or 39/340. Of the patients who survived, the underlying prognosis continued to be poor, and the patients left our institution to a hospice setting. There were no survivors to discharge in 1994 or 1995. We do not know the length of survival after discharge; however, we do not believe that is relevant. The goals of terminal weaning are to reduce a patient’s distress, remove burdens, and permit a more natural illness/injury course. The length of survival after weaning is less relevant than the patient/family comfort and satisfaction during and after the wean.

We disagree with Gilligan and Raffin when they suggest that the goal of withdrawing care is death. Death is not the goal, it is the predicted outcome. If death is the goal, then there are more successful interventions than terminal weaning, such as active euthanasia.

In conclusion, we believe the following factors. First, the goal of terminal weaning is to reduce patient distress, remove unwanted therapy, and allow a more natural illness/injury course. Second, terminal weaning over a period of minutes to hours is an optimal method for ventilator withdrawal. The method should be adjusted for each patient to give consideration to their specific comfort needs, with consideration of their underlying pathology and consciousness. Our experience suggests that the wean can occur more quickly (avg 30-60 min) in coma, and over a few hours for more awake patients (a very few of our awake, autonomous patients did not want deep sedation). A longer period of time, such as days, may be a physical or emotional strain for all involved. Third, we cannot support a position that a prolonged wean will permit communication of the possibility of survival. The goal of weaning is to reduce an unwanted, or useless, or burdensome intervention when the patient is not expected to survive. Communicating something different is ambiguous and may confuse the patient or family. We do acknowledge that some patients will survive long enough to leave the hospital for a community-based hospice setting; however, the prognosis for long-term survival has not changed. Fourth, more research needs to be done to analyze patient responses during this process. And finally, we are convinced that point-counterpoint articles such as those by Gianakos, and Gilligan and Raffin are important and useful to clinicians who deal with these issues.

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To the Editor:

At Saint Vincent’s Hospital and Medical Center, the members of the department of Critical Care Medicine have been directly involved in all ventilator withdrawal requests since the approval of such a policy in 1988. Withdrawal of ventilatory support may occur in the ICU as well as the general medical floor, where many ventilated patients are moved when aggressive measures are no longer indicated and a do not resuscitate order has been obtained. The number of ventilator withdrawals may be greater than two per month. With this extensive experience our department agrees with Dr. Raffin and Dr. Gilligan that prolonging the process with a so-called “terminal wean,” only prolongs the suffering for the family when they are ready to mourn. Also in our experience the nursing staff, respiratory therapists, physicians, and house staff are uncomfortable caring for such a patient when the ventilator withdrawal process is drawn out.

Finally throughout the years, I cannot remember a patient who was discharged from the hospital once ventilatory support was withdrawn.

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Get Real, Dr. Stobo

To the Editor:

Physicians are quite as intolerant as theologians. They never had the power of burning at the stake for medical opinions, but they certainly have shown the will.

—Harriet Beecher Stowe, 1866

Dr. John D. Stobo, the William Osler Professor of Medicine at Johns Hopkins and physician-in-chief at its hospital, urges us to be intellectually curious. We should have “a burning desire to ask a question,” he says (CHEST 1995; 108:565-69).

Intellectual curiosity might be fine for him, but for everyone else practicing in the stultifying atmosphere brought about by the audit/peer review/guidelines movement, it’s suicide. Sooner or later, a curious physician will challenge received wisdom, but adherence to standard practice is what peer reviewers enforce.

Patients want cures, and care nothing about how they’re achieved, nor should they. Peer reviewers demand adherence to standard treatments, which give such outcomes as they may, and care nothing about cures. Despite ceaselessly blowing their horn about better outcomes, no reviewer auditing, say, a practicing physician in a community hospital, will be at all susceptible to a demonstration that the doctor got better results than he would have attained by standard methods. Peer reviewers are not about to put themselves out of business by tolerating innovation and the doctor’s best judgment. In short, it’s deviation that’s the crime, and the punishment, death of career and livelihood.

Four years ago in the Lancet,1 I asked how a knowledgeable physician should act if he is the first to suspect that a standard practice is harmful. Our doctor can be guided only by experience and intuition, I said, and because he’s the first, he can cite no published work. Most important, he cannot ask his patient to return in 5 or 10 years, when doctors might know more. That is, his patient cannot await the fullness of time, in which most standard practices have been overthrown. I gave a number of historical examples and here mention just a few more.

Every 19th-century doctor knew that masturbation posed a grave threat to physical and mental health. When Kintighoven laid a cable through the streets of Leiden from a hospital to his physics laboratory to record his first three-lead electrocardiogram, his colleagues thought he had gone insane, but in 1924 he won the Nobel Prize.2 Forssman, who performed the first human catheterization on himself in 1929, was eventually fired for his “foolish act.”3 Ilizarov,

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