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Ethical criteria for withholding and/or withdrawing from selected forms of intensive therapy

The so-called contemporary 'technicalization' of medicine, whose progress in recent years has been exceptionally rapid, offers new possibilities in terms of the treatment of many previously incurable diseases, as well as the sustainability and prolongation of human life. In everyday doctor's work, he or she has much to do with patients struggling for life. However, it is worth bearing in mind that knowledge and technology are "the precious means at human's disposal, and when used in their service, they contribute to the integrated and beneficial development of all, however, they cannot themselves prove the sense of their existence and human progress. By being addressed to humans, from whom they originate and thanks to whom they develop, they derive the directives as for their purposefulness and consciousness of limitations from the person and their moral values"(4). Knowledge should be the wisdom's ally. Knowledge and technology are expanding, which means every day the borders are changing. Wisdom and conscience set them the impassable borders of what is human (5).

In present day, the role of doctors has changed. Previously, they were trying to cure a patient by having recourse to all available methods that their medical knowledge allowed them to. Presently, wider accessibility and improvement of the quality of medical care caused doctors working in Polish clinics and hospitals to face a dilemma of asking themselves questions like: 'how long shall we prolong the life of a terminal patient?', 'when to stop it?', 'when to refrain from therapy that may only prolong the suffering and agony?' These questions do not only concern anaesthesiologists working at intensive care units or intensive therapy units, but also doctors of different specializations, because the decisions of desisting or/and ceasing the therapy are more often made in hospital units of dissimilar profiles. A fairly hard problem for many doctors is to differentiate the passive euthanasia from the desisting from the so-called persistent therapy, 'that is, from certain medical measures which are no more adequate to the actual situation of the patient, because they do not commensurate with the results that should be expected, or they are unbearable for the patient and his family. In such cases, when death is inevitable and soon, one may refrain from treatment, without being conscience-stricken, that would only cause painful and provisional prolongation of life. However, the regular therapy, which the patient requires in such circumstances, should not be ceased.'(3) Persistent therapy denotes persistent, continual doctor's interventions focused around actions taken at all cost in order to shortly prolong the life of a terminal patient.

Termination of persistent therapy is nothing else but the acceptance of the unavoidable fact of human's death. Persistent therapy does not belong to regular treatment measures and methods. Its application is by no means a doctor's obligation – especially when it is becoming a great torment for a patient. Prolonging this therapy becomes pointless when the available medical knowledge does not offer any hope for recuperation and the medical measures serve merely the extension of the process of dying. Unlike persistent therapy – euthanasia is understood as "a deed or negligence which by nature or by the doer's intention causes death in order to avoid whatever suffering there may be "(3). The consequence of the termination of persistent therapy – which can be twofold: withholding (not initiating the therapy by means of extraordinary, disproportionate measures), or

withdrawal (stopping the ongoing therapy) is obviously the patient's death. A research performed in France (1) or in Great Britain (2) shows that presently deceases in intensive therapy units are preceded by the decisions of withholding the treatment or withdrawing from the treatment. Likewise, Polish clinics and medical centres take decisions of cessation or/and desisting from intensive therapy, although there is no precise data as for the scale of the occurrence.

The purpose of the countrywide opinion survey is an attempt to define the scale of the occurrence of withdrawal from or withholding different forms of intensive therapy in Polish medical centres, as well as the definition of the most frequent dilemmas that doctors taking such decisions must face. The survey also aimed at defining the possible criteria of withdrawal or withholding different forms of intensive therapy and intensive medical care.

MATERIAL AND METHODS

The survey was held between 15 May and 30 June, 2005 and was based on a self-developed survey questionnaire consisting of 23 questions of different answer variants (single choice, multiple choice and open questions).

The questionnaires were sent to directors and heads of hospital units of 1,788 Polish clinics and hospital units of hospitals of different specializations: anaesthesiology and intensive therapy, internal diseases (cardiology, endocrinology, gastrology, haematology, pulmonary medicine, nephrology and dialysis centres), neurology, urology, oncology and palliative medicine. Their addresses were available on www sites. Until 15 October, 354 completed questionnaires had been returned, which comprised 20.5%.

RESULTS

54% (191) of the surveyed doctors encountered the events of withdrawing from intensive therapy, 46% (162 persons) claim that such occurrence never takes place in their wards. Only 151 persons out of 191 (who experienced the withdrawal from intensive therapy) gave precise figures of how often it had happened last year. Thirty-seven persons (24.5% of the surveyed) answered that during the past year they once witnessed an incident of withdrawal from intensive therapy. A similar number, 34 persons (22.5% of the surveyed), had to do with the withdrawal from intensive therapy twice. Ten persons (6.6% of the surveyed) stressed that they had often encountered the withdrawal.

When responding the question of the source of the withdrawal from intensive therapy, 52.6% of the surveyed (100 persons) admitted that the withdrawal had taken place as a result of agreed decision of the doctors' team, family and patient; 40.5% (77 persons) answered that it had been the doctor to take the decision on withdrawal, and only 4.7% (9 persons) answered that it had been the patient to ask for the measure in question. The withdrawal from intensive therapy mostly concerned patients with a cancer development – 53.4% (101 persons responded in this way); next there were the patients with multi-organ failure – 49.7% (94 persons responded so); the third group consisted of the patients who suffered form neurological illnesses – 33.3% (63 persons).

Among the respondents, 227 persons (64.7%) have witnessed an incident of withholding intensive therapy in their professional life; 124 persons (35.3%) have never gone through this problem inside their wards. From almong 227 persons who experienced the withholding of intensive therapy, only 173 persons gave the figures concerning their whole professional life. 43.4% (75 persons) underlined that such events had happened a number of times, although there were some voices that the scale of the phenomenon was much greater; 6 persons (3.5%) openly admitted that in their wards the incidents of withholding intensive therapy had run into hundreds. According to our respondents, withholding intensive therapy was largely the effect of a mutual decision of doctors, patient's family and the patient – so responded 103 persons (46.6%); next, the surveyed pointed to the doctor's decision – 95 persons (43.0%); only 4.5% of the surveyed (10 persons) mentioned the patient's decision as the cause of desisting from medical action.

Withholding intensive therapy mostly affected the patients who suffered from cancer – 153 persons gave such answer, which is 69.5% of the respondents, and patients with multi-organ failure – 93 persons, 42.3% of the surveyed.

Among the criteria which should be taken into account while making the decision on withholding intensive therapy, the respondents listed the following: 1) the opinion of the specialist team (68.0% of the surveyed – 236 persons); 2) prognosis concerning life expectancy (59.7% – 207 persons); and 3) patient's decision if taken consciously (50.4% – 175 persons). The least significant factor is the patient's sex (0.6% – only two persons considered the sex a factor to be allowed for when creating the criteria). The major criteria which should be taken into account while making the decision on withholding intensive therapy in case of patients with a chronic multi-organ failure are: 1) the opinion of the specialist team (68.6%) – 238 persons); 2) prognosis concerning life expectancy (67.7%) – 235 persons; 3) patient's decision if taken consciously (55.6% – 193 persons). Only one person considered the sex a factor to be allowed for, and 7.8% (27 persons) mentioned treatment costs as a factor.

DISCUSSION

The performed check demonstrated the widespread character and scope of the occurrence of withdrawing from intensive therapy or/and intensive medical care in Polish medical centres: 54% of the respondents at least once experienced such a case in the past year in a ward or a clinic they managed. The widespread quality ought to be likewise referred to the withholding of intensive therapy (64.4% of respondents had to do with it in their work). What follows, however, it the problem of interpretation of 'withdrawing from intensive therapy or/and intensive medical care' and similarly, 'withholding intensive therapy or/and intensive medical care'. The lack of respondents' precision with regard to the figures concerning the incidents, as well as the term 'multiple' used throughout the survey uphold this observation. The avoidance of precisely calculated answers, particularly when it comes to 'withholding intensive therapy', may suggest an obscure scope of the terms in respondent's view.

As a result of the performed research, we now possess the picture of actual decisions mostly taken by teams of doctors, doctor in charge or patient's family. The results analysis shows that in the cases of withholding intensive therapy in more than half of all cases (52.6%) the decision was made by a team of specialists, patient's family and the patient. With slightly less percentage, though still high, (40.5%) it was the doctor to make a choice. Only in 4.7% of cases it was the patient to decide to withhold intensive therapy. A paternalistic but also 'multi-thread' model of solutions is exhibited by nearly identical structure of decision-making in the cases of withdrawing from intensive therapy: in merely 4.5% of cases the patient's will was taken into account. In 46.6% of cases withdrawing from therapy was the effect of an agreed decision of team of doctors, family and patient; in 43.0% of cases reported in the survey decision was made by the doctor in charge. Both in the cases of withdrawing and withholding persistent therapy the most numerous group of patients affected were those suffering from cancer.

Besides, we developed a model, as proposed by the respondents, of decision-making solutions that should be put into effect. With regard to withdrawing from intensive therapy, the criteria to be considered in our respondents' opinion are: the position of a team of specialists, prognosis on the life expectancy and patient's decision if made when of sound mind. The major criteria to be considered when withholding intensive therapy are: the position of a team of specialists, prognosis on the life expectancy and patient's decision if made when of sound mind.

Both in the case of the proposed decision-making structure relating to withdrawing as well as withholding persistent therapy, the 'multi-thread' aspect was confirmed, that is, simultaneously taking into account several factors, which was revealed in real cases recorded in the survey as well. It is worth noting that the patient's decision gained lesser status of importance than the opinion of specialists and life expectancy prognosis. The cost-effective factor was not expressly significant in the decision-making; merely 7.8% (27 persons) mentioned treatment costs as a factor

to be reflected on. At this point, we can observe a considerable difference when comparing our check to the research on the issue of withdrawing or withholding intensive therapy done in other European countries.

CONCLUSIONS

1. The occurrence of withdrawing or/and withholding intensive therapy can be regarded as present in the Polish medical centres.
2. Withdrawing or/and withholding persistent therapy largely affects patients with cancer and those with multi-organ failure.
3. In medical practice in Poland such decisions are mostly taken collectively by a team of doctors, patients' family and the patient, or only by the doctor in charge of the treatment.
4. The factors proposed by the respondents that should be provided for in the decision-making process of withdrawing or/and withholding intensive therapy are: the position of a team of specialists, prognosis on the life expectancy and patient's decision if made when of sound mind.
5. In the decision-making model proposed by the respondents some subsidiary influence of economic factor was registered.
6. The interpretation scope for the analyzed terms (withdrawing, withholding intensive therapy) is not accurately established in the views of a large part of the respondents.

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SUMMARY

Presently, wider accessibility and improvement of the quality of medical care caused doctors working in Polish clinics and hospitals to face a dilemma of asking themselves questions like: 'how long shall we prolong the life of a terminal patient?', 'when to refrain from therapy that may only prolong the suffering and agony?' These questions do not only concern anaesthesiologists working at intensive care units or intensive therapy units, but also doctors of different specializations, because the decisions of desisting or/and ceasing the therapy are more often made in hospital units of dissimilar profiles. The consequence of the termination of persistent therapy – which can be twofold: withholding (not initiating the therapy by means of extraordinary, disproportionate measures), or withdrawal (stopping the ongoing therapy) is obviously the patient's death. A research performed in France or in Great Britain shows that presently deceases in intensive therapy units are preceded by the decisions of withholding the treatment or withdrawing from the treatment. Likewise, Polish clinics and medical centres take decisions of cessation or/and desisting from intensive therapy, although there are no precise data as for the scale of the occurrence. The purpose of the countrywide opinion survey is an the attempt to define the scale of the occurrence of withdrawal from or withholding different forms of intensive therapy

in Polish medical centres, as well as the definition of the most frequent dilemmas that doctors taking such decisions must face. The survey also addressed the definition of the possible criteria of withdrawal or withholding different forms of intensive therapy and intensive medical care.

Kryteria etyczne zaniechania i /lub zaprzestania wybranych form intensywnej terapii

Coraz szersza dostępność i poprawa jakości opieki medycznej powoduje, że lekarze pracujący w polskich oddziałach i ośrodkach klinicznych stają przed nowymi dylematami, zadając sobie pytania: jak długo należy przedłużać życie nieuleczalnie chorego pacjenta? W jakich sytuacjach nie podejmować terapii, która jedynie przedłuży cierpienia i agonię pacjenta? Pytania te nie dotyczą tylko lekarzy anestezjologów pracujących w oddziałach intensywnej terapii lub intensywnej opieki medycznej, ale także lekarzy innych specjalności medycznych, bowiem decyzje o zaniechaniu i/lub zaprzestaniu terapii są podejmowane coraz częściej w oddziałach szpitalnych o różnym profilu. Konsekwencją rezygnacji z uporczywej terapii, która może mieć dwie formy zaniechania, a więc nierozpoczynania terapii przy użyciu środków nadzwyczajnych, nieproporcjonalnych lub zaprzestania, przerwania już trwającej terapii, jest śmierć pacjenta. Badania przeprowadzone we Francji i w Wielkiej Brytanii pokazują, że obecnie coraz częściej zgony w oddziałach intensywnej terapii poprzedza decyzja o powstrzymaniu się od leczenia (*withold*) lub jego zaprzestaniu (*withdraw*). W polskich oddziałach i ośrodkach klinicznych również podejmowane są decyzje o zaniechaniu i/lub zaprzestaniu intensywnej terapii, choć nie ma dokładnych danych co do rozmiaru tego zjawiska. Celem przeprowadzonego ogólnopolskiego badania ankietowego była zatem próba określenia skali zjawiska zaprzestania lub zaniechania różnych form intensywnej terapii w polskich ośrodkach medycznych oraz zdefiniowanie najczęstszych dylematów, przed jakimi stają lekarze podejmujący takie decyzje. Badanie było ukierunkowane również na określenie możliwych do przyjęcia kryteriów zaprzestania lub zaniechania różnych form intensywnej terapii i intensywnej opieki medycznej.