What to Do When the Patient's Goals are Non-Medical?

Our position is that the patient's goal to prolong her life is, in fact, a typical, if not the most common, goal of medicine. That her life expectancy is short and her quality of life is perceived to be low do not override the legitimacy of her desire to prolong her life. Her motive for preferring aggressive life support rather than only "comfort measures" is indeed personal, not medical, but life extension itself is a well established goal of medicine.

Stating the problem as what to do when a patient's goals are non-medical is somewhat misleading because patients' preferences are often influenced by both medical goals and non-medical motives or intentions. Patients enter the health care system with personal values that explain what they care more about, what they care less about, and which goals, motives, or purposes they may wish to pursue. For example, a terminal patient may choose aggressive therapy because he is a 17-year-old and desires to stay alive long enough to graduate with his high school class; or a 47-year-old may make the same decision because he wishes to see his daughter's wedding; or, as in this case, an 87-year-old may ask that her life be prolonged "long enough for her divorce to be finalized so that the appropriate inheritance could go to her children." The medical goal in all three instances is to promote the continuance of life by whatever means are available. The non-medical motive is to be alive for a specific event: a graduation, a wedding, a divorce.

Similarly, a patient will have non-medical reasons for refusing recommended treatment options that might well promote the medical goal of restoring health. A 27-year-old might refuse a radical mastectomy because she is concerned about her disfigurement; her non-medical intention is to retain her sense of bodily integrity and pleasing appearance.
A 57-year-old might decline a coronary bypass procedure because of the financial and emotional burdens it could place on his family; his non-medical purpose is to remain financially solvent and to ensure the psychosocial well-being of other family members. A 77-year-old cancer patient may refuse additional chemotherapy because his future life appears meaningless since the death of his spouse; his non-medical preference is to appreciate the life he has enjoyed while accepting the inevitability of his own death.

This particular case also raises another interesting question: should the patient’s age be a factor in the decision-making process? Callahan has asserted that there are only two proper goals of medicine: relief of suffering and extension of life (1). Additionally, he makes the controversial claim that providing medical care to the aged, defined by him as late seventies or early eighties, should be limited to the relief of suffering. Under his scheme, aggressive medical technologies should not be used to extend the lives of elderly persons who have already lived out a natural life span, because the treatment plan cannot offer the patient "any hope of being restored to good health." However, in this case, the patient is not looking for a miraculous restoration to good health; rather, she wants only the opportunity to attain a meaningful life goal according to her own personal values. Her decision is not based on false hope but on a realistic assessment of the situation. To deny her the option of extending her life on the basis of age alone does not respect her personhood.

It is well documented that competent patients have an absolute right to refuse medical care that is recommended by their physicians; it is controversial, however, whether and to what extent a patient has the right to demand to receive treatment. Who should decide when a conflict occurs between the patient’s and families’ request to “do everything” for end-of-life patients and when the judgment of the health care providers is to recommend limiting or withdrawing aggressive treatment? In the Helga Wanglie case, a state district court ruled that her husband had the right to demand continuation of ventilator support despite the objections of the hospital staff who argued that physicians were not obliged to provide treatment that was no longer beneficial to the patient, in this case a permanently unconscious octogenarian (2). "Justification for the staff’s position was drawn from accepted professional standards of medical practice and the rejection of a preference for life at all costs" (2, p. 25). It would grossly oversimplify the complexities and ambiguities of this case.