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COMMENTARY

Responding to a Non-Imminently Dying Patient's Request for Pacemaker Deactivation

Kelsey Gipe

Program in Medicine and Human Values, California Pacific Medical Center, San Francisco, CA, USA and Department of Thanatology, Marian University Wisconsin, Fond du Lac, WI, USA
Email: gipe.kelsey@gmail.com

Based on Nathan Goldstein's case report, "But I have a pacer…there is no point in engaging in hypothetical scenarios": A Non-imminently Dying Patient's Request for Pacemaker Deactivation, it is reasonable to conclude that it was, all-things-considered, ethically appropriate to grant the patient's request to deactivate her pacemaker. Philosophically, and as a clinical bioethicist, I support the team's decision to honor the patient's request for pacemaker deactivation. However, it is worth exploring a bit further whether the distress on the part of the outside hospital's ethics committee and providers—who declined to honor the patient's request for pacemaker deactivation—may actually track something of moral significance. Might their discomfort around deactivation be "truth-tracking" in moral terms?

The relevant driving intuition here, put simply, is that when a device like a pacemaker has been implanted inside of a patient and becomes a feature of their daily life, it seems importantly different from ICU-level life support machines to which the patient is only connected in the acute setting and which operate largely external to the patient. Deactivating or otherwise compromising the functioning of such an object may very well *feel* more akin to actively ending a patient's life rather than a standard case of withdrawal of life support. What might account for this feeling of difference?

It has been argued that pacemakers are part of a class of "biofixtures": objects that become part of a patient in a morally significant way such that they more closely resemble—in moral terms—a native body part rather than a typical life support therapy.[1] In this view, a pacemaker would more closely resemble the conduction system of a native heart than it would a ventilator or hemodialysis machine. A pacemaker is a destination therapy that fulfills a function pathologically lost by the body. Once implanted, pacemakers are fully internal and integrated within the patient's body. Burdens are typically minimal, such that patients may "forget it is even there" in the course of their day-to-day life. On the basis of these features, it can be argued that a pacemaker should be considered to be a part of the patient in the morally significant sense that grounds biofixture status.[2]

If deactivating a pacemaker qua biofixture is morally more akin to compromising the function of a native heart than to removing a patient from a ventilator, it makes sense that providers might experience discomfort at a request to deactivate a pacemaker, particularly when the request is presented under the description of "withdrawal of life support." A person can endorse the moral permissibility of medical aid in dying (MAiD) and at the same time be uncomfortable being asked to do something that they feel resembles MAiD as if it were simply another instance of life support being withdrawn. This discomfort would likely be greater the further the patient is from imminent death.

The intuitions and considered judgments underlying this feeling of discomfort may be outweighed by other considerations, as they were in the case presented. It is worth noting that, while not imminently dying, the patient did have a progressive disorder that, in the absence of other life-ending health crises, would eventually lead to her death: Alzheimer's dementia. Although the patient declined to trade in hypotheticals when asked by the outside hospital's ethics committee, her subsequent choice to Voluntarily Stop Eating and Drinking (VSED) was, in effect, her answer to the committee's question. The patient's decision made it clear that without a pacemaker, and under the same circumstances, she simply would have declined to eat and drink until she passed away. Actions, after all, do speak louder than

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words. The patient thus appeared to be confident in her judgment that a life of progressive deterioration due to dementia was not acceptable and her action bore out the consistency and durability of her stated preferences. Even the patient's guilt over "cheating" when she would sneak a sip of water speaks to how important avoiding a future of advanced dementia was to her. And, it is clear that a quicker death following pacemaker deactivation would entail less suffering than a prolonged death due to VSED. On the basis of these considerations, respect for the patient's autonomy and a moral responsibility to minimize unnecessary suffering ultimately outweigh concerns regarding the provision of MAiD as if it were simply another instance of withdrawal of life support.

Even if pacer deactivation, in this case, can reasonably be viewed as morally akin to MAiD rather than a standard case of withdrawal of life support, it is important to note that in the current landscape of MAiD in the United States, access is extremely limited. In such a context, deactivation under the heading of "withdrawal of life support" may be the most ethically appropriate option despite potential theoretical commitments to the concept of a pacemaker as a biofixture and accompanying moral entailments. Providers should generally be honest and thoughtful about what they are doing, but the duty to alleviate suffering and respect patient autonomy means that sometimes providing a service morally analogous to MAiD, under a different description, may be ethically appropriate—and even desirable.

Notes

1. See Gipe K. Heartbeats, burdens, and biofixtures. *Cambridge Quarterly of Healthcare Ethics* 2021;**30**(2):285–96.
2. See Gipe K. *Journal of Medicine and Philosophy* 2024; forthcoming.

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