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 a mark of respect, and an episode of further personal grieving maybe, but not enlightenment. This was not the case.

The lasting impression has been that of the dangers of efficiency as a value in itself, the inadequacy of outcome measures if the array is incomplete, and the need for clear articulation not only of goals, but of the presuppositions underlying the formulation of goals.

One does not need to explicate these points with reference to the Holocaust, save to note that outcome measures related to saving of funds, accumulation of objects of material value, even perceived community benefits and achievement of specified goals, must all be subordinated to outcomes related to the good of the affected individual human persons. Efficiency and efficacy should not in themselves be accepted as goods (but may be); they have value only in the light of legitimate goals. What has this to do with contemporary medical practice?

For a start, outcome measures are prominent in policy formulation at health system level—and efficiency is (rightly) highly prized, especially where the use of expensive hospital resources is concerned. The concept of diagnosis related groupings (DRG) and guidelines concerning expectations of length of stay have dramatically influenced the profile of hospitals—structure, size and function.

In the hospital sector, outcome measures are being achieved: diminishing length of stay appears to be seen as a mark of excellence by administrators, insurers, funding authorities and many clinicians, and the efficiency of the use of hospital resources has vastly improved. All sorts of procedures previously presumed to need admission are now widely undertaken in ambulatory contexts.

It is in such situations, where outcome measures, related to the specified goals, are being efficiently achieved, that articulation and review of the underlying presuppositions may be necessary.

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.\footnote{1 Alexander L. Medical science under dictatorship. New England Journal of Medicine 1949;241:39-47.}

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

First, it is fairly clear that, contrary to the role of hospitals in society in the past, hospitals are now places for anti-disease interventions (in a human atmosphere) but not for care, except that care which is necessarily associated with therapeutic interventions.

Second, it is assumed that efficient use of hospital resources should permit funds to flow to other areas of the health care system to ensure that care is available for all in accordance with need.

There is need for debate concerning such presuppositions—as well as scrutiny of the array of outcome measures in place or necessary as part of the evaluation of a health system (especially hospitals) in contributing (efficiently) to human flourishing. Do we still have lessons to learn from Auschwitz?

References


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Treatment of patients who are Jehovah’s Witnesses

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I read with interest the recent articles by “Lee Elder” and O Muramoto,\footnote{313:1463-4.}
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


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Jehovah’s Witnesses—the blood transfusion taboo

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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.

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