Death in the ICU

Feelings of Those Left Behind

Heyland and colleagues deserve congratulations for their study, “Dying in the Intensive Care Unit: Perspectives of Family Members” in this issue of CHEST (see page 392). In this multicenter study conducted at tertiary care centers, the authors documented the fact that 83% of family members were satisfied with the care that their loved ones received. The authors credit the good communications, decision making, respect, and compassion shown in the care of patients and their families for these results. The experience of the American investigators has been much less satisfactory than their Canadian counterparts. Lynn and colleagues1 reported in 1997 on the larger Study To Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT) and the Hospitaled Elderly Longitudinal Project. They were less sanguine about their findings. On interviewing surrogates of the elderly or seriously ill patients who had died within a year of the hospitalization, they found that almost 60% of patients would have preferred comfort care. They also discovered that in 10% of the cases, care was contrary to the preferred approach. The 11% rate of attempted resuscitation was almost four times higher than the 3% rate in the study by Heyland et al. The SUPPORT study revealed that one third of the patients were in unexpected pain at the time of death vs good pain management found in 90% of Canadian patients.

Lynn et al referred to the only substantial study published by legendary William Osler in 1908. Reporting on 486 deaths at Johns Hopkins, he was convinced that only 90 patients felt pain at the time of death. Unfortunately, Osler’s own end was not free of pain! Nuland,2 through Osler’s own words, provides a poignant description of the 6 weeks of his enduring sharp pleuritic pain and bouts of coughing. In those primitive days, he had undergone two operations to drain empyema under general anesthesia. Two weeks later when he died,
pneumonia had not been the “friend of the aged.” Nuland observed, “By and large dying is a messy business.”

The stark contrast between the findings of the study by Heyland et al and the SUPPORT studies is troublesome. Is that difference due to cultural, attitudinal, and organizational differences for the delivery of critical care in Canada and America? The easy explanation that American patients want more treatment even at the risk of discomfort may or may not be true. After years of public and often acrimonious debate, à la Quinlan and Cruzan, physicians may feel unsettled with the following question. Are our medical practices regarding the dying more humane than they were 30 or 40 years ago?

Legally and ethically, a lot of ground has been covered. The death-with-dignity movement, living wills, durable power of attorney, and even assisted suicide (in Oregon) are society’s attempts to deal with difficult bioethical issues. Yet why do most family members feel betrayed and burdened when their next of kin die in the ICU? The vigorous ethical debates do nothing for the anguish of surrogates caught in the maze of “full code” and “DNR” designations in the hospital. Practically, who decides the question of whether to institute mechanical ventilation or artificial feeding becomes more important than the essential goodness of the decisions.

Although the current study did not report too many out-of-control treatments, many families are fearful, Callahan3 has referred to the illusion that we could master our medical choices: “Yet there is hardly below the surface, a remarkable and rising anxiety about dying—not necessarily death as such but the combination of an extended critical illness gradually transformed into an extended dying.” His personal considerations border on accepting decline and death in an almost fatalistic manner, which is unusual in Western thought.

In an ever-shrinking world, we should not underestimate the effect of life-support technology and medical know-how in societies in which ethical and legal constraints are weak or nonexistent. One often hears of the “illegality” of discontinuing mechanical ventilation in dying patients! Yet, with few support systems, these interventions may be stopped abruptly after the financial ruin of the families. Unfortunately, the immorality of such practices is rarely questioned. Decision making in these highly paternalistic medical systems requires some scrutiny. I feel that we have an obligation to our colleagues in less affluent societies. A universal ethical code for the use of life-support technology in this young century is a laudable goal.

**Severe Acute Respiratory Syndrome**

Severe acute respiratory syndrome (SARS) is an emerging infectious disease with a formidable morbidity and mortality. In March 2003, there was a serious outbreak of SARS in Hong Kong.1 Within a month, the disease also spread to Singapore,2 Vietnam, Taiwan, Germany, Canada,3 and the United States. As of May 10, 2003, 7,296 cases have been reported in 30 countries, with a death toll of 526.4

**Epidemiology**

The early cases of SARS probably occurred in southern China. In November 2002, there were many cases of severe pneumonia of unknown etiology in Guangdong Province in southern China, with a high rate of transmission to healthcare workers.5 A 64-year-old physician from southern China, who visited Hong Kong on February 21, 2003, and died 10 days later of severe pneumonia, is believed to have been the source of infection, causing subsequent outbreaks of SARS in Hong Kong,1,6 Vietnam, Singapore,2 and Canada.3 The index patients of these cities had been exposed to the Guangdong physician while they were visiting China or had been staying on the same floor of the same hotel. While investigating the outbreak of SARS in Hanoi, Dr. Carlo Urbani unfortunately contracted the disease and died.

SARS appears to spread by close person-to-