Orchestrating a Dignified Death in the Intensive-Care Unit

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Approximately 2 million people die in the United States each year, 80% of them in acute- or chronic-care institutions. Physicians now have at their disposal interventions that can postpone death in almost every instance. In these circumstances the critical-care physician cannot avoid the responsibility of orchestrating death by balancing factors such as the patient’s autonomy and best interests, medical uncertainty and futility, and notions of “passive” (permissible) and “active” (forbidden) euthanasia. Pressures to make decisions unilaterally and without patient input threaten to undermine important physician/patient/family dialogue. On the other hand, the fact that medical resources are becoming increasingly expensive and scarce will inevitably lead to atoning. The critical-care physician will be caught in the middle—orchestrating clinical care to balance the interests of individual patients and families against those of the larger community.

Approximately 2 million people die in the United States each year, 80% of them in acute or chronic health-care institutions. Even when death is imminent, we have interventions that can postpone it for hours, days, or weeks in almost every instance. This is especially true in the modern, technology-dense, intensive-care unit (ICU), where medicine and highly trained health professionals can monitor, support, or substitute for nearly every life function. As the President’s Commission noted, under such circumstances, "Matters once in the province of fate have now become a matter of human choice" (1).

Such choices are an awesome responsibility. The critical-care physician can be likened to a conductor/composer, struggling to balance and blend various clinical, legal, moral, psychological, spiritual, and, increasingly, economic influences to permit patients an optimal death in less than optimal circumstances. Maintaining life as long as possible without regard to the suffering and wishes of the patient is no longer acceptable, but the alternatives involve painful judgments about the patient’s desires and best interests, family sensitivities, clinical probabilities, legal risks, and benefit/burden ratios. Using case examples, I will illustrate and examine some of these issues in more detail.

Patient Autonomy

Some would disagree with my characterization of the critical-care physician as the conductor/composer who orchestrates death in the ICU. After all, isn’t the patient the final decision maker? Am I not ignoring or dismissing the notion of patient autonomy?

Ideally, the ultimate authority rests with the patient. However, the realities of critical care make realizing this ideal extremely difficult (2). Critically ill patients are often comatose, delirious, or unable to communicate effectively because of endotracheal tubes. Even when effective communication is possible, these patients are frequently frightened, anxious, or depressed. Sleep deprivation, pain, physical helplessness, lack of privacy, and separation from loved ones do little to bolster the critically ill patient’s self-esteem or autonomy—predictably, they foster a sense of helplessness and dependency.

Finally, both the rapidly evolving, highly unstable nature of critical illness and the complex character of its treatment make it difficult if not impossible for most patients (or their families) to manage the decision-making for their own critical illnesses.

In short, the balance of power and control, if not moral authority, inevitably rests with the critical-care physician and staff. What they might do with that power is the subject of this paper. Hopefully, ensuring patients’ participation in decision-making is high on the list. Patient autonomy does not arise de novo in critical-care environments, nor can it long survive without active support and nurturing by health professionals. Like many other aspects of critical care, the level of patient autonomy must be orchestrated by those who hold the power.

Mrs. Smith

Mrs. Smith was a 47-year-old married woman with metastatic breast cancer who was admitted to the ICU with adult respiratory distress syndrome and probable sepsis. After 48 h her condition continued to deteriorate; her physicians considered it unlikely that she would recover. At rounds they discussed the patient’s resuscitation status—what they should do if her heart stopped. There was a general consensus that cardiopulmonary resuscitation (CPR) would not be successful and that a do-not-resuscitate (DNR) order should be written. In fact, the patient’s husband agreed with this course of action.

One of the residents asked if the decision should be discussed with the patient. Another resident said no, because such a decision would be too upsetting for the patient. Another physician pointed out that because the patient was intubated, it was very difficult to communicate with her. She could only communicate with nods of her head. Attempts to have her write on a pad of paper met with mixed results; the patient became quickly exhausted and her handwriting was almost illegible. It was even difficult to determine if the patient understood what they were communicating to her on rounds, although one of her nurses felt the patient generally understood what was going on.

What does honoring Mrs. Smith’s autonomy mean? On one hand it seems reasonable to spare this woman the pain of making a terrible decision. This is the old notion of “therapeutic privilege” or the "therapeutic exception”—i.e., a physician may eschew the informed consent process with patients if, in the physician’s judgment, such discussions

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1 Nonstandard abbreviations: ICU, intensive-care unit; CPR, cardiopulmonary resuscitation; and DNR, do not resuscitate.

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would cause patients undue upset. Of course, the therapeutic exception can be used more to protect the physician from painful discussions than to spare the patient. But even under the best of circumstances, the judgment about whether or not to invoke the therapeutic exception rests with the physician.

Even if the decision were made to attempt to involve the patient, communication would remain a difficult problem, time-consuming and frustrating. The mere "yes" and "no" answers Mrs. Smith was capable of giving would be unlikely to capture her thoughts and feelings about levels of treatment. Furthermore, it is not even clear that she possessed decision-making capacity (competence) adequate to make decisions about limiting treatment.

How much time should the physicians and nurses in the unit have spent trying to communicate with Mrs. Smith? Let us assume that the ICU was filled to capacity with critically ill patients and their families. Could staff take time away from the care of other patients in an attempt to communicate with Mrs. Smith? From which patients and how much time?

None of the above problems has ready answers. They involve matters of judgment—wise and educated judgment, it is hoped, but judgment nevertheless. Involving the patient’s husband may make those judgments better ones, but even the degree to which the husband should be involved is a matter of judgment—the judgment of the responsible physician. By use of concepts (like therapeutic privilege and competence) and by making choices about when and how much to tell, the critical-care physician, above all others, is in a position to orchestrate the degree to which Mrs. Smith makes her own treatment decisions.

While accepting my observation that critical-care decisions are orchestrated by health professionals, some would criticize my emphasis on the physician as conductor. What about critical-care nurses and the concept of the healthcare team? I think this is a fair criticism. Increasingly, nurses see themselves (and are seen) as professionals with their own set of rights and duties. Nurses spend the most time with patients and their families and are often in a position to know not only their questions and concerns but also their wishes regarding treatment and outcome. Whatever decisions are made regarding life-sustaining treatment, it is the nurse who spends the most time living at the bedside with the palpable results of that decision. Thus, nurses have valid (i.e., data-based) clinical and moral claims to participate in decision-making.

Nurses are often in a position to protect and nurture patient autonomy by making patients’ wishes known to physicians, helping patients maintain their dignity and self-respect, and generally acting as patients’ advocates. Yet, they too must make judgments about patient autonomy. The following case illustrates how nurses may limit patient discretion to help orchestrate what they judge to be the best overall outcome.

Mr. Black

Mr. Black was a 65-year-old businessman who was admitted to the ICU for ventilatory support. A progressive neurological disorder had left him paralyzed and unable to breathe on his own. Although the condition was ultimately reversible, he was in the ICU for three months, fully conscious but totally dependent upon the staff for even the most elemental functions.

After discharge from the hospital he was discussing the issue of autonomy. "I had no trouble about the major decisions," he said. "was always consulted and my opinions were taken into consideration. The real problem came with the little day-to-day decisions that are not very dramatic. When it came time to be rolled over, weighed, or suctioned (all extremely painful) the nurses would say ‘We have to roll you over now, OK?’ If I said no, they ignored me ‘We’re sorry, we have to,’ and they’d roll me over anyway. It made no difference what I said. I was totally helpless and they were going to do what they felt was necessary. It’s fine, I understand it but don’t talk with me about patient autonomy.”

Society has tried to enhance patient autonomy in critical-care environments by means of advance directives Advance directives are formal documents that allow competent persons to decide in advance what interventions they would or would not want for themselves at some time in the future, when and if they were no longer able to express their own wishes (3). Living wills are one type of advance directive: written documents specifying one’s treatment/nontreatment preferences. Proxy directives (or durable power of attorney agreements) are another type of advance directive by which one can authorize another specific person (e.g., a spouse or child) to make medical decisions when one loses decision-making capacity. A combination of living will and durable power of attorney would both designate a proxy for making health-care decisions and provide guidelines to the proxy for making those decisions. A majority of states have enacted legislation that gives legal sanction to living wills or durable power of attorney arrangements.

At first glance, advance directives are appealing. What better way to assure that the patient and (or) a family member, rather than the health professionals, will have the authority to orchestrate death. Unfortunately, the promise of advance directives has not been realized. First, most people have chosen not to execute an advance directive—the most optimistic estimates indicate that only 15% of Americans have done so (4). In my experience, far fewer of these directives ever show up in an ICU—an indication that either the 15% is an overestimation, or that executing an advance directive and putting it into effect are two different things.

Why is it that these arrangements, which offer the promise of autonomous decision-making, are so little utilized? Part of the explanation is undoubtedly that many persons simply have not heard of them or do not know how to put one into effect. It is also likely that many people would prefer to deny the reality of their death than to plan for it. Finally, surveys repeatedly demonstrate that a sizable minority of persons simply do not want to make their own health-care decisions, preferring instead to turn them over to their physicians.

There are other serious problems with advance directives. Their language is often so vague and general that health professionals must interpret it to a degree that makes the “wishes” of the patient almost meaningless.

A 70-year-old woman was admitted to the hospital in severe congestive heart failure. A widow, she had lived alone in an apartment for 10 years, where she was able to take care of her own needs without assistance. She had suffered from heart disease for several years and knew it would likely be the ultimate cause of her demise. She had executed a living will that said, "I realize that I have lived a full life and am ready to meet God. In the event that I am dying, I do not want heroic measures undertaken to start my heart beating. Nor do I want to die attached to machines." The patient was, however, satisfied with her current quality of life out of the hospital.
When she experienced extreme shortness of breath, she had a friend take her to the emergency room and agreed to admission "if you doctors can get me better and back home." She brought her living will, which her physicians entered into the medical record. She reiterated her wish not to be resuscitated or attached to a breathing machine. A DNR order was written. Early the next morning, a nurse found the patient seizing and unresponsive. Artificial respiration was initiated with bagging and 100% oxygen. Medication was administered to stop the seizures, with no effect. The cause of the seizures was unknown. After 15 min the seizures continued and the patient was still not breathing on her own. A decision had to be made about whether to intubate the patient and transfer her to an intensive-care unit.

Does the patient’s advance directive make it clear what the physicians should do at this point? I think not. Was the patient "dying"? Would attaching her to machines violate her wishes? Perhaps, but the etiology of the seizures was unclear. What if the cause was relatively benign but reversible—e.g., withdrawal from Valium, which the patient had been taking regularly but which had inadvertently been discontinued by her physician on admission to the hospital? Furthermore, failure to vigorously treat her respiratory insufficiency might lead not to a peaceful death but rather to severe neurological deterioration, which the patient would survive for months or even years in a debilitated dependent state.

On the other hand, intervention might indeed guarantee that the patient would die on machines, the eventuality she specifically and expressly sought to avoid by making out a living will. This case makes it clear that advance directives do not solve the "autonomy problem." Even in their presence, decisions often remain a matter of judgment for the physician.

Futility of Treatment

Futility of life-sustaining treatment has often been cited as a justification for withholding or withdrawing it (5). The reason seems clear. There is no obligation to subject a patient to a medical intervention, especially one that causes suffering and indignity, if there is no prospect that the intervention will achieve the desired result. In fact, some persons are calling upon physicians to forego futile life-sustaining interventions (such as CPR), either against the patient's and family's wishes or without informing them (6). Upon closer scrutiny, however, the notion of futility is more complex than it appears at first glance. I will examine two problematic aspects of futility: medical uncertainty and the inevitability of value judgments.

Medical Uncertainty

How certain do we have to be that a given intervention will not succeed before we can judge it "futile"? In fact, there are almost no clinical situations where the probability is zero that a given intervention will be successful. The clinical state of "brain death" (irreversible loss of all brain function) may be the one exception. It is a diagnosis that can be made with relative ease (in adults) by any trained critical-care physician. The fate of patients who have suffered irreversible loss of all brain function is absolutely clear. Despite the most aggressive "high-tech" interventions by the best critical-care physicians and nurses, brain-dead patients never wake up, never recover, and, in fact, predictably suffer irreversible asystole within hours, days, or, in rare cases, weeks. Series of hundreds of patients have revealed no exception to this rule. Clinical intervention in brain-dead patients is truly futile.

However, in the vast majority of situations, futility is less absolute. For some conditions insufficient numbers of clinically identical patients have been studied to warrant a conclusion that treatment is always futile. For other conditions the numbers are sufficient but reveal the rare or occasional patient for whom treatment was successful. Critical-care clinicians are all too aware of the pitfalls of prognosticating death for their patients.

Let us consider this issue in the context of do-not-resuscitate (DNR) decisions. CPR is a potentially life-sustaining treatment that often fails. If success of CPR is measured by the resuscitated patient living to leave the hospital, studies demonstrate a success rate of 20% at the most. In some subpopulations the success rate approaches zero (7, 8). Murphy et al. (9) reported a dismal rate of success for CPR in a study population of patients ages 70 and older: only 3.8% of 503 resuscitated patients lived to leave the hospital. The results were even worse in specific subgroups: only 1 of 116 patients with unwitnessed arrest, and 1 of 237 with terminal arrhythmias survived hospitalization; in the subgroups, the success rate begins to approach zero.

Such data (9) are helpful in resolving issues of medical uncertainty. While several research efforts attempt to identify other conditions for which specific interventions are similarly ineffective, it is doubtful that many situations will be found similar to "brain death," where medical certainty is absolute. Diagnostic and prognostic uncertainty will continue to plague clinicians' judgments of futility.

The Inevitability of Value Judgments

A pronouncement of futility will always involve value judgments. In the examples cited above, demonstrating the poor success rate of CPR, one must still make a judgment about whether or not a 15% chance, or a 3% chance, or even a <1% chance of surviving resuscitation to leave the hospital is a chance worth taking. This judgment will inevitably involve a balancing of the burdens of intervention with its potential benefits. If a given intervention had only a 1% chance of succeeding but was easy to administer, caused no pain or disfigurement, and would never leave the patient in a worse condition, there would be little reason not to try it.

Unfortunately, CPR does not fit this benign picture. In many ways, it is the ultimate assault, regularly leaving the patients with fractured ribs, pneumothoraces, and other serious complications. When patients survive CPR, there is a fair likelihood that they will have an even more compromised quality of life—attached to a respirator in an ICU with endotracheal tube and chest tubes in place and some degree of brain damage—until death occurs anyway a few hours, days, or weeks later. On the other hand, if resuscitation is not attempted, death will occur immediately and with absolute certainty. Immediate death without CPR might be the more reasonable and attractive alternative for many patients; for others, it is not. Let us consider the following two cases to illustrate the complexities of judgments about futility.

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Mrs. Jones

Mrs. Jones was a 65-year-old woman admitted to the ICU after suffering a major stroke that left her ventilator-dependent and with a right hemiparesis. Initially, she was comatose; after two days, her neurological picture improved and she gradually awakened, but she was still unable to communicate effectively.

Mrs. Jones also suffered from metastatic colon cancer. Metastases to the brain had been identified on a recent outpatient computed tomographic scan. Until the recent stroke, however, Mrs. Jones had been active and living on her own. She knew that her death was near but maintained a positive attitude. "I have a little time left," she said "and I'm going to make the most of it." She had specifically stated that she would like to live to see the birth of her first grandchild, due at any time. Mrs. Jones's physicians thought she had little chance of leaving the hospital. If she became arrested, the chances of successfully resuscitating her would be even less, "below 5%" they told her family.

Yet, when DNR was discussed with the family, they insisted that the patient would have wanted every opportunity to live, if only for a short time, to see her first grandchild. In fact, she had stated so explicitly and written it in a living will that the family presented to her physicians. No one supported this position more than Mrs. Jones's pregnant daughter. "Mom is a fighter," she said. "She wants to live to see my child. Then she will be ready to accept her death."

The next day Mrs. Jones developed ventricular fibrillation, which was identified immediately and responded quickly to defibrillation. Two days later she regained full consciousness. One week later she was weaned from the ventilator and transferred to a medical ward in time to see the birth of her grandson, with whom she had time to visit briefly before she died 10 days later from complications of pneumonia. The family had by then agreed to a DNR order and the patient was not transferred back to the ICU.

Mr. White

Mr. White was a 45-year-old man with metastatic lung cancer. His physician had given him less than three months to live. While at home with his family he experienced severe shortness of breath and chest pain. He was taken to an emergency room and admitted to an ICU, unconscious. Ten days later he remained unconscious. He developed adult respiratory distress syndrome, heart failure, renal failure, and sepsis. He was ventilator dependent and required regular renal dialysis. His physician wanted to write a DNR order. The chances of successful resuscitation, he concluded, were "infinitesimal." The patient had never indicated his wishes about CPR or any aggressive treatment. The physician told the family that Mr. White was not doing well and was likely to have a cardiac arrest in the very near future. He asked them, "Do you want us to do everything?"

The cases of Mrs. Jones and Mr. White illustrate the problem of values in determinations of futility. While Mrs. Jones's physicians indicated that CPR was futile because her chance of surviving it to leave the hospital was <5%, the family (representing Mrs. Jones's wishes) felt it was a chance worth taking. Mrs. Jones would not consider the resuscitative effort futile if it enabled her to see her grandchild—even if she did not live to leave the hospital. She might argue that even if the attempt had failed, it would still not have been futile because a DNR order would have taken away hope in her last days of life. Such reasoning is not uncommon in ICUs, even among physicians.

Mr. White illustrates an operational problem with the concept of futility. Even if physicians think an intervention is futile, they may present the choice to the family in a manner that implies otherwise. Asking Mr. White's family if they want the physicians "to do everything" places an unfair burden on the family.

Blackhall (10) notes that when families say yes to such questions they are "actually choosing something that [does] not exist—a chance for the patient to live." He suggests several strategies. First, the family needs to get more information, realistic information about the patient's prognosis. Provision of adequate information is often enough to let them agree that CPR is futile. Second, families may feel tremendous guilt—whether over past behavior toward the patient, resentment about burden imposed by the patient's illness, or even wishes that the patient die sooner rather than later. Guilt may only be intensified by putting the determination of futility on families' shoulders. Third, families like Mr. White's may demand aggressive interventions like CPR as a cry for help, an expression of desperation. As Blackhall notes however, there are more constructive ways of dealing with guilt and desperation than "offering CPR as a sort of high-technology placebo."

Such reasoning has led commentators like Blackhall (10), Murphy (6), and Tomlinson and Brody (11) to suggest that physicians need not offer futile CPR and that they can refuse requests for it. A patient's autonomy, they argue, does not include the right to demand futile therapy. Furthermore, the act of offering it implies that it might work—a potentially cruel, if unintentional, deception. Finally, physicians also have rights, and one of these rights is to practice good medicine. This does not include breaking patients' ribs and putting them on machines for their last few hours simply because patients or their families demand it.

Although this position contains a great deal of wisdom, it has pitfalls as well. First, as I have indicated earlier, most judgments of futility involve values, not merely objective facts. Whose values should hold sway? Mrs. Jones wanted to take a "long shot" to see her grandchild born. Was this wrong? Should she have been overruled by the physician's judgment that, considering the potential suffering and the <5% chance of success, CPR was "futile" and should not even be offered?

Studies have revealed tremendous inconsistency and variability about how and when physicians judge futility. Bias may lead them to write DNR orders for patients with AIDS, cancer, or for elderly patients while at the same time they provide full treatment for patients who are younger or have less stigmatized illnesses. Pronouncements of futility may also hide social judgments about the relative worth of one individual over another or idiosyncratic views on what constitutes an acceptable quality of life.

Second, unilaterally withholding an intervention like CPR without telling family members may engender mistrust or worse. Many patients and families are sophisticated enough about medical treatment to know that the last step before you die is cardiac arrest and that there is specific intervention for it, i.e., CPR. Every hospital has policy that CPR will be given in the event of an arrest unless there is a DNR order to the contrary. If nothing is said, many patients and families expect it will be given. If it is not given, they may well know it. In such circumstances, withholding CPR when it is expected without saying anything would be a tactical error of considerable magnitude.

Third, urging physicians not to talk with patients and families about such difficult and complex issues may set an unfortunate precedent by encouraging them to find rationalizations to avoid other difficult discussions. In fact, such
ies of DNR repeatedly show that physicians fail to communicate adequately with families and patients about decisions regarding treatment limitation. Most often this results in physicians overtreating patients because they never discussed the patients’ DNR preferences, waiting instead until it was too late (12). We cannot risk encouraging physicians to make decisions without consulting the persons who will be most affected by them.

How should physicians behave when they believe treatment is futile? I believe there are many options between the extremes of unilateral and clandestine withholding of CPR on one hand, and asking, “Do you want us to do everything?” on the other. When Murphy et al. (9) spoke candidly with patients and families in a nursing home about the futility of CPR, 23 of 24 agreed to a DNR order. Frank talk yields positive results. Furthermore, it creates an atmosphere of openness and trust in which other difficult decisions can be discussed, debated, negotiated, and, it is hoped, resolved. When they explain their own notions of futility, physicians may discover the different but equally valid perspectives of patients and families. Such communication might modify the thinking of both parties.

When physicians take these measures but fail to reach an agreement with the patient, there may be a good reason for refusing to honor persistent demands for futile treatment. At this point physicians have the option of removing themselves from the case after helping the patient and family secure another physician. Frequently, the threat of such action alone—it should never be used manipulatively—is enough to bring an unreasonable family back to reality.

There is no question that economic considerations and inadequate resources are increasingly creating pressures to limit life-sustaining treatments that are judged to be “marginally beneficial” (another word for futile). Accordingly, the judgment of futility is more likely to be made in relation to the goals of society rather than those of the individual patient. Physicians will increasingly find themselves in the position of saving resources for their hospital, HMO, or other medical-administrative unit. However, unless there are uniform guidelines and standards for judging futility, physicians would do better to convince patients and their families that a given intervention is futile rather than to make unilateral and secret decisions about what is either in society’s or their patients’ best interest. Furthermore, such guidelines or standards should not remain an institutional or professional secret. Rather, they should be shared with patients openly and up front, and subjected to the scrutiny of the larger community.

Fluids, Nutrition, and the Euthanasia Debate

The last two decades have seen a consensus in our society that has legitimized ceasing medical treatment that is refused by a competent patient or that does not serve the best interests of an incompetent one. Recently, however, considerable controversy has arisen around the issue of foregowing life-sustaining fluids and nutrition. Many see this limitation, in contrast to that of other life-sustaining interventions, as unacceptably close to the practice of active euthanasia. This debate has cast real doubts on some of the assumptions of the past two decades about what is meant by the terms “active” and “passive.”

While sanctioning the limitations of various life-sustaining interventions, the health professionals, the courts, and society at large have focused on patient autonomy and best interests (the ratio of burdens and benefits of intervention) as moral justifications. In doing so, they have largely ignored the issue of health professionals’ responsibility for orchestrating the death of another human being. Usually, when the issue of responsibility is addressed, it is passed off to a symbolic or abstract third party such as “nature” or “the disease process.” Thus, when a ventilator is disconnected, it is chronic obstructive lung disease, not the physicians and nurses, that causes the patient to die. When dialysis is discontinued in a patient with chronic renal failure, we are simply “letting nature take its course.”

Provision of fluids and nutrition has not lent itself to this facile analysis. Many persons, including State Supreme Court Judges, have seen withdrawal of artificially provided fluids and nutrition as active killing. Several factors explain this phenomenon. Unlike ventilators or hemodialysis machines, fluids and nutrition remain a powerful symbol of the basic care of one human being by another. As such, halting their provision seems to many like an unacceptable shirking of responsibility. Furthermore, stopping fluids and nutrition for a person who cannot eat or drink leads with certainty to death. When other life-sustaining interventions like ventilators or antibiotics are limited, death does not seem as certain, and there is often the notion (usually an illusion) that the patient might spontaneously breathe or otherwise recover against expectations. Thus limitation of the latter treatments is not seen as a “death sentence.”

The Supreme Court of the United States has heard the case of Nancy Cruzan, a young woman in a persistent vegetative state kept alive by artificially provided fluids and nutrition. How the Court rules in the case of Nancy Cruzan will inevitably influence the exact ways in which physicians will orchestrate death; but, be assured, they will continue to do so.

The technological imperative, the pressure to use new technology to save and prolong lives, will continue to exert a powerful influence on medical practice. Fear of malpractice litigation will continue to plague physicians who feel themselves to be caught “between a rock and a hard place”—increasingly fearful of being charged with either wrongful death or wrongful life. Studies will identify more and more marginally beneficial treatments, but Americans will continue to value their freedom to choose the long shot, to take risks, and, above all, to control their own destinies—even when such control is illusory. At the same time, economic pressures will encourage health-care institutions and third parties to limit use of marginally beneficial or excessively expensive life-sustaining interventions. Government regulations will increasingly set standards for communication and decision-making. Such standards will inevitably be too vague or restrictive to be really helpful. The bureaucratization of dying will inevitably be a failure.

In the trenches, however, will be the same physicians, nurses, patients, and families, struggling with the same critical illnesses and the inevitable judgments and decisions that accompany them. No matter how well we can orchestrate it, death is inevitable. When do we fight and when do we accept it? As long as we have choices, this question will not be easily answered.

References