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WITHHOLD OR WITHDRAW FUTILE TREATMENT IN INTENSIVE CARE.

Arguments supported by physicians and the general public.

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Akademisk avhandling

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Avhandlingen kommer att försvaras på svenska.

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Abstract

Background: Since the 60s and with increasing intensity a discussion have continued about balance between useful and useless/harmful treatment. Different attempts have been done to create sustainable criteria and recommendations to manage the situations of futile treatment near the end of life. Obviously, to be able to withhold (WH) or withdraw (WD) treatment which is no longer appropriate or even harmful and burdensome for the patient, other processes than strict medical (or physiological) assessments are necessary.

Aim. To shed light on the arguments regarding to WH or WD futile treatment we performed two studies of physicians' and the general populations' choice and prioritized arguments in the treatment of a 72-year-old woman suffering from a large intra-cerebral bleeding with bad prognosis (Papers I and II) and a new born boy with postpartum anoxic brain damage (Papers III and IV).

Methods. Postal questionnaires based on two cases presented above involving severely ill patients were used. Arguments for and against to WH or WD treatment, and providing treatment that might hasten death were presented. The respondents evaluated and prioritized arguments for and against withholding neurosurgery, withdrawing life-sustaining treatment and providing drugs to alleviate pain and distress. We also asked what would happen to physicians' own trust if they took the action described, and what the physician estimated would happen to the general publics' trust in health services (Paper IV).

Results. Approximately 70% of the physicians and 46% of the general public responded in both surveys. The 72-year-old woman: A majority of doctors (82.3%) stated that they would withhold treatment, whereas a minority of the general public (40.2%) would do so; the arguments forwarded and considerations regarding quality of life differed significantly between the two groups. Quality-of-life aspects were stressed as an important argument by the majority of both neurosurgeons and ICU-physicians (76.8% vs. 54.0%); however, significantly more neurosurgeons regarded this argument as the most important. A minority in both groups, although more ICU-physicians, supported a patient's previously expressed wish of not ending in a persistent vegetative state as the most important argument. As the case clinically progressed, a consensus evolved regarding the arguments for decision making.
The new born child: A majority of both physicians [56 % (CI 50–62)] and the general population [53 % (CI 49–58)] supported arguments for withdrawing ventilator treatment. A large majority in both groups supported arguments for alleviating the patient's symptoms even if the treatment hastened death, but the two groups display significantly different views on whether or not to provide drugs with the additional intention of hastening death, although the difference disappeared when we compared subgroups of those who were for or against euthanasia-like actions.

Conclusions. There are indeed considerable differences in how physicians and the general public assess and reason in critical care situations, but the more hopelessly ill the patient became the more the groups' assessments tended to converge, although they prioritized different arguments. In order to avoid unnecessary dispute and miscommunication, it is important that health care providers are aware of the public's views, expectations, and preferences. Our hypothesis—physicians' estimations of others' opinions are influenced by their own opinions—was corroborated. This might have implications in research as well as in clinical decision-making.

Keywords. Withdrawal life-sustaining treatment, Futility, Neonatal intensive care, Intentions, Hastening Death, Value-based medicine, Evidence-based medicine, Decision-making , Personal values

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