

Ethics and Life-Sustaining Interventions

The ethics goals in the area of life-sustaining interventions in general but also specifically in cardiac interventions (cardiovascular implanted electronic devices CIEDs such as pace makers, and left ventricular assist devices LVAD); pulmonary interventions (mechanical ventilation for both acute and chronic and degenerative conditions); and renal disease (dialysis) are as follows:

- Relieve suffering
- Respect the experience of living and support the process of the dying process
- Promote well-being
- Respect persons
- Respect dignity
- Respect relationships
- Respect difference
- Promote equity
- Preserve professional ethical integrity
- Use organizational systems to support good care and ethical practice
(Berlinger, Jennings, and Wolf- *The Hastings Center Guidelines for Decisions of Life-Sustaining Treatment*. P.12)

These goals are simply an expansion of the basic biomedical principles with which you are already familiar:

- Respect for autonomy
- Beneficence
- Social/distributive justice
- Norms of the medical profession
 - Non-maleficence/fidelity/integrity

Patient centered care establishes a priority on the patient experience and expectation in dialogue with the healthcare practitioner. The practitioner's interest is on the patient's identity within her or his illness, fragility, and mortality. Patient centered care is a process that respects personal autonomy and sovereignty. When a patient (or surrogate) is treated by a practitioner's beneficence, the active promotion of the patient's well-being and authentic informed consent (or informed refusal) will result. Informed consent promotes well-being because fully informed patients and surrogates are in the best position to make treatment decisions that are likely to promote their interests. True informed consent is not a thing, it is not a signed form: it is a process of conversation over time.

When a patient or surrogate is considering a life-sustaining intervention such as dialysis etc. there are several steps that the practitioner must take. These steps are taken within a conversation with the patient/surrogate's autobiography. This is to say that the patient/surrogate is not just an organ system or a person with a pathologic and problematic organ but is a person in relationship with others; one with life goals and values; and a person with spiritual or religious sensitivities. Therefore these steps must take place within the patient/surrogate narrative of the self. The steps are as follows:

- Review and discuss any prior advance planning or any treatment goals that been expressed prior to the proposed interventions
- Make sure that the goals of any intervention is clear and that the patient/surrogate understands the diagnosis and prognosis
- Explore with the patient/surrogate the possibility of time-limited trial of the intervention with an option to either continue or discontinue the intervention.
- **Informed consent and informed refusal (including the discontinuation of interventions) are morally and legally equal.**
- Explain how comfort or palliative measures will be taken to encourage the comfort and minimize symptoms throughout the intervention and in the case of withdrawal of the intervention
- Document the conversation with the patient/surrogate which may require the updating of previous care plans and advance directives and medical orders

Of course things do not always go smoothly. Conflicts and misunderstanding can always mitigate the process. Remember that in medical practice when this process becomes difficult it is usually because of a conflict between one or more of the basic principles of medical ethics. For instance, a request for an intervention may from a medical standpoint have no real chance of providing the goal of care as expressed by the patient. In fact, it may cause harm to the patient. In this case we would understand this as a conflict between the respect for patient autonomy and physician beneficence or perhaps non-maleficence. Another example might be a person on dialysis wanting a kidney transplant but medically for a variety of reasons is not a candidate. Here might be a conflict between patient autonomy and social/distributive justice (patients selected for transplant are in part selected on the basis of likelihood of positive outcome in the face of a demand greater than the supply).

In cases of conflict the wise practitioner understands that allowing communication to unfold through active listening more often than not achieves positive results. With time, compassion, patience and understanding people can come to their own wise counsel. When conflicts seem intractable inviting others into the conversation might be helpful. Family clergy, other family members as well as medical colleagues and perhaps an ethics consultation can often help things along.

Brian H. Childs, Ph.D.