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Palliative measures may provide better end-of-life care than life-prolonging treatment. Overtreatment may reduce the quality of life.

How doctors do *not* wish to die

In our part of the world, significant resources are spent on the critically ill, enabling many people to survive serious illnesses and injuries. However, there is a great deal of overtreatment, whereby very elderly or extremely ill patients receive full intensive medical treatment despite a poor prognosis. This results in many of these persons undergoing a long period in intensive care, associated with significant discomfort, suffering and grief before they die.

As an anaesthetist I spend a large part of my working life in the intensive care unit, where it is a privilege to help save lives. Yet I often witness the unnecessary prolonging of the dying process, when seriously ill patients who have reached the final stage of life are transferred to the intensive care unit to be given demanding mechanical ventilation before they die. For these patients, palliative treatment would be preferable. Nor is it unusual for us to have elderly, demented patients admitted who have suffered cardiac arrest in the nursing home and been resuscitated. Because the heart has recommenced beating, they are admitted to the intensive care unit, where they usually die shortly after – in a bed full of tubes, leads and technical equipment. There is reason to ask whether these patients should not have been spared resuscitation in view of their extremely poor prognosis (1).

It appears that we – both doctors and the general public – have developed a fear of allowing people to die naturally. Higher expectations of what doctors can and should assist with may result in demands for actions that are not always advisable (2). In a questionnaire survey among Norwegian doctors, approximately half responded that they perform unnecessary medical interventions in order to cover themselves, and almost three-fourths responded that they feel the risk of making mistakes to be a mental strain. Doctors allow themselves to be influenced by pressure from patients and their next of kin (3). Is much of the overtreatment a result of unrealistic expectations on the part of next of kin, and of doctors' fear of criticism by next of kin and colleagues? Is it in fact *this fear* that we are treating? I know colleagues who have been threatened by patients' relatives if full intensive medical efforts are not undertaken, despite the fact that the doctor considers them to be futile.

It cannot be expected of persons with no medical experience to understand the burden that life-prolonging treatment may represent; nor do they have any basis for assessing a patient's prognosis. As doctors we must communicate this to the patient and next of kin in an empathic manner that builds trust. There is reason to believe that much overtreatment could be avoided if doctors in hospitals and nursing homes took the time *at an early stage* to talk to the patient about future treatment, and whether a limit should be set, for example with regard to resuscitation or ventilation therapy. Geriatric patients are overwhelmingly positive towards such advance care planning discussions and their views on end-of-life treatment are important – quality of life means more than length of life (4).

Doctors know better than others that modern medicine has its limitations. So how do they themselves wish to die? There are several studies available, including from the USA, which show a clear difference between how doctors themselves would like their final stage of life to be, and how their patients die (5). Doctors suffering from incurable cancer often choose *less* treatment than non-doctors. They more often choose to spend the remainder of their lives with their families and to engage in pleasurable activities before dying at home – rather than undergoing demanding treatment that might perhaps prolong their lives by a few weeks or months, but would give them a poorer quality of life (6).

In an American study, two-thirds of the doctors who were asked had made plans for the end-of-life treatment they wished to receive. Almost all of them declined to be resuscitated. Most wanted pain management, but not life-prolonging treatment (7). Other studies support these results (8). As doctors we have seen so many tragic outcomes that we understand that death is not always the worst of these. It is possible to be «saved» for a life that no one would wish for – for instance with severe brain injury after cardiac arrest.

Death comes to us all. Avoiding thoughts of how we wish to die – or rather, how we do *not* wish to die – may result in an unnecessarily long and painful death. It may be too late to address this question once we are critically ill and incapable of communicating our wishes. We all wish to receive the best possible treatment if we become seriously ill, but the «optimal» treatment is not always that which prolongs life. Frequently the best treatment consists of palliative measures which can make the final days of life worth living.

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