

resolve the situation, a negotiated plan of treatment may be necessary. The aim of these efforts should be to set an acceptable trial period for the continuation of care. Presently, the attending physician feels that it is still too early to rule out a recovery for the patient. Unless there is strong reason to believe that the patient would not value a recovery of the sort described by the attending physician, treatment should continue. However, the parties involved must remain cognizant of the patient's desire not to have the dying process extended unnecessarily. A definitive end point to the trial should be set, at which point all the stakeholders can reevaluate whether the treatments have been efficacious in meeting the patient's goals of care.

#### Note

1. See *Re Quinlan*, 70 N.J. 10, 355 A.2d 647 (NJ 1976) and *Cruzan v. Director*, MDH, 497 U.S. 261 (1990).

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### Commentary: The Need for More Questions

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This case is a good example of why it is important to investigate cases thoroughly before making recommendations. On an initial read-through, a few things stand out: (1) according to the attending physician, there is a significant chance that the patient will not recover, and (2) according to the patient's son, the patient would not want to undergo needless suffering—indeed, he did not want to undergo chemotherapy to begin with. If he's not likely to survive, treatment causes suffering, and he did not want to suffer, what's the dilemma? Let him go! And while that may wind up being appropriate, there are many

questions that need to be addressed first.

Acute myelomonocytic leukemia is a cancer that is considered especially curable (albeit predominantly for younger patients), but the treatment for it is punishing. The patient's son should be asked what he understood his father to mean when he said he did not want to be kept alive in a debilitated condition or undergo needless suffering, as well as what he has in mind by stopping treatment. On only day four after completion of chemotherapy, he is not yet being *kept alive* in a debilitated condition. (However, if there is a good chance that he will not recover, he might be undergoing needless suffering.) The state he is in now is not unusual for this point in the course of treatment; that is, this situation should have been part of what the patient agreed to when he consented to chemotherapy. Does the son know this? Perhaps more importantly, does he know if the patient knew this?

Moreover, the attending needs to explain why there is a significant chance that he will not recover. Was this expected? If so, what led to the decision to try this course of treatment? Alternatively, has the patient not responded as well as expected, such that things look worse now than they did when the patient made his decision? If so, some prognostication is owed to the son. Acknowledging one's own epistemic limits is a virtue, but the attending has a better idea of reasonable parameters than the family does and should be transparent about her expectations. It is not clear whether the attending is also the oncologist, or perhaps a hospitalist or intensivist. Certainly, if the attending is not the oncologist, the oncologist should be consulted, and any discussions the patient had with him or her should be taken into account. The son says his father was reluctant to undergo chemotherapy but was pressured by the

family to do so. This needs to be investigated as well. Who did the pressuring, and why? Is the son himself feeling guilty for having talked his father into treatment that has left him debilitated? Does he think his mother coerced his father into treatment because of dysfunction in their relationship?

Considering the questions about whether the patient would want to continue, about his current debilitated condition, and about the attending's assessment that there is a significant chance that he will not recover, it seems reasonable to hold off on another round of chemotherapy. To discontinue basic medical care (e.g., labs, fluids, treatment for his infection, etc.) to focus exclusively on comfort is less defensible at this point, particularly if it is likely that his encephalopathy could clear and his preferences could be elicited. We need to know more. In any case, we need to make sure his symptoms are well controlled. If the institution has a palliative care team, consulting them for symptom management should be considered.

We should also look at the allegations of abuse. It is entirely appropriate to consider the state of life that we deliver patients into when considering treatment plans. If somehow we could be certain that the patient would undergo a long, painful course of treatment; arrive at a new baseline that is only minimally acceptable to him; and then be discharged to a home in which he is going to be abused, we could hardly be said to be "doing no harm" in providing further treatment. However, at this time, each of those dimensions of the case (how likely it is that treatment will be successful, what his new baseline would be, and what his discharge possibilities are) is unclear. If continuing treatment turns out to be otherwise in accordance with the patient's wishes and interests, a safe and acceptable discharge plan should be assured. Conversely, if it cannot be

assured—for example, if the allegations of abuse are well-founded, the abuse substantial, and other discharge options are known to have been unacceptable to the patient—care should be taken not to cure him into a life situation he would have preferred to decline.

That said, we should remember that so far we have heard the patient's narrative only from the son. It can be tempting to hear a compelling account and assume that it is representative of the whole story, but that temptation should be resisted. The son appears to have his father's best interests in mind and to be trying to advocate for him, but so far we have not heard from (or even identified) the other stakeholders. Does the patient have other adult children? Siblings? Is it known why the patient selected his son rather than his wife to be named in the durable power of attorney (DPoA)? There are many plausible backstories for how we got here, and some would lead us to different conclusions than others. It will be important to get the patient's wife's perspective, as well as those of any other relevant family members and/or friends. The son's perspective on his parents' marriage or his father's expectations about treatment may not be shared by his father; until and unless the patient can speak for himself, hearing from others will paint a richer picture of his life, preferences, and interests.

Although it can't help us now, it's worth mentioning that it would have been helpful if good advance care planning had taken place. The patient's having designated a DPoA is one important piece of this, as were the discussions between the patient and his son. (I am assuming that the general DPoA here included medical decision-making.) However, the case, as written, does not indicate that the attending knows much about what the patient's wishes or values are, or that there was a

written account of these. Ideally, with any life-changing diagnosis, and especially one in which decisional incapacity is expected during the course of treatment, the informed consent process with a capacitated patient should take place together with the surrogate decisionmaker, and perhaps with other members of the social circle.

Taking the time to fill in the picture the son has sketched of his father's preferences is the only way to respect the patient, the family, and the health-care team. Thoroughly addressing the patient's symptoms should alleviate the distress he and his son are experiencing to allow enough time for that picture to emerge.

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### *What Actually Happened*

Due to the attending physician's doubts about whether it was ethically acceptable to honor the son's request to discontinue life-extending treatment, she requested an ethics consultation. After discussing the case with the attending and reviewing the patient's chart, the ethics consultant met with the patient's son. The consultant spoke with the son and concluded that his primary reason for wanting to stop treatment and change the goal of his father's care to keeping him comfortable was to honor his father's wishes and to spare him from a more protracted and painful death. The consultant also concluded that the son's concern about the quality of his parents' relationship did not appear to be a major factor in his request to stop treatment. The consultant recommended that the patient's son contact other family members before making a final decision, and the son agreed. Two days later, after consulting various family members, including his mother, the son decided to stop treatment, and the attending physician wrote an order to "withhold all support" and to limit care to "comfort measures only." The patient died a few days later.