

# Editorials

## Withholding and Withdrawing Life-sustaining Therapy

### Ethical Considerations

The American Thoracic Society is to be commended for producing so detailed a policy statement on the difficult and agonizing decisions associated with non-treatment and cessation of treatment decisions. One is struck by the explanatory text even more than by the specific principles and directives. Its thoroughness is solid evidence that the issues have been grappled with rather than glossed over, and its argumentation clearly locates those directives in the mainstreams of contemporary American legal and bio-ethical reasoning.

All the same, there are several points in the Statement that seem to be not fully explored. The following comments are offered in the spirit of furthering the discussion of these difficult matters, not as criticisms.

Perhaps the most troublesome passage in the Statement occurs in Section I.

Physicians and other health care providers have a responsibility to respect patient autonomy by withholding or withdrawing any life-sustaining therapy as requested by an informed and capable patient. In this regard, there is no ethical difference between withholding and withdrawing. Helping a patient forgo life support under these circumstances is regarded as distinct from participating in assisted suicide or active euthanasia, neither of which is supported by this statement. However, if carrying out such a request would violate the personal moral code of a physician or other health care provider, that individual generally has the right not to participate in the process. If this occurs, others should be made available to carry out the patient's request. (1)

I should like to comment on five elements of this paragraph as containing notions that physicians may be expected to find ethically troubling.

First, I note that the responsibility to withhold or withdraw life-sustaining therapy on the request of an informed

and capable patient may not be one that rests easily with physicians. (Howard Brody's remarkable dialogue between a traditionalist physician and a medical student [2] comes to mind here.) The notion that an informed and capable patient would even contemplate declining life-sustaining therapy may strain credulity, particularly in the instance when the therapy is not medically futile and the patient has a good chance of recovery with it. Medicine's traditional conception of its practitioners' responsibilities includes preservation of life and promotion of healing, with the caution of not harming the patient through those pursuits. The view that "primum, non offedere" trumps "primum, non nocere" still strikes many physicians as a dismaying development.

The ATS Policy Statement identifies the new responsibility as rooted in a duty to respect patient autonomy. An alternative and more palatable grounding might seek to connect a duty to withdraw life-sustaining therapy with a subjective notion of harm. A conception of the patient as identifier of harms, burdens of treatment that become sufficiently onerous that the patient is no longer willing to shoulder them for the benefits they bring, would be more congruent with the traditional medical ethics. Whereas patient autonomy can seem to have as its corollary physician subservience (a view that Robert Veatch has dubbed "the engineering model" of patient/physician relations [3]), the patient-as-harm-monitor locates both patient and physician within the traditional values of medicine and recognizes a proper role for the patient in countering the increased potential for harm that accompanies the power of modern medical technology. Such a rationale, however, would only partly capture the scope of the ATS injunction, for presumably a patient who has not experienced a life-sustaining therapy will be in no position to judge its burden and thus to opt not to undergo that therapy.

Second, the ATS Statement proceeds

to assert, "In this regard, there is no ethical difference between withholding and withdrawing." Physicians and nurses have long found the distinction between withholding and withdrawing a powerful one, and it is a distinction that has long been recognized in the law. Extra effort, then, is needed to unpack the significant qualifier, "In this regard. . . ."

We must be clear that all other factors in cases of supposedly ethically identical withholding and withdrawing are parallel: the patient's wishes regarding the therapy must be the same; the provider's motives must be the same; the outcomes must be the same. The implication of the ATS Statement is that a decision or action to withhold and a decision or action to withdraw life-sustaining medical treatment thus are morally impermissible when either results in the informed and capable patient's death when that result is not accepted by the patient. Still, we might assign differing degrees of culpability, holding that withholding in such a situation is a form of negligence but that withdrawing is a form of homicide. Too, situations may differ in respect of the certainty of outcomes. The Karen Ann Quinlan case involved a patient whom most believed would die if removed from a respirator. Perhaps at one time in her history this was so. But, sufficient neurologic function was recovered so that, after the painful battles had been fought in the courts successfully by her parents, withdrawing the "life-sustaining" treatment only showed that it wasn't at that time life-sustaining after all.

Third, one is struck by the absence in the ATS Statement of a requirement paralleling that of the American Medical Association's 1973 statement:

The cessation of the employment of extraordinary means to prolong the life of the body *when there is irrefutable evidence that biological death is imminent* is the decision of the patient and/or his immediate family (4). (Italics denote my emphasis.)

The ATS Statement does not limit the occasions that physicians may omit or cease life-sustaining therapy at patients' or families' behests to those when such treatment is medically futile, or when biological death is clearly imminent. Such a decision is thus one step removed from medical judgment, and this gap again implicitly asserts the primacy of patient's wishes over physician's judgment. A patient or patient's family who are informed and capable may, nonetheless, seek to block treatment in circumstances when there is significant chance of improvement. Under the ATS Statement, physicians confronted with such wishes may only opt out, and then only if a more willing replacement can be found. I shall return to this point again below.

The absence of a requirement of medical futility or imminent death also renders troublesome a fourth element in the ATS Statement. "Helping a patient forgo life-support under these circumstances is regarded as distinct from participating in assisted suicide or active euthanasia, neither of which is supported by this statement" (1). The circumstances are only "the request of an informed and capable patient." There is no additional requirement of medical futility, imminent death, or evidence of excessive burden other than the patient's wishes to forgo

life support. Moreover, there is no determination to be made of the patient's motives. Although the Statement does not endorse the use by the patient of the option to forgo life-sustaining treatment in order to commit suicide, it endorses no effective guard against it. Furthermore, inasmuch as it enjoins physicians to "help a patient forgo life-support" by providing drugs in quantities sufficient to relieve suffering, even if they hasten death, the Statement has no safeguard against a patient's use of the physician to assist in what, from the point of view of the patient's intent, is suicide.

Finally, the suggestion of an implicit engineering model of patient and physician relations recurs in the Statement for the physician who finds that carrying out the request of a patient to forgo life support violates a personal moral code. For, "if this occurs, others should be made available to carry out the patient's request." The physician, it would seem, is to be either the direct or indirect instrument of the patient's will, obligated to participate in the process of assisting the patient to forgo life-sustaining treatment or to find others who will do so.

As I write this essay, the top book on the *New York Times* list of best-selling nonfiction is Derek Humphrey's *Final Exit*. It advocates the view that physicians

should move now to the role of assisting their dying patients to commit suicide. Clearly the book has struck a responsive chord in the public. The success in avoiding prosecution by doctors who have assisted their patients' suicides and discussed those actions publicly (such as Jack Kevorkian and Timothy Dutton) will continue to add to the expectation of the public that physician's proper role sometimes involves hastening death. The ATS Statement, wittingly or not, has been influenced by the social forces that are redefining the traditional values of medicine and the relationship of physicians to their patients.

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#### References

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3. Veatch RM. Models for ethical medicine in a revolutionary age. *Hastings Center Report* 1972; 2:5-8.
4. House of Delegates, American Medical Association. Statement adopted December 4, 1973.