“Life Sustaining Treatments”
Lecture Transcript
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SLIDE 1 **Life Sustaining Medical Treatments** are medical procedures, medicines or any other type of intervention administered to a patient with the goal of delaying death. These treatments may, but need not, address the underlying pathology. For example, a patient with end stage cancer might be resuscitated but the long term prognosis would not change.

Why would some patients or patients’ family demonstrate a strong desire to ward off death if only for a few hours, days, or weeks? The answer is that death is a permanent and irreversible loss. It should never be taken lightly. Therefore, medicine rightly has a presumed bias toward preserving life. Still, all lives end and at the end of life the ethical question must be asked “How can we decide when we should keep treating and when to help someone die more peacefully?”

SLIDE 2 **Life Sustaining Medical Treatments**

It is common to speak of life as being “sacred.” Even people with no religious inclination understand that life is something that cannot be taken for granted. After all, death is irreversible. This means that decisions about the end of life deserve the utmost care. This is why in most cases the default decision is to preserve life.

In addition, most people admire “fighters” and we hate to “give up.” Some people may feel that their religion teaches them to have faith, even in the face of death. In such cases, giving up on life can be seen as lack of faith.

SLIDE 3 **Life is a great good, but it is not an ultimate good.**

One thing we know for sure, everyone dies. Asking questions about life sustaining treatments is really a way of asking what it means to be human. If being human is more than having a pumping heart and working lungs, then we must look beyond keeping the patient’s organs functioning as the goal of medicine.

Illness, suffering and death are part of life. Knowing that we, as humans, will come to our own end shapes the entire arc of our lives. We understand that at some point we must depart and that not only impacts the future but also the present. We are finite beings and to accept death as part of what it means to be a finite being is to grasp the wonder of life itself.

Whatever the final decision, the decision should be made with empathy, as well as with reason and professionalism.

SLIDE 4 **Natural life is not best measured by duration.**

Though there is a presumed *prima facie* bias toward preserving life, there is no absolute duty to prolong a life through medical interventions. When it comes to making decisions about life sustaining
medical treatment, medical ethicists also ask questions about human dignity, relational potential, and quality of life.

Death itself is natural and even basic acts of care, including respiration, nutrition and even hydration can be withdrawn as a means of reducing suffering when their only purpose is to delay the dying process.

The gift of life must be seen in relationship to other goods such as justice, faith and love. Helping patients, families, and friends come to grip with the fragility and the fleetingness of life is a challenge for healthcare professionals in the midst of life and death decisions.

SLIDE 5 Dignity and personhood

In their book Health Care Ethics, Garrett, Baillie and Garrett assert that “the individual person is the central value in terms of whose dignity all consequences are to be judges.” In other words, we have moral duties to individuals because they are persons who have dignity. What does this mean?

Garrett, Baillie and Garret do not define dignity but rather describe it as the special status afforded to persons in the traditions of our society. Certainly dignity is associated with human freedom and autonomy. But, if dignity were based solely on freedom and autonomy then it would be unclear what dignity would mean for infants, those with mental illness and those with traumatic brain injuries.

Christian teaching ascribes this dignity to the fact that all persons are created in the likeness of God. If this is correct then every person has an inherent and inalienable dignity regardless of age, cognitive ability, or any other physical or social condition.

Theologically, the moral principal on non-maleficence is also a way of preserving human dignity. “Because we are made in God’s image, the human person has a great dignity that cannot be attacked, degraded, or harmed, be it at the very beginning or at the very end of life.”[1] Human dignity does not diminish even as human minds and bodies diminish because human dignity is an external dignity, coming from God and not from the individual

Others ascribe dignity to the fact that humans, a social beings and part of humanity are more than the individual sum of their parts. Disregarding the dignity of one person is in fact a diminution of the dignity of all humans.

To paraphrase the poet John Donne:

No one is an island,
Entire of themselves,
Every person is a piece of the continent,
A part of the main.
If a clod be washed away by the sea,
Europe is the less.
Any person’s death diminishes me,
Because I am involved in humanity.

If, as Joseph Fletcher says, we are shaped by the concept of the inherent dignity of every member of the human family, no matter what his or her predicament, then we have a duty to care for defenseless persons as if the basis of our own dignity were at stake.[2]

SLIDE 6 **Life Sustaining treatments should only be used when they are medically indicated.**

Decisions concerning when to treat and when not to treat can be difficult. Treatments that prolong the dying process but do not address underlying medical factors are especially difficult. These include but are not limited to: resuscitation, assisted respiration, intubation, nutrition & hydration.

For example, a patient with end stage cancer might choose to tell the doctor that they do not wish resuscitation or intubation if their condition worsens even if these procedures could extend their lives. The principle here would be non-maleficence. Neither resuscitation nor intubation would address the basic pathology of cancer but would only extend the dying process, thereby increasing suffering.

SLIDE 7 **Standards of treatment and decision making**

Because they have autonomy, patients with capacity have final say over the decision to treat or not treat, even when family and the medical teams disagree with the choice. There are four basic standards that are commonly considered when making decisions to begin or end life-sustaining treatments, when the patient does not have decision making capacity. These considerations include: medical indications, best interest, relational potential and benefits and burdens.

Medical indications focus on the physical condition of the patient. Does the treatment address the underlying pathology? Is the patient healthy enough to undergo treatment?

Best Interest focuses on the quality of life after treatment. This standard takes into consideration the values of the patient. Will the patient’s future life be made better by the treatment or will that life become unbearable by the patient’s standards. If the patient’s standards are not known will the resulting quality of life be acceptable to most reasonable people?

It is common for people to state that their highest value is the relationships they have with family and friends. Relational potential focuses on the patient’s ability to have continued “meaningful relationships” during or after treatment, even if those relationships are minimal. Without such relationships, life losses its appeal.

Benefits and burdens compares the pain and suffering that treatment imposes on the patient and compares it to the benefits that the patient will receive from the treatment. Benefits and burdens also considers the riskiness of the treatment and the likelihood that it will be successful. Does treatment provide more benefits than the burdens that it imposes on the patient?

SLIDE 8 **Medical futility**
Patient’s often indicate, directly, through their advanced directives, or through a health care agent that in the case of severe illness their wish is to “have everything done.” For example, a patient at the end of life may be unable to swallow and hand feeding results in the patient inhaling small particles of food or drops of liquid into the lungs causing respiratory distress. The family requests that the patient be given a feeding tube.

After careful assessment, the care team concludes that while intubation may extend the patient’s life for a few days it would not change the goal of treatment and it is also likely to extend suffering. The conclusion is that intubation would serve only to prolong the dying process and therefore is not medically indicated.

SLIDE 9 Medical futility

The idea of medical futility is an attempt to add clarity over decisions to treat or to forego treatment. While in theory the idea of medical futility could be applied to any intervention, it is usually reserved for end of life situations.

There is no consensus about futility within the medical community, the question of when and how aggressively to treat a dying patient is one of the most common problems faced in healthcare ethics. Some general agreement has arisen.

First, interventions should only be based on medical indications. The right to “have everything done” does not mean that the patient has a right to treatments that have been shown ineffective and are potentially harmful.

Second, the assessment that an intervention is futile does not mean that other treatments will be futile. Futility refers to specific interventions and not to the patient’s condition.

This means that each intervention must be assessed independently. For example, the patient in in respiratory distress because he is aspirating food may not be a candidate for intubation but may still receive penicillin to relieve distress from pneumonia.

Even when assessment finds that particular interventions are futile, patients should continue to receive appropriate medical care.

SLIDE 10 Medical futility

The purpose of medicine is helping the sick. Health care providers do not have a moral duty to offer treatments that do not help. Futile interventions may in fact cause suffering by giving patients and their families a false sense of hope or by increasing or prolonging their pain and discomfort in the final days and weeks of life;

While futility is largely determined by probability, it is grounded in the principle of non-maleficence, the desire to avoid interventions that create suffering without a reasonable chance of benefiting the patient.