QUALITY OF LIFE AND THE RIGHT TO LIVE

By Gwee Ah Leng

In the last ten years, there has been a great deal of interest and controversy regarding death, and the recent case of Karen Ann Quinlan in New Jersey of United States has brought the problem into sharp public focus [1]. Actually, the issue in Quinlan's case has only little to do with brain death, and is in fact, an argument on euthanasia. The definition of brain death, according to the court in Karen's case, should be entirely medical. This conclusion by the court reflects a widely-held concept by the public that the doctor is the best person to determine when the event of death has occurred.

Traditionally, death has been regarded as a state that ensued after cessation of heart beat and/or respiration, and the medical profession has hitherto accepted death as occurring after a cessation of heart beat for one minute and/or respiration for five minutes. This in fact, is no epoch-making medical discovery. Death has been for long a recognised phenomenon, and is generally breath-orientated. Thus, we hear of phrases like "taking a last breath", "making a last gasp", "giving up the breath", and "expired". It can be seen that the classic medical concept of death is no more than a restatement of common knowledge. The medical profession can only lay claim to introducing the concept of time limit, for death is regarded as having occurred medically after cessation of the heartbeat for one minute, or stoppage of respiration for five minutes. What has caused the misconception of medical expertise in the judgement of death may have resulted from two situations: firstly, the doctor is summoned to testify to the fact of death in some situations like judicial executions; and secondly, most developed countries require every death to be certified by a doctor before burial. However, the former involves no real specific medical knowledge, as the criteria used, as we have seen are actually derived from popular knowledge. The requirement that a doctor should ascertain the facts reflects more a confidence in the integrity of the profession. In certifying death, the doctor's expertise is in fact directed towards establishing the cause of death rather the fact of death itself, for he is often in fact permitted to accept the fact of the event of death on hearsay alone ("as I have been informed").

In the last two decades, advance in technology has brought about difficulties in the concept of death in two ways. Firstly, the use of cardiac pacing would postpone the stoppage of heartbeat, and similarly the use of respirators could keep breathing going passively. This would mean the event of death can be postponed. The ability to keep many cases going for months and years without hope of recovery or termination becomes such a strain that voices of doubt began to be heard, and even the late Pope of Rome was consulted on the propriety of keeping such cases going. A well-known quote has been that of Arthur Clough's 'Modern Decaloque', one of whose couplets runs:

> 'Thou shalt not kill, but needst thou strive Officiously to keep alive?'

This unfortunately is a misquote of a satire with quite the opposite meaning, but has found its way to the mouths of many of the leaders of the medical fession, showing perhaps that doctors are after all poor readers of literature in spite of their pretensions!

The momentum gathers strength, and as the burden becomes heavier with the collection of brain-damaged children and adults resulting from birth trauma, infections, injury and other causes of serious cerebral anoxia, one begins to hear catch phrases like "the right to die", "doctors have to play God because someone has to do it" [2, 3] and "someone must turn off the respirator, and the doctor is probably the best person to do so". Life ceases to be desirable under certain circumstances, and even a profession like medicine dedicated for centuries to uphold the sanctity of life has begun to talk of the "quality of life" [4]. It has become necessary to establish indications for termination of life regarded to be sub-standard—a qualified euthanasia, in other words. Some paediatricians and obstetricians have openly voiced their opinion about the wisdom of allowing grossly defective babies to be born or maintained alive—e.g. gross hydrocephalus, meningoencephalocele, and severe birth trauma to the nervous system. "Someone has to play God. It may as well be the doctor," they say. Even they, however, admit that decisions have to be arrived at with "agonising soul-searching deliberation". The patient can be alive for a long time, needs care in personal hygiene, nutrition, and general nursing usually within the competence of relatives. His survival however, is nothing more than a sheer burden to his kin and indirectly to society. Should effort be wasted to maintain "human vegetables"? Should precious medical and human resources needed elsewhere be diluted by the need to satisfy such thankless demands? These searching questions boil down to a basic fact; should man have a right to survival or should his survival be qualified by the potential he has?

Hitherto, of course, it has been assumed that life is sacred and desirable per se. This concept in fact has a religious origin, in the West and the East, in Christianity, Buddhism and Islam. With the rise of

GWEE AH LENG, M.D., F.R.C.P.
50, Killiney Road, Singapore 9.

agnosticism, the concept has not died off, and instead has been affirmed as the right of survival of man. The concept is upheld by the medical profession and enshrined as a basis of ethics—the sanctity of life, and the medical profession vows to do no harm to the patients and to hold life sacred.

With the advent of the idea of quality of life, there would naturally be confusion of attitudes, for as long as life is held sacred, to be alive is to be protected against injury. But when the question of quality comes up, one has to attain a certain level of capability before one can be regarded as fit to live. Moreover, the posing of a concept like quality has its inherent difficulty, for unlike life and death, which are absolute, quality is relative, and has to be defined in terms of degree of efficiency or ability before it has a practical meaning. Hence, pertinent questions like "what constitutes the minimum quality to be suited for survival!" and "what degree of impairment of quality must be reached before life is to be judged worthless!" With the increasing number of head injury, war victims, and birth trauma, the number can be considerable. Unless society can see value in making a sacrifice of a fairly large one, one is hard put to argue for the prolongation of life in such a state [5].

There has been the argument that withholding of treatment is different from euthanasia, as no positive steps have been taken to injure. The opinion has been expressed that a doctor is not obliged to prolong life with artificial means [6]. However, all medical treatments in a sense are artificial. The use of insulin and oral anti-diabetics in diabetes, hypotensives in malignant hypertension, steroids and immuno-suppressives in autoimmune diseases, and antibiotics in overwhelming bacterial infections are all artificial means and in this respect resemble the use of respirators or cardiac pacers in the prolongation of life. A doctor would find it equally difficult to withhold any of these at the cost of the patient's life. Perhaps, it can be argued that in those cases where significant recovery is expected, all means artificial or otherwise, should be employed without question, but when useful recovery is in doubt, then prolongation of life becomes a meaningless effort. This would again comes back to the basic question of how much loss of ability should a patient have before he can be declared unworthy of being kept alive, and society must make clear its intent to accept burdens up to a point and no further in clear-cut terms much in the same way as one lays down the rules in the criminal code together with the prescribed penalties, except that in this instance, there is only one sentence—the sentence of death.

Of course, it can be argued with conviction that a society cannot learn to be charitable and humanitarian if it avoids social burdens, and also in looking after such extreme cases of incapability, medical science develops techniques and facilities of life-saving value. Moreover, it is only when medicine is faced with incurables and massive demands that it can be stimulated to solve the unsolvable, often with very startling results. There was a time when epidemics were regarded as divine visitations and therefore unavoidable, and diseases like leprosy and syphilis as sinful fruits and therefore hopeless. If the concept of quality of life had been invoked, they would have remained unavoidable and hopeless.

In conclusion, the advance of medical science has made it possible to sustain life at a very low level of survival potential for a long period. This has induced the medical profession and the society at large to re-examine the question of life and death. Actually the medical profession is neither by training competent nor by the common concept of natural justice, ethically correct to assume the roles of reporter, assessor and executioner. The more satisfactory solution would appear to be one in which society sets guidelines on the minimum acceptable regarding quality of life, the medical profession reporting to an independent non-medical trained judge who receives and assesses the evidence and delivers the sentence of execution to be carried out by an official terminator, who can turn off the tap with a clear conscience.

REFERENCES

1. Newsweek, December 1975.
2. Wolf W. Zuelzer: In Ethical Dilemma in Current Obstetric and Newborn Care, Report of 65th Ross Conference on Pediatric Research. Published by Ross Laboratories, 1973, page 18, 1973.
3. Ibid, Page 19.
4. Fletcher, Ibid, Page 70.
5. Hatwick R. E., Ibid, Page 41.
6. Peckham, Ibid, Page 63.