The Moral Permissibility of Discontinuing Life-Support

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Abstract:

In this paper I will discuss the morality of life supporting measures. I argue that once an individual is either permanently unconscious or is in persistent vegetative state that it is morally permissible to cease life supporting measures. Throughout this paper I define persistent vegetative state and utilize this definition as one of my claims for why I argue ceasing life supporting measures is morally permissible. I also include real life cases, such as the highly publicized end-of-life case involving Terry Schaivo, that showcases some of the implications of my claims.
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Many people would agree that once you are a “vegetable” there is nothing to life and no real reason to live. With that said, if you are in that state, you are not actually living and you have become just a biological remnant of yourself and not an actual version of ‘you.’ However, due to the technological advances in our world, medical institutions are capable of artificially prolonging someone’s life for an extensive amount of time. By enabling someone to continue to breathe or to continue to have a heartbeat artificially while being bed bound is no way to live. I argue that once an individual has become permanently unconscious or is determined to be in persistent vegetative state that it is morally permissible to cease life supporting measures. I will argue this stance on the ideas that by not ceasing life supporting measures we are prolonging an extremely low quality of life and furthering a patient’s suffering, that there is an inherent right to die which must always be granted and lastly I further argue that the patient’s assigned power of attorney should stop the life supporting treatment. The patient's assigned power of attorney would be aware of the patient’s end of life wishes and would be qualified to make decisions for the patient as he or she would be unable to do so for themselves. Living by the means of machines is no way to live. Especially when many would agree that passing peacefully is better than suffering in a vegetative state where one is bed bound and completely incapacitated.
Furthermore, living in such a state when one is entirely dependent on others for care and daily functions is not living.

Before I present my argument, it is essential to know the definitions of terms that I will be using throughout the content of my paper. First, persistent vegetative state is defined as “when a person is able to be awake, but is totally unaware” (1, Arenella). A person in a vegetative state is also unable to think, reason, and relate meaningfully with his or her environment, and unable to recognize the presence of loved ones or feel emotions or discomfort. The higher levels of the brain are no longer functional. “A vegetative state is called “persistent” if it lasts for more than four weeks” (1, Arenella). Similar to someone in a coma, someone in PVS is bed or chair-bound, is totally dependent for all care needs, cannot eat or drink, cannot speak, and is incontinent of urine and bowels. Someone who shows all those characteristics of persistent vegetative state would be considered incapacitated, which is defined as being deprived of ability and strength to complete functional tasks. Many people today have end of life plans in the event that they are unable to participate in the decision making process due to he or she becoming permanently unconscious or in a PVS. In such cases the patients have their end-of-life wishes expressed in legal documents called living wills or advanced directives. “A living will or advanced directive can apply to life longing procedures; such as, any medical treatment or intervention, including artificially provided sustenance or hydration, which sustains, restores, or supplants a vital organ. Often also included in a living will is an assigned durable power of attorney. “A durable power of attorney is defined as a person an individual would designate as an agent to make all decisions about their health care if they are unable to do so” (6, Haman). However, sometimes a living will does not already exist, which normally occurs in the case of a traumatic event. In a case where
there is no living will or advanced directive available a surrogate decision maker would be assigned based on a system of hierarchy. A surrogate decision maker is someone who makes decisions for the patient because he or she is aware of the patient’s wishes and is close to the patient. Another concept that I will discuss in this paper is the sanctity of life. The concept of sanctity of life is to say that life is sacred. A sanctity of life proponent would believe that lives have sanctity regardless of the degree or kind of suffering, deterioration, dependency, or development they manifest, and regardless of the imminence of death, the burden on others, and the wishes of the subject to live or die (5, Gillett).

ARGUMENTS

I argue that a person who is permanently unconscious or in a persistent vegetative state is not living a life worth living. The comfort and dignity of a person is greatly reduced to the point where there may not even be any sense of comfort or dignity at all. Imagine being in a persistent vegetative state. That would mean you are unable to do anything for yourself and you have to rely on others for all of your daily functions. I argue that being in such a condition is extremely degrading to the affected individual. This argument is a common sense argument. I refuse to think that being bed ridden is any form of having a life. Although you may have life biologically, there is no other life present. In almost all cases in which someone is defined as being in persistent vegetative state they can’t feed themselves or even perform bodily functions on their own.

Unless the patient demonstrates evidence of self or environmental awareness on a reproducible or sustained basis and demonstrates the following simple commands, gestural or verbal yes or no responses, intelligible verbalization, purposeful behavior including movements
or affective behaviors that occur in contingent relation to relevant environmental stimuli and are not just due to reflexive activity then the individual is permanently unconscious or in PVS (4,Giacino).

Furthermore, being defined by conditions of PVS is sufficient enough to sustain the idea that the particular individual is not actually living a fruitful life, but is just alive in the biological sense. Another important concept I want to implore to support my argument is the principle of proportionality. The principle of proportionality is when in cases of intervention and support that sustains life artificially, the intervention causes more burdens then benefits for the patient. If intervening is harder on the patient and causes more suffering than support then it’s only logical to cease the support so the patient can just remain in a peaceful natural state. With that said, considering the principle of proportionality, it is not worth continuing life supporting measures.

A person’s ‘right to die’ is honored by “granting permission for certain persons to aid others in dying” (7,Parks). In relationship to my argument, satisfying one’s ‘right to die’ would be to accept and perform the necessary tasks to satisfy the patient’s wishes that are either expressed through a living will or through the assigned power of attorney. “The ‘right to die’ has become the slogan of those who insist on their right to refuse life saving treatment” (3,Campbell). As mentioned earlier, patients who are still “capable of making decisions exercise the right to die by creating living wills in hopes of exempting themselves from cruel or pointless treatment that they do not wish to receive” (3,Campbell). And in regards to those who are not capable in making such impactful decisions there would be the assigned power of attorney to do so. A prominent ethical debate that exists regarding a patient’s right to die is deciding whether the right to die is universal or does the right only apply to certain
circumstances. For the purpose of my argument, I will focus on the idea that the right to die applies to certain circumstances and I will refrain from regarding the right to life as something universal because that idea brings forth other issues that do not relate to my paper. Such as the legality of suicide and euthanasia. I argue for circumstances when the right to die should undoubtedly be recognized and that is when a patient is in persistent vegetative state or is deemed permanently unconscious. A patient’s right to die is associated with the idea that one’s body and one’s life is one’s own and is to be disposed as one seems fit. So given that every human is granted the right to die, it is morally permissible to cease life supporting measures for an individual in order to recognize his or her ‘right to die.’

Whether there is a living will or not, the declared power of attorney has the best interest of the incapacitated individual who in that state, is unable to make their own decisions. A power of attorney is either identified in an individual’s living will or if there is no written living will then the power of attorney is assigned based on a hierarchical system. The hierarchy system goes in order of first, legal guardian, then the individual given power of attorney for healthcare decisions (if there is one in place), spouse, adult of a child patient, parents of patient, and lastly the adult siblings of the patient. People closest to the patient are expected have their best interest in mind and therefore are deemed able and willing to make the decision for the patient to cease life supporting measures. Therefore, I argue that it is morally permissible to allow the decision to be placed in the hands of the assigned power of attorney.

OBJECTIONS

To address the opposing side to my argument, which would be that it is not morally permissible to cease life supporting measures for a patient in PVS or who is permanently
unconscious, I present the sanctity of life objection. Sanctity of life is the principle of implied protection regarding aspects of sentient life. Which are said to be sacred or otherwise of such value that those aspects are not to be violated. Proponents of sanctity believe that life is of absolute value and no other value is absolute (8, Suber). A life having sanctity means that no other value ever supersedes the value of biological life. To the sanctity of life proponent, lives have sanctity regardless of the degree or kind of suffering, deterioration, dependency, or development they manifest, and regardless of the imminence of death, the burden on others, and the wishes of the subject to live or die. With that said sanctity proponents would object to my thesis that it is morally permissible to cease life supporting measures because they believe life has sanctity over all else.

Through research conducted a response to the sanctity of life objection is that the idea of human life having sanctity has recently been pressured from new technological and demographic developments. Technologically, we are now able to produce images of soft tissue increases which means we will be able to determine with a high degree of certainty that some living and breathing human beings (in PVS or permanently unconscious) have suffered such severe brain damage that they will never regain consciousness. So “in these cases, with the hope of recovery gone, families and loved ones will usually understand that even if the human organism is still alive, the person they loved has ceased to exist” (8,Singer). Hence, the decision to cease life supporting measures would be deemed morally permissible by the decision maker because it would be a decision to end the life of a human body, not of a person. Socially, there is now the existence of the concept, the ‘gospel of life’ (3,Campbell). The ‘gospel of life’ regards death as something that should neither be hastened or unduly delayed so that we should aim for a ‘natural
death’ in so far as that is possible in our medically technologically advanced world. Research conducted discovered that those who believe in the gospel of life characterize one’s life as a narrative, and that we tell our own stories between birth and death. Further stating that it is a basic feature of the life of any person that he or she should live out his or her own story and that it is just not futile to keep an irreversibly comatose body alive in PVS. But rather, doing so is a certain kind of violence (or disrespects the sanctity of) toward the subject as a self-determining human being, who deserves to live our their story comfortably and with dignity. Remaining unconscious or in PVS while being sustained by life support is no way to do such.

Another objection to my thesis is that the fate of someone’s life should not be placed on one person’s decision making. Does the assigned power of attorney really have the best interest of the individual? “A landmark case illustrates when there are problems with the power of attorney, the case of Terri Schaivo. Theresa Marie Schiavo was in a persistent vegetative state for 15 years before her artificial hydration and nutrition was stopped and she proceeded to pass. A dispute between her husband and her parents produced what is arguably the most important end-of-life cases. I have included a summary of the case:

Terri Schiavo entered a vegetative state in 1990 for undetermined reasons, possibly related to her long-term, untreated bulimia. In this persistent vegetative state she remained the last fifteen years of her life. Both Schiavo's doctors and her court-appointed doctors expressed the opinion that there existed no hope of rehabilitation. Her husband, Michael Schiavo, contended that it was his wife's wish that she not be kept alive through unnatural, mechanical means. More than twenty times the Schiavo case was heard in Florida courts. On all occasions the court ruled that the Terri's fate was under her husband's control, respecting the sanctity of
marriage. Schiavo's parents, Bob and Mary Schindler, refused to accept this verdict, feeling that their daughter would somehow recover. Of this struggle, Schiavo's attorney George Felos told the US District Court, "The real grievance is not they [the Schindlers] did not have a day in court, that they did not have due process. The real grievance is they disagree with the result.

In 2003, a court-appointed guardian for Schiavo wrote that during the protracted legal struggle, her parents had "voiced the disturbing belief that they would keep Theresa alive at any and all costs", even if that required amputation of her limbs. "As part of the hypothetical presented", the guardian's report stated, "Schindler family members stated that even if Theresa had told them of her intention to have artificial nutrition withdrawn, they would not do it." Politicians inserted themselves into the fray. The case was the catalyst for Florida's controversial "Terri's Law", which gave Gov. Jeb Bush the authority to have Schiavo's feeding tube re-inserted when a court ruled that her husband could have it removed. The U.S. Congress quickly passed legislation allowing federal courts to intervene, and President George W. Bush flew back to Washington to sign the bill into law. Schiavo's feeding tube was finally removed on March 18, 2005, and she passed away 13 days later. In a final postscript to Schiavo's life, the autopsy conducted after her death established that her brain weighed half that of a healthy human brain -- severe damage that left her blind and incapable of thought or emotion. Quoting the medical examiner: "This damage was irreversible. No amount of therapy or treatment would have regenerated the massive loss of neurons.

In the case of Terri Schiavo is can be argued that neither her parents nor her husband had her best interest in mind when making the decisions regarding her end of life care. This case is further complicated because Terri Schiavo did not have a living will at the time of her cardiac
arrest which is why her husband was granted power of attorney. But did he really have her best interest? That is a common objection to my argument because not always is there someone with the best interest of the patient there to make selfless decisions for the patient.

Although an objection to my argument is that the assigned power of attorney may not have the best interest of the patient, there have been cases when the assigned power of attorney does fulfill the wishes of the patient. Patients who are on their death bed after being deemed to be in PVS or permanently unconscious and have either had their wishes granted because of what was stated in their living will or what their power of attorney allows regarding the desired end-of-life procedures. The assigned power of attorney expresses the patient’s wishes of potentially stopping life supporting measures and should feel that they morally ought to do so. The assigned power of attorney also does not allow for any influence or intervention for others, which would effect the outcome of the decisions made. In cases where the decision is made to stop life support, families and loved ones find doing so essential for allowing the patient to die peacefully and they are able to accept the passing of their loved one. In the case of a living will, if ceasing life support at the point of unconsciousness or being in PVS is stated in the will then by law the patients wishes are to be granted. In cases such as these, my argument is upheld because the power of attorney has the best interest of the patient in mind and will only allow for the patient’s wishes to be expressed while allowing no intervention or influence from others.

CONCLUSION

When someone is unconscious or in a vegetative state, shows no signs of improving, is incapacitated and entirely dependent on others, I argue it is no way to live. That, to me, is only living biologically, nothing else. Being in such a state strips one of their dignity and pride. I
argue that it is morally permissible to cease life supporting measures in the case when the individual is permanently unconscious or in persistent vegetative state. It is morally permissible to do so because individuals in either of those states are not living a life of quality.

CONTRIBUTION

As I began my research on this topic I found it easy to argue my position based off a common sense argument. The common sense argument being that no one wants to artificially live as a vegetable and would rather die naturally than having his or her life artificially prolonged. I argue that living in those two states is no way to live and a patient’s right to die must be satisfied. Furthermore, if the patient has stated in their will that they wish to not be artificially sustained then their right to die must be recognized. Although, many do agree with my argument, there are strong objections to it. One that I was unfamiliar with prior to research is the sanctity of life objection. I was unaware of that concept and was quickly intrigued by it. With that being said, I was glad I was able to utilize the concept in my paper and share it with others.

Overall, my goal for this paper was to help others understand why it would be morally permissible to cease life support measures for a permanently unconscious individual and that the decision to do so should not be regarded as killing or ending someone’s life prematurely. I would also suggest further research on this topic. Such as the psychology behind the decision making. For example, the emotional or psychological aspects the either the close family members of the patient or the power of attorney experience. Another suggestion for further research would be to look into the financial burden life support measures place on the families of the patient, as hospital stays and medical support is expensive. In conclusion, I hope my contribution of this
paper changes the thought process of some and changes the stigma on the action of ‘pulling the plug’ and to believe that doing so is morally permissible.
Works Cited


5) Haman, Edward, 2004


