From Death + Decision
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What Is the Function of Medicine?[1]

Eric J. Cassell

Thought about the care of dying patients has changed over the past several decades. The questions raised initially concerned physicians' obligations towards the dying. As the technical power of medical practice increased, thought was given as to whether "ordinary" or "extraordinary" means must be used to keep the terminally ill alive. In more recent times, the emphasis has shifted from the obligations of physicians, to the patient as a possessor of rights. A glance at bibliographies of bioethics will show the same increasing preoccupation with the rights of the sick in all areas of medical care. Whether one sees the topic of the dying patient from the point of view of physicians' obligations or patients' rights, it is clearly concerned with the doctor-patient relationship. I am going to examine the issue of the patient's right to be allowed to die to see what it can tell us about the doctor-patient relationship and equally what it can reveal about the intimately related question - what is the function of medicine?

It is reasonable to start by seeing what universe of patients we are talking about. It seems to me that we are talking about three classes of patients. First are those patients whose disease is completely curable but if untreated will probably be fatal. The serious infectious diseases such as the bacterial meningitides or septicemias come to mind as examples. But also included would be surgical emergencies such as hemorrhage, shock, head injuries or perforated ulcers.

A second group of patients are those whose disease is not curable but who will, with continued treatment, live in functional health for a variable but meaningful time. In this class are patients with heart failure, certain malignancies such as Hodgkins' disease, patients with end-stage renal disease who require regular dialysis with the artifi-

cial kidney, and persons with certain chronic anemias who need repeated transfusions. This class of patients is expanding as more cancers become responsive to chemotherapy and other diseases are controlled by newer therapy. The key characteristics of these patients is not simply that they live longer but that they require continuing treatment to remain alive.

The final group are the terminally ill. Their disease is not curable, and treatment offers nothing beyond the prolongation of their dying.

Although it is the contributions of technology and physicians to the sufferings of this latter group, paradoxically, that initially raised the issues I am examining, the question of the patient's right to be allowed to die was gradually extended to the former two groups in both theory and practice.

An example from each of the first two groups should help unpack the issues.

A thirty-eight year old man who had a mild upper respiratory infection suddenly developed severe headache, stiff neck, and a high fever. He went to a local emergency room for help. Brief examination confirmed the physician's suspicion that the man had meningitis. Based on the story of the illness and the age of the patient, the most likely diagnosis was pneumococcal meningitis. This kind of bacterial meningitis is almost uniformly fatal if not treated, and if simple antibiotic treatment is delayed, although cure will result, permanent neurological damage is likely. The doctor told the patient the problem and how important urgent treatment was to save his life and forestall brain damage. The patient refused consent for treatment saying that he wanted to be allowed to die.

Does such a patient have a right to be allowed to die? On the face of it the answer must be yes. That is because the patient cannot be legally treated without his consent. But I would guess that it would be a rare hospital where such a patient would not be treated against his will. The physicians would ask for a psychiatric consultation to declare the patient incompetent and then start therapy. Since penicillin works equally well against the bacteria whether the patient wants to die or not, he would recover.

Why is my expectation (and sincere hope) that such a patient would be treated despite his declared wish to be allowed to die? When a patient enters the hospital (or doc-

tor's office) for help, he enters into a relationship with the treating physicians -- and by extension the hospital itself. While the nature of that relationship is still obscure, we know that when the physician enters the relationship he acquires a responsibility for the patient that cannot be morally relieved merely by the patient's refusal to consent for treatment. But more simply, the physician could not stand aside and allow the patient to die from a disease otherwise easily treated without feeling that he, the doctor, was responsible for the death. Much is said of the patient's rights in the doctor-patient relationship, but the patient also has obligations. In giving himself into the responsibility of another, he is obligated not to injure the other morally or legally by making it impossible for the physician to act on the responsibility. In coming into the emergency room for help (he could have not come at all) he caused the physician and the hospital to become responsible for him without beforehand limiting the nature and degree of their responsibility. Although not meaningful in this case, such antecedent limits might allow the physician to refuse to enter the relationship.

In the situation I have described, by refusing treatment, the patient is effectively committing suicide. As opposed to going out a high window, here he is enlisting the aid of others in his suicide. On the other hand, if he is not committing suicide, his motives are not clear. Therefore, if he resists treatment, the doctors might reasonably believe that the patient does not know what he is doing. The element of time appears to play a part. But time for what? A different but similar situation may make clear what function time serves and what is lacking in this case of the man with meningitis.

A Jehovah's Witness, injured in an accident, comes to the hospital bleeding profusely. Blood transfusions are necessary to save the patient's life before surgery can be done to stop the bleeding. The Jehovah's Witness refuses transfusions. While there will probably be much agonizing over the decision, or even recourse to the courts, the patient's right to refuse treatment (even though death will follow) may be -- indeed has been, acknowledged. The situations are similar. The condition is curable, but without treatment death results. What is very different is that the patient's motive is well known to us and has been expressed by a durable agent, his church, over time. Further, the patient's decision is consistent with a set of beliefs well known to us, whatever we may think about them.

In addition to highlighting the element of time in