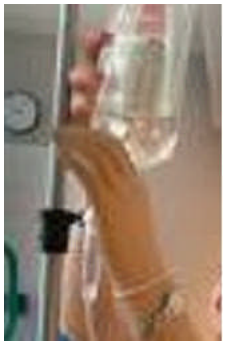
A CASE OF TREATMENT WITHDRAWAL



Please note this case is fictitious, but used as an exemplar of problems junior doctors face. Ethical advice is available from colleagues and also from local clinical ethics committees. The Catholic Medical Association (UK) also has a number of professionals who are experts in Medical Ethics.

"I am a VTS trainee currently working in Hospital Geriatrics. During our ward-round today, we reviewed a 77 year old lady who had been transferred from ITU/HDU. She had been there for 2 weeks. Prior to admission, she had been in reasonable health and was only taking aspirin and a blood pressure pill. She had been living alone and was quite independent. On admission, she was diagnosed with cerebral haemorrhage. Since then, her progress has been slow. She was initially on a ventilator and was subsequently taken off this. On assessment, there was some response and movement on the left side. There was no speech. She was still being fed by naso-gastric tube and she also required some IV fluids. The opinion of my consultant is that if she does not come off NG tube feeding in the next 2 or 3 weeks, treatment should be considered futile. He has further stated that PEG feeding is not an option and neither is resuscitation. It was also decided that she would not be transferred back to ITU/HDU. She would not be given antibiotics were she to develop a chest infection.

My worry is that my consultant, who seems to believe that it would be a blessing if she were to die, actually wants her to die. How should I respond as a Christian? Neither the patient nor her family appear to be religious.

I would like some help by Friday (my Consultant's next ward-round)."

OUR RESPONSE

Dear Trainee,

As promised we are responding to your problem before your Friday ward round. Thank you for asking our advice. A number of CMA members have discussed the situation. This is clearly a patient whose prognosis is likely to be 'poor', but we agree with you that it does seem a bit quick to be 'giving up'. We urge you to talk to the relatives in simple terms, to see what their expectations are and if they know what the patient's wishes were. Then talk to your consultant in a sort of "wanting to learn" way, to see if you got his/her views right at the beginning of the week; seeing whether the situation has changed at all.

Regarding DNAR, it may not be that unreasonable to sign this. You will know that results of bed-side resuscitation are pretty poor, and stroke patients tend to do particularly badly, so you may agree with your consultant on this in the end. Regarding food and fluids, we feel you should stress that it is fairly "early stages" in a stroke case, and that you feel that food and fluid should be continued for a few more weeks at least. Intermittent NG tubes (as they may be pulled out) and subcutaneous fluid would work for a few more weeks, but a PEG tube could be discussed. Again, your consultant will have more experience of these. They are not always that successful and do have problems, and as part of your training, it would be a good idea to go and talk about them, in a general way, with your GI Team. Not giving antibiotics in a life-threatening infection, or trying to get her back to ITU, are very similar really, almost like the DNAR, so these may well be very reasonable decisions. Please let us know how you get on, and if you want to discuss anything further.