MORAL AND ETHICAL DILEMMAS IN THE CARE OF CRITICALLY ILL PATIENTS

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The knowledge explosion in Science and Technology tends to overwhelm us and we get confused in a maze technicalities and methods often forgetting the patient we are treating and who becomes a conglomerate of signs and symptoms instead of a person. Advances in resuscitative technology have enabled anaesthetists to almost indefinitely prolong the life-supporting systems of critically ill patients who would formerly have been pronounced as dead after simple traditional measures had failed. The dilemma lies in the moral and ethical necessity of providing maximal care for patients who are terminally or irrepairably ill but who have a chance to survive their present catastrophe (Declaration of Helsinki, 1964; Resolution 613, 1976). It is agreed that permanent functional death of the brain stem constitutes brain death and further artificial support is fruitless and should be withdrawn (Honorary Secretary, 1976).

In a dilemma one is faced with two alternative choices, neither of which seems a satisfactory solution to the problem. They arise in situations of uncertainity and ambiguity when the general principles upon which one normally relies either offer no help or seem to contradict each other. Such decisions have to be distinguished from the many important clinical decisions which must also be taken by doctors. These decisions may present as dilemmas but their resolution is dependent solely on the doctor's knowledge, experience and intuitive abilities. All these factors are certainlyhelpful in a moral dilemma but are insufficient to unravel the moral conflict, because a different kind of decision has to be made. The more concerned the profession has become about the formulation of codes of ethics the more they have become aware of the complexity of the moral problems. The profession simply provides some generalalised statements in everyday language and leaves it to the good sense and good will of its practitioners to deal with the ambiguous situations.

The individual conscience is thought of as a kind of inner voice warning you against wrong and creating remorse when the warnings have been disregarded. Following conscience is the most common way doctors seek to solve the moral dilemmas they encounter. Peoples "intuitions" about right and wrong often conflict sharply. It seems that conscience is a powerful force in controlling the actions of most individuals; but although powerful, it may not always be right.

There is confusion about what is useful and advantageous to the majority and what

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we feel all men ought to value. Treating every individual justly usually does benefit society as a whole. Respect for the rights of individuals is a more fundamental moral value than the happiness of the majority. We are still primarily concerned with caring for people and the art of medicine should not be forgotten in the enthusiasm for scientific precision. Sympathy and understanding are just as important as diagnostic acumen (Payne, 1978). However, in many dilemmas of personal and social morality the criterion of general happiness is a good corrective to personal bias and idealistic mouthing of principles.

What we appear to be searching for is a set of absolute or fundamental values which will clearly and unambiguously inform our choices and decisions in any given situation. Such a calculus of human rights cannot and will not be done. Rule-following, much of it habitual and unquestioned, characterises a high proportion of our daily activities. Our behaviour is confined within the limits of the socially acceptable, the legally sanctioned and the routines of personal preference and conviction. A rule-governed approach to morality becomes a wholly depersonalised one. What is missing is any consideration of the persons who hold the principles and the persons to whose circumstances the principles are applied.

It is said that Hippocrates forbade the administration of remedies to those who were past hope. This injunction we may heed as advice not to make difficult the final stages when we recognise their finality. None can relieve us of the responsibility of judging when this moment shall have come. We should bring to the bedside a great hopefulness, a determined optimism, but if the futility of the struggle is clearly evident, then we should put aside our remedies as cures, and make the patient easy with such solation as may offer (Gavey, 1950). We are asked to give guidance, to judge dispassionately upon reasonable probabilities The fact that many of our prognosis prove wrong should not detract from a genuine attempt at a correct forecast. As Osler said : errors of judgement must occur in the practice of an art which consists largely in balancing probabilities".

The question : "should the doctor tell ?" is guided in practice by the circumstances of each case which suggests the line that should be taken. In general, a guarded prognosis slowly revealed enables a patient to prepare himself, retaining a hopeful attitude in the background. In these matters few demand to know the truth and nothing but the truth and even if a direct question is asked the patient usually welcomes an answer which does not shut out all hope. The patient senses the true position far more accurately than one might imagine and any attempt to soften the blow is welcomed. There are occasions when it is best never to disclose the true position, even at the end. The human capacity for self-deception is great and this characteristic needs to be promoted occasionally.

Intensive medical care is designed to diagnose, treat and maintain patients with immediate, acute but potentially reversible life-threatening impairments. It also aims at prophylactic management to avoid such catastrophes as cardiac arrest, respiratory arrest, shock, renal failure, and overwhelming sepsis. There is a growing belief that medical and technological capabilities should not necessarily be used simply because they exist.

Is there an ethical imperative to preserve all patients in life-threatening situations

including those for whom existence seems only a fiction and others for whom it promises to be only short and severely diminished ? On one view, it is justifiable tc moderate the therapy even though earler death will occur, when this will result in relief from pain and suffering. Another view is that "our training is to preserve life and functions whenever possible". We are not trained to decide who is better off dead". The patient who is alive has an overriding right to life and deserves the maximal possible therapy (Cohen, 1977).

This conflict has implications for the care of those who are not terminally ill, but who are potentially salvageable with the chance that survival will be accompanied by severe physical or mental impairment or both. It is these difficult cases concerning the level of salvageability that lead to the widest divergence of opinion. The problems are complicated by the fact that it is often not possible to evaluate the likely outcome of intensive care treatment until the patient has been monitored for some days and even then, predictions are open to revision in many cases (Cullen et al, 1976; Criner, 1973). It is also to be remembered that there is a moral difference between "Killing" and "letting-die". Dying is the final event of a valueable human being and no one else is morally empowered to initiate and transact. When a decision has been that maximal treatment is inappropriate it is not an acceptable ethical alternative to kill the patient, but it is permissible to allow the patient to die (Mc Cormick, 1974).

Western ethical tradi tions have reached some general agreement that it is necessary to use "ordinary" but not "extraordinary" means to support and comfort patients in such cases (pope pias XII,1958). By "ordinary" means is meant "all medications, treatment and operations which offer a reasonable hope of benfit for the patient and which can be obtained and used without excessive expense, pain or other inconvenience". "Extraordinary" means are those that do not offer such hope or cannot be obtained or used without those kind of liabilities. There is a professional and moral relationship entered into with each patient admitted for intensive care in which it is understood that the patient will receive appropriate care. Such care cannot be terminated later on the grounds that another patient with a higher potential for survival needs intensive care without violating the original obligation to the admitted patient and wirhout violating the ethical principle that we cannot aid some by harming others (Report of Clinical Care Committee,1976).

Survival though important, is not to be bought at any cost and that to attempt, but fail to achieve, may reduce so-called intensive care management merely to the level of prolonging the process of dying (Rabkins et al, 1976). It is of primary importance from an ethical perspective to determine whether the right to life is absolute or whether it can ever be overridden with justification, Our conclusions will not apply with absolute finality, like mathematical equations, to all cases as individuals have very different conceptions of how to exercise their right to the pursuit of happiness within the limits of the ethically possible. Reverence for life must be temperd by restraint and an equal respect for the dignity of death. In the last analysis, our choice is influenced by the way the personality regards its destiny and our own conception of death.

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