Withdrawal of life support often an imperfect compromise

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Intensive Care Unit (ICU) doctors seeking to balance the complex needs of their patients and the patients' families may make an imperfect compromise, withdrawing life support systems over a prolonged period of time. This practice is much more common than previously believed, and is also surprisingly associated with higher satisfaction with care-at least among surviving family members.

"We found that sequential withdrawal of life support is not as rare a phenomenon as previously believed," wrote J. Randall Curtis, M.D., M.P.H., section chief for pulmonary and critical care medicine at the Harborview Medical Center and the University of Washington, in Seattle. "It occurred in nearly half of the patients we studied."

The findings will be published in the second issue for October of the *American Journal of Respiratory and Critical Care Medicine,* published by the American Thoracic Society. The study was funded by the National Institute of Nursing Research.

Dr. Curtis and colleagues examined medical charts and family questionnaires for more than 500 patients who had died at the ICU or within 24 hours of discharge out of a pool of 2,003 consecutive patients in 15 Seattle or Tacoma hospitals. During their final days, the patients studied were on a median of four life-support systems, from mechanical ventilation to tube feeding.

Interestingly, among patients whose stays at the ICU were more

prolonged, families seemed to be more satisfied when the withdrawal process was longer. "This finding is in the opposite direction to our original hypothesis," wrote Dr. Curtis, noting that "a longer duration of withdrawal of life support seems unlikely to be beneficial for the patient because it represents the prolongation of non-beneficial and sometimes painful therapies in a situation in which life-sustaining therapies are being withdrawn in anticipation of death."

A possible explanation for the higher rate of satisfaction among the families of patients who were removed from life support over time is that poor communication between physicians and families impedes decision making and delays the families' emotional readiness.

"Families need time and support to move from a situation of focusing on hoping for the patient's survival, to a situation in which they have accepted that death is inevitable and they are preparing for the best death possible. If families are not adequately prepared for such a transition, withholding all therapies the same day, followed by a quick death, could be experienced as abandonment," said Dr. Curtis.

Dr. Curtis and colleagues believe that, while sequential withdrawal of life support may be experienced more positively by some families, it is nonetheless a result of "incomplete decision making [that] serves as a way to compensate for the existing gap between physicians' decisions and family expectations."

The study also found if patients were extubated prior to death, family satisfaction tended to be higher, suggesting that extubation may be the best approach for many patients undergoing withdrawal of life support.

"The take home message" says Dr. Curtis "is not to prolong the withdrawal of life-sustaining therapies to the possible detriment of the patient, but to facilitate better communication between ICU clinicians

and patients' families. When physicians make a decision to withdraw support, they have often not prepared the family sufficiently and physicians may consequently embark on 'stuttering' withdrawal of life support in order to have more time to prepare the family."

Dr. Curtis concluded: "A better solution for improving family experience while also providing the best possible care to patients is to prepare the family for the possibility of the patient's death earlier in the ICU stay rather than waiting until the physicians have decided that withdrawal of life support is indicated."

Source: American Thoracic Society