EDITORIAL

"JUDGEMENT DIFFICULT"

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The article in this issue by Kevin McIntyre on medical legal aspects of resuscitation highlights two current trends in medicine that seem paradoxical. On the one hand patients want to be treated as the unique persons they are, not as objects or as containers of disease. On the other hand, there is constant talk of patients' rights, the specter of legal action, demands for lower cost medical care, and an often adversarial quality to the relationship between physicians and patients. It might be objected that no paradox is presented by these two trends, they are merely different aspects of the same thing -- the increasing insistence throughout our society on what might be termed personalized individualism. Not merely the political individualism so important in the history of our democracy, but a "me, myself, and I" kind of individualism. "Treat ME, doctor, not just my body or my disease -- treat me, as the person I am!" This social change, in its widespread manifestations perhaps one of the most important of our generation (it cannot be dismissed with perjorative references to a "culture of

narcissim"), has led to the unprecedented expressions of patient autonomy of which we are all aware. The paradox comes from the fact that, at least in these early stages, the desired humanization of the treatment of patients has often been accompanied by a dehumanization of doctors.

Physicians know that it is difficult to be concerned with and focus on the sick person rather than primarily on the disease when that patient seems poised to find fault in the physician's actions. While it may be briefly amusing to find that your patient owns a PDR and is researching each of your prescriptions (as though only the patient was intent on avoiding harm), there is nothing amusing about going through the mail with the not far distant thought about who is going to sue you today. In fact, if patients are persons and are to be treated as persons, then it must be true that doctors are also persons and that the relationship between doctor and patient is vital to both of them. It is simply a fact that machines cannot treat persons AS persons because so much that is necessarily subjective is involved in the care of the sick. The loss to medical care that comes from the dehumanization of physicians is great, but not so great as what physicians themselves lose in the process.

I have always thought that it is unnatural to be a good doctor. Is it not unnatural to expect someone to perform as well at two in the morning as at two in the afternoon? And to take care of people who are often unpleasant to each of the five senses and may be angry, resistant to care or even combative -- to say nothing of the inevitable suffering and loss that attends the care of the sick? But it is because of the

burdens that the rewards come. It used to be said that medicine is an ennobling profession. While, sadly, one does not hear that very much anymore, we still expect high standards of behavior from physicians -- and that is one of the best things about being a doctor. We expect doctors to come through for their patients, almost no matter what that obligation costs in doubt, worry, inner fears, and the weight of personal responsibility -- and that, also, is rewarding. Where those moral demands are lacking, patient care suffers; no one has found a technological substitute for personal committment and responsibility -- nor any other way to make good doctors.

In the light of what I have written, I am disheartened by Kevin McIntyre's article and by the advice that he gives. Patients' rights to refuse treatment and to have their wishes respected in regard to their care I find not only unassailable, but a welcome addition to medical practice. Rather I find painful the implication that in instances of "DOA", irreversible brain damage, or even prolonged resuscitations, resuscitative efforts should be made or continued until, I guess, the patient begins to smell (he is not clear on this point), in order to avoid legal sanctions. At one point he states that it is better "to give the patient the benefit of the doubt, initiate CPR, and deal with the outcome as a second level issue." I thought we had all finally come to realize that medical care was not simply about keeping people alive, that the outcome was the MOST IMPORTANT issue. But in these matters and in his advice to seek the courts' opinion whenever in doubt, instead of the family, trusted friends, or wiser colleagues he expresses the depressing trends of the day. Although his closing paragraphs urge us

to keep our patients' best interests at heart, it would be a rare young physician that was not frightened by his article into resuscitating almost everybody.

Runaway technology intrudes once again. This time it is not the technology of medicine making the trouble, but unrestrained legal technology. In many respects the law serves as a technical substitute for moral concerns. Problems of sentiment, conscience, responsibiltiy, and knowledge of what is right and good shift from the arena of the moral to technical questions of the law. Here, as in other dimensions of life, the technical is a poor substitute for the moral. But lawyers and the law will have to discover what physicians and medicine have already discovered -- one must not do something because it can be done, but because it SHOULD be done. Until lawyers come to that understanding, and until the relationship between doctor and patient again resumes its central place in medical care, advising physicians when to resuscitate will be difficult. "Telling doctors to resuscitate first and think later is bad for patients and bad for doctors. What is good advice to lawyers is good advice to doctors -- resuscitation should be undertaken not because it can be done, but because it SHOULD be done. In that determination the outcome is crucial. The matter is made difficult because some outcomes go beyond the patient. Once again, judgement is necessary.