Religious perspectives on withdrawal of treatment from patients with multiple organ failure

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ABSTRACT

- Religious or spiritual values often influence health care decision-making by patients and their families, particularly in times of crisis.
- Though religious values might seem to be irrelevant where continuing treatment is judged to be "futile", such clinical assessments should instead serve to open a dialogue about values and beliefs.
- The six major religious traditions in Australia have some similar values and principles about death and provision of care for the dying, but differ in their processes of ethical reasoning, cosmologies, and key moral concepts.
- Engaging with religious traditions on the common ground of basic values (such as human dignity, care, the sacredness of human life, non-violence, compassion, and selflessness) promotes negotiation of the manner in which care is provided, even where conflicts exist.

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For decades there has been debate over whether family members, health care professionals, or other surrogate decision-makers should be permitted to make the decision to withdraw ventilation and artificial nutrition and hydration from patients who are no longer able to breathe on their own or feed themselves, when such withdrawal will inevitably lead to death. This debate is characterised by a general, moral presumption in favour of maintaining and preserving life, along with widespread recognition that there are circumstances in which it may be morally justifiable to refuse, withhold, or withdraw life-sustaining therapy.

Health professionals in Australia must negotiate differences both between and within different religious traditions on the issue of withdrawal of treatment. They should also be guided by broad, liberal principles of respect for, and tolerance of, the variety of religious practices and beliefs. They should also be sensitive to religious perspectives on this issue insofar as they are important to patients and their families, particularly in times of crisis.

To increase knowledge and awareness about religious perspectives on withdrawal of treatment, we solicited commentaries on a hypothetical case from scholars representing the six major religious traditions in Australia. Each commentary covers a range of views within each religious tradition, and is grounded in key texts, scholarly and popular interpretations of these doctrines, and contemporary religious practices in Australia.

A hypothetical scenario

David is a 54-year-old computer engineer from Sydney. He is married with three children, and has always enjoyed good health. About 9 months ago, he was found to have stage IIB Hodgkin's lymphoma. He was treated with standard chemotherapy and attained a complete remission, with an 80%–85% chance that his lymphoma would never return.

David later developed a dry cough, sore throat, and fevers. He became progressively short of breath and, on admission to hospital, was diagnosed with severe influenza pneumonia. He was transferred to the intensive care unit (ICU) where he had to be sedated, intubated, and ventilated because of worsening hypoxia. A nasogastric tube was inserted to enable feeding (thus providing artificial nutrition/hydration).

David's condition continued to deteriorate and, after 12 days, he was still ventilator-dependent on 100% inspired oxygen, and required adrenaline and dobutamine infusions to maintain his blood pressure, and dialysis because of kidney failure. There was no evidence that he had brain damage. He also required continuing sedation so that the ventilator could work effectively, and this could not be stopped in order to wake him and establish his wishes regarding treatment.

In light of these events, David's team met with his extended family to discuss his situation.

At this meeting, David's ICU specialist and his haematologist explained that, in their opinion, David was not going to survive, and that further treatment would only delay his death. They recommended to his wife, Erica, that he remain sedated, that the medications supporting his blood pressure be discontinued, and that he be taken off the ventilator. The family was told that if this approach was taken David would be likely to die within minutes. At this point of the discussion, Erica was asked whether she needed more information before the decision was made to withdraw medications and ventilation, and whether she would like to speak with hospital support staff, such as a chaplain.

A Catholic perspective

Mindful that human dignity is preserved in every stage and state of life, Catholics recognise that the direct and voluntary killing of an innocent human person is always gravely wrong.[1] Where life-saving or life-sustaining treatment is withdrawn or withheld with the intention of ending a person's life, this is an unethical action or omission irrespective of any good motive, and so is regarded as morally equivalent to euthanasia or suicide.[1] However, to forgo treatments because they are likely to be futile or overly-burden-

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some (or have become so) need not be equivalent to euthanasia or suicide, but an acceptance of the human condition in the face of death.[1]

David's condition is continuing to deteriorate in spite of intensive treatment, and his treating doctors do not expect him to survive. If the ventilator and blood pressure medications are unlikely to sustain David's life for much longer, they may be regarded as therapeutically futile and, on a Catholic account, may no longer be ethically required. Even if some of his treatments — such as ventilation — do continue to offer some therapeutic or physiological benefit, these may well be overly burdensome, as is indicated by the need to heavily sedate David in order to ventilate him. In such cases there is no moral requirement to accept such an intrusion in order to secure a few days' more life.

Until now, David has been sedated so that the ventilation can work effectively. If the ventilator is removed, and there are no other symptomatic benefits to be gained from continued sedation, the sedation should also be withdrawn. Sedation should not be continued if its only foreseeable effect will be to hasten death by further compromising David's breathing. If David's sedation can be lightened to a level that is compatible with comfort as well as some degree of lucidity, albeit for a short time, he may have an opportunity to say his goodbyes, receive the sacraments or otherwise prepare himself for death. Catholics would regard this as a great benefit.

Doctors expect that David's death will follow soon after withdrawing ventilation. Catholics would not regard withdrawal of treatment in this case as homicide, suicide or euthanasia, because the intention is not to shorten David's life but rather to withdraw a futile or overly-burdensome treatment. It is foreseen that this might shorten his life, but shortening his life is not the reason for taking the course of action and there is a good reason to take this risk.

A test of what the clinicians and family intend would be to ask, what if, after removing the ventilator, it was found that David was able to breathe unassisted? If the doctors and family would not regard this with disappointment, as if their goals were somehow defeated, then they can honestly say they are not removing the ventilator with the intention of shortening life. Erica, for one, might be delighted, so her goal here is clearly not euthanasia. And if David's condition continues to deteriorate, the clinicians and family would presumably ensure that David received all appropriate palliative care.

Importantly, Catholic ethics emphasises that *futility* and *burdensomeness* never pertain to the life of a patient, but to discernible features *in and of the treatment*.[2] The burdens of treatment are usually considered alongside the benefits that can reasonably be expected to follow from a particular treatment regimen, and within the context of a patient's overall condition and its potential for improvement, his resources, and sensibility. Catholic ethics aims to avoid two extremes: an unrealistic and unkind survival-at-any-cost mentality, which bears no relation to the overall wellbeing of the patient; and an all-too-ready disregard for the value of life, based upon misplaced compassion or resource-focused pragmatism.

An evangelical Protestant/Anglican perspective

Anglicanism includes a wide spectrum of viewpoints on withdrawal of treatment. Some Anglicans may accommodate the option of withdrawal, while others may want life extended at all costs. In the following account, the use of the first person "we" is intended to reflect the evangelical mindset, which is characterised by a strong commitment to the Bible as the final authority in matters of faith and life. Not all Anglicans are evangelical, and evangelicalism is not confined to Anglicanism.

In our understanding, death was not originally intended for humanity. It was defeated by Jesus Christ in his resurrection, and will one day be eradicated by God. Until then, we are certain that we will die, and that judgment by God will follow. This motivates us to find forgiveness and peace with God through Jesus Christ before death. It also means that we do not expect life to be preserved indefinitely or "at all costs". But as humans are made for life, we urge and expect doctors to continue fighting for as long as they can, and we trust that they will have the wisdom and expertise to know when the battle is lost. Given all this, we will often accept "withdrawal of treatment" and "allowing to die" as necessitated by death's current grip on humanity.

Medical personnel should also be aware that we may express conflicted reactions to dying and death. First, we are not always true to our convictions. In our grief and pain, we may desperately cling to life at all costs, as if humans never need die, and as if medical science has conquered death. We may forget to trust our Lord, as if this life is all there is, and as if there is no hope for eternity.

Second, we long for every avenue to be exhausted in the fight for young spouses or children. We may find it easier to accept that our grandparent's "time" might "have come", even though we implacably oppose any judgment that the elderly are less precious or more expendable because of their age. But in common with the

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rest of humanity, we may be very unreasonable about withdrawing treatment from young people.

Third, we are concerned about the eternal destiny of our loved ones, and wish for them to make their peace with God. Hence we may press forcefully and irrationally for extra time, without revealing our concerns to medical personnel, who may not share our beliefs and who may be perplexed by our requests.

If we imagined Erica to be an evangelical Christian, then she can allow David to die because she knows that all must die. However, she would expect medical personnel to give good reasons for their advice, and would press for detail as to why further treatment is futile. She would want to know why the battle for David should not continue, and she might wonder whether medical advice was driven by professional pride, by concerns about scarce resources, or by a failure to esteem David as precious enough for care. Were she convinced of the goodwill of medical personnel, and that the battle was lost, her Christian faith would not, in itself, prevent her from allowing David to die, although her grief may hinder her. She will be more troubled, however, if she thinks David has not found forgiveness and peace with God. In that case, she might press harder for the extension of his life, but may be embarrassed to articulate this motivation to medical staff, given that many dismiss the reality of a judgment beyond death.

An Orthodox Jewish perspective

Judaism views every moment of life as sacred. The daily prayers open with, "You preserve the soul within me and You will in the future take it from me". Only God, who is the source of all life, can take life away: "Until all vital forces ebb from the body as evidenced by total cessation of both respiratory and cardiac activity, human life must be treasured as a sacred gift".[3] Even the desecration of the Sabbath is mandated by the Talmud if the reason is to rescue someone who might be alive.

Jewish law designates a patient whose death is imminent and inevitable as a *gosses* (which can be defined as the state of being of someone who is dying until his or her soul has departed). Such a person has full legal capacity and is able to transfer property or issue a divorce, since "[a] *gosses* is to be considered a living person in every respect . . .".[4] The Sabbath must even be violated to save or prolong the life of a *gosses*: "The mitzvah [good deed] of saving his life applies even if it is clear that he cannot live for even another hour . . .".[5] There is, however, no requirement to *start* treatment to prolong life which will only add suffering to a patient who has reached the natural end of a disease.

In Jewish law, a physician has the responsibility to treat a patient, even if only to prolong life. He may not withhold food, fluids, or oxygen, even if these need to be delivered by artificial means.[6]

Acts or interventions intended to hasten the death of a *gosses* through physical contact are identified as murderous. However, it is permissible to make someone more comfortable in their dying, for example by silencing troublesome noises, even though the alleviation of the distress might both ease and accelerate the patient's dying.

Where a patient is beyond cure, but there is the possibility of treating pain, this is permissible. Some authorities will allow for the inevitability of consequential morphine-induced respiratory depression, so long as the primary purpose of the medication is clearly to alleviate pain and not to hasten death.[7] In contrast, the withdrawal of artificial ventilation is considered by many authorities as an overt act, and is prohibited under all circumstances except if the patient is brain dead. For example, Rabbi Eliezer Waldenberg states that a respirator should not be disconnected from a patient if it is unclear whether it is keeping him alive or merely ventilating a corpse. He does, however, recommend that ventilators be fitted with time-clocks set for a 12-hour or 24-hour period so that they switch off automatically, thus enabling observation of the patient for signs of spontaneous respiration. Where these signs are absent, and if the heart is not beating and the brain is irreversibly damaged, there is no need to reconnect the ventilator.[8,9]

In David's case, his brain is fully functioning. There is no question of his being brain dead. Thus, even if he could be brought to consciousness, under Jewish law, he would not be allowed to direct that his treatment be discontinued.

David is a *gosses*. While his death is inevitable, under Jewish law the doctors must continue to treat him. This includes both medication for his blood pressure and continuation of his ventilation.

An Islamic perspective

In Islam, death is a stage of divine evolution, and the eternal existence of Muslims after death is determined by what they do with their lives. Muslims try to pass this "test" by submitting to the rules of God. Many seek advice about right conduct from the clergy. Islamic scholars (Ayatollahs and Muftis) are responsible for *Feqh* (Islamic law and rules of conduct), which draws on four traditional sources of moral authority for decision-making (*Ijtihad*):

- the *Koran* (the Holy text);
- the *Sunnah* (words or deeds of the prophet);
- the consensus of the learned; and
- *Aghl* (wisdom).[10]

These authorities are listed in order of reliability. Thus, if if the Koran provides an answer to an ethical dilemma, Muslims do not refer to the *Sunnah*. If the answer cannot be found in the Koran or the *Sunnah*, and there is no consensus between scholars, Muslims may follow the authority which seems most reasonable to them.

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Because most ethical problems raised by modern medicine cannot be "solved" by recourse to the Koran or the *Sunnah*, Muslims must consult all these sources of moral authority.

According to Islam, life is a precious gift bestowed by God; therefore, we do not have absolute power over it. Furthermore, the prophet Mohammad said, "Seek treatment, for every illness God created a treatment".[11] So, based on Islamic doctrines, in the scenario described, neither David nor his family are allowed to discontinue his life if there is a possibility of recovery:

> Whoever takes a human life, for other than murder or corruption in the earth, it is as if he has taken the life of all mankind. (*Koran* 5: 32)[11]

Although most Muslim authorities agree that brain death constitutes acceptable grounds for discontinuing life support, David has multiple organ failure without brain death. Because he still has the possibility of an active, conscious life, his eternal fate is still in his hands, and he should be allowed to use every minute of that life.

In cases such as this, most mainstream Islamic scholars would regard withdrawal of David's treatment as non-voluntary active euthanasia, and any form of euthanasia is forbidden in Islam. As Ayatollah Makaram Shirazy states:

> Killing a human being is absolutely forbidden even with the patient's permission, and with the intention of reducing suffering . . . The permission of such an act makes it open to abuse. This could be used as a legitimate way to commit suicide. Besides, medicine . . . is not able to be absolutely certain about the outcome of treatment . . .[12]

Thus, most Islamic scholars would choose to wait for nature to take its course, rather than withdraw ventilation and circulatory support. According to others, such as Dr Hassan Hathout:

> If there is no hope of treatment, you may withdraw the life support equipment. In an attempt to prolong life without quality, one must not prolong the misery at a high cost.[13]

Other Muslim intellectuals, such as Dr Abdulkarim Soroush, argue for a modern approach that emphasises thinking rather than simply following,[14] and that deems moral values to have an extra-religious origin. This approach, which is rooted in the *Mu'tazilah* (Schismatic) school of Islamic philosophy, allows for more flexibility and debate. However, it has been marginalised by both Sunnis and Shiites. Historically, Islam has been dominated by the rival '*Ash'ari*' philosophy, which holds that good and bad are meaningless outside religious teachings. Muslim theologians have recently tried to revive *Mu'tazilah* ideas, both in the interpretation of Koran and in *Feqh*.[15]

Because both traditional and modern movements are alive in Muslim communities, an open and honest discussion is the only way to learn a Muslim family's wishes in a case like David's.

A Hindu perspective

Hinduism comprises many autonomous sects and has no centralised authority. Nor is it a religion of "the book". However, contemporary debates about termination of treatment can legitimately draw on the longstanding debate about self-willed death in a religious literature that dates back to 1500 BCE.[16] The debate surrounding this practice provides grounds for supporting — or at least not condemning — the withdrawal of treatment from terminally ill patients, if regulated by well defined criteria.

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Classical Hindu literature distinguishes between suicide, voluntary heroic death, and voluntary religious death. Suicide was clearly condemned in ancient times. Voluntary heroic death was considered not only acceptable, but meritorious. It was practised by ancient warriors to avoid capture, by women to avoid rape or enslavement, or by a king to allow peaceful succession to the throne. Voluntary religious death was practised by the incurably ill, or by those unable to perform the mandatory rites of bodily purification because of age or incapacity. This was also considered a legitimate exception from the general rules of *dharma* (social order) and *ahimsa* (non-violence), and was considered a religious act by Hindu jurists. Community leaders (Brahmins) decided whether any case of self-willed death was legitimate.

The law of *karma* (actions which earn the individual merit or demerit) is also central to the classical Hindu discussion of self-willed death. While suicide was considered a sin leading to hell, religious or heroic self-willed death could burn up bad *karma* and thereby expiate sin and produce good *karma,* triggering salvation. A religious or heroic self-willed death was distinguished from suicide by a formal and public announcement of intention, and the subsequent exercising of willpower to achieve it.

By the 10th century CE, strong criticism of euthanasia had developed within Hinduism, probably because of perceived abuses of this and related practices of self-willed death. With the advent of British law in India, suicide was deemed to be a criminal act, and was interpreted so as to include all forms of self-willed death.

Mahatma Gandhi, an uncompromising proponent of *ahimsa,* accepted suicide and euthanasia in certain cases: "Should my child be attacked by rabies and there was no hopeful remedy to relieve his agony, I should consider it my duty to take his life". He also approved of the mercy-killing of a calf, calling it "an expression of purest *ahimsa*", and added that he would "do the same for his own child".[17]

Contemporary Hindu attitudes to euthanasia were examined in 1988 in *Hinduism Today.*[18,19] Four Hindu doctors and six Hindu religious leaders (all practicing in the United States) were questioned about the treatment of terminally ill patients including "ceas[ing] everything but minimal care after a short time". Support for active euthanasia among the doctors reflected the results of a recent California poll (70% in favour). The six religious leaders generally opposed active euthanasia, but their specific comments on the issue revealed little consistency in their reasoning on the issue of withdrawal of treatment.

I sought an opinion on the hypothetical case in question from an Australian Hindu and consultant physician, Dr S Siva Kumaran. He believes Hindus are more accepting and less fearful of death because of their belief in *karma*, and therefore would not support the unnecessary prolongation of life. He supported this view by

citing a passage from the *Bhagavad Gita*. He agreed with the withdrawal of treatment in cases similar to David's. He said that Australian Hindus would not seek advice and solace from a priest in such circumstances, but would rely on family advice and seek solace and aid from their community.

A Tibetan Buddhist perspective

There is a range of perspectives regarding the process of dying among Buddhist traditions, with no clear consensus, and opinions about the morality of withdrawing life-sustaining treatment will vary between adherents of these traditions. Asian Buddhist teachers have generally been unwilling to weigh in on bioethical debates such as withdrawing treatment from terminally ill patients, organ donation, and abortion. To date, most of the work on these issues has been done by Western Buddhist scholars, who extrapolate Buddhist principles that are pertinent to current conundrums.

Buddhist traditions unanimously condemn suicide and premature ending of life, but allow it in exceptional circumstances in which a person ends his or her life in order to help others, as manifested in past-life stories of the Buddha himself.

These principles can be extrapolated to the case of withdrawing life support from a terminally ill patient. To be morally "in the clear" from a Buddhist perspective, a doctor or relative who decides to terminate extraordinary measures for maintaining life should be an advanced practitioner who can read the mind of the patient and accurately foresee the results of various possible choices. If the decision to withdraw treatment is based on certainty that the patient will suffer needlessly from further treatment, and the decision is taken in order to avoid pain and facilitate a better rebirth, then it is blameless — even admirable — from a Buddhist perspective. But for those who lack the cognitive abilities attributed to advanced Buddhist practitioners, any decision regarding termination of life support becomes problematic, because ordinary people cannot foresee karmic futures.

Tibetan Buddhism has the most extensive literature on death and dying of any Buddhist tradition. According to the Tibetan medical system, largely derived from the *Kalacakra-tantra*, living beings, including humans, are conceived mainly in terms of subtle energies which circulate in energy channels throughout the body. During the process of death, these energies coalesce in the region of the heart (which is the seat of consciousness, rather than the brain). As a person dies, the various elements that sustain life dissolve, and one becomes progressively unable to function. As the coarser levels of mind disintegrate, progressively more subtle ones manifest.

The point of actual death occurs when the "mind of clear light" manifests. Following this, the mind of clear light acquires a subtle body which it will inhabit during the "intermediate state" (*bar do*) between one life and the next. This state can last between 7 and 49 days, after which one will be reborn in another body in accordance with one's past actions (*karma*). According to standard notions of *karma*, death occurs as a result of one's actions and various external factors, and extraordinary methods to prolong life are an imposition on this process and ultimately pointless. Death is not viewed as a tragedy, as one has died countless times in the past.

Once the process has begun and the first stage of dissolution has occurred, death is inevitable, and the patient has no chance of true recovery. Extraordinary means for prolonging life merely hold karmic outcomes in temporary abeyance and bring unnecessary suffering to the patient. Hence, there is little point in prolonging the life of a terminally ill person whose *karma* has precipitated the process of physical dissolution. The finality of death is certain, and nothing can be gained by artificially interrupting the process — particularly as any such intervention may cause pain and mental anguish, which negatively affect a person's thoughts at a crucial time. The best course is to let the process of dying continue, while ensuring that the person is as comfortable as possible.

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Discussion

Religious beliefs may have considerable influence on decisions made by patients, their families, and their carers, particularly at the end of a life. While some would suggest that values, including religious values, are irrelevant in situations where continuing treatment is judged to be "futile", we suggest that such clinical assessments should serve to open a dialogue about values and beliefs, rather than to circumvent it. It is therefore important that clinicians have some understanding of the differences between and within the main religious traditions in Australia. Clearly, given the cultural diversity of Australian society, and that comparative religion is not part of traditional medical curricula, this is no small task.

We have tried to provide some guidance by soliciting case commentaries on a specific ethical issue from each of the six main religions in Australia. The brevity of these commentaries means that they cannot represent the full breadth of views within each religious tradition, and we accept that other members of these religious traditions may take issue with the interpretations provided. Nevertheless, the commentaries are instructive in four ways.

- They show how religious traditions and religious authorities may differ with respect to the degree of guidance they offer in the face of ethical dilemmas created by modern medical practice, such as withdrawal of treatment. Some may give explicit rulings about whether such an action is permissible in a particular case; some may offer general guidance about the moral significance of specific actions such as withdrawing sedation or communicating with the family; and others may offer no specific guidance, but provide a means of framing the issue by extrapolating from its traditional stories or its history of debates.
- They give some sense of the heterogeneity of interpretations, beliefs, and practices *within* each religious tradition. This provides a salient reminder that assumptions about a particular religious view, or about a particular individual, may often be erroneous, or may simply prejudice clinical interactions.
- They emphasise that, while it is important to gain an understanding of the variability between and within religious traditions from authoritative sources, the importance of religion differs between individuals, and choices and behaviours are unlikely to be influenced by religious beliefs alone. Culture,

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A Catholic perspective

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political beliefs, and life experiences also contribute to the choices that people make and the way they live. In light of this, there is no substitute for talking with patients and their lay carers in order to better understand their religious beliefs, their worldviews, and the moral concepts or values that are important to them, and the way each of these may impact on their preferences for health care.

• They show that religious and secular views are most likely to find common ground within a discourse on basic values such as human dignity, care, the sacredness of human life, non-violence, compassion, and selflessness. Except for the notion of sacredness, this list has much to recommend it from the point of view of secular morality.

Different religious traditions have diverse perspectives on death and the provision of care for the dying, and not all may be commensurate with contemporary understandings of biology, or with various institutional demands. However, by engaging with religious traditions on the common ground of basic values, it may be possible to negotiate the manner in which care is provided — even where conflicts exist.

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Competing interests

None identified.

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