

Comfort Care vs. Euthanasia: Why are we Still Having This Discussion?

C. McClain, A. LeBel and D. Waisel

Department of Anesthesiology, Children's Hospital, Boston, MA 02115

Introduction: The important distinction between end-of-life comfort care and euthanasia has been extensively discussed in the medical and lay literature. The recognition of this distinction can make a tremendous difference in the quality of not only the patient's end-of-life experience, but also the family's experience as they bear witness to the death of a loved one. We recently encountered a case in which the inability to make this distinction affected patient care. We present the case of K.A. in an attempt to prompt discussion of this extremely important issue in a vulnerable patient population.

Case Report: K.A. was a nine-year-old male afflicted with refractory ALL who had undergone a failed bone marrow transplant. Following lengthy discussions among the patient, his family and the care team, a DNR order was instituted for K.A. and only comfort care measures were to be provided.

Later that same day, the acute pain service (APS) was asked by the patient's nurses to come to the bedside and aid in management of K.A.'s distress. The APS involvement to this point had been rather peripheral. In our institution, the oncology service essentially manages their patients' pain issues with "big picture" recommendations from the pain service (e.g. use a PCA, try an NSAID, etc.). The APS found K.A. to be extremely anxious and writhing from intense abdominal pain. His family expressed their desire for us to "do something" as they simply did not want him to suffer. Discussion among the care team and the APS centered on whether aggressively treating the patient's discomfort with narcotics or other sedative agents would constitute euthanasia. Following these discussions, the APS began to aggressively treat K.A.'s pain and discomfort with increasing amounts of hydromorphone. Large doses of diazepam and lorazepam were used to help control his anxiety. K.A. appeared much more calm after aggressive measures were taken to alleviate his psychological and physical discomfort. The APS remained continuously at his bedside titrating medications to keep K.A. comfortable. K.A. died peacefully in his mother's arms approximately 5 hours after the APS initiated active care. Despite their obvious sense of loss and grief regarding the death of K.A., the family was extremely thankful that he was comfortable at the end of his life.

Discussion: We present this case to emphasize that some physicians may have difficulty differentiating between end-of-life comfort care and euthanasia. It is well established in bioethics that in end-of-life care, treating pain, discomfort and distress with medications designed to treat these problems is absolutely appropriate. (1) Thus, it is appropriate to attempt to make patients comfortable by titrating medications such as analgesics and anxiolytics to manage pain and distress (in accordance with the patient's desires, who, for example, may choose to accept discomfort in exchange for greater awareness) regardless of the possible undesirable side effects such as apnea. These standards are equally appropriate in adult and pediatric end-of-life care. We were stunned, in fact, to meet well-respected, well-intentioned colleagues who differed from what we perceived to be the standard approach.

We present this abstract in part to ask the following questions:

- 1) Have others met with similar recalcitrance to providing adequate end-of-life comfort care in pediatric patients? Is this problem more common than we thought? And if it is, is it because people are unaware of the distinctions between end-of-life comfort care and euthanasia or because people actively disagree with these purported distinctions?
- 2) Hypothetically, is it inappropriate for an APS who has only had peripheral contact with the patient to provide acute end-of-life care? Or, is it more appropriate for the APS to provide the care, given the knowledge and expertise of acute pain specialists in titrating analgesia and sedation to certain effects?

References: Beauchamp TL, Childress JF. Principles of Biomedical Ethics, 5th Edition, 2001.