COVID-19 and Unilateral Withdrawal of Life-Sustaining Treatments

Tragedy in Crisis, and Lessons for Everyday Medicine

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The COVID-19 pandemic has forced ethical questions that once served as mere thought experiments to be considered with newfound urgency. The unprecedented strain on our health care system has collapsed the gulf between theory and practice in bioethics, laying bare both the need for well-formed crisis response plans and the practical challenges to their sound implementation.

Against this backdrop, authors from opposing vantage points take up the important question of whether it is ethically permissible to unilaterally withdraw life-sustaining treatments (LST) for reallocation during crisis standards of care in these “Point-Counterpoint” essays1,2 in this issue of CHEST. Through their thoughtful examination of the theories that should guide our practice, they highlight the ethical tensions this pandemic accentuates, and they help us to see where such tensions lay hidden in plain sight in our everyday practice.

Jeffrey Bishop and Jason Eberl1 assume the “Pro” side of this debate, arguing that such unilateral withdrawal is permissible, providing certain conditions have been met.

They ground their claim in the societal “state of exception” that the current pandemic has occasioned, arguing that the exigencies of COVID-19 create a crisis state within medicine that is analogous to wartime in military ethical theory.1,3 More specifically, the authors draw on Just War Theory (JWT), which recognizes a societal state of exception (namely war, after all peaceable alternatives have been exhausted) that makes possible certain actions that are typically impermissible (ie, combat) for purposes of proportionate societal good. JWT therefore can offer moral coherence to unilateral withdrawal of care during a health care crisis through maximizing societal benefit by enhancing the chance of survival for patients deemed less sick.

While Bishop and Eberl1,3 ground their justification in JWT, Daniel Sulmasy and Fabien Maldonado2 base their argument against unilateral withdrawal on discrete critiques that, taken together, create a compelling case that such action ought not be permitted even when medical resources are exhausted.2 Their claim rests on five arguments: that reallocation is practically unrealistic; that it is wrong to remove life-sustaining treatment from those who may survive if such treatment is maintained; that the process of reallocation contravenes the fiduciary commitment of the physician to the patient; that such practices may disproportionately affect marginalized populations; and that the rule of double effect (an ethical theory closely related to JWT) cannot be invoked to justify removal of LST.

On one level, these “Pro” and “Con” essays can be read as expositions on the theory behind and practice of appropriate actions during times of crisis, respectively. Bishop and Eberl1,3 mount a strong case for the prima facie permissibility of LST removal grounded in moral theory that has existed since antiquity, and Sulmasy and Maldonado2 thoroughly address the problems with practical application of this or any theory that would justify LST removal. However, this simplified reading neglects one of the central questions with which both sets of authors grapple: what is the nature of the physician’s commitment to the patient in front of her, and how might this change in the face of competitors for her care?

As both sets of authors note, the physician’s fiduciary commitment to the individual patient is constitutive of
the medical practice and overrides any competing societal claims that may vie for the physician’s time and care. But is this unqualified commitment still operative during times of crisis, when she may have a duty to others who may benefit more from LST? Put another way, if the patient-physician relationship serves as the foundation of medicine, does the “state of exception,” which introduces novel and pressing competitors for the physician’s life-sustaining care (ie, different prospective patients) mean she is no longer practicing medicine, so understood?

The dilemma of unilateral LST removal brings this question into stark and uncomfortable relief, but if we pay attention we recognize that the tension between meeting the needs of this particular patient against competitors for time, resources, and energy are in fact commonplace in everyday clinical practice. Very often, the competition for our care of individual patients is not another patient, but rather the increasing burden of nonclinical responsibilities that persistently pull us away from the bedside.

The question of LST removal for reallocation is, quite literally, of vital importance. And yet, it is a task of choosing between real goods; that is, between the ability of different individual patients to survive and to heal. Such choices between competing, irreconcilable goods are remarkably difficult—the ancient Greeks in fact referred to the genre of theater dedicated to dilemmas that depicted the necessary loss of a good as tragedy.4

Yet worse than tragedy is when we feel repeatedly compelled by the systems in which we operate to choose less worthy objects of our time and care than the good of the patients in front of us. We see this in the resident who isolates himself in a workroom to write notes rather than visit with patients at the end of his shift, or when the primary care doctor fails to fully advocate for insurance coverage for her patient in the face of the hours of bureaucratic maneuvering this would entail. We may not feel the visceral discomfort of such choices because they have become so commonplace, or because the implications of the choices are not so clear as the death of one patient so that another may live. However, for clinicians, the day-to-day decisions can feel like death by a thousand cuts even as they lack the singular force of the question of LST removal during crisis.

Bishop, Eberl, Sulmasy, and Maldonado provide clear and compelling arguments as to how we might bridge the gap between the theory and practice of reallocation of life-sustaining treatments during this (and any other) time of medical crisis. Regardless of whether we ultimately find this particular action permissible or impermissible, perhaps what is most important is that we learn to detect the moral dilemmas that subtly inhere in our everyday care for patients, where crises may be muted but still present.

References