Avoiding nosocomial dysthanasia and promoting eleothanasia — let's speak simply!

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To the Editor: I read with pleasure the editorial by Corke and colleagues in the December 2010 edition of the Journal.[1] I applaud the idea of introducing the terms dysthanasia and eleothanasia for consideration and debate. However, I wish to make a few observations. The creep in expectations, and frankly the lack of understanding by society in general and even by our non-intensivist medical colleagues, about what can be achieved in the intensive care unit leads to constant pressure on intensive care physicians and much disappointment when unrealistic expectations are not met.

I think there needs to be education about an even more fundamental concept than dysthanasia and eleothanasia, and that is that death is in fact not only an acceptable outcome, but sometimes the only realistic outcome in many conditions. Administration of futile care does not alter this, and one must question who the futile care is being directed at. Logical assessment of the situation makes it clear that the patient often does not benefit, so who are we treating — ourselves, the relatives, or the referring physician?

Even before we start thinking and speaking of a "bad" death or a "merciful" death, let us speak about death plainly and openly. I liken this to the analogy of a lawyer taking on an unwinnable case. Regardless of which court he appeals to, the verdict remains the same. Needless to say, the costs will escalate as the appeals proceed, but the case will still be lost. Unlike lawyers, medical professionals routinely take their "unwinnable" cases to the "supreme court" — spending a lot of money doing so and seemingly oblivious to the suffering this approach entails — only to lose the case (the life of the patient). Using this analogy, intensive care physicians should indeed act as barristers for the toughest cases, but know when the appeal will be or has been lost!

I suggest, then, to further advance debate on this important topic, that we don't look for new Greek words to describe a difficult situation, but that we use plain and simple English. If we see a "bad" death being perpetrated, we should speak up. And if, when death is inevitable, we can provide a "merciful" death, we should do that. I fear that if we introduce new words that people don't fully understand, these words may soon become emotive, as is the case with "euthanasia".

Like all doctors, I hate death, but I hate a "bad" death most of all.

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References

1. Corke C, Silvester W, Bellomo R. Avoiding nosocomial dysthanasia and promoting eleothanasia. *Crit Care Resusc* 2010; 12: 221-2. ❑