Commentary

Evaluating our end-of-life practice
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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 communication 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.

ICU = intensive care unit.
In this context of trust between patients, families and care investigators want to do their best for patients, and this includes finding a suitable message to patients and their families; physicians agree that further aggressive care will not benefit, they feel withholding or withdrawal of care to be appropriate. It is reassuring to know that the intent of care 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 physicians across the Atlantic is similar to 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.

**References**

1. Vincent JL: Information in the ICU: are we being honest with our patients? The results of a European questionnaire. *Intensive Care Med* 1996, 22:1251–1256.
2. Vincent JL: Forgoing life support in western European intensive care units: The results of an ethical questionnaire. *Crit Care Med* 1999, 27:1626–1633.
3. Roupie E, Boulle R, Lepage E, Lemaire F, Lepone JL, Montagne O: Patients' preferences concerning medical information and surrogacy: results of a prospective study in a French emergency department. *Intensive Care Med* 2000, 26:52–56.
4. Hickey M: What are the needs of families of critically ill patients? A review of the literature since 1976. *Heart Lung* 1990, 19:401–415.
5. Johnson D, Wilson M, Cavanaugh B, Bryden C, Gudmundson D, Moodley O: Measuring the ability to meet family needs in an intensive care unit. *Crit Care Med* 1999, 27:266–271.
6. Singer PA, Martin DK, Kelner M: Quality end-of-life care: patients' perspectives. *JAMA* 1999, 281:163–168.
7. Ferrand E, Ingrand P, Lemaire, for the French LATAREA group: Withholding and withdrawal of life support in intensive-care units in France: a prospective survey. *Lancet* 2001, 357:9–14.
8. Jamerson PA, Scheibmeir M, Cobb AK: The experiences of families with a relative in the intensive care unit. *Heart Lung* 1996, 25:487–474.
9. Hanson LC, Danis M, Garrett J: What is wrong with end-of-life care? Opinions of bereaved family members. *J Am Geriatr Soc* 1997, 45:1339–1344.
10. Pendergast TJ, Luce JM: Increasing incidence of withholding and withdrawal of life support from the critically ill. *Am J Respir Crit Care Med* 1997, 155:15–20.
11. Luce JM: Making decisions about the forgoing of life-sustaining therapy. *Am J Respir Crit Care Med* 1997, 156:1715–1718.
12. Goold SD, Williams G, Arnold RM: Conflicts regarding decisions to limit treatment: a differential diagnosis. *JAMA* 2000, 283:909–914.
13. Asch DA, Hansen-Flaschen J, Lanken PN: Decisions to limit or continue life-sustaining treatment by critical care physicians in the United States: conflicts between physician's practices and patients' wishes. *Am J Respir Crit Care Med* 1995, 151:288–292.