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, the surrogate must act in the patient’s “best interests.” But whichever standard is employed, the surrogate’s decision must reflect only patient-centered considerations. Zier et al. ask “whether it is appropriate to override a surrogate’s deeply held religious belief.” The answer to this question depends on data that Zier et al. did not collect or report. Specifically, does the patient share the surrogate’s religious beliefs? Did the patient specifically grant the surrogate unusually wide discretion to consider her preferences as not binding but merely informative? 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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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-interests 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 request 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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REFERENCE


Rescue Treatment in Asthma

To the Editor:

We read with great interest the clinical commentary in CHEST (June 2009) by Papi et al.1 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
treatment become linked in a continuous feedback loop. For the patient, this implies a remaining burden of symptoms. Of course, one can argue that even with maintenance therapy, most people with asthma will remain symptomatic to some extent. In the Gaining Optimal Asthma Control study, maybe the most ambitious of asthma studies, total control was achieved in approximately 40% of participants at best. But what to do with those punctual types among our patients, who are perfectly happy with a daily maintenance medication and the carefree respiration they may be rewarded with. Should we change them over to an as-needed regimen with, for them, intrinsically less result?

Problems may also arise when maintenance dosing is withheld from people with more severe asthma, who generally require more medication for satisfactory control. Their feedback loop will achieve its equilibrium not only at a higher medication dose but also, as an unintended backlash, with more residual asthma symptoms. To avoid this, the loop will have to be recalibrated as asthma becomes more severe (eg, by increasing the steroid dose taken at each occasion). So for severe asthma, maintaining a daily maintenance dose, or even increasing it, may be preferable. Hopefully, the upcoming Pan-European Eurosmart study (http://clinicaltrials.gov; identifier NCT00463866), which compares two dose levels of regular treatment with a budesonide/formoterol association, both with extra inhalations as needed, will provide more insight.

Another set of patients for whom a fixed maintenance dose may be necessary are the so-called “poor perceivers”: quite evidently, if they have to rely on what they feel, these patients may react too late.

In conclusion, we believe that treating asthma with a combined inhaler on a strictly as-needed basis will emerge as just one more option and that physicians will have to continue tailoring asthma treatment to their patients’ individual needs and characters.

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Response

To the Editor:

We thank Drs Bogaerts and de Pauw for their insightful comments on our Clinical Commentary recently published in CHEST (June 2009). Although they support our proposal to move from rapid-acting inhaled β₂-agonists alone to a corticosteroid (ICS) with a rapid-acting β₂-agonist combination inhaler as standard reliever treatment in asthma, they raise concerns about the more provocative proposal on the use of combination inhalers on a strictly as-needed basis without regular maintenance treatment.

By way of clarity, we wish to emphasize that our Commentary was focused on the emerging clinical and pharmacological evidence that rescue combination inhalers are more effective than currently recommended short-acting β₂-agonists for all degrees of asthma severity. At the end of our Commentary we speculated that in the future it might be even possible to show that the use of a rescue combination inhaler alone is sufficient to control asthma. Although we agree with some of the concerns raised by Drs Bogaerts and de Pauw, we still believe that the option of using the combination as rescue alone without regular maintenance therapy at least needs to be tested in controlled trials. In an era in which we desire to personalize medicine, some patients with asthma might accept a certain degree of symptoms, while adjusting the amount of treatment in response to symptoms, and forgo the total symptom control that is currently attainable (even with the most stringent step-up approach) only in around 40% of patients.

Patients with more severe asthma would take more inhaled steroid along with bronchodilators, whereas taking a β₂-agonist alone would not improve their control. In the real world, the same group of patients is likely to take little maintenance inhaled corticosteroid and thus will not be well controlled.

Some evidence backing our proposal is already available for mild asthma. Whether an as-needed-only approach is also appropriate for patients with more severe asthma is still under investigation. From a pathogenetic perspective, a recent study showed that lower airways eosinophilic inflammation is well controlled using low doses of ICS with no obvious difference in clinical control between low and high doses of ICS.

With these premises, we do not suggest to initiate an as-needed-only regimen in all patients with asthma. For those who achieve asthma control and are happy with regular maintenance treatment there may be no need to modify their treatment regimen, although an as-needed-only strategy can still represent a step-down option for well-controlled patients. Obviously, the use of an as-needed-only strategy is not a recommended option for the clinical phenotype of the poor-perceiver patient with asthma, who may need objective monitoring with peak expiratory flow measurements.

We agree with the conclusion that, if the ongoing studies will confirm its efficacy, the as-needed-only strategy will become an appealing therapeutic option for tailoring asthma treatment to patients’ needs.

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