The Principle of Proportionality: Foregoing / Withdrawing Life Support

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Introduction

Thirst and hunger are basic physiological conditions that trigger on the search for food and fluids. Both sensations are mediated cortically; therefore, they cannot be present in patients in a permanent vegetative state (PVS).[1] Similarly, PVS patients may react to painful and other noxious stimuli but do not *feel* pain in the sense of conscious discomfort.[2] Furthermore, PVS patients lack gag and swallowing reflexes; therefore, they cannot be fed by mouth.[3]

Discussion

In order to provide sustenance or life-support, patients in such situations are given total parenteral nutrition (TPN) (also called hyperalimentation) to supply proteins, carbohydrates, fat, vitamins, and minerals. The administration routes vary from intravenous (IV) lines, nasogastric tube (NGT), to gastrostomy. The IV access is through the right subclavian vein. The technique carries several important risks such as accidental pneumothorax, arterial puncture, air embolus, and septicaemia.[4] Prolonged NGT feeding results in diarrhea, vomiting, abdominal distension, and imbalance of essential nutrients.[4]

Despite the risks and side-effect of medically administered nutrition and hydration (MN&H), not to mention the exorbitant cost of TPN, some argue that feeding is so basic a human function and so symbolic of care that it constitutes "ordinary means" and should never be forgone.[5] The debate between ordinary versus extraordinary means has moral implications since ordinary means are morally obligatory, whereas extraordinary means are not. In this essay, we will examine three basic moral questions related to nutritional support and hydration by parenteral means.

Is MN&H just care (ordinary) or sophisticated (extraordinary) medical treatment?

Providing food and water is considered ordinary and humane care. Is it the same when food and water are administered parenterally? Or is MN&H an extraordinary means? The question is far from trivial for if MN&H is ordinary care it becomes ethically obligatory. Extraordinary means, on the contrary, are not morally required because they provide proportionally more burdens than benefits.[2]

Besides the debate between ordinary and extraordinary means, there is a debate about the symbolism and social importance of food and nourishment. Beauchamp and Childress have summarised the arguments pro and con as follows.[6] The advocates maintain that: 1) nourishment, fluids, and routine nursing care are fundamental matters of human dignity; 2) it is intuitively devastating to starve someone; and 3) withholding MN&H opens the way to undertreatment for cost-containment (the slippery slope argument). The opponents argue that: 1) one should not underestimate the risks of harm, discomfort, indignity, and pain resulting from MN&H; and 2) it is misleading to project the common experience of hunger and thirst on a dying patient who is malnourished and dehydrated. About the second point of the opponents Shannon and Walter say that: 1) the patient is *fed* (doesn't eat); the symbolism of the meal is utterly absent; and 3) the patient doesn't feel hungry or thirsty.[2]

Extraordinary means are those that cannot cure the underlying condition that makes their use necessary.[7] They include *medical* technologies such as mechanical ventilation and renal dialysis. *Ordinary* means refer to *sustenance* technology. Whether the supply of nutrition and hydration is purely sustenance rather than medical technology is a matter of debate. At stake is the problem of justified or unjustified foregoing of life-sustaining treatments.

According to Beauchamp and Childress, "no relevant differences distinguish MN&H from other life-support measures (viz. it is an extraordinary means); therefore, it can be "sometimes unjustifiably burdensome" (viz. withdrawn). It results that the rules concerning withholding/withdrawing apply just as they would in the case of mechanical ventilation.[6] Shannon and Walter defend the view that one should not define ordinary and extraordinary means by classifying the technology but by considering their impact on the patient's overall condition.[2] We will return to their view when considering the third question.

Should MN&H be reserved for patients with a reasonable chance of recovery?

Ackerman and Strong are of the view that TPN should normally be reserved

for patients with a reasonable chance of recovery.[4] However, if (as argued above) MN&H is a life-sustaining technology (viz. that doesn't cure the underlying condition that makes its use necessary), then the question appears irrelevant. Most of the debate surrounding MN&H addresses end of life situations and the attached fore-going/withdrawing problematic. And yet, there obvious cases such as cases of extensive burns where MN&H is administered to curable patients. In this context, however, the ethical debate would be about distributive justice in the allocation of scarce resources. None the less, the question illustrates the shortcomings of classifications of life-support technology in terms of ordinary and extraordinary. If MN&H is needed to help burn-patients to survive a critical period but is classified as extraordinary means, it becomes *morally optional* to administer or not a life-support technology. Hence, Shannon and Walter's suggestion to view ordinary and extraordinary means *in context* seems very appropriate.

Can a life-sustaining technology such as MN&H be withheld or withdrawn?

The question of withholding/withdrawing life-support (assuming that MN&H is one) has been and still is a matter of hot debate. If MN&H is an *ordinary* means, it is morally required and cannot be forgone. Period. However, if MN&H is an *extraordinary* means there are conditions where it can be forgone.

Some see the withdrawing as the immediate cause of death (not the disease that necessitated it), hence as "mercy killing", whereas others see MN&H as prolonging the inevitably dying. But this, says Pence, is a conceptual confusion. The real question should be: is it a benefit or a burden to the patient?[3] Along the same lines, Shannon and Walter claim that forgoing/withdrawing is not an advocacy of any kind of euthanasia policy. The clear intent is to end a procedure that is not proportionally benefiting the person or to release the person from entrapment in technology. It is, they say, a *moral option*, not a mandatory practice.[2]

Their view is now quite widely accepted by ethicist under the name of "the principle of proportionality". It expresses the view that the correct test of the ethical obligation to recommend or to provide an intervention is the estimate of its promised benefits over its attendant burdens. It states that there is no absolute duty to preserve life unless life can be judged more a benefit than a burden. It gives patients and surrogates the right to determine what they will accept as benefits and burdens. It puts on the physicians the duty to formulate their perception of the benefit-burden ratio to recommend appropriate options.[5]

Conclusion

Most ethicists no longer consider the distinction between omission or commission, withholding or withdrawing, active or passive, ordinary or extraordinary means. Replacing these, the principle of proportionality has been endorsed. In this perspective, the conditions of forgoing life-support are the following:

1) it is virtually certain that further medical intervention will not attain any goals of medicine other than sustaining life (but there is no absolute duty to preserve life);
2) the patient's preferences are not known and cannot be expressed;
3) the quality of life clearly falls below the minimal; and finally that there is
4) expressed accord from the family.[5]

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