Pharm 543 Pharmacy Laws & Ethics – End of Life Cases

Case 1.

A male Alaska Supreme court Justice was admitted to Swedish Hospital in Seattle for management of Acute Lymphocytic Leukemia. He underwent urgent chemotherapy, plasmapharesis and following remission induction was given the option of a bone marrow transplant despite his older age status. He immediately "failed" the BMT, and his daughter and son flew down from Alaska to visit him in hospital as he was progressively getting worse due to Leukemia. When his daughter, M. (who is a social worker and law student), arrived, he was on a ventilator (in the ICU) and he was unable to converse. He was able to open his eyes to her voice but appeared to have not much more strength or ability to communicate. He consistently pulled at the machinery as if he wanted it off. The daughter waited a day or two to observe and evaluate her father's situation:

> "… and per my brother (who is a medical oncologist) he had no realistic hope of recovery".
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> "My father's doctor was out of town, but the nurse called him about whether to pull the machinery. He indicated that 'maybe it is just his time.'
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> "The nurse on the wing told us what the doctor said, and we were all in agreement that given that he looked so uncomfortable and given that he got worse on a daily basis, we should pull the machinery.
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> "There was one relative who disagreed with my mother, sisters, brother and me - that was my father's brother who wanted him to stay hooked up if there was even some small chance. What I recall is that as the equipment was pulled off, the nurse gave my father large amounts of intravenous morphine and it did not take long at all for him to die. It seemed that the nurse had done this type of thing before and that written consent for the exact procedure was not necessarily in place. I don't recall the nurse checking any papers (advance directives?) to see whether these various procedures described above were authorized per se. My impression was that she and the doctor ceded to our wishes given the deteriorated and deteriorating condition that my father was in". (recent story told by daughter).

Questions: Was procedural due process under WA's Natural Death act, followed? What are the "requisite conditions" required under the Natural Death act for the advance directives to become activated? Does this make sense? Was this done here? Was this euthanasia? If so, is it legal or illegal? If not, why not? Was the patient conscious or unconscious? Does the doctrine of double intent apply here? Why or why not? Did the Justice pull at the ventilator because it was uncomfortable in his throat, or because he wanted to be extubated and he was ready to die? Does the answer matter? How does this scenario differ from the prescriptions provided to patients in Oregon, for their assisted suicide?

Case 2.

A young beautiful excitable woman in her early 30s presented to clinic with Stage IV ovarian carcinoma. The Pain and Palliative care service had been asked to assume her primary management as she had "fired" multiple surgeons and oncologists for failure to return her calls and emails and for keeping her waiting in their exam rooms. The hospital Patient Representative accompanied her to our clinic room. On initial examination she took over 2 hours to interview and examine. She had many, many complaints including hair loss, fatigue and crampy abdominal "discomfort" that occasionally became a level 3/10 pain. She was enrolled in the Supportive Care program (usually reserved for much sicker paients-where a nurse and MD visit dying patients in their homes) more to keep her in close contact with a nurse as a preventative measure as the team felt that her suffering was enormous and the potential for crisis development was large. She initially and repeatedly refused psychiatric evaluation. Despite lack of formal assessment, the team believed that she had a personality disorder that contributed the level of anxiety and suffering in her life (most likely "borderline"). It gradually emerged that she had had an abusive and emotionally devastating childhood. She worked in an office and was a single mom. She had very little family support. She did have a large circle of devoted female friends. Her most successful relationship, and the one she was most dedicated to, was with her teenage daughter.

She was a patient for 2 years. She went through many medical and personal crises. She had multiple episodes of renal failure requiring kidney stents, and episodes of partial bowel obstructions. The medical oncology team was called in for the performance of multiple abdominal taps to remove quarts of malignant ascites, for both comfort and to prevent bowel perforation. She had numerous sclerosis procedures to

attempt to prevent the rapid reappearance of the ascites. The effect on her physical appearance was devastating to her as she was very beautiful physically. She told us she wanted to live until her daughter graduated and until she had all the paperwork in place for her best friend to adopt her daughter. Just after these events happened, her abdomen became very large again, and she required another admission to hospital. Her impending death had been discussed with her and her daughter on multiple occasions. As her mode of death was anticipated to be bowel perforation (which is very painful due to spillage of acid into the abdominal cavity) and a PCA pump was rejected by her when this approached, the possibility for terminal sedation was raised and agreed to between the patient and the medical team.

On this last admission, her kidneys began to fail and she requested that sedation be started. She was made very sleepy and then comatose with intravenous. sedatives and barbiturates and died in hospital two days later. While advance directives were filled out, the team all felt that continuous evaluation of this pt's needs and wants were going to be more helpful in her management and she required extensive care until her death.

Questions: Why do health care providers reject "difficult" patients? Is terminal sedation legal or illegal? Is it any different than Oregon style assisted suicide? Why or why not? What do you think about the doctrine of "double effect"[1] here? What do you think about terminal sedation being used on a patient without informed consent? In the recent movie "Twit" the older male oncologist said that his female patient had "suffered enough" and the (female) nurse was ordered to dial up the morphine. In that movie, there was no discussion between the team and the patient about the death process, or what was being done. Thoughts? Who should decide?

Kathryn Elliott, 2005

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[1] Beauchamp & Childress (Principles of Biomedical Ethics, 5th Edition, Oxford, 2001, p. 129 *et seq.*) describe the "rule of double effect" as used to distinguish between intended outcomes (i.e., death from overdosing with an opiate) versus unintended outcomes (i.e., providing sufficient analgesia to control pain, with respiratory depression , etc., leading to death as a side effect). The double effects are (1) analgesia and (2) respiratory depression. They describe four conditions for the latter to be morally permissible: (1) the act must be at least neutral or good, (2) the agent's intent is good, (3) the pathway between means and consequences must not include the bad outcome: "the bad effect must not be a means to the good effect". (4) the beneficial effect must outweigh the bad one.