About Intending Death: The Family and Quality of Care

I applaud Freeman and Pellegrino[1] for furthering the discussion on physician-assisted suicide and intending death. However, while they succinctly evaluated the values and perspectives of patients and physicians, those of the family and society were not well articulated. Moreover, their emphasis on the ultimately similar ethical treatment of one patient raises the question of quality of health care outcomes for patients with *similar* illnesses who receive care from providers with *dissimilar* ethical approaches.

In their first mention of surrogate decision makers, they state that life-support decisions "must be made by and with the patients or in consultation with their valid surrogates." The use of "or" implies that the family is excluded from the decision-making process unless the patient is incompetent. The authors allude to legitimate family interests again when they state that balancing the interrelationships between effectiveness, benefit, and burden should be possible "in consultation with the patient and/or surrogates." The use of "and/or" suggests that family participation is optional. The first specific mention of family and societal interests occurs in the authors' discussion of the need for mechanisms for conflict resolution. It is unfortunate that consideration of legitimate family and societal interests is only actively encouraged when conflict resolution through the courts looms. An approach that integrates these legitimate interests much earlier is sorely needed.

The authors' surprise in finding their similar management of *one* case despite divergent moral and ethical beliefs suggests that the provided example may be an exception. Two patients with the same severity of illness and same preferences who are cared for by attending physicians with different moral and ethical beliefs can conceivably receive markedly different quality and quantity of care as a rule. The quality of care that a patient receives at the end of life may be more dependent on the provider than on the patient's preferences or the severity of the illness. Research on practice variation between diverse or similar geographic locations in clinical ethical decision making is desperately needed.

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1. Freeman JM, Pellegrino ED. Management at the end of life: a dialogue about intending death. *Arch Fam Med.* 1993;2:1078-1080.

In reply

We thank Fetters for his compliments. We clearly believe in the importance of the values of the family and of society in making critical decisions at the end of life, but we believe in the primacy of an individualized, patient-centered approach. Throughout the article, we emphasized certain principles that should guide all providers. These principles are independent of the nature of the illness and the ethical approach of the providers.

Decisions at the end of life should always involve the family and should be in concert with the wishes of society as expressed by its laws. However, decisions must always be patient centered, even when surrogates are "legally" appointed.

Fetters is correct in stating that two patients with the same severity of illness could receive markedly different quality and quantity of care from two equally conscientious physicians. Indeed, two patients with the same illness could receive different care even from the same physician. Each physician is obligated to provide what he or she considers quality, but that definition should be heavily weighted by the priorities and values that patients, families, and physicians put into their own definitions of quality. The words that each chooses and the ideas that they mean to convey are filtered by the comprehension of the listener. The need to pay attention to these subtleties of communication is an important part of the message of our article.

Individuals may indeed receive different quantity and quality of care at the end of life, since persons of goodwill can in good conscience disagree in a pluralistic society.

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Incorporation of Genetics in Primary Care Practice

The article by Geller et al[1] published in the November issue of the ARCHIVES is a great compliment to the teachers of family medicine. The role of the family practitioner is to provide