Withdrawal of life-sustaining low-burden care

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A 90-year-old diabetic man with unreconstructable peripheral vascular disease, end-stage chronic obstructive pulmonary disease, relentless ischemic rest pain, and severe disability returns to your clinic asking you to deactivate his implanted pacemaker. To do so would likely precipitate his demise, and you ask him if he is aware of this. He tells you that he is and that he has been considering this request since he last saw you 3 months ago. Relief of his chronic pain would require bilateral hip-disarticulating amputations, procedures with a prohibitively high operative mortality rate, particularly with his age and comorbidities. He has been evaluated by a psychiatrist and found to be mentally competent. His treatment by a pain specialist, who used his full armamentarium of high-dose narcotics, electronic devices, nerve blocks, and psychological techniques, has been unsuccessful. You do not reside in Oregon. What is your most ethical course of action? (J Vasc Surg 2005;42:176-7.)

Advances in medical technology often have replaced a “natural death” in the United States with various life-prolonging therapies. The artificial extension of life against disease or injury during the last century was not only approved legally and ethically, but also became mandatory medical practice. Prolonging life was the supreme measure of success. Beginning in the last two decades and still evolving, examination of when to use life-support technologies, when to discontinue them, and who should make those decisions is an essential ethical issue in modern medical practice.

It is well established in both law and the medical ethics of informed consent that a competent adult patient is entitled to accept or refuse a proposed medical therapy. It is similarly well accepted in law and ethics that a competent adult patient has the right to decline continued administration of an ongoing treatment modality. Most often, patients exercise this right by discontinuing their own medications or no longer appearing for scheduled follow-up visits. When patients elect to discontinue treatment without further notifying their physician, the physician has no ethical basis for intruding on the decision. Medical paternalism has been out of favor for at least half a century.

Competent adult patients likewise may refuse intensive treatment that necessitates the close involvement of their physicians. A patient hospitalized in a surgical intensive care unit, intubated and on a ventilator, is entitled to refuse further mechanical ventilator support. The surgeon in such cases is ethically and legally obligated to ensure that the patient understands that imminent death will be the likely consequence of that decision if it is implemented. The patient should also be advised of any pain and discomfort associated with discontinuation of therapy, and the physician should offer help in reducing these undesired side effects. Should the competent adult patient remain committed to withdrawal of care, even life-sustaining care, the physician should promptly order palliation and extubation as requested. Patients also have the right to make and record such decisions in advance directives before they contract terminal or irreversible conditions and can no longer make decisions for themselves. Nevertheless, our patient’s pacemaker is neither the source of his intolerable discomfort, nor a cause of additional pathology, nor in and of itself burdensome for him to endure.1, 2 His pacemaker is physiologically effective in maintaining normal heart function. 3 Should this affect his right to insist that his physician discontinue the treatment?

This patient’s current quality of life is not acceptable to him and cannot be significantly improved by medical treatment. He is miserable continually and is, in the terminology of our psychiatric colleagues, anhedonic: he is no longer able to experience happiness. His pain can be mitigated...
only by sedating him into unconsciousness, eliminating as well his ability to act and interact within his environment. Quality of life is a subjective measure of an individual’s ability to engage in chosen activities and to derive satisfaction from them. The determination of an individual’s quality of life is not an expert judgment; indeed, external observers tend to underestimate quality of life when compared with patient self-evaluations. This patient’s ability to engage in valued activities and emotions has been thoroughly nullified by the severity and persistence of his pain and disability. Although physiologically successful in extending his life, ongoing pacemaker management is qualitatively futile for this patient. Is it ethically defensible, or desirable, to permit a patient to lapse into death by meeting his request to terminate a life-sustaining treatment that causes him no pain, inconvenience, or dangerous side effects because, in his estimation, his chronic disease processes have utterly and irremediably destroyed the quality of his life?

Option B is not an appropriate response to this question, constituting as it does a physician-assisted suicide, which is illegal in all states but Oregon. Violating the law by writing an intentionally lethal prescription constitutes neither principled civil disobedience nor an expression of moral purpose, and no moral authority attaches to it. The State of Oregon limits access to the provisions of its Death With Dignity Act to bona fide residents of the state. Out-of-state referrals cannot call on Oregon physicians to assist them in ending their lives, even when other criteria are met. Option C is therefore not available as a remedy for this patient.

The patient has been psychiatrically evaluated and found to be mentally competent and, as such, is not a legitimate candidate for involuntary commitment to inpatient care and the highly restrictive measures associated with suicide precautions. Clearly these steps will do nothing to answer his complaints of intolerable chronic pain or his progressive physiological disease processes. They would actually say more about your attitude toward patients’ deaths and your morbidity/mortality statistics than about your concern for patients’ suffering and would represent a misuse of the psychiatric commitment process, which in most states requires that a court can order involuntary hospitalization only when a patient is dangerous to himself or others by virtue of mental illness. Despite his very advanced age, the patient has shown no evidence on formal examination, or in his interactions with you, of cognitive or affective deficit. Although his conclusions may be debated and, indeed, are the subject of our debate, this patient has made a rational decision to end his suffering by ending his life. Option D is therefore not an ethically acceptable selection.

Many physicians would elect option E, explaining to the patient that a physician cannot ethically perform a medical procedure that would be harmful to a patient. Modern medicine challenges the concept of natural death. In considering requests for hastened death by terminally ill patients with overwhelming suffering despite excellent palliative care, the End of Life Consensus Panel of the American College of Physicians and the American Society of Internal Medicine concluded, “In legal application, the biggest stumbling block is the physician’s intention: whether it is the relief of suffering (legal) or the active hastening of death (illegal).” It is becoming generally accepted that when a physician extubates a terminally ill patient in irreversible respiratory failure by request, the physician is not introducing a new pathology as a cause of death; that pathology is already present and is then permitted to run its natural course without further intervention. We argue that in deactivating the pacemaker, the surgeon is not introducing a new pathology; the patient’s existing heart disease is being allowed to complete its course. Our patient’s response to the physician who says he cannot consent to a harmful procedure will likely be that the greater harm is done by prolonging his continued pain and suffering, and the lesser, by relieving it. Nevertheless, no turn of logic can escape the fact that deactivating this patient’s pacemaker will very likely result in his death within 48 hours. If a physician’s conscience simply cannot accept that relief of even the most intense and intractable suffering can be ethically purchased at such a price, then an impasse has been reached between the patient’s conception of his needs and best interests and the physician’s. Referral to another physician better prepared to work with this patient should then be considered.

In the tightly circumscribed conditions described, we recommend option A over option E as the most ethically sound course. Because a competent adult patient autonomously requests deactivation of the pacemaker, has made the request after long consideration and a careful judgment about his negative quality of life, and is fully aware of the consequences of doing so, the surgeon’s responsibility to preserve life becomes properly secondary to respect for the patient’s autonomy, concern for the magnitude of his suffering, and empathy for the qualitative futility of continuing to support his life with medical technology.

REFERENCES