Certificate in Bioethics and Philosophy of Medicine

End of Life Decision Making

Advance Directive – a written statement in which an individual specifies preferences for medical treatment in circumstances when they are no longer capable of communicating decisions. Related terms: living will, durable power of attorney for health care, substitute decision-maker. Example: a patient with progressive ALS drafts an advance directive refusing mechanical ventilation. Practical application: health-care providers review the document before initiating life-sustaining measures. Challenges: variability in legal recognition across jurisdictions and difficulty interpreting vague language about “quality of life.”

Advance Care Planning – a systematic process of discussing and documenting future health-care preferences, goals, and values with patients, families, and clinicians. Related terms: shared decision-making, goals-of-care conversation, patient-centered care. Example: a geriatric clinic integrates a structured advance care planning session into annual wellness visits. Practical application: facilitates timely alignment of treatment with patient wishes. Challenges: time constraints, cultural differences in discussing death, and limited provider training.

Aid in Dying – the provision of medication or assistance that enables a competent adult to intentionally end his or her own life to relieve suffering. Related terms: physician-assisted suicide, voluntary euthanasia, lethal injection. Example: in jurisdiction X, a terminal cancer patient obtains a prescribed lethal dose under strict safeguards. Practical application: offers a legal route for patients seeking control over timing of death. Challenges: ethical controversy, risk of coercion, and variability in eligibility criteria.

Beneficence – the ethical principle obligating health-care professionals to act in the best interests of patients, promoting well-being and preventing harm. Related terms: non-maleficence, paternalism, therapeutic beneficence. Example: a surgeon decides to withhold a high-risk operation that offers only marginal benefit. Practical application: guides clinicians when weighing aggressive interventions against comfort-focused care. Challenges: balancing beneficence with respect for patient autonomy, especially when preferences diverge from clinical judgment.

Capacity Assessment – the evaluation of a patient’s ability to understand information, appreciate consequences, reason about options, and communicate a choice regarding health-care decisions. Related terms: decision-making capacity, competency, mental status exam. Example: a psychiatrist conducts a capacity assessment for an elderly patient who refuses feeding tubes. Practical application: determines whether a surrogate decision-maker may be invoked. Challenges: fluctuating capacity, subjectivity in assessment tools, and potential bias.

Do-Not-Resuscitate (DNR) Order – a medical order indicating that cardiopulmonary resuscitation (CPR)

should not be performed if the patient's heart stops or breathing ceases. Related terms: DNAR, no-code, code status. Example: a hospice patient with metastatic disease has a DNR documented in the chart. Practical application: prevents unwanted invasive interventions during cardiac arrest. Challenges: ensuring patient and family understanding, documentation errors, and institutional policies that may conflict with patient wishes.

End-of-Life (EOL) Care – a multidisciplinary approach that addresses physical, emotional, spiritual, and social needs of patients approaching death. Related terms: palliative care, hospice, comfort care. Example: a multidisciplinary team provides symptom management for a patient with end-stage heart failure. Practical application: improves quality of life and reduces unnecessary hospitalizations. Challenges: resource limitations, cultural attitudes toward death, and coordination across care settings.

Euthanasia – the intentional act of a health-care professional to cause the death of a patient, at the patient's request, to relieve suffering. Related terms: active euthanasia, passive euthanasia, physician-assisted suicide. Example: in Country Y, a physician administers a lethal injection to a patient with irreversible neurodegenerative disease. Practical application: legal in limited jurisdictions, often subject to strict procedural safeguards. Challenges: profound ethical disagreement, risk of slippery-slope arguments, and societal implications.

Futility – the assessment that a medical intervention will not achieve its intended physiological effect or will not provide a benefit aligned with the patient's goals. Related terms: physiological futility, quantitative futility, qualitative futility. Example: administering chemotherapy to a patient with terminal pancreatic cancer who is unlikely to experience tumor reduction. Practical application: guides clinicians in discontinuing non-beneficial treatments. Challenges: differing interpretations of "benefit," potential conflict with family wishes, and legal ramifications.

Informed Consent – the process by which a competent patient voluntarily agrees to a proposed medical intervention after receiving adequate information about risks, benefits, alternatives, and uncertainties. Related terms: disclosure, autonomy, shared decision-making. Example: a physician explains the risks of a tracheostomy to a patient with chronic respiratory failure before obtaining consent. Practical application: protects patient autonomy and legal accountability. Challenges: ensuring comprehension in cognitively impaired patients and addressing emotional distress that may impair decision-making.

Living Will – a type of advance directive that specifically outlines the types of life-sustaining treatments a person does or does not want when they are no longer able to communicate. Related terms: advance directive, health-care proxy, treatment preferences. Example: a patient states in a living will that they do not wish to receive artificial nutrition if in a permanent vegetative state. Practical application: provides clear guidance to clinicians during emergencies. Challenges: ambiguous language, updates over time, and conflicts with surrogate decisions.

Medical Futility Policy – institutional guidelines that define criteria, processes, and dispute-resolution

mechanisms for determining when to withhold or withdraw treatments deemed futile. Related terms: ethics committee, conflict resolution, policy framework. Example: a hospital policy requires a second-opinion review before discontinuing dialysis deemed futile. Practical application: standardizes decision-making and reduces moral distress among staff. Challenges: variability in policy interpretation and possible tension with state law.

Non-Beneficial Treatment – an intervention that does not improve the patient's health status, relieve suffering, or align with the patient's expressed goals. Related terms: overtreatment, low-value care, therapeutic inertia. Example: continuing intravenous antibiotics for a patient with terminal sepsis who has refused further treatment. Practical application: facilitates resource stewardship and respects patient preferences. Challenges: distinguishing between "non-beneficial" and "potentially beneficial" in uncertain prognoses.

Palliative Sedation – the monitored use of medications to reduce consciousness for the purpose of relieving intractable suffering in a patient near death, when other symptom-control measures have failed. Related terms: terminal sedation, refractory symptoms, proportional sedation. Example: a patient with advanced lung cancer experiences uncontrolled dyspnea; clinicians initiate palliative sedation. Practical application: alleviates severe distress while maintaining ethical distinction from euthanasia. Challenges: determining proportionality, obtaining informed consent, and addressing family concerns.

Patient-Centered Goals of Care – individualized objectives for treatment that reflect the patient's values, preferences, and life-context, rather than disease-oriented targets. Related terms: goals-of-care conversation, value-based decision-making, narrative medicine. Example: an elderly patient prioritizes staying at home over extending life by a few weeks. Practical application: shapes care plans, including decisions about ICU admission or hospice enrollment. Challenges: eliciting authentic goals, reconciling differing family perspectives, and integrating goals into fast-paced clinical environments.

Physician-Assisted Suicide (PAS) – the act of a physician providing a patient with the means to end his or her own life, typically by prescribing lethal medication, upon the patient's voluntary request. Related terms: aid in dying, self-administration, lethal prescription. Example: a patient with ALS receives a prescription for a barbiturate under a jurisdiction's PAS law. Practical application: offers a regulated pathway for patients seeking control over dying. Challenges: professional conscience objections, fear of misuse, and legal liability.

Quality-Adjusted Life Year (QALY) – a metric that combines length of life with a weighting for health-related quality of life, used in health-economic evaluations and sometimes in end-of-life resource allocation. Related terms: utility, cost-effectiveness, health economics. Example: a new drug for terminal cancer adds 0.2 QALYs at a high cost, prompting policy debate. Practical application: informs decisions about funding high-cost therapies. Challenges: ethical concerns about valuing life, especially in vulnerable populations, and cultural differences in quality-of-life assessments.

Respect for Autonomy – the ethical principle that acknowledges individuals' right to make informed,

voluntary decisions about their own bodies and medical care. Related terms: self-determination, informed consent, patient empowerment. Example: a competent adult chooses to decline a recommended surgical procedure despite physician advice. Practical application: underpins legal standards for consent and refusal. Challenges: balancing autonomy with beneficence when choices appear self-harmful, and addressing cultural contexts where collective decision-making is normative.

Shared Decision-Making (SDM) – a collaborative process in which clinicians and patients (and often families) exchange information, discuss preferences, and arrive at mutually agreed-upon health-care choices. Related terms: decision aid, deliberative dialogue, patient participation. Example: a decision aid helps a patient with advanced heart failure weigh options between ventricular assist device implantation and comfort-focused care. Practical application: improves satisfaction, adherence, and alignment with values. Challenges: time pressures, health-literacy barriers, and reconciling divergent opinions.

Surrogate Decision-Maker – an individual legally authorized to make health-care decisions on behalf of a patient who lacks decision-making capacity, often guided by the patient's prior expressed wishes or best-interest standards. Related terms: health-care proxy, durable power of attorney, fiduciary. Example: an adult child acts as surrogate for a parent with severe dementia, choosing hospice enrollment. Practical application: ensures continuity of decision-making when capacity is lost. Challenges: surrogate conflict, uncertainty about patient's values, and jurisdictional differences in authority.

Terminal Illness – a disease that is expected to lead to death within a relatively short time frame, often defined as six months or less, despite optimal treatment. Related terms: end-stage disease, life-limiting condition, prognosis. Example: metastatic breast cancer with extensive organ involvement is classified as a terminal illness. Practical application: triggers eligibility for hospice and prompts goals-of-care discussions. Challenges: prognostic uncertainty, denial, and variable patient acceptance.

Therapeutic Futility – a subset of futility focusing on interventions that, even if physiologically successful, will not achieve a meaningful benefit as defined by the patient's goals or acceptable quality of life. Related terms: qualitative futility, patient-defined benefit, value-based futility. Example: initiating aggressive chemotherapy for a patient who values comfort over any extension of life. Practical application: supports ethically justified refusal of non-beneficial treatments. Challenges: subjective nature of "meaningful benefit," cultural differences, and potential legal disputes.

Withdrawal of Life-Sustaining Treatment (WLST) – the deliberate discontinuation of interventions such as mechanical ventilation, dialysis, or artificial nutrition that are maintaining a patient's physiological functions. Related terms: treatment limitation, de-escalation, end-of-life decision. Example: a family consents to removal of a ventilator in a patient with irreversible brain injury. Practical application: aligns care with patient values and avoids prolonging suffering. Challenges: emotional distress for families, procedural safeguards, and distinguishing withdrawal from euthanasia.

Willful Killing – an act, performed by a health-care professional, intended to cause the death of a patient,

distinct from letting a disease take its natural course. Related terms: homicide, intentional killing, legal distinction. Example: a physician administers a lethal dose of medication without patient request, constituting willful killing. Practical application: generally illegal and ethically prohibited, except where specific statutes (e.g., PAS) provide a legal framework. Challenges: defining intent, differentiating from permissible palliative measures, and legal consequences.

Whole-Person Palliative Care – an approach that integrates physical symptom control with attention to emotional, spiritual, social, and cultural dimensions of suffering at the end of life. Related terms: holistic care, interdisciplinary team, compassionate care. Example: a palliative care team includes a chaplain, social worker, and pharmacist to support a patient with advanced lung cancer. Practical application: improves overall well-being and may reduce health-care costs. Challenges: resource allocation, training multidisciplinary staff, and measuring outcomes beyond symptom relief.