CASE #4

APPARENT ACTIVE EUTHANASIA OF A PATIENT WITH TERMINAL LYMPHOMA

CASE PRESENTATION

Complaint

The hospital's department of quality assurance, concerned about the possible use of active euthanasia, requests investigation of the death of a 55 year old college professor with terminal lymphoma.

Medical History

The patient was well until five years prior to this admission when he developed lymphadenopathy. Node biopsy was positive for diffuse histiocytic lymphoma. Initial chemotherapy with M-BACOP was successful and he remained without symptoms for four years. Disease recurred one year prior to admission. A second course of chemotherapy resulted in a partial tumor response and several hospitalizations due to treatment toxicity Three weeks after the last chemotherapy, the patient was hospitalized with cough, fever, and neutropenia. Pneumocystis carinii pneumonia was diagnosed by bronchoscopic lung biopsy. Despite improved leukopenia and appropriate treatment with intravenous pentamidine, then trimethoprim-sulfamethoxazole, he developed worsened constitutional symptoms and respiratory failure requiring mechanically-assisted ventilation. Two milligrams of morphine sulfate were administered every four hours to keep the patient comfortable. After two days of life support, all members of the health care team agreed that the patient was imminently terminal. Support was withdrawn in keeping with the patient's treatment preferences. As recorded in the resident physician's note:

> "[The patient] was given 50 mg [morphine sulfate] IV push and the FiO_2 [decreased]. As the O_2 saturation and respiratory rate decreased, he was changed to [Continuous Positive Airway Pressure]. He was then given an additional 20 mg [morphine sulfate] IV push. At 7:55 p.m. his EKG monitor showed no further electrical activity and he was pronounced."

Diagnosis

The patient died from profound respiratory failure caused by pneumocystis carinii pneumonia occurring as a complication of refractory diffuse histiocyte lymphoma. Expiration appears to have been hastened by inadequate mechanical ventilation and narcotic administration.

Social History

The patient had been a tenured college professor of English and philosophy for the last 20 years and was able to continue teaching until this final hospitalization. He had been happily married for 32 years and was supported by his wife, son and two daughters through his entire illness. The patient, family and attending physician had discussed the use of life-sustaining treatments on multiple occasions. The patient consistently stated, and the family concurred, that he did not want life supporting treatment including mechanical ventilation. He reluctantly agreed to a two-day trial of such support but did not want continued treatment without improvement. The attending physician believed the patient had the capacity to make this decision and depression was not influencing the patient's decision. The withdrawal of the ventilation and the patient's expected death were in keeping with patient and family treatment preferences. The family was satisfied with the outcome and was not aware of the exact manner in which support was withdrawn.