Withdrawal of Life-Sustaining Treatment vs. Physician-Assisted Death: Is There a Moral Ambiguity?

Withdrawal of life-sustaining treatment continues to pose an ethical as well as medical challenge to critical care practitioners. Despite numerous consensus statements and published guidelines, there appears to be significant variability in the manner by which withdrawal of life-sustaining treatment is performed. Lack of education and training in both the conceptual and technical aspects of withdrawal of therapy have created situations whereby aggressive medical intervention has led to persistent patient suffering and prolonged death. In addition terminology often clouds physician and patient perspective by alluding to withdrawal as voluntary passive euthanasia. The decision-making process that leads up to the withdrawal of life-sustaining treatment must focus ultimately on the goals of either the patient or the family. Benefits and burdens of persistent treatment must be reviewed and both routine and complex monitoring and therapeutic interventions must be addressed. Unnecessary interventions such as frequent laboratory testing, hourly vital sign monitoring and aggressive pulmonary hygiene (e.g., frequent suctioning and/or percussive therapy) should be avoided. Alleviating pain and suffering must be mainstays of therapy, however, suffering must be assessed in the context of a patient's and family's religious and spiritual needs. Nonphysical suffering may have important religious or spiritual meaning to both the individual patient and family. A goal-oriented approach to withdrawal of life-sustaining treatment outweighs perceptions regarding cost or invasiveness of therapy, or a physician's concerns regarding the need to maintain therapy in the setting of iatrogenic complications.

The pharmacologic approach to patient comfort and relief of suffering centers on the judicious use of analgesic and anxiolytic therapies. Opioids are often considered a mainstay of therapy to control pain. Although morphine is the most commonly administered opioid, narcotic therapy should be tailored to both the patient's physical needs as well as to the side effects of the individual agents. Benzodiazepines appear to be the most frequently administered anxiolytic agents; however, continuous infusions of propofol may be warranted for short-term therapy, and haloperidol can be used to treat those patients who suffer from delirium. All agents should be titrated to achieve their therapeutic effect with the intent to relieve suffering. The ethically acceptable principle of the double effect applies when such therapies lead to profound respiratory or circulatory depression, resulting in either respiratory or cardiac arrest. Provided that the intent is to ease suffering, death would be considered an acceptable outcome. Studies have shown that those patients who receive either benzodiazepines or opioids as part of withdrawal of life-sustaining therapy do not have their death hastened.

Nonpharmacologic approaches to pain and suffering also need to be considered not only for the purposes of withdrawal of life-sustaining treatments, but also for all patients who are in ICUs. Patients should be situated in private rooms where noise and light are reduced. Appropriate times and duration for family visitation should be addressed with environment allowing for the use of music, prayer or other ritualistic ceremonies that may be invaluable to patients and their families at the end of life.

Despite the fact that withdrawal and withholding of life support have been determined to be ethically indistinguishable, many published surveys continue to show reluctance of critical care practitioners to withdraw life-sustaining interventions, especially if they were instituted for iatrogenic complications or were part of long-standing care. Specialists tend to be most comfortable withdrawing support within their field of expertise. In this regard, anesthesiologists
and pulmonologists are more comfortable withdrawing mechanical ventilation whereas nephrologists are more comfortable withdrawing dialysis. Nonetheless, 15% of critical care physicians report that they rarely withdraw mechanical ventilator support, citing a moral difference between non-initiation of therapy and withdrawal of support as the basis for this decision. There appears to be a debate within the ethical and critical care literature regarding terminal weaning vs. terminal extubation as it applies to withdrawal of mechanical ventilation. Proponents of terminal weaning have indicated that extubation leads to a perception of "killing" the patient and does not allow for the possibility of successful weaning. Supporting such statements are data suggesting that up to 11% of "terminal weaned" patients may survive to hospital discharge. Proponents of terminal extubation cite that terminal weaning prolongs the dying process and limits intimacy by maintaining an artificial barrier, i.e., the endotracheal tube, between patient and family. It would appear, however, that both processes may be employed in an expeditious and timely fashion, thus securing patient comfort and avoiding misconception. Terminal weaning should not take place over days, but rather, with consideration given to patient comfort, be performed within a matter of hours. The use of opioids or sedatives at each stage of weaning can be introduced so that the patient will be comfortable with no excessive work of breathing, before extubation. The use of nondepolarizing muscle relaxants has no purpose and violates the intent of terminal care, as these agents paralyze the patient and offer no analgesic and anxiolytic properties. Patients who receive nondepolarizing muscle relaxants to facilitate mechanical ventilation should have these agents discontinued so that patient awareness may be assessed before terminal weaning. In the event that patients have prolonged paralysis secondary to long-standing use of these agents, withdrawal of life support should not be delayed, but rather larger doses of opioids and sedatives should be administered to assure patient comfort. Questions of patient awareness will always be of main concern under these circumstances and will continue to pose a challenge to the critical care practitioner. In this situation terminal weaning may be more appropriate than terminal extubation. It should be emphasized that nowhere is it more important to provide continuity of care than during withdrawal of life-sustaining treatment. Nurse and physicians should constantly be available to offer answers to questions that the patient's family may have during this difficult moment, as well as to provide necessary adjustments in therapy. Attending physicians should be responsible for the physical act of removing endotracheal tubes or other life-support systems such as intra-aortic balloon pumps, which may lead to rapid patient demise. It is inappropriate to ask respiratory therapists, nurses, resident physicians, or medical students to perform such interventions, given the emotional and ethical complexity of these tasks. Finally, it is inevitable that discussions regarding withdrawal of unwanted or burdensome therapies lead to questions of what can be done for patients who have no external devices to discontinue, but rather desire to end their lives with the assistance of physician prescribed or administered medication. Are there moral differences between the two? If we accept brain death then should we accept the concept of brain life? In this regard when the body, like the ventilator, becomes a burden, is there not justification for its “withdrawal” when all other palliative care options have been exhausted? These are the questions that must be posed and addressed as we continue to care for patients at the end-of-life.
References


