Clinical Guidelines and Clinicians’ Intentions in End-Of-Life Care

To the Editor:

Guidelines that broadly interpret the principle of double effect can enable the practice of consensual and nonconsensual euthanasia (ie, physician-assisted death) under the premise of palliation. Kuschner and colleagues1 implemented guidelines following alleged euthanasia in four ICU patients so as to avoid wide-ranging interpretations about end-of-life care. However, these guidelines can inherently generate more confusion about clinicians’ intentions and actions when the recovery of transplantable organs is added as a treatment goal in patients dying in the ICU.1,2 Such guidelines are recommended as good palliative care, although transplantable organs may be recovered from donors before fulfilling the legal definition of death.3

Furthermore, Kuschner and colleagues3 state that “Opioids or benzodiazepines used to treat [discomfort] after withdrawal of ventilator support do not appear to hasten death. The important principle is that opioids and sedating medications should be titrated to achieve the desired effect of [comfort].” Titrating continuous infusions of opioids and/or sedatives for subjective symptoms such as “discomfort” and/or achieving “comfort” allow broad interpretations by clinicians of the desired effect and dosage.1,2 Such broadness reinforces the ambiguities favored mainly by advocates of conflating the practice of euthanasia and physician-assisted death (an intended death) with the practice of palliation (a foreseen death).4 The use of continuous (vs intermittent) infusions of opioids and sedatives can also cause ambiguities and uncertainties regarding intentions and causations allowing for psychological acceptance of euthanasia as palliation.5

One argument has been made6 to invoke the morally distinct action of “the devil’s choice” for those venturing into practices conflating euthanasia and physician-assisted death with palliation. However, many religions and cultures condemn intentionally hastening death. Clinicians are reminded that:

The principle of double effect is at home in a tradition of morality which takes seriously the moral psychology of the one who acts. Therefore, a focus on intention (among other things) is included in any moral appraisal of human action … other things also matter, such as the moral nature or moral kind of an act (whether it is an act of deception or of honesty, of empathy or manipulation), the intention with which an act is performed (whether to alleviate pain or to end a person’s life, to teach or to misguide), the motive with which an act is performed (whether out of kindness or contempt, generosity or selfishness), and the kind of person we become when we act in one way or another (a healer or a killer, a teacher or a liar).6

Intentions are private and often undisclosed. Neither the law nor practice guidelines can regulate the true intentions and safeguard the integrity of actions. Only bedside clinicians can.

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Response

To the Editor:

Rady and colleagues have raised concerns about the implementation of our guidelines and clinicians’ intentions in end-of-life care. We acknowledge that our guidelines do not eliminate moral confusion about end-of-life care in the ICU, and we agree that a focus on intention should be included in any moral appraisal of human action. While our guidelines, template physician note, and order set do not regulate the integrity of clinicians’ actions, they do provide a normative basis around which consensus regarding best practices can develop. That is, they provide a standard framework for developing and communicating the goals of care and support consistency in efforts to achieve them.

Guidelines for the withdrawal of life-sustaining treatment and other palliative measures of last resort, such as palliative sedation, make a distinction between palliation and euthanasia not only on the basis of clinician intention (symptom relief vs patient death), but also on the basis of methods (use of sedative medications sufficient to relieve symptoms vs administration of lethal medications) and the definition of successful outcomes (removal of treatments that are no longer desired or do not provide comfort vs patient death). Moreover, the rationale for permitting patients and their surrogate decision makers to stop life support is based not only on clinician intention, but also on patient autonomy and informed consent, and the principle of proportionality. Miller and Truog have observed that this rationale exists apart from the question of whether withdrawal of life-sustaining treatment (minimization of suffering), and the expected harms (possible shortening of survival time); then, to conclude that the cessation of life-sustaining treatment is the most proportional action among the available choices.

Rady and colleagues expressed concern regarding the titration of medications to achieve comfort. Titration is central to successful symptom management in palliative medicine. Moreover, opioids and sedatives may prolong life rather than hasten death after ventilator withdrawal in critically ill patients.

In delivering palliative care at the end of life, the subjective experience of patients and family is of paramount importance; objective metrics are typically less relevant. The decision made by the patient or a surrogate decision maker to shift treatment goals to comfort care is consequential: the primary goal of health-care providers shifts to keeping the patient comfortable. Except for the magnitude and the immediacy of the consequences, such a choice is like others we support in the course of clinical care. Accordingly, the withdrawal of life-sustaining treatment in these situations honors the individual’s autonomy and is the most proportionate response in desperate circumstances without a more desirable and achievable outcome. Finally, it continues to be our impression that our guidelines, template physician note, and order set support patient autonomy at the end of life, as well as strengthen understanding about palliative care practices in our ICU; reduce ethical conflicts, and improve patient care.

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Autosomal-Dominant Polycystic Kidney Disease

To the Editor:

I read with interest the article in a recent issue of CHEST (January 2009) by Li and colleagues. However, some points need to be clarified. First, the abbreviation ADPKD stands for autosomal-dominant polycystic kidney disease. Second, the authors think of ADPKD as being unlikely based on the absence of a family history.