What is the ethical thing to do when a patient is refusing life-preserving care? This is the dilemma providers faced when 26-year-old Elizabeth Bouvia checked herself into the psych ward of a California hospital in 1983. Elizabeth's cerebral palsy had progressed to quadraplegia, but the doctors deemed that as long as she had nutrition, she could easily live another 15-20 years. She was mentally competent when she refused artificial nutrition via an NG tube, stating that her suffering was too great and she wanted to succumb to her illness (Liang 177-182). What happened next raised a profound ethical dilemma and would send ripples throughout healthcare: Elizabeth's team forcibly placed an NG tube inside of her against her will. Elizabeth went on to sue the hospital, but the initial court decision ruled against her, and she was mandated to receive NG feedings. After appealing this decision, an appellate court sided with Elizabeth's autonomy to refuse treatment. Should Elizabeth's autonomous decision to refuse life-sustaining therapy be overridden by the healthcare team's commitment to beneficence?

The two core ethical principles that are front and center in this case are autonomy vs. beneficence. Autonomy states that a mentally competent person has the right to make decisions about their health care, which is informed by their beliefs, values, and personal preferences. Beneficence states that caregivers aim to provide the greatest amount of good for, and act in the best interest of, their patients. The hospital and the state argued in favor of beneficence, stating they are obligated to give Elizabeth feedings for 3 reasons: to preserve life, prevent suicide, and maintain the ethical standard of the medical profession. Conversely, Elizabeth was arguing in favor of autonomy; it was her right to refuse treatment despite the consequences. In the appellate court, the following excerpt speaks volumes about Elizabeth's quality of life and how this influenced her decision making: "In Ms. Bouvia's view, her quality of life has been diminished to the point of hopelessness, uselessness, unenjoyability, and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless" (Liang 177-182).

I am in full support of the appellate court, which decided that the hospital could not override Elizabeth's autonomy in their desire to preserve life. While the state tried to argue that the hospital was justified in forcing the NG feedings, Elizabeth's team made a point that is fundamental to the principle of patient autonomy: a competent individual has the right to refuse medical treatment, regardless of their condition. By focusing solely on Elizabeth's need for life-sustaining care, the state overlooked this essential right. A statement from the AMA clearly supports this stance: "The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail" (AMA 2.20). I believe that for a person in Elizabeth's position, the only one who can truly determine their lived experience is Elizabeth herself. Therefore, in the matter of end-of-life care, autonomy must take precedence over beneficence.

The hospital's team presented a valid concern which was addressed by the courts, setting a precedent for future ethical dilemmas: Does the withdrawal of life-sustaining care qualify as assisted suicide, violating core principles of medical ethics? The appellate court clarified that withdrawal of life-sustaining therapy is distinct from physician-assisted suicide and is an expression of a patient's autonomy to accept the fate of their underlying illness. This clarification from the court provides a framework for clinicians to traverse this ethically difficult landscape without compromising their core principles (Liang 177-182).

The case of Elizabeth Bouvia highlights the complex ethical landscape that can arise when a patient's autonomy may seemingly conflict with the principle of beneficence. The key to traversing these dilemmas is open communication centered around the patient's experience, preferences, and values. As a future provider, I believe the art of medicine will lie in balancing the ethical principles while guiding patients towards care that reflects their core values and beliefs. This case will forever serve as a benchmark, showcasing the importance of patient autonomy related to end-of-life care.

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