THE SANCTITY OF SOCIAL LIFE: PHYSICIANS' TREATMENT OF CRITICALLY ILL PATIENTS by Diane Crane (Russell Sage Foundation, 1975, 212 p. hardcover, $12.95)

Diane Crane’s most important contribution to medical ethics will not be the cogency of her ethical reasoning about what physicians, as a matter of fact, are doing in their treatment of seriously ill and dying patients.

Her analysis is based on interview and questionnaire data obtained from over 3,000 physicians, in a variety of specialties. Her major conclusion, based on this data and corroborated by an examination of actual hospital records, is that physicians generally do not base their treatment of critically ill patients on physiological grounds alone, but also on the patient’s capability of interacting with others and of resuming his social role.

The two introductory chapters provide a thoughtful survey of the literature and central issues involved in the care of the critically ill, as well as identifying some of the methodological problems encountered during the research. One of the most prominent of such problems was the “clinical mentality” of physicians which was seen in their resistance to making generalizations about patient care and their preference to consider each case as unique.

Part I discusses the use of case histories in the study, the physician’s use of medical-social factors in decision making, the distinction between acute and chronic illnesses in patient care, and norms concerning resuscitation.

Part II attempts to locate the sources of variation among physicians in their treatment of the critically ill by examining certain organizational, social, and cultural variables. An appendix helpfully includes replicas of the questionnaires and the case studies used in the study.

Other, more specific results of Crane’s research are at least noteworthy, more likely provocative, and certain to fuel the ongoing debate about what physicians ought to do in their treatment of the critically ill. Pediatricians, for example, were found to be significantly influenced by the family’s attitude toward treatment in their decision of whether or not to treat a brain-damaged child. The consent of adults was found to be only one factor in treatment decision making for them. In fact, adults with severe physical damage but with the ability to be maintained for a considerable period of time are likely to be treated even against their own wishes. Thus, in spite of the legal and moral right to refuse treatment, no guarantee exists that patients will be treated according to their wishes. The data further indicates that there is a 20-25% “hard-core” of physicians who will treat all their patients until the matter is taken out of their hands, that is, regardless of the patient’s social potential or their physical/mental condition.

The data also points out that Catholic physicians appear to be characterized by a concern for the preservation of life. Catholics are unlikely to incur high risk to the patient in the use of pain-killing narcotics, yet, surprisingly, they are significantly influenced in their treatment decisions by social class and age, more so than either Jews or Protestants.

Crane’s evidence strongly indicates that it is the sanctity of social life which concerns physicians today rather than the more traditional sanctity of biological life. She has performed an invaluable service by showing that physicians do adopt multiple points of view in making important treatment decisions. The book deserves serious attention from physicians and all those embroiled in the heart of medical ethics debate for this reason alone. Crane offers reliable, well-documented, and understandable factual insight into what physicians do in their treatment of the critically ill. What remains is to figure out if this is what they ought to be doing.

Reviewed by
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The vital issue of survival after death is receiving renewed attention. Due probably in part to the spate of “death and dying” bills appearing in a number of state legislatures and to the recent judicial decisions regarding the conditions for removal of life support systems from a terminally ill patient. Increasingly, the public has become aware of persons who were alleged to have died, or had been a heartbeat away from death, but returned to give an account of their experiences after they had “died.” One of the recently published books on the subject, Life after Life, written by Physician Raymond A. Moody, Jr., considers the evidence contained in the intensive personal interviews he conducted with fifty persons who had had these kinds of experiences. He judiciously refers to these events as “near-death” experiences and offers the cautious conclusion that these “... represent a novel phenomenon for which we may have to devise new modes of explanation and interpretation.”

These experiences not only raise interesting questions about the nature of the dying process but also questions about both the criteria used to determine the cessation of life and the conditions for organ donation. For a fuller analysis of this book, reference is made to Fr. Moraczewski’s review scheduled to appear in the April (1977) issue of SIGN magazine.
From The Editor’s Memo Pad:

Pandora’s Box—1977

Joan Beck, writing in AMERICAN MEDICAL NEWS (November 22, 1976, Page: Impact/4), expresses deep concern about the problems which are about to result from the lifting of the lid by abortion. It is quite certain that inexpensive and highly accurate methods of determining the sex of the unborn child by the eighth week of its existence will soon be available. Furthermore, it is predicted that shortly there will be effective methods for favoring the conception of a child of the desired sex. In the event of failure, abortion would be available to make the correction. Such technological capabilities, combined with a world-wide attitude among parents that prefer a boy-baby to a girl-baby, especially for the first pregnancy, can well result in a continuation of male leadership roles and a male-dominated international society, characterized by violence and wars.

REFLECTION: What can be done to avert the realization of these dire predictions? While a variety of stop-gap measures might be introduced, it seems to me that the public must ultimately be made to realize the consequences of such applied technology and that public opinion make it unpopular and unprofitable to develop technology in such anti-life directions. Such technological capabilities, combined with a world-wide attitude among parents that prefer a boy-baby to a girl-baby, especially for the first pregnancy, can well result in a continuation of male leadership roles and a male-dominated international society, characterized by violence and wars.

and Greek, slave and free, male and female, but all of you are one in Christ Jesus.” (Galatians 3:28). For those persons who think abortion is strictly a private matter between the woman and her physician, it must have become apparent by now that the impact of such action goes far beyond the white sterility of the clinic. On the positive side, as Dr. Herbert Hatner has pointed out, the potential mother may begin to realize that conceiving and bringing forth a human life has a significance which extend in concentric circles from the family hearth to the forums of international diplomacy. When a couple experiences the support of the community in their role as parents, that is, when they see the extended family and the societal community approving their child-bearing as something important for the well-being of society; then they are better able to carry out their parental role. In turn, a husband’s tender, loving support of his wife in the role of mother provides her with the additional encouragement to extend tender, loving care to the child. All this is very important, both for the individual and for society, because the child’s first personal relationship is with the mother, and the experience of that first interpersonal relationship will markedly influence all subsequent relationships. In turn, the quality of these bonds do much to shape the character of the community.

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