

## Commentary

# Withdrawing and withholding life-sustaining therapies are not the same

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See related commentary by Vincent, page 226 [<http://ccforum.com/content/9/3/226>]

## Abstract

Numerous lines of evidence support the premise that withholding and withdrawing life support measures in the intensive care unit are not the same. These include questionnaires, practical observations and an examination of national medical guidelines. It is important to distinguish between the two end of life options as their outcomes and management are significantly different. Appreciation of these differences allows the provision of accurate information, and facilitates decision making that is compassionate, caring and adherent to the needs of the patient and their family.

During rounds in the critical care unit a discussion arises regarding continued antibiotic therapy in a patient who has not responded. Should antibiotics be added, should the current therapy be maintained, or should the antibiotics be stopped? No one would dispute that these options are different. Replacing the word 'antibiotics' with 'inotropes', 'ventilation', or 'life support' does not alter this reality. Stopping life-support measures (withdrawal of therapy) is not the same as refraining from starting them (withholding) or maintaining current therapy. The former is an active measure, whereas the latter two are passive. Often patients' families clearly understand this difference; they ask, 'Are you just going to let him [the patient] go doctor, or are you going to pull the plug?'

An appreciation of the differences between withdrawing and withholding life-support therapies can also be found in the medical literature from physician questionnaires and empirical observations of end-of-life practice. The experience of withholding as compared to withdrawing therapy has been examined in two large questionnaire-based surveys, one from North America and the other from Europe. In the North American study [1] 26% of physicians reported being more disturbed at the prospect of withdrawing therapy than they

were about withholding. Similarly, the European survey [2] showed that more physicians were willing to withhold treatment in a patient vignette than were willing to withdraw. In an additional study [3], when directly questioned on the equivalence of withdrawing and withholding treatments, only 34% of 1446 physicians and nurses saw these two options as equivalent. These surveys indicate that, regardless of theoretical equivalence, physicians do not see withholding and withdrawing as the same.

Practically, a recent large European study [4] highlighted the differences in effect of withholding and withdrawing therapy. The circumstances surrounding the deaths of 4248 ICU patients were recorded in this study. Following withdrawal of therapy 99% of patients died, and death ensued within a median of 4 hours. In marked contrast, when therapy was withheld 11% of patients survived, whereas for those who died death ensued after a median of 14.3 hours ( $P < 0.001$ ). The interpretation of this study is limited by its observational nature; the patients for whom therapy was withheld or withdrawn might not have been similar. However, this does not detract from the main finding, namely that withdrawal of therapy is followed by a near certain and rapid death.

Furthermore, the differences between withholding and withdrawing can be demonstrated by considering the extremes. The 'simplest' form of withholding therapy is determined by the do not resuscitate order. Such an order may be placed in a living will by somebody who is in perfect health. This patient may not experience any medical intervention at all for many years. In contrast, once a decision is made to withdraw therapy, ventilation or inotropes will be stopped, heavy sedation is usually commenced and death will typically ensue. These extremes are clearly very different.

Even guidelines relating to end-of-life care are careful in their terminology. The American Medical Association guideline [5] (paragraph 2) states that, 'there is no ethical distinction between withdrawing and withholding life sustaining treatments', whereas the UK General Medical Council guideline [6] states (paragraph 19) that, 'there is no ethical or legal obligation to provide it [a treatment not in the patient's best interest] and therefore no need to make a distinction between not starting the treatment and withdrawing it'. Neither guideline states that there is no difference between withholding and withdrawing therapy, but rather that they are equal legally and ethically. Indeed, immediately prior to the statement quoted above, the General Medical Council guideline describes a clear difference between withholding and withdrawing therapy, stating that, 'it may be emotionally more difficult ... to withdraw a treatment ... than to decide not to provide a treatment in the first place.'

What, then, is the importance of distinguishing between withholding and withdrawing therapy in daily practice? The principle of patient autonomy determines that the patient or their proxy should be in possession of relevant information before determining the appropriate course of action. Given that there are significant practical differences between withholding and withdrawing therapy, where appropriate the patient or proxy may wish to be made aware of the implications of their decisions. On a more personal level, end-of-life decisions are always difficult. Good communication and the reduction in uncertainty probably help to mitigate these difficulties to some degree. Once a decision has been made to either withhold or withdraw therapy, a clear explanation of what the family should expect, in terms of actions to be taken and the expected time course of events, might in part reduce uncertainty and prepare the family for the difficult and final parting from a loved one.

Having established that there is a difference between withholding and withdrawing life-sustaining measures at the end of life, we are unwilling to be drawn into a discussion of what is better and worse end-of-life care. There is no single formula for better or worse treatment at the end of life – there is only good treatment. Good treatment is that which is compassionate and caring, and adheres to the needs and requirements of the patients or their families.

Among the physician's many duties is the obligation to try and persuade the patient (or their family) to accept the best treatment available. To enter into an end-of-life discussion with the preconceived belief that withdrawing is better than withholding therapy is equivalent to saying that it is the physician's duty to convince the ICU patient or their family of this. This abrogates the basic understanding that, at the end of life, different strategies are equally right for different people, based not on APACHE scores, organ failures and machines, but on culture, upbringing and personal belief. The

application of preconceived beliefs also negates the principle of patient autonomy at the end of life.

So, to conclude, do not enter into discussions with the ICU patient or their family with the notion that withdrawal of care is the only or preferable option. Explain that the situation appears hopeless, and then listen – listen to what the family is telling you.

### **Withdrawing may be preferable to withholding: response to commentary by Vincent**

One of the first arguments Professor Vincent [7] presents is based on the fallacy of the full ICU. Vincent claims that if withdrawal of therapy were not to be performed, then the ICU would be full of hopelessly ill patients maintained indefinitely on life support. This is not the case. The recent ETHICUS study [4] showed that the median time to death for patients in whom therapies were withheld was 14 hours, rather than 4 hours in those whose therapy was withdrawn. This 10 hour difference is unlikely to differentiate between an ICU that is full and one with empty beds. In our ICU, and many others, it frequently takes longer than 10 hours to find a vacant ward bed for a patient who is ready for ICU discharge. Furthermore, as the association between intensive care and expertise in end-of-life care becomes a reality in the hospital environment, we have been witness to a paradoxical increase in ICU admissions of the hopelessly ill.

Vincent is also concerned that refusal to withdraw care might introduce hesitation into the actions of ICU physicians. We would hope that the ICU physician dealing with an acute life-threatening situation will concentrate on steps to save lives rather than consider ICU occupancy statistics. There is always another bed available, be it in the recovery room, following discharge of another patient, or in another hospital. Bed space issues are important but should not be considered at the expense of life-saving procedures.

Vincent suggests that it is the option for withdrawal of therapy that allows for the performance of an 'ICU test' for the frail elderly patient with pneumonia and guarded prognosis. We would argue that if doubt exists regarding the poor prognosis, then efforts should be made to admit the patient to ICU care regardless of end-of-life options. After all, is it right to refuse ICU admission only because that admission may be prolonged and is not guaranteed to succeed? Furthermore, in situations of doubt, we would suggest that within the ICU a 'withholding test' has merit. The ETHICUS study [4] showed that 99% of patients for whom therapies were withdrawn died, whereas 11% of patients for whom therapy was withheld survived to hospital discharge. So, when therapy appears to be failing and the prognosis looks grim, withholding therapy may be preferable to withdrawing because it allows for the limitation of potentially inappropriate therapy while not irrevocably determining outcome.

Finally, our experience of widely accepted withdrawal of therapy has been the opposite to that presented by Professor Vincent. Rather than an option that encourages the treatment of difficult patients whose benefit from ICU admission may be marginal, the acceptability of withdrawal may lead physicians and nurses to give up earlier. Statements such as, 'We all know that there is no hope; let's speak to the family about withdrawal' are often uttered early in the ICU course, before all therapeutic options have been explored, and not only in the frail and elderly. In fact, the ability to predict which individual patient will survive severe illness is far from perfect. Furthermore, the willingness of patients who have recovered from ICU admission to undergo ICU care again, including the associated suffering, and even for very short periods of survival [8] cannot be ignored. One wonders indeed whether the frequent enthusiasm for withdrawal of therapy does not more reflect the difficulties and fears of the ICU care team when exposed to the severely injured or chronically ill ICU patient, rather than their concern for the suffering of the patients themselves.

### Competing interests

The author(s) declare that they have no competing interests.

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