

A Few Words about Life Support

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Abstract

When more than one rescuer is present, one performs a heart massage and the other artificial respiration. If they are able, they should be changed every two minutes to prevent colleague fatigue. If a person begins to breathe normally or signs of life are noticed, these activities should be stopped. If the chest does not rise during inhalation, then it is necessary to check the airway before the next inhalation and, if necessary, clean it of foreign bodies if they are visible.

Keywords: Life Support, Life Support, Life-threatening Conditions, Law

Introduction

Clients who have suffered trauma or devastating brain damage may require ventilation as a part of their care [1]. During this treatment, the ventilator takes the part of the client's respiratory system in order for the body to receive sufficient oxygen for its physical needs; this is often termed 'life support'. Relatives and therefore the health care team is also faced with the difficult dilemma of whether the machine should be turned off and therefore the client allowed to die, and during this situation, the law, through examination of individual cases, has developed a format as a guide to those caring for the client. There are broadly two situations within which life support systems is also discontinued. The first is that if the patient, after careful testing, is shown to be dead. Two doctors must conduct the tests, one amongst whom should be the consultant who has been treating the client, the second another experienced doctor. They test the essential reflexes originating within the brain stem (hence 'brain stem death'), reflexes affecting the eyes, the respiratory reflexes and functions that are essential to life. The second situation occurs if the patient's probable long-term outcome is extremely poor. Then, whether or not the patient can breathe unaided after ventilation has been discontinued, the machine needn't be restarted should the patient relapse; alternatively, ventilation might not be attempted at all.

Health Status

Topics to explore include gaining an understanding of

patient and family values and beliefs with reference to what makes life worth living [2]. Sometimes this subject can be explored through a discussion of undesirable outcomes or situations during which the patient would prefer death over continued existence on life support. Patients frequently identify persistent vegetative states and other conditions as a "state worse than death." If they mention these states, it's important to explore what it's about them that they consider unacceptable, especially because patients frequently end up in situations that don't exactly match their conceptualizations. The term "vegetable" can mean many alternative things to different people. Therefore, it's important to own the patient and define the term. Additionally, some patients have strong feelings about "never being on machines." It's important to explore the source of those feelings because they're frequently based on misunderstandings of what the treatment entails or because they are doing not know about the choice of therapeutic trials that may be stopped after a brief time. Discussions about specific treatments must always be framed around goals of care and the way those treatments are accustomed to reach the required outcome, not the result in and of itself.

The patient and therefore the surrogate should discuss the degree of interpretive leeway that may be exercised in adhering to the patients' previously expressed preferences. Research has documented that a lot of patients are comfortable with allowing surrogates some leeway in decision making.

Additionally, although autonomy is that the major principle that guides advance care planning, some patients who still retain decision-making capacity like better to defer to the judgment of their surrogates and acknowledge that the best outcome is also one that doesn't always maximize their personal autonomy. One reason that patients defer decision making and permit surrogates leeway in interpreting their preferences is to avoid burdening their loved ones and since they recognize that members of the family have—and should be able to consider—their own needs and interests.

It is important to determine whether the surrogate is comfortable with the plan and to debate any anticipated difficulties (e.g., discomfort making the decision to withdraw life support) or fundamental differences in values (e.g., definition of acceptable quality of life). Surrogates often need support with coming to terms with their loved one's illness and impending death. Sometimes differences in values reflect surrogates' difficulty with letting go and should signal the requirement for help with anticipatory grief or with feeling overwhelmed by the responsibility for creating life-and-death decisions. It can be helpful to reassure surrogates that the clinical team are responsible for making treatment recommendations and treatment decisions about the withdrawal of life support. The surrogate's role are to represent the patient's values and preferences with relation to the goals of care. this may help to alleviate the surrogate's feelings of responsibility for causing the patient's death when, as an example, decisions about withholding or withdrawing life-sustaining treatments must be made.

For patients with chronic illness or those whose trajectory of decline is somewhat predictable, it's very useful to discuss contingency plans for the way the patient and family may respond to acute exacerbations or other sudden changes in health status. Patients and families report that being prepared for the following steps on their illness journey is highly valued. Knowing who to call and where to go in an emergency helps patients and families to manage the uncertainties of illness and dying.

Client

The first a part of this section rested on the law referring to health care professionals working with terminally ill clients [1]. Central to the concept of euthanasia are the clients and their wishes. Although the relatives and carers legally haven't any rights within the decision making, they will play an oversized part within the communication of the client's wishes to

others. Knowing what the client's own wishes are may help health care professionals to create a choice about what is also done in the client's best interests. Indeed, the carers' advice on the client's care can be sought by the professional team and prove to be invaluable. There is, however, the matter of the relatives and carers having a vested interest, either physically or emotionally, within the survival or demise of the client. As all told other areas of care, dying clients must have choice over their treatment and be able to participate within the planning of care or have their wishes met whenever possible. The meeting of the clients' wishes within the period leading up to their death falls within palliative care: When the doctors responsible for the patient confess that nothing more can be done to reverse the process of his illness, palliative care begins'. The interval between this time and therefore the death of the client is also either short or long, in some cases years, with distressing symptoms, as against the underlying illness, receiving treatment.

The hospice movement founded by Dr Cicely Saunders at St Christopher's Hospice in London is that the leader within the field of palliative care and therefore the relief of distressing symptoms. Pain, and also the relief of pain using high dosages of analgesics, forms much of the work of the hospice staff, who are often willing to advise health care professionals on the therapeutic uses of drugs used not only in pain relief, but also within the control of other distressing symptoms. Hospices are registered with the office as nursing homes under Part 2 of the Registered Nursing Homes Act 1984 and funded by a mixture of sources. local authority and health authority grants, along with local fundraising efforts, combine to assist the client who incorporates a life-shortening illness for whom palliative care is that the most appropriate option. Care of the client within a hospice demands the abilities of the many professional groups and isn't confined to medicine and nursing: the multidisciplinary team may include radiotherapists, those concerned with the spiritual and psychological care of the dying client likewise as complementary therapists.

Life-threatening Conditions

Life-threatening conditions are defined as an acute disease or chronic illness expected to cause death within the immediate or near future without ongoing and life supporting healthcare treatment directly provided by a healthcare professional, the technique of advanced cardiovascular life support isn't specifically different for older patients, and also the primary assessment and stabilization should follow

the European and international resuscitation guidelines [3]. However, specific consideration to physiologic reserve of older patients managing life-threatening conditions during this specific population mainly depends on underlying chronic conditions.

If a patient has a life-threatening condition, the assessment and treatment should start immediately, and during this situation, the diagnostic procedures should go simultaneously with the treatment modalities unless there's a transparent Do Not Attempt Resuscitation (DNAR) document. This example is often encountered in prehospital settings. Except during this specific situation, the resuscitation must start immediately with a simultaneous call to the emergency medical services (EMS) dispatching center asking for help.

In older patients, chronic diseases and medication effects superimpose on age-related physiologic changes and should conceal a critical illness. Compared with the general population, older patients are more acutely ill, more frequently admitted to the hospital (especially to the intensive care units), and more likely to suffer a cardiac arrest. Emergency physicians (EPs) or nonmedical professionals are frequently confronted with the question whether resuscitation is an appropriate treatment for older people. For physicians, patients, and relatives, it's important to grasp the possibility of survival and also the functional outcome after resuscitation in order to create an informed decision.

Informed Consent

The primary physician usually begins the family meeting with a quick, clear report on this condition of the patient [4]. Supporting documentation of this condition, like recent laboratory data or other diagnostic test results, is also helpful to some families. The patient and/or family should be provided all the time necessary to raise concerns, clarify information, and have their questions answered. The identical questions are also raised time and time again to different team members, and need to be answered with consistent information to reduce uncertainty. Next, the treatment options should be discussed. When discussing terminal sedation options, it's important to assess the patient's and family's cultural and spiritual beliefs and concerns. Documentation within the chart should include the parties present, the explanation for sedation (symptom distress), and also the primary goal (patient comfort), in addition to patient terminal status, notation of any professional consultations, documentation that the patient is near death and has refractory symptoms, planned

discontinuance of treatments not focused on comfort, plan regarding hydration and nutrition, and anticipated risks or burdens of sedation. Either at the end of the family meeting, or the following day in non-emergency cases, some institutions require that an informed consent document is signed by the patient, family, or health care agent. Because it always isn't possible to speak verbally with the sedated patient, it's important to make sure that the patient and family are given time to speak with each other and say their goodbyes, if that's possible, prior to proceeding with sedation. A well-planned family meeting decreases miscommunication and supports the family during a difficult decision-making time by allowing all pertinent parties to listen to the identical information at the identical time. The choice for palliative sedation or terminal weaning may be a patient/agent/family decision (whoever is that the decisionmaker) with guidance from the palliative care team.

In the ICU setting, there should also be a succinct description of the terminal weaning process. One of the foremost common reasons for withholding or withdrawing life support is that the patient has a very poor prognosis and is unlikely to improve. Although there are published guidelines for withholding and withdrawing life support, the actual implementation of such measures is often difficult for the health care team members likewise because the patient and family. Physicians may have a difficult time discussing such interventions with patients and families, and this successively may result in the continuation of treatments that are medically inappropriate, increase suffering, or are futile. The patient and family members must be allowed sufficient time to reach a consensus about whether to discontinue life support. It's their decision. This is a process that's made easier by the availability of consistent, compassionate, accurate information about the patient's prognosis and certain course. Ongoing nurse-physician communication is important so the patient, where possible, and therefore the family, is given consistent information about the patient's status. Clear documentation as indicated earlier is additionally essential so all members of the team and others involved within the patient's care are clear about the goals of care and treatment care.

Withdrawing Life Support

Withdrawing life support could also be emotionally tougher than withholding life support because the physician performs an action that hastens death [5]. When life-sustaining treatment is withheld, on the

opposite hand, death occurs because of an omission rather than an action. However, as most bioethicists now recognize, such a distinction lacks ethical significance. First, the distinction is commonly meaningless. as an example, if a physician fails to produce a tube feeding at the scheduled time, wouldn't it be a withholding or a withdrawing of treatment? Second, ethical relevance doesn't lie with the distinction between acts and omissions but with other factors, like the motivation and professional obligations of the physician. as an example, refusing to initiate ventilator support, despite the patient's need and request, because the physician has been promised a share of the patient's inheritance is clearly ethically more objectionable than stopping a ventilator for a patient who has competently decided to forgo it. Third, prohibiting the withdrawal of life support would inappropriately affect a patient's decision to initiate such treatment. If treatment cannot be stopped once it's initiated, patients and physicians could also be more reluctant to begin treatment when there's a possibility that the patient may later want the treatment withdrawn.

While the principle of autonomy requires that physicians respect competent patients' requests to forgo life-sustaining treatments, there are potential negative consequences of such a policy. First, deaths may occur as a result of uninformed decisions, or from pain and suffering that would be relieved with measures which will not cause the patient's death. Further, subtle or overt pressures from family, physicians, or society to forgo life-sustaining treatment may render the patient's choice less than free. These pressures could revolve around beliefs that such patients' lives no longer possess social worth and are an unjustifiable drain of limited health resources.

The physician must ensure that the patient has the capacity to create medical decisions before carrying out the patient's decision to forgo (or receive) life-sustaining treatment. in particular, physicians must be aware that the patient's decision-making capacity is diminished by a misunderstanding of the medical diagnosis and options or by a treatable state of depression. It's also essential that everyone efforts be made to maximise the comfort and dignity of patients who are dependent on life-sustaining treatment which patients be assured of those efforts. With such assurances, patients will be less likely to forgo life support because of suffering or anticipated suffering that would be palliated.

ADRT

An ADRT (advance decision to refuse treatment) is

considered valid if it [6]:

- Is written by an individual aged 18 or over who had the capacity to form, understand, and communicate the decision when it absolutely was made.
- Has clearly specified which treatments they need to refuse.
- Has explained the circumstances during which they want to refuse them.
- Is signed by the individual and by a witness if he or she wants to refuse life-sustaining treatment.
- The individual has made the advance decision of their own accord, with none harassment by anyone else.
- The individual has not said or done anything that might contradict the advance decision since it was made.

Some proformas of ADRTs are available online, and also the National Health Service (NHS) Improving Quality has published guidance in collaboration with the National Council for Palliative Care.

However, significant problems with ADRTs are raised. there's no national registry for ADRTs, so finding whether a patient has one may be difficult. Some general practitioners (GPs) don't seem to be aware of the legal constraints on validity, and a few lawyers aren't aware of the details of medical treatments, so that, of the few ADRTs that are written, many don't seem to be valid. an easy wish to not have cardiopulmonary resuscitation (CPR) attempted, as an example, might not be considered valid if the circumstances within which the arrest happened aren't documented. To be legally binding, it might must be written: 'should my heart stop, i'd not want any attempts at resuscitation, in any circumstance. I understand that this is a refusal of life-sustaining treatment' then have it dated and signed. But this sort of ADRT may force people into extremes they didn't mean to instruct; what about a patient who is choking? So, then someone might write: 'I don't wish to have resuscitation attempted unless there's a transparent reversible cause'—but then is hyperkalemia a transparent reversible cause? Would you wait until you knew the potassium before stopping CPR?

One approach to the present problem is to make sure that an 'advance statement' coexists with the ADRT. While patients don't have the proper to request treatments, they'll write about their treatment preferences (e.g., 'I would really like to die at home if possible' or 'I would really like all treatments to prolong life to be considered' or 'quality of life is that the most significant thing for me: please only give me

treatments if you're thinking that i've got a good chance of retaining my mental functions'). Providing treating clinicians with an 'advance statement' alongside an ADRT allows them to interpret the ADRT for the circumstances that exist. a brand-new charity, 'Advance Decisions Assistance', has mocked up some appropriately legally and medically worded ADRTs and combined them with 'values statements' to travel alongside them, to assist patients in understanding what might help ensure their wishes are respected.

Death

Death is a process, rather than an event: this could make it difficult to define when death occurs [7]. Nevertheless, it's important to have a legal definition of death for various reasons. It is important for property purposes, likewise as in relation to organising estate and probate matters. Clearly, defining death is additionally vitally important for those involved in organ transplantation from deceased donors, as organs can't be lawfully removed until the donor has been declared dead. This can be underpinned by what's colloquially known as the 'dead donor rule', which holds that 'patients must be declared dead before the removal of any vital organs for transplantation'. Historically, it had been relatively easy to determine death – a person's heart ceased to beat, and that they stopped breathing. With advances in medicine and (bio)technology, however, the cessation of the heartbeat or of breathing doesn't necessarily mean someone is dead. Cardiac arrest has been followed by successful resuscitation and artificial ventilation has also improved techniques in resuscitation and provided life support for people who are severely ill or are seriously injured.

Ethics

Modern philosophy links the definitions of morality and ethics [8]. Within the simplest forms, morality is that the difference between right and wrong, while ethics represents the critical study of morality. Individuals make a choice from a spread of sources of ethical authority, like religion, cultural norms, politics, and law. As such, persons may regard situations or objects differently, supported the worth systems espoused by their source of ethical guidance. Ethics represents the cognitive evaluation of a principle or situation, acknowledging the actual fact that individuals possess different moral backgrounds. Ethical dilemmas arise when there's a conflict of values between persons advocating competing moral imperatives – when people cannot agree on what's right and what's wrong.

Medical ethics is a discipline that studies differences in value systems as they apply to clinical situations. Medical ethics is most typically taught through classroom discussion, as a method to familiarize providers with common ethical principles. Applied health care ethics is that the practical extension of such discussion, recognizing that like all clinical decision-making, ethical dilemmas require action. The word "applied" then refers to the reality that physicians mediate ethical dilemmas and make tough decisions daily. they're not philosophers, but practitioners of medical philosophy.

Most American physicians guide their ethical decision-making from duty-based concepts known as the "principles of biomedical ethics." These principles include respect for autonomy, non-maleficence, beneficence and justice. Respect for autonomy is demonstrated when the patient is given the ability to exhibit self-governance, or self-determination. Patients should be allowed to create choices regarding their own health care. Non-maleficence is loosely translated into the statement "do no harm." Physicians have an ethical obligation to limit the risks of poor outcomes which will result from diagnostic or therapeutic interventions. Beneficence in health care refers to the fundamental challenge to optimize a patient's condition and well-being; this could be through treatment of disease or provision of comfort care. Justice refers to the fair and equal treatment of patients, both in access to and quality of health care. Justice is additionally manifest through systems and institutional ethics, which in today's marketplace must answer the reality of limited health care resources.

All difficult situations faced by patients with serious illness and their families potentially have ethical ramifications [9]. These are more likely to be recognized as "ethical issues" when someone perceives some kind of conflict or tension. Conflict or tension can arise when the various parties involved within the patient's care assign different levels of importance to competing values (e.g., comfort and longevity; alertness and symptom control) or particular healthcare options. These parties might include patients, families/friends, members of the healthcare team, regulatory bodies and/ or payers. additionally, these parties might themselves feel torn among competing views and perspectives.

Ethical issues may be viewed as dilemmas or problems. Taking a "dilemmatic" view, situations are seen as involving a choice between two or more incompatible options, and therefore the task is to select the "best" answer. for instance, clinicians might wonder, should they follow a patient's previously

stated wishes to avoid prolonged life support or follow the wishes of the patient's appointed healthcare proxy, who insists that this exceptional circumstance warrants mechanical ventilation? A dilemmatic view assumes that all options are known, discrete, mutually exclusive, and unlikely to change over time (at least before a brand new situation emerges that a separate decision will be needed). Taking this view, the clinician can engage during a decision analysis that mixes the clinical evidence and therefore the patient's preferences for the choices and their likely outcomes. Ultimately the task is seen as that of identifying which of the available options is "best."

Law

Life ends when a human being stops breathing, the heart stops pumping, and the brain ceases to function [10]. Within the usual case, all three functions will disappear simultaneously or almost simultaneously. As an example, 'cardiac arrest' produces respiratory failure which rapidly produces 'brain death' where the cessation of brain function is irreversible.

Advances in life science have rendered it possible for a variety of life to continue although one or other of those functions is lacking. Someone suffering from respiratory failure could also be kept alive by mechanical ventilation. The blood may be made to circulate within the absence of effective cardiac function. Under such conditions life might not be 'worth living', but it's nevertheless a form of life. Removing these artificial aids will precipitate the irreversible loss of brain function responsible for consciousness, sentience and everything else which distinguishes an animal from a cadaver. In short, it'll 'kill' the patient in a sense we will all recognise. This condition is known as 'brain death'. This is generally described as involving the irreversible loss of all functions of the brain including the brainstem. These functions comprise breathing, circulation, responsiveness to stimuli, muscle activity and electrical brain activity. Where 'brain death' has occurred, the removal of life support will don't have any meaningful consequence for the patient. Under such circumstances, the only interest advanced by maintaining such functions are the possible public interest within the provision of organs for transplant. The sensible position taken at common law is that an individual who has suffered brain death is legally dead. The legal consequence of this can be that such an individual can not be 'killed', whether by a health professional or, one must assume although there's no authority on the matter, by anyone else.

The removal of artificial life support where brain death has not occurred leads to the death of an individual

'in being'. Life 'of a sort' continues as long because the brain is capable of function while there are many conditions within which that function is so attenuated on remove any recognisably human characteristics whatsoever. An example is persistent vegetative state, an irreversible coma where the brain stem functions but little else. The removal of life support to an individual suffering PVS (persistent vegetative state) is lawful if performed by medical practitioners since their duty to sustain life lasts only so long because the patient's interests are being furthered. It'll not, however, be lawful if performed by a stranger or member of the patient's family, however hopeless the patient's condition. Removing life support is interpreted, within the case of medical practitioners acting in accordance with their duty, as 'letting the patient die'. Otherwise it's an unlawful killing, even as if a lethal injection had been administered.

Conclusion

Early identification of life-threatening conditions and an effective procedure in their elimination is a basic prerequisite for good medical care. Knowledge and application of the principles of early detection and timely treatment in many cases can prevent critical deterioration of the patient's condition, cardiopulmonary arrest and death. The clinical signs and physiological parameters that occur in life-threatening conditions are a reflection of disorders of the respiratory, cardiovascular and neurological systems and are generally similar regardless of their cause. A structured approach to assessing the condition of a critically ill person ensures that those life-threatening conditions are noticed and treated in a timely manner.

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