WITHDRAWING OR WITHHOLDING TREATMENT

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Major advances in medicine have led to dramatic changes of physicians to prolong life. Despite intensive care, individuals may remain hopeless ill with increased suffering. Over the last two decades, many authors documented a significant increase in the frequency of withholding and withdrawal of life support (WH/WDLS) from patients dying in ICU. In the recent literature, the percentage of patients dying in ICUs throughout the world after WH/WDL varies from 53 to 90%. Guidelines have been published to help physicians to manage end of life in ICU patients. Patients who experience WH/WDL are older and have a higher SAPS II than the remaining patients, with a higher proportion of cirrhosis, severe cardiac or respiratory insufficiency, cancer, multi organ failure and cardiac arrest before admission to the ICU. Futility of care is the main reason of WH/WDL. Withholding without withdrawal of life-support therapies is associated with a lower mortality compared with mortality after withdrawal decisions. Most of the time, ICU specialists tend to mix the two types of decisions in the same patient. Decisions to limit care should be taken only after consultation with the medical and nursing staff. An ethical process implies information and consent of patients, their families, or both. In fact, ICU patient are rarely associated to the decision process as they are acute ill and most of the time comatose. Families should be systematically involved in the decision-making process. The proposition of the staff and the family response has to be written in the patient's chart. Two distinct methods of ventilator withdrawal have been described. Terminal extubation entails the rapid cessation of mechanical ventilation and the removal of artificial airway. Terminal weaning is a step-wise reduction of ventilatory support, leaving the artificial airway in place during the withdrawal of ventilation. Patients can be kept comfortable with morphine and benzodiazepines.