

## Commentary: Is This Palliative Care Medicine?

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A 24-year-old woman was hospitalized following intentional drug overdose. Serious medical complications marked a prolonged hospitalization. She was discharged to long-term care with a tracheostomy and feeding gastrostomy. Considered to have "extensive brain damage," she became agitated, was transferred to a psychiatric institution, developed neuroleptic malignant syndrome, returned to an intensive care unit and eventually to a general medicine ward. With the staff's support, the family agreed to discontinue nutrition and antibiotics and deny resuscitation. Useless brief trials of morphine and benzodiazepine followed. Ultimately, consultants properly questioned the underlying diagnoses and the idea that she was dying. She had a "remarkable recovery," and, after six months was discharged to a "suitable placement."

This case raises questions about current palliative care. Some might say that the distressing events of this patient's story are a result of a trend in palliative care toward seeing itself as a technical activity—marked by primary concern with methods and technologies. Many believe that medicine, also, has turned away from the historically moral nature of its concern for the welfare of the patient toward the technical order that is concerned with what is expedient, feasible, and economically and politically practical. This case represents an even greater change from the origins of palliative care, which has developed in response to mainstream medicine's nearly exclusive concern with disease while failing to meet the physical, emotional, and social needs of dying patients and their families.

Palliative medicine is medicine, however, and is as much beholden to the fundamental

rules of the profession as any other branch. The care of the dying is no exception. Everything physicians do originates from knowledge of the underlying disease process—the diagnosis—and the nature of the sick person. This patient *had no diagnosis*. As this case illustrates, in the absence of a diagnosis, the future cannot be predicted, rational therapy cannot be designed, effective communication between caregivers will be limited, and appropriate attention to the sick person and the family is impossible. From the time of Hippocrates, physicians have known the importance of prognostication—forecasting the future of the illness. "It is necessary, therefore, to learn the nature of diseases."<sup>1</sup> The cornerstone of prognostication in clinical medicine is an accurate diagnosis based on agreed-upon objective criteria. In its absence, physicians are, as in this case, rudderless. Nothing in the case history gives reason for or supports the statement that the patient has "extensive brain damage." Nothing suggests that her physicians knew that after profound suicidal overdosage (particularly if the drugs the patient took are unknown), this chain of events is not unexpected, but eventual recovery is common.

In the absence of a diagnosis, how was it possible to prognosticate that this 24-year-old patient was terminal? A prognosis is not a social function arrived at by the consensus of doctors, nurses, and social workers, to which an attending physician "defers." It is a sophisticated judgement based on experience and medicine's knowledge base and is the responsibility of the attending physician. Difficulty in arriving at a diagnosis and prognosis is adequate reason for consultations—one or many—until the issue is resolved, or a plan of action is chosen for solving the problem. How was it possible, without a firm diagnosis, to request the family's approval for the withdrawal of antibiotics and nutrition? It is difficult to avoid seeing unseemly haste. If it was the family's idea, which was not based on any knowledge of the disease process, why was it heeded without a court order: This would be required if the patient had, for example, sepsis, and the family requested the withdrawal of treatment.

Everyone seems to have been troubled by the patient's agitation—their concern elicits our sympathy—but we never hear why she was agitated. This was another instance of the in-

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ability to explain events because there was no diagnosis. Perhaps there were sustained attempts by physicians to sit with this patient and reduce her agitation, but this we are not told. Nor do we know what was said in her presence about dying or terminal illness, as though she could not hear. The palliative care physician arrived at the case and gave first a signature dose of morphine—no other indication is evident—then an impressive course of midazolam. Fortunately, the consultant, an internist, set things straight. The rise and acceptance of hospital palliative care will be faster if it brings to

the bedsides that others shun—critical medical thinking in consonance with its historical mission, rather than merely applying certain drugs or techniques.

### *References*

1. Hippocrates. Prognostic. In: Hippocrates, vol. 2, Trans. by WHS Jones. Cambridge: Loeb Classical Library, Harvard University Press, 1923;1917:7.

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