

Commentary

Evaluating our end-of-life practice

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Abstract

Ferrand et al's recent study of withholding and withdrawing life support in intensive care units in France reminds us that reporting end-of-life practices is an important step towards enhancing end-of-life care. The study highlights differences between the parentalistic approach to decision making in Europe, and the patient autonomy model in the USA. However, the reasons intensivists report for withholding or withdrawing life support are similar in both cultures. Intensivists in France make decisions despite a lack of formal guidelines in their country. This study should serve as a stimulus for educating the public and motivating more groups to monitor their end-of-life practices.

Keywords death, decision making, education, France, life support care

End-of-life care for intensive care unit (ICU) patients in the USA has been well described, but only recently have reports been published describing this care in Europe [1–3]. In both cultures, however, the public and physicians have begun to pay more attention to the way in which death is handled in the ICU. Without question, end-of-life care in the ICU is undergoing radical transformation. In order to effect any change, however, we need to look at what our practices are, what influences our decisions, and how this affects our care for patients who are dying in the ICU.

Why monitor end-of-life practice?

Why have discussions about end-of-life care become so prominent recently? Over the past few years, several surveys [4–6] have reported dissatisfaction on the part of families who have had loved ones die in the ICU. These surveys have convinced both the public and critical care clinicians that something is amiss, but for a long time physicians have been reluctant to deal with this difficult issue. Often, because of the discomfort that accompanies the emotional turmoil of death and dying, we avoid conversation and rely on other less sensitive means for communi-

cation with families, such as light-hearted quips, or quick, one-line expressions of sympathy. Consequently, families often feel abandoned by ICU care givers as their loved ones deteriorate and as the approach to care is changed from curative to palliative.

We must commend the efforts of Ferrand *et al* [7], who represent the French LATAREA group, for their willingness to examine end-of-life practices across a wide spectrum of French ICUs. The major findings of this study were that despite French legislation to the contrary, withholding and withdrawal of life sustaining therapies are common practice in French ICUs. In addition, most decision-making is done by physicians alone, rather than in collaboration with families or other members of the critical care team. As the authors conclude, France does not have official, sanctioned guidelines for withholding or withdrawing life-sustaining therapies, which may limit end-of-life decision-making in the ICU. This study represents a bold, courageous step toward enhancing care for patients dying in French ICUs. It illustrates why it is so important that we are willing to monitor and report our end-of-life practice patterns, even if it makes us a bit uncomfortable.

Cross-cultural differences

The major cultural difference between the USA and Europe is the parentalistic approach of the latter to end-of-life decision-making. The LATAREA study reported that patients' families were informed and involved in only 44% of cases, and the decision to withhold or withdraw was made by physicians without involving nursing staff in 46% of cases.

The predominant ethical construct in the USA is patient autonomy, which should imply full participation in decision-making by either patients or their surrogates. It is interesting to note, however, that most recent US surveys demonstrate a considerable amount of family dissatisfaction with the quality of communication with ICU care givers [8,9].

Good intentions

The similarity between US and French ICU end-of-life practices is even more interesting. Despite the lack of guidelines, as well as obvious cultural differences, the LATAREA study shows that French intensivists do withhold and withdraw life-sustaining therapies, albeit at a lower rate than do their US counterparts [10]. Just as importantly, the reasons cited by physicians in France for limitation of care are strikingly similar to those often quoted by US intensivists [11–13], with futility and poor expected quality of life being the most frequently cited reasons in this study.

These facts tell us that, when physicians come to believe that the care they provide is unlikely to have any further benefit, they feel withholding or withdrawal of care to be appropriate. It is reassuring to know that the intent of care on the part of physicians across the Atlantic is similar to that of physicians in France.

Decision-making: 'who' or 'how'?

The LATAREA study should serve as a potent stimulus for education of the public. We may debate, across cultures, about who should be involved in the decision-making process, but the more important point is that the decision is made. At a time when more and more sophisticated technology and drugs are being introduced into the intensive care arena, the global medical community must educate the public that death is ultimately unavoidable. Patients and families must be helped to realize that there frequently comes a point during ICU care when most physicians agree that further aggressive care will not result in survival and will only prolong the suffering of patients and their loved ones.

This unanimity of view should serve as an important, reassuring message to patients and their families; physicians want to do their best for patients, and this includes finding the point at which aggressive care no longer makes sense. In this context of trust between patients, families and care givers, mutual, shared decision-making can help patients

to receive the best level of care, with the highest likelihood of success and in accordance with their wishes. In some cultures, this trust is implicit, as in the parentalistic model. In some cultures, this trust must be explicitly developed and stated, based on patient autonomy. However, in both models there is much work to be done to identify clearly our true end-of-life practices and to enhance communication within the critical care team, as well as between the team, patients, and families.

Conclusion

The LATAREA study reminds us that simply reporting end-of-life practices is an important first step in the process of enhancing end-of-life care. We should applaud the group for their bravery and, ultimately, for their compassion in enhancing the quality of care received by their dying patients in the ICU.

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