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The Conundrum of the End of Life Issues in the Intensive Care Unit

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Because of our increasing technical capabilities in general and in intensive care medicine, in particular, patients may survive under ICU care even when there is no likelihood of any meaningful recovery and herein it props up issues related to end of life care. In the past, many patients would have died despite attempts to save them. Currently, patients are maintained on artificial life support until the physician or a family member realizes that there is no hope for a meaningful recovery, envisaging the withdrawal of life support.

Death is considered a blessed release or a merciful, welcome end when it comes to the very old or to those suffering from a painful and terminal illness. Those who nurture such a thought regard death as acceptable only if it comes unbidden of its own accord. However, if death is encouraged to appear, although merciful is its appearance, those who have provided the inducements or issued the commands may be considered as having conducted a criminal offence or at least a moral wrong.

Nevertheless, if we decidedly come to the conclusion that death is a benefit, then how can those who confer it fail to be benefactors? And if they are benefactors and no one suffers, how can it be morally wrong?

After the death of Julius Caesar, Shakespeare's conspirators chanted slogans of happiness that they have done Caesar a mighty service as appears in the tragedy:

Why, he that cuts off 20 years of life,
Cuts off so many years of fearing death
Grant that, and then is death a benefit,
So are we Caesar's friends, that have abridged
His time of fearing death (1).

Let us cast an eye on Caesar's own attitude to the prospect of his death:

Cowards die many times before their death,
The valiant never taste of death but once
Of all the wonder that I yet have heard
It seems to me most strange that men should fear,
Seeing that death, a necessary end,
Will come when it will (1).

Caesar's conspirators aired this argument that Caesar's assassination was, in fact, a benefit to others and to Rome itself, enforcing the idea that there indeed were moral reasons for the assassination of Caesar.

Terminating a person's life would seem to be justified in the following circumstances:

Where he is a threat to somebody else's life,
Where he himself wants to terminate his life; die;
Where he would be better off not alive,
And where his death would secure a value
Sufficient to outweigh the moral cost of securing it.

Apparently, letting such people who want to die, for whom death is the best prospect and who cannot terminate their lives is not only the right moral choice but also a caring and humane thing to do.

Among the different types of euthanasia, involuntary euthanasia where a decision is implemented against the express wishes of the individual will always be wrong and non-defendable.

Non-voluntary euthanasia where a decision is implemented without the consent of the individual concerned will undoubtedly be wrong unless it is conceived that the individual would prefer to die but under the duress of circumstances, his consent cannot be obtained.

Voluntary euthanasia tantamounts to suicide and since it violates God's law, it seems ill-advised and as such would be morally wrong. If a person, however, has ceased to value life and prefers death to an existence that does not matter, then perhaps he is not morally wrong to bring an end to his life and likewise, anyone who assists him in this act is also not morally wrong.

Selective treatment where patients neither are given food nor are infections treated is according to all practical purposes of euthanasia and similarly, the case of patients who are declined to offer resuscitation as per hospital's euthanasia program is another form of euthanasia not universally acknowledged as such.

Again, when potent analgesics are administered to terminally ill patients, which hasten death, it is non-voluntary euthanasia.

It is a sad irony that we mostly dwell and concentrate on the tip of the iceberg represented by voluntary euthanasia and totally neglect the much larger and more sinister, covert euthanasia widely seen and practiced in the area of health care.

Care of critically ill patients necessarily involves an acknowledgment that some patients will die despite best medical treatment. Many studies reveal that most of the deaths in ICUs today are preceded by a decision to withhold or withdraw some form of therapy. Thus, willy-nilly, we are somehow or the other facilitating deaths in the ICUs. Some questions naturally crop up, and we may put a few of them as under:

1. Morally speaking, is letting die as bad as killing?

2. If under the duress of circumstances we omit something, then should we be accountable for those omissions?

3. Does it involve any breach of duty or obligation if we do not resuscitate a terminally ill patient on the verge of death or fail to treat infections with antibiotics?

Such decisions will eventually lead to death. Thus, non-actions do entail responsibility. These fall under the category of selective non-treatment in which the medical staff has to preside over the slow and lingering demise of their patient.

If it had been the patient's desire to live, then it seems difficult to justify the withholding of an effective treatment in achieving a meaningful therapeutic target. How can we accept that positive steps to end life are forbidden but negative or passive ones permitted and widely practiced under the notion that they do not violate the norms and values of human dignity?

Again, withdrawal of a therapy does not appeal to common sense and seems annoying because it tantamounts to an attempt to kill the patient but withholding appears to be more acceptable because the treatment has not been started and depending upon the whims of the physician can easily be withheld. Again, the application of such controversial strategies such as withholding depends on the agreement and consent of the surrogate or defecto surrogate who is charged with executing the patient's wishes should he or she becomes incompetent.

According to Islamic doctrine, an individual's moment of death is foreordained: His birth and his death are already recorded- that is, who will be born and how he is to die. Clearly, euthanasia constitutes interference with divinity. Nevertheless, perhaps withholding or withdrawing is not an act of any intrusion but rather an act of non-interference with God's will. It is not clear and certain as to whether prolonging death, or maintaining life artificially without any hope of recovery tantamounts to truly following God's will or instructions, or is against God's will. 'Pain and suffering are part and parcel of the reduction of sin' in Islamic thought. To terminate suffering would interfere with the expiation of sin. Since Islamic thought is against euthanasia, and Penal Codes in Islamic states declare it as a crime, I reckon that such states do not currently have clear-cut legal or ethical guidelines related to end of life care. Nevertheless, euthanasia is an act of providing a good and peaceful death to the terminally ill patient, and for all practical purposes, it is not linked to avoiding or stopping therapy. It is also being held that the ICU is not an environment where euthanasia takes place. On the contrary, euthanasia is planned well beforehand in a very different environment.

In France, 53% of the ICU deaths were preceded by a decision to withdraw or withhold life support therapies (2). In Canada, surveys disclosed that 87% of the public favored the family as a decision-maker for an incompetent patient and 84% supported the right to withdraw life support from a comatose patient (3). Futility and benefit suggest that patient consent to the withholding or withdrawing treatment might be ethically required from the patients themselves or their proxies (4). Despite published guidelines that address the withholding or withdrawal of life support, dealing with such issues is often difficult and tantalizing for health care providers, patients, family members, and surrogates.

Despite the significant advance, we cannot stop death but can only prolong a futile life in the futile hope and utopian dream of rendering services to the patient and the family. Non-voluntary euthanasia hangs like a Democele's sword round our necks and continues to remain a bone of contention between people of different ideologies, cultures, beliefs, backgrounds, and social upbringings. At present, we cannot provide a clear-cut answer to the innumerable questions raised against non-voluntary euthanasia.

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