarantees women's rights to "bodily and physical integrity", including the right to "make decisions concerning reproduction".[5] These guarantees must incorporate the right afforded to every woman to determine the fate of her own pregnancy. Thus the unborn child is deemed to be a non-person and is not the bearer of constitutional rights.[6] In South Africa, about 50 000 legal abortions are performed in state hospitals and clinics every year. Conflict arises when the doctor refuses to perform the termination due to his or her beliefs. In many African countries, abortions are performed by unskilled practitioners under unsanitary conditions, and these abortions often cause the death of the mother or permanent injuries to her reproductive organs. There is much to be done to improve the rights of women concerning safe access to the termination of pregnancy in the rest of Africa.[7]

There is increasing evidence of the real and long-lasting harm that can come from not aborting – a girl may lose her hopes of a career, or have a breakdown when she is forced to abandon her baby, and the child who is rejected may not have good prospects. To present just one example of this evidence: in 1966, two Swedish psychiatrists reported the first ever long-term follow-up of children who were born after their mothers had been refused abortions.[8] A total of 120 children were followed up until their 21st birthdays. Children born from the group who were refused abortion showed a consistently higher incidence of: 1. Psychiatric consultation and hospital treatment; 2. Being registered juvenile delinquents; 3. Requiring increased public assistance after the age of 16; 4. Having less education than the legal minimum; and 5. Having an insecure childhood (fostered, or placed in children's homes). Clearly the harm may be great and long-lasting.

One of the biggest public health problems facing the world today is the population explosion, the need for restricting the rate of population increase and a curtailment of the number of babies being born with various mental or physical abnormalities.

Although abortion should be induced in the presence of quite a number of disorders, who is to be the judge? Antenatal diagnosis therefore may present us with an awkward predicament, namely discovering that a human being will become subnormal. But it will not help us to define what is too subnormal to endure – what kind of human is not worth preserving?

There is a fascinating legal twist to this. Since 1970, there has been a growing number of 'womb risk' lawsuits in the USA, where handicapped children have sued their mothers' doctors for refusing to abort them – the plaintiffs – although the doctors knew that the mothers ran a special risk of carrying defective foetuses because of X-ray exposure, German measles, etc. I leave you to ponder on the astounding phenomenon of somebody suing someone else for not preventing him/her from being born. Many doctors in the front line of the salvage campaign are becoming alarmed at what they are doing. Salvage can often be an expensive and futile road to misery. How well are these children cared for? Occasionally they are cared for exceptionally well, on the whole not at all well, and quite often abominably badly.

There is evidence that, given individual, warm attention at home, a far greater level of performance can be expected than from a child with a similar handicap reared in an institution. So it is best for the child to be kept at home, and it is then left to the parents to try to carry the burden of caring for the child without totally ruining their own lives or the upbringing of their other offspring.

Kidney dialysis machines keep patients alive artificially. Indeed, more than 80 000 Americans are being kept alive by dialysis. "There is a 2-or-3-months euphoria to dialysis," says Robyn Higley, a nurse who underwent treatments herself until she had a kidney transplant. "You feel so much better as the poisons decline in your system. Then comes the grim reality of the dialysis routine: three times a week to the same machine by the same bed for four or more hours each time. You know that, barring a transplant, you will be hooked to this machine for the rest of your life." When should the technology be used to prolong life and when does it merely prolong dying? One person's salvation is another's living hell.[9] A panel of experts selects patients for this special treatment. At the moment, medical facilities in South Africa are inadequate for providing treatment for all. One day there may be enough machines for all, which means that people who are psychologically or temperamentally unsuitable will have to be included.

After an unsuccessful application to the Durban High Court, Mr Thiagraj Soobramoney, a diabetic with heart problems, asked the constitutional court to compel Addington Hospital in Durban to provide him with free dialysis treatment. His case was based on the constitution's guarantee to the "right to life" and on statements by the Department of Health that patients could not be denied emergency medical treatment. The court rejected these arguments. The president of the court, Arthur Chaskalson, said: "The hard unpalatable fact is that if the appellant were a wealthy man he would be able to procure such treatment from private sources; he is not, and he has to look to the state to provide him with treatment." He described the disparities of wealth and resources in the country and said that, for as long as they continued, the aspirations of South Africans to human dignity, freedom, and equality would have "a hollow ring".[10]

Sir George Pickering,[11] the Regius Professor of Medicine at Oxford University, said that "the present goal of medicine seems to be indefinite life, perhaps in the end with somebody else's heart or liver, somebody else's arteries, but not with somebody else's brain. If other transplants succeed, as they now give promise of doing, those with senile brains will form an ever increasing fraction of the inhabitants of the earth. I find this a terrifying prospect."

The Bushmen abandon their aged and infirm while on a forced march for food and water. An old person unable to keep pace would be placed in a screen of bushes, provided with firewood, food and water, if available, and deliberately abandoned. If food or water were found soon, he would be rescued; but death often followed and the hyenas completed the cycle of nature. Greece used euthanasia for the aging so there would be sufficient food for the remainder.[12] The Romans followed a similar pattern. Seneca stated that euthanasia should be chosen when death is imminent. A former Dean of St. Paul's Cathedral, the Very Rev WR Matthews, has said,

"It seems anomalous that a man may be punished for cruelty if he does not put a suffering animal out of its misery, but is liable to be hanged for murder if he helps a cancer sufferer to an overdose of morphine. I do not think that we can assume that God wills the prolongation of torture for the benefit of the soul of the sufferer." However, the wish of the patient should be honoured if a "living will" is available.

The corollary of the requirement of informed consent for medical treatment is the right of a patient who has the necessary mental capacity to refuse to undergo treatment. In accordance with this, the following is currently allowed under South African common law in the context of terminal illness:

- The withdrawal or withholding of medical treatment from a terminally ill patient suffering from unbearable pain. This is sometimes referred to as "passive euthanasia" and would include the withdrawal of treatment and nourishment from a patient in a permanent vegetative state with no prospect of recovery; and the termination of treatment in hopeless cases after all possible procedures have failed, so as to allow the patient to die naturally.
- The administration of drugs to relieve pain, even when there is no longer any hope of recovery.
- The administration of drugs to alleviate pain and suffering by a patient with a terminal disease, even if such drugs incidentally reduce the patient's life expectancy.

Valid consent by the patient concerned is required for the above conduct and it therefore is clear that a mentally incompetent person cannot consent thereto. In the case of a mentally incompetent person, an application will have to be made to the High Court to have a curator appointed with the specific power to authorise the cessation of treatment. The court would probably appoint a curator for such purpose if the medical evidence unambiguously indicates that there is no prognosis for the patient recovering to the point where he or she will enjoy some quality of life.[13]

The cardinal fact that fires the protagonists of euthanasia is organic pain, the continuous, unbearable, nagging, unremitting, hopeless, incurable pain that occurs in the terminal stages of disease. The only way to terminate pain, they argue, is to painlessly terminate the life of the sufferer. There so often is nothing noble or of spiritual value (in the religious sense) about suffering such pain. The patient's whole world is pain, his every waking hour is pain and, because of it, he is no longer capable of logical thought. Besides the physical pain, one must not forget the 'mental anguish' that may also qualify a patient for consideration of euthanasia, were it legalised. The complete sense of frustration and uselessness that arises in certain conditions renders the sufferer completely and incurably helpless.

For those with religious convictions, including Judaism and all the major Christian religions, most arguments in favour of euthanasia, when analysed dispassionately, are confounded by the Sixth Commandment of the Decalogue: "Thou shalt not kill". Clear and unambiguous! The Old Testament qualifies this in Exodus (23:7): "the innocent and just men thou shalt not kill". Of course, similar precepts exist in Islam and other Oriental religions. Even for the non-religious, the concept of terminating a patient's life runs entirely contrary to that basic principle of the medical discipline, namely to save life.

South African law officially does not permit active euthanasia. Presently, it is legal for doctors in England and South Africa to practise "passive euthanasia", i.e. taking away or withholding treatment even if the person will die. However, it is illegal for doctors to directly help the person to end his or her life, i.e. practise "active euthanasia". There have been a rare number of cases where doctors have been prosecuted for practising euthanasia. Dr Cox (1992) prescribed a lethal injection of potassium chloride and was convicted of attempted murder, even though he had the patient's consent.[14] Active euthanasia was briefly legalised in the Northern Territory of Australia in July 1996, but the legislation was overturned by the Australian Federal Parliament in March 1997 after four patients had died in this manner.[15]

Active euthanasia and assisted suicide have been widely practised in the Netherlands for 25 years.[16] In Belgium and Oregon (USA), physician-assisted suicide has been legalised.[17,18] At this time, no other countries have legalised either active euthanasia or assisted suicide.

In conclusion, it should be remembered that, for the terminally ill, the issue is about the choices that they can or cannot make at the end of their lives. Active euthanasia and physician-assisted suicide should be legalised (under strictly defined circumstances). This would enable people to have a choice, and surely people themselves should be allowed to choose how they live and how they die.

Finally, I wish to state that the views expressed in this article are those of the author.

Acknowledgements:

With thanks to Prof. GA Culligan, for constructive advice, and Mrs B Pretorius, for her assistance as a librarian.

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