Medical Decisions in a Context of Conflicts*

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The question of when to use modern medical technology in the treatment of patients is complicated by conflicts among the goals to which our culture and our health care systems are committed. I will attempt to suggest why it is so hard for us to decide when to initiate or to discontinue treatment in circumstances where the outcomes are unclear. First, our health care system professes four incompatible goals: (1) the provision of the best of health care to all under all circumstances, (2) the provision of equal health care to all, (3) the maximization of patient and provider free choice, and (4) cost containment. The difficulty is compounded when one addresses the issue of "do not resuscitate" or "do not intubate" orders or decisions to extubate a patient when death is likely to follow. Further conflicts stem from our departure from the traditional Greek and Hippocratic notion that one should not treat hopeless cases.¹

Ordinary vs Extraordinary Care

The Greek notion of setting limits to the use of health care resources received a modern rearticulation in the hands of Christian scholars during the Renaissance. In deciding when one was obligated to treat a patient, a distinction was drawn between ordinary vs extraordinary care. Extraordinary care was that care that was, under usual circumstances, not obligatory. It was that care that constituted an undue inconvenience to the patient or his family. Extraordinary care thus did not mean the exotic or experimental treatment, nor did it simply mean expensive treatment. It meant any form of treatment that constituted an undue burden.² An undue burden might include circumstances where a farmer from a rural community would need to go to a large, distant city for treatment, entailing a major disruption in his way of life. The point is that limits to the duty to treat were recognized. Such limits were perhaps more plausible in a society that expected an afterlife and where the unreserved commitment of resources to stay alive in this world appeared disproportionate. It is only in modern times that the duty to treat is seen to be nearly absolute. In such a context, the right to life becomes tantamount to the duty to stay alive. This might, in part, be traced to the secular assumption that one only lives once and therefore should hold onto this life at all costs. In any event, one finds a conflict between the traditional view that there are limits to the duty to treat and a more modern sentiment that one should invest resources in saving lives no matter at what cost and how unlikely the prospect of benefit.

This conflict is further compounded by the tension between the developing notion of the rights of individuals to determine their own treatment and the old Anglo-American legal presumption against suicide. In almost all Anglo-American jurisdictions, it was presumed that suicide was a crime and that aiding and abetting suicide was a felony as well.³ A classic articulation of this point is provided by William Blackstone,⁴ who held that the state should forbid suicide because: "The suicide is guilty of a double offense; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects. . . ." This understanding of the citizen as owned by the sovereign conflicts with the moral view that individuals have an area of privacy within which they are free to determine the circumstances of their own lives, and even, under certain conditions, their death. A locus classicus for this view is found in a Dissent by Justice Brandeis in Olmstead v United States:⁵ "The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the most valued by civilized men. . . ." This point was further developed by Justice Warren Burger when, as a member of the Washington, D.C. Circuit Court, he wrote a dissenting opinion supporting the right of a Jehovah's Witness to refuse a blood transfusion:⁶ "Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to sensible beliefs, valid thoughts, reasonable emotions, or well-formed sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk." Here, again, one finds a conflict, this time between a state interest in preserving life and the right of individuals freely to determine the disposition of their own lives.

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*Selected Topics from the ACCP 50th Annual Scientific Assembly

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In summary, one finds physicians, patients, and the families of patients attempting to make decisions about the use of high technology medicine for the prolongation of life in circumstances where there are no clear—in fact conflicting—cultural cues. As the foregoing suggests, there are explicit sources of conflict as a result of the tension between (1) the traditional views that there are rather straightforward limits on the duty to preserve life vs (2) a modern, often unexamined assumption that one should save life at all costs, this tension being further compounded by (3) a tradition of state intervention to prevent suicide, which is in conflict with (4) a developing understanding of the rights of individuals to choose the circumstances of their own lives and death. These conflicts themselves reflect even more fundamental moral conflicts: the conflict between (5) the moral obligation to do good to others and (6) the moral obligation to respect the free choices of others, as well as the moral tension between (7) that element of moral discourse that is articulated in general secular language vs (8) those elements of moral discourse that depend on particular religious and ideologic traditions.

**Patient Directives**

A moral solution to this complex geography of conflicts can be found in getting to know better what patients and families really want. Such attention to the concerns of patients is not an element of health care that earns the highest remuneration. Still, it is a key to determining reasonable solutions to the questions of when to stop treatment and what level of treatment to employ. Law and public policy suggest that there are at least five ways in which individuals can express their wishes for treatment.

First, patients who are competent can inform their physicians about the kind and extent of treatment they wish to receive. For a patient responsibly to make such requests will require that the physician provide sufficient information and guidance about what choices are possible, reasonable, and desirable. Such exchanges of information take time and require patience.

Second, patients can inform their physicians and family how they wish to be treated if they become incompetent. Even in the absence of written statements, such communications may provide a sufficient basis for a substituted judgment regarding what a patient would have wanted. Waller. Of course, a third option is even better—an actual written statement, which not only provides a better basis for substituted judgment from a legal point of view, but also provides an important moral instrument. If a physician anticipates conflict among family members regarding the treatment of a patient who will become incompetent, a written living will signed by family members can become an instrument for their facing together the inevitable decisions and committing themselves to the choice endorsed by the patient. The fourth vehicle for expressing one’s wishes, and the third variety of advance directives, is provided by natural death acts, which formalize living wills. Such instruments are often cumbersome, difficult to exercise, and provide little space for a complete expression of a patient’s interest or concerns. Their major advantage is the liability protection they offer to physicians. Finally, in many states, there is the possibility of using a durable power of attorney to appoint a surrogate decision maker. The responsible use of any of these vehicles will usually require an extensive and sympathetic conversation with a physician. In such circumstances, physicians must play the traditional—in fact, ancient—role of counselors of finitude, by aiding patients in coming to terms with the limits and finite character of human life.

Such decisions, no matter how complex and fraught with tension, are relatively simple when they can be decided on the micro-level, in terms of the wishes of actual patients. In such circumstances, one can always advance the moral argument that, “I did not necessarily agree with the patient; however, I was obliged to respect his choices regarding the circumstances of death.” In such contexts one can avoid deciding what the proper choice should be and rely instead on the moral principle of respect for the freedom of persons that underlies the practice of free and informed consent.

The more difficult problems involve the setting of limits for health care entitlements. With the development of DRGs, we are just beginning to face the task of limiting the duty to treat in terms of which interventions are likely to be of only marginal benefit. To approach this problem, we will likely need to appeal to an insurance metaphor, where we envisage ourselves writing a finite policy to provide health care when we lose both the natural and social lotteries, ie, when we are both ill and disabled, as well as without financial resources to pay for all of the treatment that might be of marginal benefit. The creation of a social insurance policy for health care needs involves the commitment of resources to medicine rather than to other social individual undertakings. Since only a finite amount of the gross national product can be invested in health care, to choose any level of investment implies setting limits on the use of marginally beneficial diagnostic and therapeutic interventions.

On both the micro and the macro levels, the theme is thus one of finitude, deciding when more technological intervention does not mean better treatment for a patient or is not “worth” the costs. This requires recognizing that the provision of care and support and the amelioration of pain and suffering are often the appropriate treatment, and that a commitment to the
Further prolongation of death is inappropriate treatment. Since the views of individuals vary greatly regarding what is an acceptable life or a good death, there is ample basis for moral conflict that may be reflected in conflicts among physicians and other health care professionals involved in the treatment of the patient. This diversity of views will also augur for an extended public debate regarding limits to treatment when intervention will only have a marginal benefit.

Due to the development of new technologies and their effects on the quality and cost of dying, medicine will participate in aiding individuals and our culture to become clearer about how to use such technologies. We will come to terms with the moral tensions that I have underscored only if we become clearer about our values and commitments and engage in the difficult choices that are unavoidable by a species with finite resources and a finite life span. This undertaking for medicine should not seem strange and alien. Medicine is, after all, one of the traditional learned professions and has much to contribute to the life of ideas and the maturity of our culture.

References

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