Late lessons from Auschwitz—is there anything more to learn for the 21st century?

SIR

A conference of philosophy of medicine in Crakow, August 2000, offered the opportunity to visit Auschwitz—an offer reluctantly accepted by the author who had two decades ago, spent some months in Israel, cried at Dachau, treated (in the course of consultant practice over three decades in oncology and palliative medicine) many holocaust survivors, and counts among close friends and colleagues persons profoundly affected by Auschwitz and associated activities. Surely, the visit would be expected by Auschwitz and associated persons profoundly.

For the holocaust, and the Nazi elimination of handicapped and elderly persons prior to 1939, the presupposition behind the specified goals appears to be that there are lives not worthy to be lived—framed by the concept that there is an acceptable view of a worthy human person—an ideal of the good. Such ideas were clearly the result of profound historical currents, as well as of the early 20th century scientific, philosophical and political environment, with doctors (academic leaders and medical associations) in the vanguard as mainly non-resisting articulators of the ideas, as well as managers of the strategies to develop and achieve goals.1

For our great hospitals, what are the presuppositions in the midst of current changes? And are they acceptable? Or contestable?

Treatment of patients who are Jehovah’s Witnesses

SIR

I read with interest the recent articles by “Lee Elder” and O Muramoto,

References


PROFESSOR J NORELLE LICKISS

Director, Sydney Institute of Palliative Medicine
Department of Palliative Care
Royal Prince Alfred Hospital
Missenden Road
Camperdown NSW 2050
Australia
along with the accompanying editorial about the treatment of patients who are Jehovah’s Witnesses.

May I say that clinicians are well advised to discuss the specific, personal management options requested by each Jehovah’s Witness; Witness patients will gladly outline their management preferences and their reasons for such.

On this point it might be timely to reiterate the guidelines issued by the Royal College of Surgeons: “It is not a doctor’s job to question these principles, but they should discuss with Jehovah’s Witness patients the medical consequences of non-transfusion in the management of their specific condition. It is essential to establish the views held by each Jehovah’s Witness patient …”.

References

PAUL WADE
Director, Hospital Information Services for Jehovah’s Witnesses Watchtower Bible and Tract Society of Britain, The Ridgeway
London NW7 1RN

Jehovah’s Witnesses—the blood transfusion taboo

SIR

There is nothing wrong with Dr Gillon’s suggestion to doctors that they ask Jehovah’s Witness patients why they refuse a blood transfusion and present alternative viewpoints. However, enforcing the argument with reference to fellow believers who do accept a transfusion will be perceived by many believers as a contradiction in terms. Since the dualistic theology of the Jehovah’s Witnesses hardly accommodates doctrinal ambivalence, any member who wilfully infringes basic teachings is simply considered a non-member. Worse than that, the umbrella organisation will anathematise such an unrepentant transgressor and symbolically rank him or her with the persistent fool in Proverbs 26, who, “just like a dog, is returning to its own vomit”.

Viewed within this context, one may wonder about the advisability of referring to these and similar dissident opinions.

References
3 Holy Bible. Proverbs xvi, 11.

RICHARD SINGELENBERG
Department of Cultural Anthropology
Faculty of Social Sciences
University of Utrecht
PO Box 80140
3508 TC Utrecht
The Netherlands