How do you decide when to withdraw life support?

A primary goal of intensive and critical care medicine is to raise standards of care and improve outcomes for patients. But when non-responsive patients are unlikely to make a meaningful recovery, difficult decisions have to be made. Decision-making is influenced by many factors: ethical, economic, cultural, legal, and the wishes of the family. When there is overwhelming evidence that further treatment or keeping the patient alive with mechanical assistance is prolonging unnecessary suffering, how can this situation be explained to distressed family members?

The terminology is in the USA, and in most of the developed world, the majority deaths in the ICU are preceded by a decision to withhold or withdraw life-sustaining treatments. It is often commented that there is tremendous variability between countries. However, there is tremendous variability from ICU to ICU within countries (including the USA and England) and even from physician to physician; variability that is not explained by patient, family, or ICU characteristics. In fact, there is as much variability within countries and ICUs as between countries. The basis for the decision to withdraw life-support should depend on patients’ and families’ goals and preferences as well as physicians’ perspectives. Ideally, we should use the full spectrum of decision-making—from paternalism (doctor decides) through to shared decision-making to autonomy (patient or family decide). Where we are on this spectrum should be determined by the patient’s prognosis, by the treatments that are available, and by the patient or family preferences for the role they choose to play in decision-making.

In Israel as in most other countries, the physician decides when the patient will most likely die and life-sustaining treatments should be limited. What is very different to other countries is that life-sustaining therapies are not withdrawn. This is based on culture, religion, and law. The Israeli Termination of Life Law 2005 prohibits stopping continuous life-prolonging treatments, but allows stopping intermittent life-prolonging therapies. Discontinuing intermittent life-sustaining therapies is regarded as omitting a therapy rather than withdrawal. The Law is based on Halacha or Jewish law where the value and sanctity of human life is infinite and beyond measure. Although the omission of life-sustaining treatments is allowed, an act that actively and intentionally shortens life is prohibited. The withdrawal of a ventilator, which is considered a continuous form of therapy, shortens life and is forbidden. Halacha considers that not only the ends have to be morally acceptable, but also the means. The Law also regards fluids and food as basic needs and not treatments, requires physicians to care for patients and families, considers palliative care as a citizen’s right, and requires that any controversies are taken to ethics committees, not the courts. Decisions are based on the autonomous wishes of the patient, which are based on advance medical directives, the appointment of a surrogate decision maker, and testimony of an incompetent dying patient’s wishes by family members or close friends.

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changing—for example, medical futility is generally regarded as an inadequate term in this setting, and consensus around the world has not yet been reached. Finally, technology is advancing and expectations around life-saving interventions are shifting, influenced by the media and the internet.

We asked experts from around the world on what basis—when, and by whom—is the decision made to withdraw life support when the patient is unlikely to make a meaningful recovery? Their answers are shown in the map below and we also discuss the issues in an accompanying podcast. What do you think? Comments are welcome via @LancetRespirMed on Twitter or on The Lancet’s Facebook page.

Jules Morgan

It is very rare to have any advanced directive regarding end-of-life care in critically ill patients. Patients and their families do not like to discuss end-of-life care in the early stages of intensive care. The role of the family is huge. Culturally, South Korean physicians will consult with a patients’ family at first, and then discuss with the patient only with the agreement of the patient’s family. Every measure, especially regarding end-of-life care, is decided after family discussion. In South Korea, it is illegal to quit a life-sustaining measure from a patient, who appears to be terminal, by a physician’s unilateral decision. Every South Korean has medical insurance, which is a monopoly managed by our government. However, insurance is on a discounted system, paying around 60–80% of total medical expenses on admission to hospital. Therefore, sometimes issues around medical futility have arisen due to the financial burden on a patient’s family. However, resources are a sensitive issue. If we raise this issue of medical expense or resource allocation, we could not make progress on developing guidelines on withholding or withdrawing life-sustaining therapy even in the terminally ill patient in our society. There is increasing consensus regarding proper medical resource allocation between stakeholders for end-of-life care.

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The health-insurance system is amazing in Japan, and the economic burden on the family is light. Almost all families request that we take care of patients at any expense. In addition, withdrawal of life support is considered to be illegal. Sometimes a patient’s doctor insists on keeping them on life support, even when the intensivist believes it to be of no benefit. It is not unusual for the patient to occupy an ICU bed for a long time. This is ridiculous, however, it is next to impossible to transfer them to a general ward. The family plays a very important role, and rarely accept the option of withdrawing life support. Cultural values occupy an important place in decision-making, but religion is not an issue. The boundaries between definitions concerning medical futility are not clear distinctions.

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In China, there is neither local nor national legislation governing withdrawal of life-sustaining treatment, and no consensus exists with regards to futile medical treatment. However, the lawsuit against the treating physician in the first reported case of euthanasia in China in 1985 resulted in more cautious and conservative attitudes towards withdrawal of life-sustaining treatment, despite the acquittal of the accused physician. In clinical practice, treatment withdrawal in patients unlikely to make a meaningful recovery, as judged by the treating physician, but often raised by the family, is always a joint decision. Nevertheless, it is not uncommon for the children to override the advanced directives of the patients for do-not-resuscitate orders, and insist on aggressive but futile therapy, because filial piety can only be shown when the parent is alive. If this is the case, the physicians usually respect the family decisions and continue life-sustaining treatment. Some families will choose to let the patient die at home, due to religious or cultural values, and sometimes due to financial difficulties.

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Through the College of Intensive Care Medicine, training in intensive care in Australia and New Zealand is strictly controlled via a formal training programme and examination process. This results in a relatively homogenous standard of practice in ICUs throughout the region. Most ICUs are closed units run by registered intensivists with the authority and responsibility for all intensive-care decisions. Practising in Australia, where there are few resource limitations and a western medical training system, we realise modern intensive care can prolong the dying process. While futility cannot be formally defined, we recognised that some severely ill patients have little or no chance of recovery to any meaningful quality of life. This would be stressed in family discussions, often asking the family what the patient would have wanted. With family assent, the intensivist will withdraw therapy for these patients and keep the patient comfortable, often with opiates. In this regard there may be some variety in practice across the region and even within units, but surprisingly little.

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