

## Review

# Pro/con clinical debate: Life support should have a special status among therapies, and patients or their families should have a right to insist on this treatment even if it will not improve outcome

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## Abstract

Most hospitals are facing the dilemma caused by demand for critical care beds outstripping supply. This imbalance is likely to get worse over the coming years as a result of many factors, including aging of the population, improved technology, and improved therapies, among other factors. As a result we are likely to have to make further tough decisions about rationing of this service. In this issue of *Critical Care*, two authors debate the appropriateness of providing life support in accordance with a family's wishes to an individual who is unlikely to survive admission to the intensive care unit. Understanding both sides of this debate is an important aspect of an intensivist's job.

**Keywords** critical care, end of life, futility, mechanical ventilation, treatment decisions

## The scenario

You are called to the medical ward to see a patient who has worsening respiratory status and may require mechanical ventilation. When you arrive you are informed that, based on many factors, including age, pre-existing quality of life, and negligible chances of 'meaningful' recovery, many members of the medical team feel that admission to the intensive care unit (ICU) would not be appropriate for this patient.

Unfortunately, there are no advanced directives from the

patient, and the patient is unable to participate in decision making. On full review you also believe that the patient would not survive ICU admission, and although mechanical ventilation may prolong life it would not correct the underlying illness. You discuss everything with the patient's family and they request ICU admission. You are uncertain about the ethics of providing life support such as mechanical ventilation when you feel that there is no chance of recovery.

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## Pro: Yes, under the current rules, life support must be given regardless of prognosis

David Crippen

The key statement in the scenario under consideration is that '... although mechanical ventilation may prolong life it would not correct the underlying illness'. There is no question that critical care can maintain 'life' almost indefinitely, and this fact is well known to the public [1]. Health care consumers are granted broad powers of choice in health care options. If they choose to

equate stable vital signs with sapient life, then physicians are not empowered to question the whys and wherefores thereof [2]. The chances of recovery are matters of opinion that are steeped in emotion and media manipulation. The entire world loves the unexpected survivor, especially after long lines of experts previously have forecasted inevitable demise.

Accordingly, the urban legend of the 'long shot survivor' figures into our definitions of futility. The current working definition of medical futility is a treatment plan that does not achieve its desired objective [3]. Physicians are not required to drill holes in crania to relieve headaches, even if demanded, because it does not work. However, the addition of 'life support' to divert a death spiral is technically effective in maintaining 'life', as defined by stable vital signs. As far as they go, these treatments 'effectively' support open-ended hope goals even in the face of convincing evidence to the contrary. As long as 'life' is supported, anything is possible. If the patient is dead, nothing is possible.

So, we take the potential for unexpected recovery into account in our definitions of 'futility'. Surrogates feel that these systems can prolong vital signs during the search for a miracle long shot cure [4]. We are obliged to provide them

because they are not 'futile' by the strict definition, and if a treatment is not futile by the strict definition then it is ethically and even legally mandated if patient or surrogate desires it [5]. The only way to change this mandate is to change the definition of futility. Instead of an inability to maintain vital signs, futility must be expanded to include irreversible multiple organ system failure. Until that occurs, it does not matter how providers define futility. The law will mandate providers to accede to the desires of surrogates, and if surrogates continue to equate maintenance of vital signs with 'life' then we must continue to support those vital signs as long as our high technology care plan is effective in doing so.

Like it or not, quality of 'life' does not enter into it. Like it or not, under the current law we must maintain this patient in the ICU for as long as the family desires it.

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## Con: No, life support: it really isn't THAT special!

Laura Hawryluck

Life support is aptly named. Fundamentally, such technologies are tools – albeit potent ones – that provide support only. The concept of life support is somewhat overblown because it never cures; it merely permits modulation of disease course so that other interventions (e.g. antibiotics) have time to affect an actual cure. It is clear that, at a certain point, for survival the body must have the capacity to heal. In this respect, although it may be associated with a higher level of acuity, intensity, emotions, and even drama, life support at its core is no different from other medical interventions and is clearly not worthy of 'special status'.

Such cold truths are seldom acknowledged and rarely understood by patients and families. The myth that intensive care medicine has incredible powers and has 'special status' permeates the language used to discuss these interventions. It is commonplace to pose questions such as 'Do you want us to do everything?' and 'Would you want to go on life support?' without any further explanation of what exactly is involved, what can and cannot be achieved, what the burdens may be, what the likelihood of achieving the goals is, what the impact on quality of life may be, and what the alternative treatment options are. Failure to provide such basic information has led to important decisions regarding life support being the least informed decisions in health care, and precludes any notion of informed consent. Moreover, rates of success [6–8] are grossly inflated whereas the discomforts are rarely portrayed.

Autonomy has led to the effacement of health care providers in decision making, and to a prevailing sense that patients and families have the only say and can receive almost any

intervention that they insist upon. However, health care providers still have an ethical and legal obligation to help patients and families place all decisions in context and to recommend a treatment plan [9,10]. Glorifying life support as a 'special' intervention would appear to render any discussions less than honest and may help health care providers to evade communication regarding death and dying.

Larger dilemmas remain. In today's world of globalization we seek to express respect for different cultural and religious beliefs. Some believe that all possible efforts should be made to preserve life, and hence we see life support continued when it is clear that survival is impossible and serious questions about quality of life arise. How do we manifest respect for such beliefs? How is this different from saying my personal beliefs are that I want everything done to save me at any cost? Are such beliefs less worthy of respect because I do not belong to an identified religious or cultural group? Am I compelled to join such groups to be heard and respected? How vague an expression of my beliefs and values is too vague? Furthermore, faced with increasingly scarce and expensive resources, how do we balance the rights of such individuals against those of the larger collective? Certainly the idea of life support having 'special' status makes any resolution more difficult for all involved, both emotionally and psychologically.

It is only by accepting and explaining that life-sustaining interventions are not 'special' that we can begin to discuss in an intelligent manner these important questions among ourselves as health care professionals and with society in general. The answers to these questions will help guide us into the next century.

## Pro response: Until we change the rules, we must abide by them

David Crippen

Patients and surrogates are allowed to demand life support without giving any justification as long as that care is effective in sustaining vital signs. Quality of life is not clearly defined ethically or legally. Most surrogates listen to reason but they do not have to. If they choose to invoke it, the current case

law is on their side, rendering end of life support issues very special indeed. Dr Hawryluck dwells on what they 'should' do. What they 'can' do is be in charge of clinical ICU care. This fact has significant practical implications for the delivery of critical care.

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## Con response: Weighing in on quality – the role, the obligation, the voice?

Laura Hawryluck

If substitute decision makers get anything they want, without regard for quality of life, then we deny the value of years of training and the carefully acquired skills to make treatment recommendations, and relegate physicians to 'option presenters'. People should be asked to look no further than the

internet and be expected to make decisions on the information they obtain, even if bizarre or downright mistaken. If we do not strongly advocate consideration of quality of life in life support decisions, then how can we say that we even begin to fulfil our obligations as professionals to 'First do no harm'?

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