Response

To the Editor:

We are grateful to Wise et al1 for their interest in our study recently published in CHEST (May 2009).2 We offer the following responses: Colonization of the dental plaque and oral mucosa has consistently been shown to be a reservoir for nosocomial pneumonia. An earlier investigation by Fourrier et al3 showed that decontamination with 0.2% chlorhexidine decreased the incidence of bacterial colonization of the dental plaque. The use of chlorhexidine oral rinse has also been shown to have a residual activity, preventing the accumulation of dental plaque even after 4 days of discontinuation of oral hygiene.4 In our study, all patients admitted to the ICU underwent oral cleansing within 6 h of admission. Hence, plaque formation and colonization should have been reduced as early as the first day in the ICU. Although the oral cleansing procedure in our study did not include brushing teeth, it included swabbing the oral, buccal, and posterior pharyngeal mucosa, which would possibly have an additional effect on a bacterial colonization of the pharynx.

Of the two studies in ICU patients using 2% chlorhexidine for oral cleansing, one did include toothbrushing as a part of oral cleansing protocol,5 although both studies showed statistically significant reduction in the incidence of nosocomial pneumonia.6,7 Hence, higher concentrations of chlorhexidine (≥2%) would still be an argument for the possible lack of benefit with 0.2% chlorhexidine in our study and an attractive option for oral cleansing in ICU patients.

Thus, although Wise et al2 may be correct in suggesting that on a theoretical basis mechanical oral cleansing with chlorhexidine accompanied by toothbrushing might be more beneficial in ICU patients, this needs to be proven in clinical studies. Early reports suggest that toothbrushing may carry an additional risk of bloodstream infections in ICU patients.8 A recent randomized trial comparing oral cleansing with 0.12% chlorhexidine with or without electrical toothbrushing failed to demonstrate significant difference.9

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Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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DOI: 10.1378/chest.09-1834

REFERENCES

1. Panchabhai TS, Dangayach NS, Krishnan A, Kothari VM, Karnad DR. Oropharyngeal cleansing with 0.2% chlorhexidine for prevention of nosocomial pneumonia in critically ill patients: an open-label randomized trial with 0.01% potassium permanganate as control. Chest. 2009;135(5):1150-1156.


Resolving Conflicts With Surrogate Decision Makers

To the Editor:

I read with interest the report in CHEST (July 2009) by Zier et al1 in which they examine surrogate decision makers’ responses to physicians’ predictions of medical futility. Futility disputes cause significant staff distress and consume prodigious palliative care and ethics consultation resources. Fortunately, most futility disputes are resolved collaboratively by providers and surrogates.2 And increasingly, with findings like those offered by Zier et al,1 the already high rate of resolution and consensus can be further improved. With a better understanding of surrogates’ motivations and rationales for resisting provider recommendations to discontinue life support, the development of empirically derived interventions can be enhanced. Process-based approaches can then incorporate...
targeted interventions and deploy them according to the precise basis for surrogate dissent.

Unfortunately, Zier et al\(^1\) fail to recognize some rather significant implications of their key finding that “surrogates with religious objections to the futility rationale were more adamant about continuing life support.” *Prima facie*, a surrogate’s own religious beliefs are wholly irrelevant to the treatment decision. Surrogates must exercise “substituted judgment” and make the medical choice that the patient, if competent, would have made. If there is insufficient evidence of what the patient would have wanted, then the surrogate must act in the patient’s “best interests.” \(^2\) But whichever standard is employed, the surrogate’s decision must reflect only patient-centered considerations.

Zier et al\(^1\) ask “whether it is appropriate to override a surrogate’s deeply held religious belief.” The answer to this question depends on what data Zier et al\(^1\) did not collect or report. Specifically, does the patient share the surrogate’s religious beliefs? \(^2\) Did the patient specifically grant the surrogate unusually wide discretion to consider her preferences as not binding but merely informative? \(^2\) To be sure, it is controversial whether a provider should override a patient’s own deeply held religious belief. But a surrogate stands in the shoes of the patient. Without evidence of patient authorization, it is not only permissible, but mandatory, that the surrogate’s deeply held religious beliefs be excluded and eliminated from the decision-making process.

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**Financial/nonfinancial disclosures:** The author has reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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DOI: 10.1378/chest.09-1637

**REFERENCES**


**Response**

To the Editor:

We thank Dr Pope for initiating a discussion about the normative ethical implications of our study recently published in CHEST (July 2009),\(^1\) which space limits did not allow us to pursue. He correctly points out that the ethical underpinnings of surrogate decision making require surrogates to set aside their own hopes and preferences for the patient and instead make decisions based on the substituted judgment or the best-interest standards. The aim of the study was not to examine this issue, and consequently our data are not helpful on this point. However, our data reveal that it is not rare for surrogates to hold religious objections to the futility rationale; therefore, further empirical research is needed to better understand how surrogates make treatment decisions when their religious or moral beliefs are at odds with the treatment course that seems most consistent with the patient’s preferences.

We agree that the ethical permissibility of overriding a surrogate’s treatment request generally hinges on whether the request is rooted in the surrogate’s own values or the patient’s values. When the treatment requested is rooted in the surrogate’s values, and those values differ from the patient’s, physicians have an ethical responsibility to ensure that the patient’s treatment preferences are respected. In our clinical experience, a careful, empathic discussion with the surrogate, often with the assistance of the hospital chaplain, can often help the surrogate understand and accept the need to respect the patient’s previously stated wishes. We have found this type of mediation to be considerably more fruitful than the alternative: time-consuming, adversarial legal proceedings to remove an individual as surrogate decision maker.

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**Financial/nonfinancial disclosures:** The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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DOI: 10.1378/chest.09-1922

**REFERENCE**


**Rescue Treatment in Asthma**

To the Editor:

We read with great interest the clinical commentary in CHEST (June 2009) by Papi et al\(^2\) in which they propose an inhaled rapid-acting β₂-agonist combined with a corticosteroid as standard reliever treatment in asthma. The science backing them is compelling. The authors then take a major leap by suggesting that maintenance treatment might be done away with, their own work already providing evidence in mild asthma.\(^2\)

As the authors remark, this approach inevitably abandons “total control” as an end point. Indeed, asthma symptoms and their