INSTITUTE TO ENHANCE PALLIATIVE CARE

PALLIATIVE CARE
CASE OF THE MONTH

Request for a Hastened Death

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Case: A 21year-old man was admitted to the Intensive Care Unit with short gut syndrome. His course was complicated by intubation, multiple surgeries, sepsis, renal failure, and a severe coagulopathy. His mother and sister hoped he would survive to receive a transplant. After 38 days in the Intensive Care Unit, his surgeon in agreement with his mother made his status "comfort measures only (CMO)," and he was started on a morphine infusion. The next day, Palliative Care was asked to see his mother to provide comfort.

The young patient was unresponsive. His skin was tissue paper thin and bleeding. There was dried blood around his tracheostomy site and mouth. His respirations were slow and unlabored. He appeared comfortable and actively dying.

The family's priest had visited twice that day.

His mother, at his bedside, said that she would never have agreed to his CMO status if she had known his dying would take so long. His young sister said she knew her brother was suffering because, "I would be suffering if I were lying there." The family expected his death within hours, but it had been longer. Moreover, the mother felt that Hospice would not have let him suffer and would hasten his death.

Discussion: Our case is one of an actively dying young man, unresponsive and comfortable by clinical criteria. His mother has requested his death be hastened to end his suffering, and believes that Hospice would more aggressively help her son die.

It may be helpful to first clarify his mother's request, then think about her suffering and what she really might be communicating, and finally consider how her suffering could be lessened.

The mother's request was not for terminal sedation—the administration of high doses of opioids or sedatives to relieve intractable symptoms and induce sleep. Our patient appeared comfortable.

Nor did the mother's request call on the Doctrine of Double Effect, which would allow administering additional doses of opioids with the primary goal of relieving suffering, even at the risk of the unintended consequence of hastening death. The Doctrine of Double Effect did not come into play, since our patient appeared comfortable.

Strictly speaking, the mother was requesting euthanasia for her son. Euthanasia is a term derived from Greek, meaning a "good death." One working definition of euthanasia is the "deliberate and painless termination of a life of a person afflicted with an incurable and progressive disease leading inexorably to death."

Several studies have highlighted physicians' ambiguous intentions when caring for terminally ill patients. In anonymous questionnaires, some physicians have acknowledged at least once intentionally hastening death in terminally suffering or imminently dying patients.

Euthanasia is illegal. Our patient's level of care had been determined by surgeon and mother as CMO. This level of care is consistent with the philosophy of the National Hospice Organization, which neither intentionally hastens nor postpones death. The mother was incorrect in her belief that Hospice would have intentionally hastened her son's death.

There was, however, great suffering in the young patient's room, and it was the suffering of his family. They had come from far away, waited in the ICU for 38 days and been present for complication after complication separated by brief periods of stabilization. Their suffering was palpable, and a complex mixture of intense grief and complete exhaustion. It is much more likely that the mother's request was a measure of her own acute grief than it was a formal request for euthanasia. She was asking for an end of suffering in a much more general sense.

How could the mother's suffering been eased? We don't know exactly all of what the mother understood in talking with the ICU physician who had explained the change to the goal of comfort. There may have been insufficient time for understanding the dying process, and that, while providing comfort, we do not intentionally hasten death. Palliative Care was called in only 6 hours before the patient's death. An earlier involvement of Palliative Care may have helped.

As it was, the mother and sister agreed to talk with Palliative Care, and accepted arrangement of bereavement counseling. The nursing care was continuous and empathic. The patient died 6 hours later.

Recommended readings:

Meier DE. Emmons CA. Wallenstein S. Quill T. Morrison RS. Cassel CK. A National Survey of Physician-Assisted Suicide and Euthanasia in the United States. *New England Journal of Medicine.* April 23, 1998. Vol 338; No 17:1193-1201.

Cohen S. Ganzini L. Mitchell C. Arons S. Goy E. Cleary J. Accusations of Murder and Euthanasia in End-of-Life Care. *Journal of Palliative Medicine.* November 2005. Vol 8, No.6. 1096-1104.

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