MEDICAL FUTILITY AND PHYSICIAN-ASSISTED DEATH*

Chinese University of Hong Kong, Centre for Bioethics
2023 Seminar on Euthanasia
February 8, 2023

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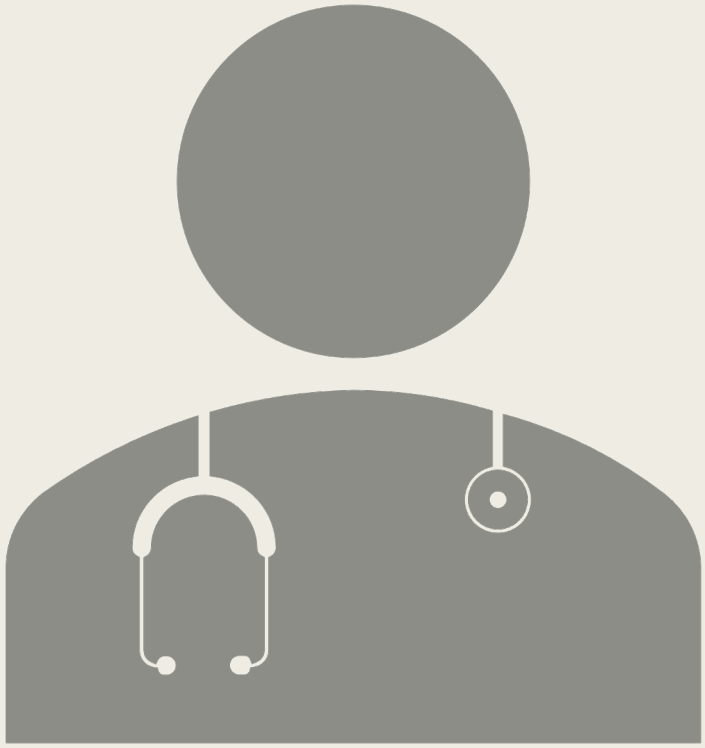
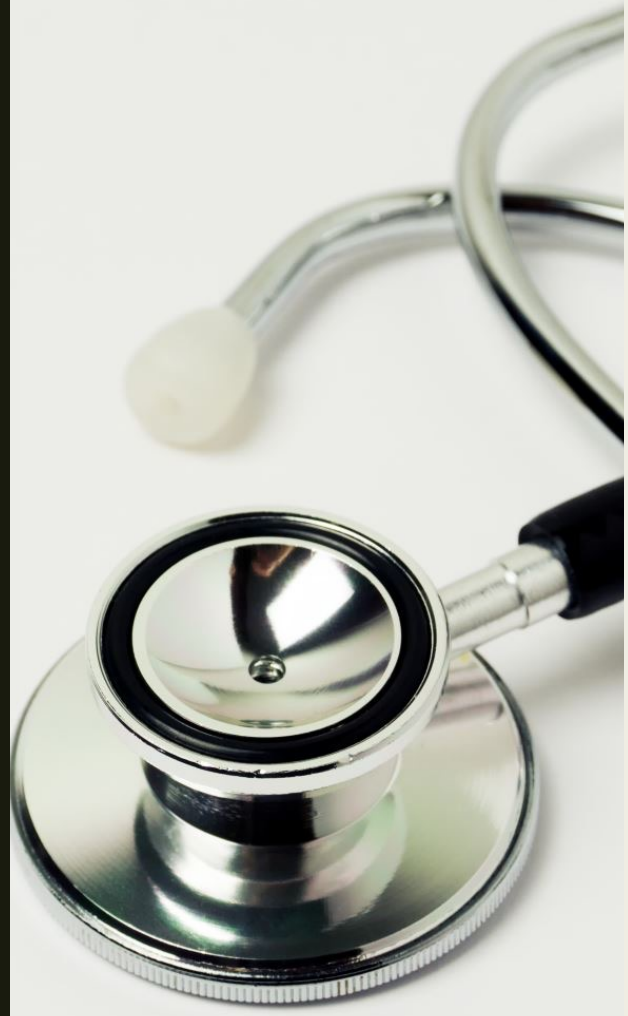
*Jecker NS, 2023, Medical Futility and Physician-Assisted Death, in Cholbi M, Varelius J, eds., *New Directions in the Ethics of Assisted Suicide and Euthanasia, 2nd edition*, Springer.

Ethics question

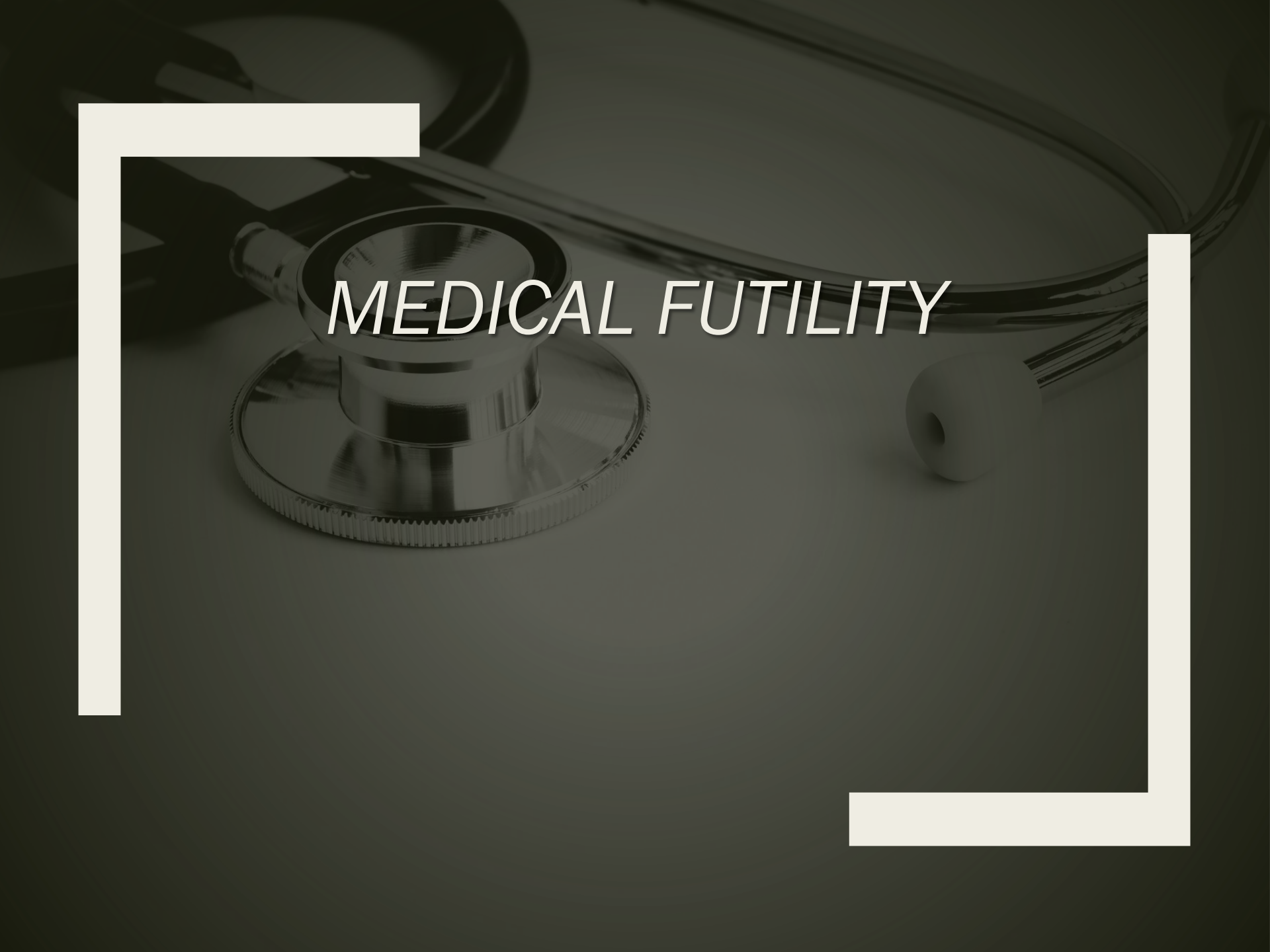
If life-sustaining treatment is *futile,* and a dying patient requests help dying, is it permissible for the physician to provide it?





Limited scope of cases

- Patient is imminently dying
- And makes a voluntary, informed request for assisted death
- Lifesaving interventions are futile



MEDICAL FUTILITY

Futile interventions do not:

- Prevent disease & injury
- Relieve pain & suffering
- Care for or cure people who are ill
- Prevent premature death
- Help patients die peacefully

Effect v. Benefit

- Interventions may produce effects without medical benefits
- Medicine’s goal is benefitting patients

MEDICAL FUTILITY

QUANTITATIVE

QUALITATIVE

- *QUANTITATIVE FUTILITY*

The *likelihood* that a medical intervention will achieve its desired end falls well below a threshold considered minimal

Reasonableness, Evidence

- Example CPR for patients when the chances of survival are no better than 1 in 100
- Reasonableness: If you need to treat 100 patients to benefit 1, is that reasonable?
- Evidence: Is there evidence of a statistically significant improvement in outcome?

QUALITATIVE FUTILITY

The *quality* of outcome associated with an intervention falls well below a threshold considered minimal

Paradigm cases

- Continuing to provide mechanical ventilation or nutrition and hydration for a patient in a permanent vegetative state
- An intervention associated with overwhelming suffering for a predictably brief period
- A patient who will never leave the intensive care unit

MEDICAL FUTILITY & ASSISTED DEATH

Doctor-patient relationship

- Do special features of the doctor-patient relationship give rise to special duties to help a patient die?

Ancient medicine

Professional honesty required withdrawing treatment when medicine had nothing to offer

Yet forbids physician-assisted death

I will do no harm or injustice… Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course (Hippocratic Oath)

Modern medicine

Today, more patients die in hospitals where physicians manage the dying process

In Hong Kong, >90% of deaths occur in the hospital, even though 30% of patient report preferring home deaths*

**Yeung, 2020, Expectation of the place of care and place of death of terminal cancer patients in Hong Kong, Ann Palliative Med 9(6)*

Medicine has made it harder to die...

When a person's heart stops beating, they can be resuscitated; when someone's lungs stop respiring, they can be ventilated; when an individual's kidneys cease functioning, they can be dialyzed

While these interventions can extend life in positive ways, they also can make a patient miserable

One reason for holding physicians responsible for assisted dying then is that in many instances, physicians bear significant responsibility for a patient's predicament

For example, in cancer care…

When oncologists extend the lives of cancer patients with chemotherapy, radiation, surgery, CPR, ventilators, & other means, they contribute to patients' subsequent condition

in the sense that absent these treatments, patients would probably have died sooner & been spared much misery

Although physicians do not cause a patient's cancer, they repeatedly furnish medical treatments that extend the lives of cancer patients

Argument based on the physician's role

Physicians may play a significant role in extending patients' lives to a point where qualify of life is poor

Medical options may be inadequate to ensure a good death & patients may ask for help dying

Under these conditions, physicians should (or may) hasten death

Argument based on the physician's relationship

Physicians are often by a patient's side throughout the course of illness

This can create a bond --patients know, trust, rely on & expect their physician to be there

Under these conditions, physicians should (or may) hasten death if a patient's requests it

Limitations

Patients have an ongoing illness, not an acute event or injury

Patient-physician relationships are positive & patients want them to continue

The arguments do not apply to every case, but they apply to many

Objections

Hastening death was not physicians' role historically

Although physicians have a duty to help, they do not have a duty to help in a particular way

Dying is already overly medicalized and we should allow

Agreement exists about omitting LST patients refuse

Disagreement exists about acting to hasten death on request

Acting v. Omitting

Argument based on moral equivalence

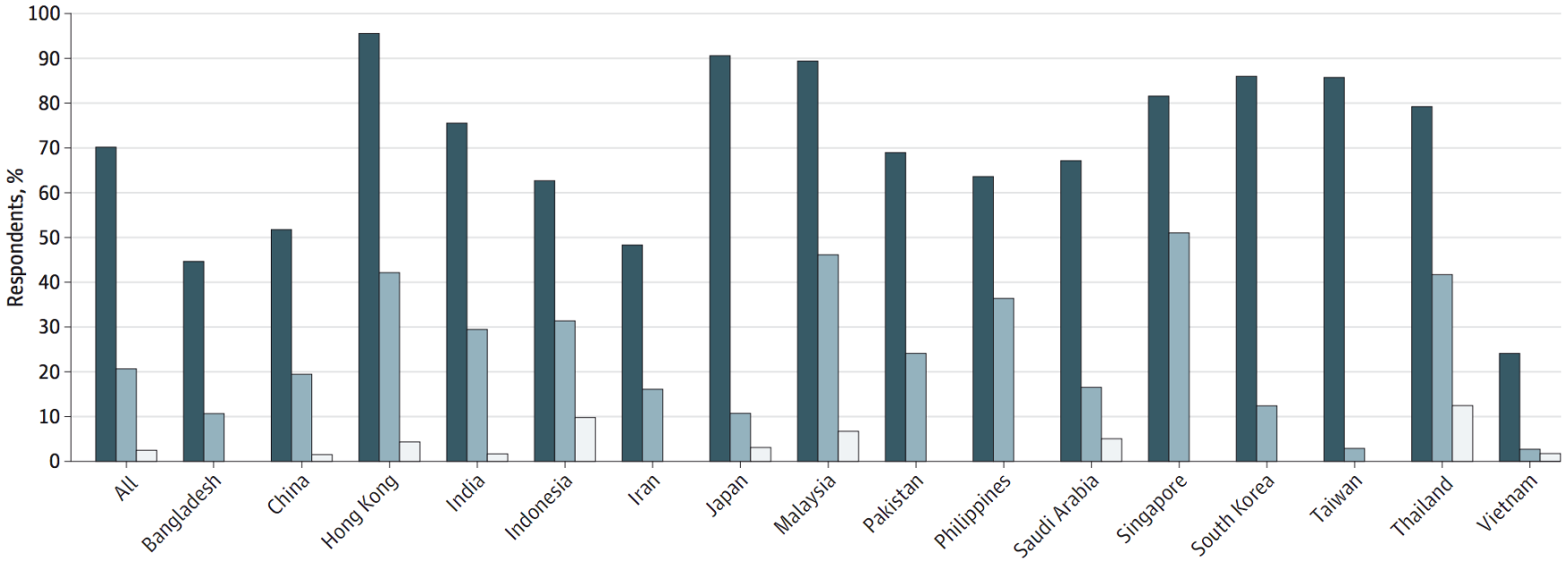
Acting and omitting are morally equivalent whenever the goal & consequences are similar

At the end of life, the goal & effect of stopping LST are like the goal & effect of hastening death

Under these conditions, if stopping LST is allowed, hastening death should be

Limitations: *Does moral equivalence apply outside the West?*

% who "almost always" or "often" withheld, withdrew, or acted to hasten death



Dark Blue: Withheld
Light Blue: Withdrew
White: Hastened Death

Phua et al, 2015, JAMA Intern Med

Dignified lives

After futile interventions are stopped, symptoms associated with end stage disease can cause a profound loss of dignity

Characteristics	2021 (N=238)		2020 (N=259)		1998–2019 (N=1,662)		Total (N=2,159)	
End-of-life concerns[6]								
Losing autonomy	222	(93.3)	241	(93.1)	1,499	(90.2)	1,962	(90.9)
Less able to engage in activities making life enjoyable	219	(92.0)	244	(94.2)	1,484	(89.3)	1,947	(90.2)
Loss of dignity[7]	162	(68.1)	188	(72.6)	1,132	(73.8)	1,482	(73.0)
Burden on family, friends/caregivers	129	(54.2)	139	(53.7)	775	(46.6)	1,043	(48.3)
Losing control of bodily functions	112	(47.1)	101	(39.0)	730	(43.9)	943	(43.7)
Inadequate pain control, or concern about it	64	(26.9)	87	(33.6)	443	(26.7)	594	(27.5)
Financial implications of treatment	20	(8.4)	17	(6.6)	71	(4.3)	108	(5.0)

Oregon Death with Dignity Act, 2021 Data Summary

A tipping point

- Reduced capabilities for thinking
- Moving independently
- Interacting with family

A tipping point is often reach when serious illness leads to permanently capability loss in areas that matter most to a patient

Argument based on dignified lives

Respecting dignity requires supporting patients' threshold human capacities

Serious illness can interfere with patients' threshold capacities and undermine dignity

Respecting dignity requires offering alternatives, including hastening death

A right to die may reduce efforts to help people with serious illness live better

A right to die may leads to a perception that there is a duty to die, esp. among marginalized groups

Objections

Argument	*Values*
Physicians' role	Responsibility for a situation a physician helped create
Doctor/Patient relationship	Duties within a fiduciary relationship
Moral equivalence	Omitting lifesaving interventions & acting to end life are morally equivalent
Patient dignity	A 'tipping point' when patients lose central capabilities that matter most to them

Physician-Assisted Death

Medical futility & assisted death

- Occur together
- Overlap conceptually
- Link to dignity

Take-Aways

People who take on the role of doctoring have a duty to withhold/withdraw medically futile life-sustaining treatment

They may also be permitted to hasten death if patients request this

These duties relate directly to medicine's goal of benefitting patients

ありがとうございました

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