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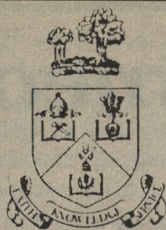

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Should Doctors Force Patients To Live?

by Robert Hercz
Canadian University Press

In a university philosophy class, a videotape is being screened. Donald C., a 26-year-old burn victim, is explaining to a psychiatrist that he wants to be discharged from hospital.

Donald is a mess. Most of his body is covered in raw scar tissue from third-degree burns. He looks more like the monstrous product of a Hollywood special-effects department than a human being. He is blind, he cannot walk, his hands are useless stubs. He is in excruciating pain. To control infection, he has to be lowered, naked, into a tank of disinfectant every day. As Donald talks, the tape shows scenes from his daily existence.

Some of the students cannot watch the tape. They are looking out the window or down at their shoes. Some of the students want to be doctors.

If Donald is released from hospital, he would soon die of overwhelming infection, which is exactly what he wants. He makes a clear, strong, and impassioned plea: "What gives a physician the right to keep alive a patient who wants to die?" But, back in 1974, no doctor would sign his release.

The case of Donald C. is ancient history in bioethics. It is an early example of the technological roots of many of these ethical dilemmas. If Donald had been burned only a few years earlier, the problem never would have arisen: he would simply have died.

"We are now able to do things in medicine that we weren't able to do five, 10, 15 years ago," says Toronto's Eric Meslin, one of a small handful of professional hospital ethicists in Canada. "We can keep patients alive virtually indefinitely on sophisticated respirators and ventilators and more powerful drugs. We're now looking at what it's possible to do and saying, should we be doing that?"

Fred Lowy, head of the University of Toronto's new Centre for Bioethics and a former dean of medicine, agrees. "In the last three decades, technology has brought us to the point where there are a lot of questions that physicians face regularly that the wisdom of the ages doesn't help us with, because the ages never had to deal with genetic engineering and in vitro fertilization."

The list doesn't stop there. Medical ethics is asking new questions faster than we can answer them. Ownership of embryos, organ harvesting (removing organs from the dead), the use of aborted fetal tissue, animals as a source of organs for transplantation, surrogate motherhood, and the allocation of scarce health-care funds are all issues of increasing concern.

When a society has more technology than cash, how do you decide who benefits and who doesn't?

One of the measures of the current gap between technology and ethics can be measured by the number – up to 10,000 in North America, according to one estimate – of people kept alive by feeding tubes in what's known as persistent vegetative state. Nobody knows what to do with this population of the living dead. Doctors, almost by reflex, have traditionally been trained to save life, not end it. And next-of-kin, who in many cases have the authority to request that their relatives be allowed to die, have often been reluctant to make such irrevocable decisions.

But that is changing. There are now geriatric hospitals which do not, as a matter of policy, resuscitate heart attack victims. Doctors in regular hospitals issue DNR (do not resuscitate) orders at patients' requests. The growing patients' rights movement, the increasing tendency to question the authority of physicians, and the trend of taking quality of life into consideration are all playing a role.

Lowy believes some doctors have not yet learned to cope with the demands of technology.

"Once in a while, you get some overzealous physician or a group of health care workers in a hospital who will try to resuscitate an 85-year-old person who is dying, without any prospect of success in the long run, just because technologically you can keep a person like that going for another few months – at great expense to the public, by the way. That's an example to me of technology running wild."

The question of rights is the great quagmire of medical ethics. As author James Restak notes in Premeditated Man, questions of ethics are often really questions of power. Who has the final say? The patient, the doctor, or the government? Who decides when life should end, and who should be allowed – or obliged – to end it? Should it be legal, under certain circumstances, to kill people? And is killing different from "allowing to die?"

It depends where you live. In Canada, a physician can let people die – if they request it – but cannot kill them. In Holland, on the other hand, a doctor can kill if requested to. Doctors and ethicists agree that today, Donald C. would probably get his discharge. But if he wanted a lethal injection so that he would not have to endure the pain of a prolonged death from infected, pus-covered sores, it is unlikely he could find a doctor in North America who would administer one.

In the Netherlands, however, thousands have requested and received such lethal injections, in the last stages of AIDS for example. There is no distinction made between "passive euthanasia", or allowing a patient to die, and "active euthanasia", or killing a patient.

"There is some moral consensus among some ethicists that that's a phony distinction," says Meslin. "If your intention is to permit that patient to die a good death, then it really shouldn't matter what the means are." Nevertheless, Meslin admits that Canada "is not prepared yet as a nation to endorse active euthanasia."

Others take a harder line. Michael Coughlin, ethics consultant at St. Joseph's Hospital in Hamilton, Ontario, feels we should keep the distinction very clear.

"I think it's an important distinction. In a sense, this is where my religious perspective comes in. We're not the masters of life. We're still dependent – on a higher power, on God – and we're also dependent on each other. Because of that, it's important that we recognize that we don't have total mastery over the world and over our lives. We have a death-denying culture. One of the ways of denying death is to show control over it by making it happen."

Continued on **Page 3**...

Morgentaler Launches Appeal In Halifax

by Padraic Brake and Dawn Mitchell

HALIFAX

(CUP) – Dr. Henry Morgentaler has launched an appeal with Nova Scotia's highest court to allow him to perform abortions in that province.

Morgentaler's lawyer filed the appeal after the provincial Tories were granted an injunction by the Nova Scotia Supreme Court forbidding abortions at the doctor's new Halifax clinic.

Under recent provincial legislation, a series of medical operations – including abortions – must be performed at an approved hospital.

"The law was established to prevent Morgentaler from operating a clinic in Nova Scotia," said Halifax clinic official Sandra Lanz. "They have stopped him for now.

"But it will continue to operate as a referral and counselling centre for women in Atlantic Canada."

About 80 per cent of the 1,500 abortion performed yearly in Nova Scotia are at Halifax's Victoria General Hospital. Women under 19 need consent from one parent, according to the Canadian Abortion Rights Action League (CARAL).

CARAL states that more than 500 Atlantic women travel annually to clinics in Quebec or Ontario. Another 400 go to the United States.

Morgentaler announced in March that he would open a Halifax clinic after the Supreme Court of Canada struck down the restrictive abortion law as an unconstitutional violation of the right to the security of the person.

The federal Conservatives introduced a bill earlier this month which makes having an abortion without valid "social, psychological or economic cause" punishable by two years in jail.

Doctors at the Halifax clinic performed 13 abortions on two separate days.

Lanz said patients included women who had travelled from Newfoundland and New Brunswick to obtain an abortion.

Noreen Golfman, an official with an abortion rights group in St. John's, said the women were those who could afford to travel.

"There is a problem with accessiblity when we receive calls daily for referral services to Montreal and Toronto when the local hospital is supposed to be providing abortion services," said Lanz.

Only one doctor in the entire province of Newfoundland performs abortions. There is often four to five-week waiting list, CARAL states.

Morgentaler has said that he will take the Medical Services Act to the Supreme Court if he has to.

There are free-standing abortion clinics in Toronto, Winnipeg and Montreal. Access across the rest of the country, said CARAL, is uneven.