The right to die and the chance to live

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Editor's note

This paper and the following ones by Giertz, Rudowski, Ajayi, Nilsson, Cook and Reiss with closing remarks by Lord Smith of Marlow were first presented at the International Federation of Surgical Colleges XXIth Annual Meeting held 2-8 September 1979 in San Francisco, United States of America. The symposium was entitled 'Ethical and moral issues in surgery and surgical research' with the first three of our papers being given under the heading of 'Ethical problems in clinical research' and the second three on the 'Ethical problems of surgical practice'. We have carried out some editorial revision of the original papers.

Jonathan Rhoads begins the symposium described above with this paper. He reflects on the doctor's dilemma of trying everything he can to prolong the patient's life but to no avail, and wonders whether or not leaving well alone might in some circumstances have been better. However, Mr Rhoads concludes by suggesting that those who are 'put through so much but without success' are paying a necessary price on behalf of those—still a minority—for whom success is achieved.

The problem which I wish to address is highlighted by the attitude of the family members who are upset by a lengthy but unsuccessful effort to prolong life. A good deal has been written in the last few years about the right of the patient to die. That this is not a new concept is evidenced by the old aphorism that the physician 'should not strive too hard to keep alive'. Many is the time that one feels regret, indeed remorse, when one has put a patient through painful operative procedures and painful or disagreeable post-operative programmes of suction drainage, intravenous feeding, repeated venopunctures, subcutaneous injections, etc., only to have the patient's disease overwhelm him in an early and fatal dénouement.

The other side of the argument is typified by the Professor of Medicine who had a series of severe heart attacks with arrhythmias which would presumably have been fatal had not the bystanders intervened with emergency resuscitative measures followed by intensive treatment in a coronary intensive care unit. This occurred not once but on

multiple occasions so that the individual had some thirteen attacks and, I believe, five cardiac arrests. Due no doubt to the promptness of the intervention, he did not suffer any evident cerebral damage and eventually recovered.

It occurred to some of his colleagues that if anyone had ever had a glimpse of a future life, that this individual should be the person, and so a committee waited upon him to ask if he had gained any insights. The internist replied that he had not had any vision of a future life but that during the period that he had been under intratracheal intubation attached to a respirator, he had had two fears; a big fear and a little fear. Upon further inquiry he explained that the little fear was that the medical house officers who were buzzing around injecting various drugs into his intravenous line would make a mistake, either in drug selection or in dosage, which would terminate his course. He went on to explain that this was his little fear because he knew the house officers were very conscientious and were well trained and intelligent. What then was his big fear? 'My big fear' he said 'was that the attending physician in charge of the coronary intensive care unit might believe in the right to die'. He explained that in spite of his multiple reverses he really was not ready to die, that there were several more things specifically that he wanted to accomplish and he was very anxious to survive and attend to them.

This illuminating story with its happy ending has provided me much food for thought. The crux of the question is, how can the physician or surgeon know which patient can respond to heroic efforts with a period of survival and which cannot. The answer, of course, is that we cannot know in most instances.

Over a fairly long period it was my experience at the Hospital of the University of Pennsylvania, that when we had three very ill patients on the service each of whom looked as though he were likely to die, and if we worked very hard over them as we did, that on the average one would recover and two would not. With hyperalimentation I think the average has been a bit better but the ratio is really set by the range of patients that one includes in the study and we have not succeeded in agreeing on a satisfactory or universally acceptable definition of who these patients are; that is, how sick they have to be in order to be included among

the desperately ill or, more pertinently, among those who might be qualified to exercise their right to die.

How large a factor is age in deciding to relax therapeutic efforts? This seems to depend somewhat on the age of the physicians making the decision. To most students and house officers, one of whom confided to my wife at a banquet 'that we cannot imagine what it would be like to be forty', an age such as 60 or 65 or 70 is advanced, indeed already excessive. On the other hand, I took care of a former patient of my father's who had achieved the age of eighty-five and who had marked gall-bladder disease but insisted that she really did not want to live any longer. We got her through a cholecystectomy and somewhat in spite of herself rehabilitated. She is now ninety-nine, having had at least a decade of very fruitful life after her cholecystectomy. Thus, I doubt that we can agree on an age beyond which no effort should be made, though I acknowledge that when I felt a sizable carcinoma of the rectum in an aunt at the age of ninety-five who had been an invalid for at least forty-five years, I did recommend a 'hands off' management. She lived two more years and the tumor never loomed large in the course of her illness.

Advanced neurological disease is probably the most solid reason for withholding treatment. It is now pretty generally agreed that when the brain waves are flat for over twenty-four hours, the possibility of recovery is nil and these unfortunate individuals become donors of kidneys and other tissues for use by those who need them to survive.

In the years of the Depression economic factors were sometimes advanced as a cause for therapeutic nihilism. Thus, individuals who were not only incapable of maintaining themselves but whose handicaps placed a severe burden on their relatives without a significant prospect of improvement, were at times thought not worth saving. Fortunately, this line of thinking did not gain much support even during the Depression and I think it has no considerable standing in the United States at present. The criterion is rather that if the patient can be rehabilitated enough to be happy his life should be prolonged.

Thus I think most of us hold the view that if a person is able to be well enough to enjoy life he should be entitled to this privilege even though the individual is not productive enough to justify it on an economic basis. In short, we do not send our old people out on the ice in the tradition attributed to the Eskimos.

Specific criteria for prognosis are extremely uncertain. I can recall as an intern when it was said that a blood urea nitrogen level over forty-five was a contraindication to a prostatectomy. I doubt if this opinion would obtain much support at present.

We come then to the diseases with a bad prognosis. Let us turn back the clock twenty years and consider the patient who had Hodgkin's disease. The chance of cure was nil but there was some chance of a worthwhile period of survival with the help of radiation therapy. Having accepted the fact that the chance of cure was nil, the general plan was to spread out the radiation in small amounts so as to make it last as long as possible. It was this concept which Henry Kaplan challenged. He pointed out that, if one believed that radiation could not be curative and simply gave small amounts at a time, then it never would be curative. He demonstrated that, properly used, it frequently was curative. Now, between high dosage radiotherapy after proper staging and chemotherapy where indicated, the cure rate of Hodgkin's disease is approaching 70 per cent.

There remain, however, many cases of Hodgkin's and many cases of other disease in which the prognosis is essentially bad. Is it justifiable to ply these patients with new methods of treatment of unproven efficacy? Here I think we must rely broadly on informed consent. There are many patients who prefer to go down fighting rather than attempt resignation when they do not feel resigned to departing this life. These warriors are in general happier if they are trying a plausible method of treatment after the efficacy of the known methods has been exhausted. In some sense it may be the failure to recognise this psychology which has given so-called quack remedies their chance of popularity. Particularly among the cancer cures there always seems to be at least one remedy discredited by the more scientific segments of the health professions which is quite popular with the public. Not all but many of the consumers accept it because the established remedies afford no hope. If an unestablished therapeutic agent is to be tried, is it not better that this at least be one which has not been proved ineffective?

My conclusion then (which is debatable) is that the patients, whom we put through so much but without success, are paying the price our species pays for the not too infrequent individual who appears doomed but who survives a period of intensive treatment, either to live a normal life span or at least to gain a worthwhile addition to his life span. Within the group of patients whom I have identified as falling in these two categories, the failures are more frequent than the successes; nevertheless, without extending the efforts to both groups, one would probably save none of them. In short, they endure the discomforts of intensive care for what I regard as at least a 33 per cent chance of a worthwhile success, though there are of course many other patients in an intensive care unit with a far better prognosis, nearly all of whom recover.