"Killing? Or Letting Die? Ethical Issues in Withdrawing/Withholding Lifesaving Treatment, Continuous Terminal Sedation, Physician Assisted Suicide and Euthanasia"

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While instances of resuscitation can be traced back to Biblical times, it was on the battlefields of World War II that resuscitation first became a practical reality, with the development of open-chest cardiac massage. Kouenhoven then took lessons learned on the battlefield and developed closed-chest cardiac massage, reporting in 1960 about increased survivorship of in-hospital cardiac arrest. This and other mid-century medical advancements, such as the development of mechanical ventilation, lead anesthesiologists to question the ethical implications of invasive and resuscitative medical care. In the middle 20th century, the World Congress of Anesthesiologist asked the Pope to address the congress regarding whether patients had a moral right to refuse medical therapy that sustained life, or whether such a decision would constitute suicide, a mortal sin. In a historic address, the Pope affirmed that persons were not required by God to pursue all possible therapies in order to prolong life, and that refusal of life-sustaining treatment was not a form of suicide.

In the context of social upheaval surrounding the Viet Nam War and a dramatic cultural shift in the U.S. celebrating the human desire toward self-actualization of the 1960’s, questioning traditional authority became commonplace. The scope of this social skepticism did not leave the medical profession untouched.

Several U.S. medical cases involving the rights of patients to refuse life-saving therapy made national and international headlines. Two notable cases were that of Karen Ann Quinlan and Nancy Cruzan. Decisions by the New Jersey State Supreme Court and the U.S. Supreme Court, respectively, established that patients have the right to refuse medical therapy founded in constitutional guarantees of privacy and noninterference. They further established that this right extended to all medical care, and not just “extraordinary care.” Federal law established in 1990 that all patients have the right to refuse life-sustaining therapy and that hospitals must not only not inform patients of those rights, but could not discriminate against them for their decisions. These decisions were reaffirmed in the long legal wrangling surrounding the case of Terry Schiavo in 2005.

Withdrawning/Withholding Life-Sustaining Care

Although both legal and ethics experts agree that both withdrawing and withholding life-sustaining treatments from competent patients who express a desire to do so, or from patients for whom surrogate decision makers express a desire to do so is acceptable, there is still both confusion and controversy about these practices. Some of the controversy arises out of a past tradition in medicine that set the saving of life above concepts such as quality of life and patient autonomy. Other conflicts arise because physicians mistakenly believe that both of these practices are ethically the same as “killing” or “euthanasia,” although clinical ethics experts generally agree that they are not. These misconceptions are perpetuated by confusing terms in the medical literature that appear to equate withdrawing/withholding of life-sustaining care as “passive euthanasia.” “Euthanasia” however, is by definition an action, and therefore the term is both inaccurate, and an oxymoron.

Double Effect

The principle of double effect is also misunderstood by physicians and other health care workers, and leads to frequent misunderstandings about ethical boundaries in end of life care. In cases of “double effect”, a physician must be taking an action intended for ‘good’, but for which it is understood that a foreseen, even probable, but
unintended consequence is not ‘good’ (e.g. death). This differs from merely accepting that a rare—and therefore generally unanticipated--reaction to a medication might be death, in that with double effect, death is both a foreseen and predictable outcome. The physician, however, does not have death as a goal, but rather feels that some other goal requires that death be risked, and that in fact the goal may not even be achievable unless death occurs. The classic example is that of a physician seeking to provide tolerable pain relief for a patient who is requiring very high doses of narcotic. In order to provide pain relief, an increase in dose may, or is even likely to, produce fatal respiratory depression. But a lesser dose does not lead to pain relief. The patient and physician accept that the higher dose should be given for the purpose of relieving pain, but is likely to result in death, too. This so-called double effect is ethically (and legally) recognized and acceptable.

Physician-Assisted Suicide and Euthanasia

A majority of Americans support PAS for terminally ill patients, and a small but significant portion supports euthanasia (EU) under similar circumstances. In European countries, public acceptance of PAS and EU appears to be higher across many societies: in Britain, 84% of the public favors PAS and EU. Yet physicians are not formally educated or trained regarding either PAS or EU, and are ill-equipped to meet this extraordinary shift in health care policy and public opinion. Studies demonstrate that physicians from specialties frequently involved in end-of-life decision-making (e.g. intensivists, palliative care specialists, and oncologists) are the most uniformly opposed to PAS and EU, while patients of these specialists are most likely to favor PAS—a critical discordance between patients and their providers.

Failing to understand the underlying causes of patient requests for PAS and EU has lead to false assertions and misdirected policies regarding these practices. Many physicians and legislative groups, for example, contend that the public interest in PAS and EU is based on a fear of inadequate clinical treatment of pain at end-of-life, and that therefore investing substantial financial and educational resources towards developing better pain control at end-of-life will reduce or eliminate the need to consider such measures. Yet studies consistently show that loss of independence, loss of “meaning,” and psychological, rather than physical suffering are the primary driving influences behind the desire for options of PAS and EU. If this is true, concentration of substantial human and financial resources on new pain management strategies is likely to have only a limited potential for addressing these concerns, and a better understanding of factors actually influencing patient decisions will be critical in refocusing policies, funding, and care initiatives to more effective strategies to meet the medical and social needs of patients at end of life.

To date, most studies of attitudes towards PAS and EU as end-of-life options have focused on patients and families whose members are under treatment for catastrophic disease and on the physicians involved in treating those conditions, rather than on the “walking well” population. Nevertheless these studies reveal some interesting findings about what influences a patient’s or physician’s acceptance of these practices.

For both patients and physicians, a primary influence on individual attitudes towards PAS and EU appears to be “religiosity,” a term referring to a measure of a person’s religious belief, dedication and activities (as opposed to their religion, which is the specific set of rituals, stories, symbols and doctrine they use to express their religiosity). The higher the individual scores on a standard “religiosity” scale, the lower their acceptance or desire for PAS or EU. And physicians’ religious attitudes appear to differ significantly from those of their patients, and of the general public. Many authors assert that the drive toward PAS and EU in Western countries is related to a general decline in religious practices, but individual attitudes do not necessarily reflect broader societal choices. And it is the broader society that determines legislation and public policies that affect health care funding and medical practice. In Switzerland, which has the most liberal legislation of all the Western countries regarding assisted suicide, public
surveys indicate that religiosity is surprisingly high, with over 75% of citizens identifying themselves as religious, for example

Depression appears to be prevalent in the terminally ill population, but a connection of depression to requests for PAS and EU has not been clearly established despite many studies attempting to do so. In addition, studies of decision-making capacity of terminally ill patients have generally failed to demonstrate that the presence of depression in this population adversely affects competence in a significant way.

Income and education are known to affect individual attitudes towards PAS and EU, but very little is known about cross-cultural, gender, and ethnicity factors that favor social acceptance of PAS and EU among Western populations and physicians. Recent studies suggest they play a significant role. In addition, nationality and legislative acceptance of PAS and EU may not merely reflect the public view, but may actually enhance or deter individual acceptance of these interventions as end-of-life choices.

Ethical concerns regarding PAS and EU often focus on the risks to vulnerable populations: will elderly, less educated, economically disadvantaged, or minority groups be disproportionately encouraged to seek PAS or EU? PAS is now legal in three of the United States, and in some European countries (Belgium, the Netherlands, Lichtenstein). More than ten years of experience in Oregon appears to show that patients who seek PAS and EU in general are more likely to be white, and of higher socio-economic and educational background than those who do not. This may, of course, be a reflection of which populations have the broadest access to health care in general.

Will physicians use legalized power to be involved in PAS and/or EU to victimize the vulnerable? Surveys have shown that physician participation in PAS and EU is surprisingly common throughout the world, including the United States, even when such activities are illegal: 36% of Australian surgeons report giving drugs to hasten death, 3.7% of U.S. oncologists admit to performing EU, and 10.8% to PAS prior to its legalization, 38% of German physicians admit to performing EU at some time, and 7.4% of surveyed UK physicians reported giving drugs with the intention of hastening death. In none of these countries was either PAS or EU legal at the time of the surveys. A 2005 NEJM study reported that 0.4% of cases involved ending a life without explicit request, a number that was cut in half by legalization and regulation. If anything, some authors suggest that legalization of PAS and EU may provide an opportunity for oversight that reduces abuses, rather than encourages them.

Terminal Sedation

A number of authors have suggested that PAS and EU have become unnecessary solutions to the problem of untreatable suffering, at least in the terminally ill, because physicians have the capacity to essentially render a patient unconscious, or “terminal sedation.” Both the ethics of terminal sedation and the details of the procedure itself (generally using such medications as barbiturates, propofol, and/or benzodiazepines) have been the subject of increasing interest in the palliative medicine literature. In surveys of physician groups in which the acceptance of EU is quite low (approximately 9%), acceptance of the procedure of terminal sedation is very high (≥ 94%), reflecting a general belief that it is morally different than ‘killing.’ Yet at least some ethicists do not agree that a substantial moral difference between the two exists, arguing that premeditated and permanent obliteration of “personhood,” even with a patient’s consent, is not significantly different than permanent premeditated obliteration of personhood by causing biological death—certainly the presence of a beating heart no longer serves as a reliable marker of continued life, if we are to accept brain death as a legal, moral and medical marker of death under other circumstances.
Summary

An increasingly challenging ethical landscape faces physicians involved in end-of-life care, as well as patients, legislators, and the general public. Most anesthesiologists encounter end-of-life ethics and decision-making at some point in their careers: whether as participation in organ transplantation, palliative care specialists, intensivists—or as patients or their family members. Greater knowledge and understanding of the ethical and legal aspects of end-of-life care is important for anyone in clinical medical practice, and for anesthesiologists in particular, as we are increasingly likely to be asked to provide education to our patients and families, or to participate in some activity that ethically challenges the boundaries of life, death, and the concepts of killing and letting die.

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