Rachel Duarte Moritz

Fairness, not maleficence, in terminal critical patients care

A equidade e a não maleficência no cuidado de pacientes críticos terminais

PhD, Supervisor for the Intensive Care Medicine Residency Program - Hospital Universitário (HU) and Professor at Universidade Federal de Santa Catarina – UFSC - Florianópolis (SC), Brazil.

In reference to the article "The morality of allocating resources to the elderly care in intensive care unit[1]", I permit myself the reflection: the physician's role in society can never be neglected. Equally, a physician, independently of the chosen specialty should always base his/her therapeutic decisions on beneficence, never maleficence. The autonomy principle, so important in the Anglo-American perspective, must be driven by the justice, equity and solidarity principles.[2]

On the other hand, human beings are entitled the right of dying without suffering. Consequently, a physician should struggle for non-prolonged dying, based on fundamental bioethics principles, for decision-making on either intensive care unit (ICU) admission or discharge.

A palliativist approach is, in many opportunities, essential. A physician should focus his/her therapeutic decisions on the ill person, broadly evaluating his/her needs. It should be here highlighted that, for such decisions, a series of factors are to be considered. It is indisputable that, given the population ageing and added the chronic diseases control, age is progressively becoming an eventual contributing aspect, but never a decision key for therapeutic decisions to be made.[3]

Definitions and concepts change according to the political and social environment. Some 20 years ago, an HIV diagnosis would be taken as a death sentence. Currently, AIDS is seen as a chronic illness. By the 9th Century, elder would be someone by the 50s. Currently we have Republic Presidents above their 70s.

The underlying disease prognosis, the therapeutic responsiveness, the pre- and possible post-ICU quality of life, are much more important factors for ICU admission or maintenance of intensive care decision making.

It is worthy to comment that, most of the authors, when mentioning therapeutic thresholds don't describe cardio-respiratory resuscitation (CRR). However, the experience shows a different picture. A Brazilian study showed that around 80% of the deaths occurring in Internal Medicine wards are not preceded by CRR maneuvers. However, no formal non-resuscitation orders are recorded in the charts. In ICUs, the therapeutic limitation is much broader than non-resuscitation. In this environment, also, little is written on the patient charts regarding the therapies considered futile or useless discontinuations or refusals.[4]

This leads me to agree completely with the author's statement on the need of widening the debate on the limitation of the physician's role as a healer,

Author for correspondence:
Rachel Duarte Moritz
Rua João Paulo, 1929 - Bairro João Paulo
CEP: 88030-300 - Florianópolis (SC), Brazil.
E-mail: rachel@hu.ufsc.br

and the human finitude. I would personally add the importance of appropriate therapy for those in their last moments, providing them supportive or palliative care.

Finally, the struggle for prolongation of death prevention is a humanitarian attitude, to be based on ethical principles. The best financial equation on therapeutic thresholds decisions should rather be a consequence than a political target.

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