Medicine and humanism

*Adolfo Saadia**

The editorials of Walter Gomes/Enio Buffolo and Domingo Braile published in BJCVS 21.4 give a practical and real feeling to such a controversial subject.

My greatest concern is currently concentrated on the development of technological processes at such a dizzy pace. We note that information technology is quickly transforming our concepts. We are not talking of decades or even 5-year periods in order to accept changes. I can say that changes are happening practically permanently. Internet search engines and blogs were unimaginable things for many of us such a short time ago. Not to mention nanotechnology that, when it is applied, will force us to find terms to describe the wonder of its use.

This unstoppable process, of great intellectual richness, but very difficult assimilation due to its profusion and speed, concerns me greatly:

How can we maintain medical humanism and the humanitarian relationship with our patients?

We can see there is confusion in the values that are entangled in the routine practices of health professionals in their day-to-day work. These considerations emerge from the conditions and indications of surgical interventions in our specialty and from the words of Enio, that is, there is a growing necessity to carefully analyze in which way knowledge and technology should be applied to the pathology on which we should act in order to maintain the basic premises of our profession.

It is necessary to avoid the jubilation or the influence of strange factors in our work, which are manual and fundamentally directed to fellow creatures.

I have always insisted in the necessity of developing, in university careers, especially in those related to healthcare, a 'complete' education including philosophy, anthropology and bioethics. This does not signify that we need to return to the classical humanities.

Nowadays, a university professional should not be graduated without this education and a 'specialist' should not be considered a specialist if he ignores the social problems, but he must evolve with a renovating spirit and humanistic feelings.

I believe all these concepts can, today and in the future, balance technoscience with humanism, as is equivocally attempted in some debates.

I am aware that I have distanced myself from specific details regarding the surgical theme, but I believe this is valid.

I changed my ideas when I was listening to Enio during his visit to Buenos Aires.

*** Cardiovascular Surgeon. Titled member of the Argentinean Medical Association and of the Argentinean Surgery Society: Emeritus member of the Argentinean College of Cardiovascular Surgeons (CACCV): Member of the editorial board of the Argentinean Journal of Cardiovascular Surgery and of the Periodic Bulletin of CACCV**

A 97-year-old patient in shock with acute aortic dissection - operate or not?

*Milton A. Meier**

At nightfall on December 31st 2005, Dr. Michael Ellis DeBakey was alone in his house when he felt a strong chest pain. A few minutes later the pain was unbearable, spreading to his neck and after to his back. As a surgeon, Dr. DeBakey immediately diagnosed acute aortic dissection and he knew that he would certainly die within a short time. This would be the best way of alleviating the pain he thought.

Dr. DeBakey preferred to hide the severity of his situation from his family by staying at home rather than going to hospital. Eventually after three days, he agreed to perform computed tomography. The examinations showed an acute type II aortic dissection, using the classification of Dr. DeBakey himself. To general dismay, the patient demanded to return home, where he remained under the care of physicians and nurses. His situation worsened and, still protesting, he went to the Methodist Hospital in Houston, almost a month after the first symptoms. More examinations demonstrated that the dissection had become more extensive. Now there was fluid in the pericardium sack with signs of tamponade. Despite this, he passionately refused surgical treatment repeating: **"I prefer to die".** At the beginning of February, due to worsening of his clinical conditions and loss of lucidity, the medical team decided to operate on him. To them the only contraindication was his age.

Then, several problems appeared. The anesthesiologists of the hospital refused to put the patient under anesthesia due to his age and his precarious physical condition. They argued that never such an elderly person had been submitted to such a large surgery.

Administrators, lawyers and surgeons discussed the situation and convened the Ethics Commission of the hospital which met late at night. The members of the commission wanted to abide by the laws of the State of Texas, which establish that physicians must always respect the wishes of patients and family. The real question was whether to follow the wishes of the patient or not. In the patient's records there was the statement: **"Do not resuscitate"** written with his agreement and with his signature. But now, Dr. DeBakey, who had always been in control of the situation, was unconscious. His wife, children and siblings put much pressure to operate. The anesthesiologists continued unchanging in their decision and refused to participate in the intervention. This situation was hardly resolved by the family, who called another anesthesiologist, who had worked in the group for many years and who accepted the challenge. The Ethics Commission decided in favor and Dr. DeBakey was taken to the surgical center before midnight on February 9th, 2005.

The surgery lasted seven hours. Using a cardiopulmonary bypass and hypothermia, Dr. George Paul Noon, a member of the team of Dr. DeBakey for more than 40 years, replaced the ascending aorta with a Dacron graft which is almost exactly the same as the one that Dr. DeBakey firstly developed in the late 1950s for the this type of surgery.

Dr. DeBakey survived! But, the postoperative period was long and with many complications. He was tracheotomized, needed respiratory assistance and hemodialysis for the first two months, and evolved with several types of infection. During the following two months, he spent most of the time in a coma. There was suspicion of severe neurological injury and quadriplegia. But, in spite of everything, in May, he was surprisingly discharged from hospital to continue treatment at home. Due to acute pulmonary edema he was re-admitted to hospital a few days later. He remained there for four months, undergoing painful treatment. Eventually he went home in reasonable conditions.

Today, Dr. DeBakey can walk, but, most of the time he moves about in a motorized wheel chair. He goes to hospital to work for a few hours some days of the week and said that he is happy with the result of the surgery declaring that, although the surgery was against his wishes, the surgeons proceeded correctly.

The experience of Dr. DeBakey brings to mind several questions. In regards to technical advances, which allowed the dramatic events of the disease to be overcome with the consequent recovery of the patient, we have to admit that there was a great lack of respect for the patient's rights. Nobody could be better informed and in better conditions to refuse surgery than him. And he had expressed his desire not to be submitted to surgery!

To enter in a coma during the final phase of a disease is the normal course of many diseases. Nowadays, there are rules that protect any patient who becomes unable to make decisions and who can become victims of their family's anxiety with the inherent difficulty of making lucid decisions. Frequently, Ethics Commissions of hospitals arrive at decisions more due to pressure from the next of kin than the involved ethics principles.

Dr. DeBakey received the best treatment in the world, staying months in hospital with more than a million dollars spent in order to save his life. Fortunately, there was a happy end. If the patient was not Dr. DeBakey, would he have undergone surgery? Should all patients at the same age with acute aortic dissections and in precarious conditions, be operated?

Should common patients, who reject invasive and expensive procedures, which only prolong the agony, countering the views of family, the state and the church, be listened to? Must we offer them these treatments only because we have the technology?

Of all the principles of ethics in the doctor-patient relationship, autonomy has to be the most important. Autonomy is the basic right that the patient has to choose what he wants for his body, the right to select, among all the possible treatments which are offered to him, what he really thinks is the best for him. Autonomy also signifies that a competent adult patient can legally refuse any type of treatment, even in cases in which this treatment is essential for his survival.

Almost all the great ethics theories converge on the conclusion that the most important thing in the moral life of people is the development of a character that allows inner motivation and strength to decide their life according to their convictions. Science is basically concerned with this distinction: what is true or false and what is good or bad. Thus, even if science is immoral, the scientist can not be. Throughout history, the main forces behind in the development of the Ethics Code have always been from the physicians themselves. It was doctors who always established the scale of values in the practice of medicine. These values not only exist, but are subjectively created and must be applied. With the continuing progress of science and of technology applied to medicine and surgery, new ethical dilemmas will emerge which must be lucidly analysed and decided.

Prof. Livre docente
Ex-president of the SBCCV

SOCIEDADE BRASILEIRA DE CIRURGIA CARDIOVASCULAR

BRAZILIAN SOCIETY OF CARDIOVASCULAR SURGERY

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