Ethics and Care of the Terminally Ill

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CASE I

A 67 year old Thai-Chinese man with severe Parkinson's dementia fell out of bed and broke his hip. Bones were osteoporotic and the fracture was fragmented and severe. Pain was moderate and manageable by immobilization. The patient had been unable to care for any of his personal needs for at least two years. He did not recognize family and had contractures of most major joints as well as multiple bed sores. He was taken to a local private hospital where he underwent total hip replacement and, when he developed urinary retention, a transurethral prostatectomy. His one month course in hospital, mostly in the ICU, was complicated by aspiration pneumonias, bilateral emphysema treated with drainage tubes and a permanent tracheostomy. His new hip also never remained in the socket. He was maintained with a transoral gastric feeding tube after placement of a gastrostomy failed. At the end of these events, he was completely unaware of his environment, responded only to strong painful stimuli and was kept alive for an additional 3 years at home. This, only at great expense and involvement of the whole family

DISCUSSION

Initially, there might have been hope for restoration of the prefall state when he was aware of his surroundings. Hospitalization and evaluation of the extent of injuries after the fall was indicated. However, this patient had not been ambulatory for over two years, was debilitated and wasted and a total hip replacement was not indicated. The family may have accepted less invasive treatment if this would have been explained to them. What was the motivation of the doctors who performed the two major surgical procedures? Cultural factors may shed some light on this. This patient came from a large and prosperous family with many friends. To let him, the "Taipan" of the clan, expire without benefit of ICU-care and attendance by prominent physicians may not have been acceptable at first. A sympathetic physician could have discussed these issues with the family and found a humane solution that would have satisfied all concerns and given the patient more comfort at the end of life. Such a solution could have been an order for "symptomatic treatment only" (STO). It consists of good nursing care, oral or intravenous fluids and liberal analgesia.

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CASE II

This 56 year old indigent HIV positive Thai male was admitted to a teaching hospital with severe emaciation, fever, headache, confusion, loss of vision and a mass in his right lung. When seen on infectious disease rounds, he had already been given a ward-staff diagnosis of advanced AIDS, CMV retinitis and cerebritis as well as either tuberculosis or a malignancy of his right lung. Repeated sputum examinations for mycobacteria were negative and he had been placed on gancyclovir by an eye physician. Consultation for bronchoscopic biopsy of the mass had been requested. One subspecialty consultant felt that aggressive diagnostic evaluation and treatment were indicated, an other one suggested no further studies and STO only that would assure the patients comfort. The first consultant won and a bronchoscopic biopsy revealed cancer. The patient became comatose and died two weeks later, still being treated with gancyclovir.

DISCUSSION

What motivated the ward staff and two consultants to proceed in an aggressive manner in this case? The residents wished to know whether the mass represented tuberculosis (a treatable disease in an AIDS patient) or cancer. This was reasonable but one might have considered simply starting this virtually moribund man on tuberculosis chemotherapy without an invasive procedure. Why was this patient started on gancyclovir, a drug where the induction course represents the equivalent of approximately 4 months starting wages of a government teacher or nurse in Thailand. Life-long maintenance therapy would also have been required. No public health care system in a developing country can afford this at the present time. Treatment was not thoughtfully planed in this case. The ward staff should have considered the most likely diagnostic possibilities and the prognosis and short as well as long term benefits of any procedure or therapy rendered. An order for STO would have been acceptable in this case.

Cases 1 and 2 point out the need for careful planning of diagnostic procedures in patients with chronic and near terminal disease. What will be gained if one of the suspected diagnoses is established? Are they treatable and will it lead to lengthening of meaningful life? They also illustrate that hospital staff should not initiate treatment with only very short term benefit which can not be continued if the patient leaves the hospital.

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