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Euthanasia and resuscitation in clinical everyday life - an ethical view from a deontological and consequentialist perspective

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Abstract

The patient's desire for suicide assistance and the resuscitation of a comatose patient are similar in terms of the life and death of the patient and also in terms of the psychological burden on the medical personnel involved.

In deontological ethics, the voluntariness of the patient's decision is the important criterion for evaluating the situation. This applies particularly to the resuscitation of patients if there is no living will. In suicidal patients studies showed that in more than 90 % of all cases pre-existing diseases restricted the patient's free choice. Even when decisions are made under time pressure, free decision-making is not always possible. And this applies both to the patient's decision itself as well as to the assessment of the situation by the medical personnel concerned. Paradoxically, the participants usually have very little time for the actual decision, while the resulting reflection of their own decision is possible for a very long time.

According to the criteria of consequentialist ethics, the most alternative results are to be preferred, which means the rejection of suicide help and the resuscitation of the patient.

The considerations lead to the practical consequence that in over 90% of cases the assisted suicide should be rejected and the resuscitation carried out. In case of doubt, the decision applies to life.

Key Words

Medical ethics, Deontologism, Consequentialism, Euthanasia, Resuscitation, Living will

INTRODUCTION

Physicians and health care professionals are faced with a serious decision as soon as comatose patients are to be resuscitated and there is no living will. In this situation, the patient's presumed will must first be determined and then fulfilled after thorough examination. This already difficult task is complicated by the fact that the decision in the clinical everyday life must be made usually fast.

A comparable situation can be found when a patient asks for suicide assistance. It is not a question of reviving a person who is very close to death, but rather of letting a person who is still alive die. It is not the patient's life itself that needs to be examined, but the justified desire for suicide and the patient's free will on which this decision is based. The legal as well as ethical bases for euthanasia are completely disregarded at this point.

Both situations have in common the decision about life and death. This finality makes the decision-making process for the healthcare personnel concerned so difficult, responsible and, above all, stressful. In addition, in practice there is often a certain time pressure in which this serious decision - resuscitation or suicide assistance - must be made. Particularly in the

in the case of a spontaneously expressed wish for euthanasia, the time is far too short to examine the viability of this wish.

Train drivers are a non-medical occupational group that comes into constant passive contact with suicides and has to deal with them at all levels. Due to the comparatively high number of railway suicides, the German Railway Authority conducted investigations into this subject more than a century ago [1]. The passive involvement of train drivers in railway suicides alone led to acute to posttraumatic stress disorders and has recently led to the development of prevention and therapy programmes for affected railway personnel worldwide [2,3].

In Europe and especially in German-speaking countries, there are no specific studies on the influence of resuscitation and suicide decisions on medical personnel. In general, physicians and health care professionals rarely seem to receive suitable psychological help after emotionally stressful moments - such as those that regularly occur in geriatric and hospice care [4]. Our own experience in nursing training and spiritual guidance has shown that experienced personnel have developed their own mindset and skills for appropriate decision-making situations over time. However, according to our observations, new entrants to the profession usually have yet to develop these skills. A paradox here is that very little time is available for the actual reaction - action or omission - while there is almost unlimited time available for the subsequent handling of one's own decision. And this long time for the reflection of the decision made under time pressure concerns both the own person and the environment.

In the sense of philosophical self-care, the possibilities of a well-founded decision for or against resuscitation or suicide assistance are to be shown here. They should lead to tight rules that relieve the burden on those responsible in the event of a crisis. In addition the question is to be examined both from deontological and from consistent setting of questions.

The deontological perspective

Suicide with medical support is final and must therefore be justified. If there is any doubt that the patient's desire for suicide has not arisen voluntarily, the final decision in favour of the suicide, or more precisely in favour of assisted suicide, must be clearly rejected.

In ethical terms, suicide is never voluntary, but the result of previous mental illness or mental problems. From a deontological point of view, suicide can therefore never be voluntary and must therefore be prevented at all costs - for the benefit of the suicidal patient. The aiding and abetting of suicide is thus categorically excluded This has a long discussion in philosophy, starting in Plato´s Phaidon in the 4th century B.C. It seems impossible to present even a shortl history of this discussion in this article.

In practice, the situation often appears unclear. Studies indicate that a large proportion of suicide candidates do not voluntarily express their desire to commit suicide. According to the study, at least 90% of all successful suicides in adulthood had a previous mental illness [5]. Further studies support this position .[6]]. Vice versa, this also means that a non-negligible proportion of suicide candidates can be assumed to have a self-determined and thoroughly voluntary decision to commit suicide. This voluntariness would therefore have to be examined by the responsible physician or health care professional and established beyond doubt. And this is where one of the main problems of modern healthcare systems comes in: the lack of time in medical care. The treating medical staff, however, just as the patient himself and his relatives have hardly any time to critically examine the freedom of will of the decision. And under such time pressure, it is at least questionable whether voluntary action can still be spoken of at all. In the case of the suicide desire it can be determined thus that with a large portion of over 90% pre-existing illnesses are present, which led to an involuntary resolution to suicide. In the case of the remaining suicide candidates, it is usually not possible in practice to sufficiently check whether the decision making process was carried out on a voluntary basis and therefore a compulsive moment must be assumed.

The situation is similar with the resuscitation of patients in coma. The omission of resuscitation is final and must therefore be justified. In the case of unclear expression of will - e.g. in the absence of a living will - resuscitation is therefore preferable.

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The consequentialist perspective

While deontological theory assumes an intrinsic character of an action, consequentialist theory aims exclusively at the morally relevant consequences of an action [7].

In this sense, the alternative with the most possibilities of action is preferable. Suicide as well as omitted resuscitation have only one consequence for the patient, namely early death. The refusal of suicide assistance or the resuscitation of a comatose patient, on the other hand, encompasses a multitude of possibilities, including death, and should therefore be preferred from a consequentialist perspective.

Conclusion for the practice

The most important criterion for the decision is the voluntariness of the patient in the sense of a free will of the decision. This concerns the voluntarily formulated desire for suicide as well as the voluntary expression of will not to be resuscitated.

The deontological as well as the consequentialist consideration of these two decisions with their alternatives - refusal of suicide assistance and resuscitation of the patient - come to the same result. In the vast majority of cases, especially when decisions have to be made under time pressure, the freedom of will in the case of suicide wish and omission of resuscitation is to be regarded as questionable. This clearly leads to the practical consequence that in case of doubt both the assisted suicide should be rejected and the resuscitation carried out. This applies all the more if the decision has to be made by the medical staff under time pressure. As a rule it can be said that the decision for life will be the right one in over 90% of cases.

Even from a consequentisitc perspective, such a decision must be made. According to this, refusal of suicide assistance and resuscitation of the patient are the alternatives with the most result possibilities and are therefore clearly to be preferred.

Paradoxically, the people involved, from physicians and health care professionals to patient relatives, usually have very little time for the actual decision, while the resulting reflection of their own decision can take a very long time.

Conflict of interest

The authors claim not to have any conflicts of interest.

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