**END OF LIFE CARE**

**Overview**

During the course of medical history there are many medical decisions based on ethical realizations by guardians, parents, spouses and care providers. Without specific written documentation on how a person views and wants to transition in terms of end of life care there are many difficult decisions that rarely please everyone involved. In the case of a soon-to-be father who is currently married, a horrific motorcycle accident placed the spouse, family and medical team in a precarious position. Although the discussion of end of life care occurred between the father and his spouse it was not documented or verbally communicated outside of that relationship. There is not a living will present that would dictate and document the expressed consent and morale, religious and personal stance on the decisions regarding end of life care.

The patient had discussed thoroughly the objectives and described their end of life beliefs which were in correlation to their morale and religious views. The parents were unaware of their son’s perspective on end of life choices, which due to the circumstances involving their own son, varied greatly in the steps and precautions they would make in the same circumstance. The medical team, while understanding the quality of life is negatively implicated, remains with a stance that life support efforts should be maintained currently and views that recovery is possible with potential brain functionality damage. The current spouse of the man does not want to continue artificial life support and is, in her views, supporting the wishes and instructions for end of life of her husband.

**Range of Actions**

The actions that can be taken with the patient range from extending the life of the patient through artificial means such as through a life support system, allowing the patient to try and resume self-sustaining life functions on his own, a combination of artificial and natural methods of recovery or inducing the end of life medically. End of life care includes but not limited to many facets and services provided by medical facilities. These actions range from antibiotic treatments to prevent future infections and their complications to the recovery process to the mechanical respirators needed to keep the oxygen flow throughout the patient’s body to sustain the core function of life.

Ethical decisions can be made in regard to withholding or withdrawing medical treatment based on the principle of proportionality and if possible the patient’s wishes on end of life decisions. The principle of proportionality encompasses the level of effort afforded to the patient in relationship to the benefits received from the efforts performed. An example of this principle is the artificial nutrition and hydration efforts and the implicated burdens associated with this action compared to the amount of impact on the dying patient’s benefit for the extension of their life. The artificial nutrition and hydration could be withdrawn in full respect to ethical behaviour devoid of the implications of death that may arise (Abbot-Penny, A., Bartles, D., Paul, B., Rawles, L., and Ward, A. 2005).

Throughout the ethical dilemma none of the parties involved were pursuing the choice for medically ending the life of the patient because the survival opportunity was possible and the question was on what path the stakeholders would travel to get to the future life of the patient or experience their loss sooner than hoped.

**Potential Resolution**

The key participants in the decision are the medical team, which possess the knowledge and experience, the patient, which the impact is direct but voice cannot be heard, the wife, which the conversation about end of life was discussed between patient and herself and the parents which are involved by the heredity of being the parents and as the closest kin. The importance of this young man in each of the stakeholders’ life is without a doubt implicit and corollary to the motivation and passion behind each of their viewpoints. The patient did not provide the documentation regarding a do-not-resuscitate order so efforts could be made to sustain life after the ventilator is removed but it would only sustain life to a decision point to stop cardiopulmonary resuscitation (CPR) is no longer feasible.

The patient expressed his wishes with his wife and since she is the current spouse of the patient in whom a decision needs to be made to either continue life support or to discontinue the efforts in hopes for a recovery based on self-sustaining activities, the decision is up to her. The basis for this is established in a hierarchy of spouse, oldest children, and then parents of the patient (Alzheimer’s Association 2011). The spouse can then make the decision to remove the life support in which the parents currently do not have a voice in the final decision.

Ethically prolonging the efforts to support life could be ended if the support efforts outweighed the potential benefits for life sustainment. The patient is not brain stem dead but the only life in the body is artificially created through life support systems. The wife understands the wishes of her spouse and can act ethically according to her husband’s verbal wishes.

References

Abbot-Penny, A., Bartles, D., Paul, B., Rawles, L., and Ward, A. (2005). *End of life: an ethical overview.* University of Minnesota’s Center for Bioethics Retrieved from <http://www.ahc.umn.edu/img/assets/26104/End_of_Life.pdf>

Alzheimer’s Association (2011). *End of life decisions.* Retrieved from <http://www.alz.org/national/documents/brochure_endoflifedecisions.pdf>