Rapid Withdrawal of Support*
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While much debate has transpired over the ethics of whether to withdraw life support from terminally ill patients, little attention has been paid to the question of how to withdraw support. In the preceding essay, Gianakos compares prolonged terminal weaning with extubation, but other, more humane, alternatives exist. Further, Gianakos contends that after a decision has been reached to withdraw life support, a gradual weaning of mechanical ventilation over several hours or days allows for more precise titration of narcotics and therapy, allows the physician more time to comfort the patient and family during the withdrawal, diminishes the emotional difficulty physicians may experience during the withdrawal, and maintains a "positive 'uncertainty' about the patient's outcome." While we find his essay thoughtful, and timely, we take issue with his conclusion and believe that a rapid reduction of ventilatory support represents both a more ethical and a more rational approach to the termination of life support.

We object to physicians terminating life support by extubating patients. Extubation of ventilator-dependent patients frequently causes marked respiratory struggling and significant distress that is profoundly disturbing for family members, loved ones, and healthcare professionals to behold. Nevertheless, the practice continues: one survey of critical care physicians found that 13% preferred extubation as a means of withdrawing ventilatory assistance.1 Reducing the fractional inspiratory oxygen (FiO2) to room air (21%) and reducing the respiratory rate to zero over a period of minutes represents a more reasonable approach to withdrawing ventilatory support. IV morphine has a rapid onset and, with the physician at the bedside, can be carefully titrated to control patient discomfort.

Among the various arguments favoring prolonged terminal weaning, we most strongly object to the implication that it increases patient survival. We concede that physicians are not 100% accurate in predicting death and that different physicians make different decisions regarding when to withdraw life support.2-4 However, the literature in this field cannot be reasonably construed as supporting Dr Gianakos' suggestion that 8% of terminally weaned patients survive beyond the weaning period. The single article on which the figure is based does not represent the number as generalizable,5 nor does it provide information either on how long after discharge the survivors lived or on their quality of life. One recent study of 237 consecutive patients who received a terminal care decision in a Jacksonville, Fla, ICU found no survivors among terminally weaned patients.6 More relevantly, to our knowledge, there exists no literature comparing survival following different methods of withdrawing life support. It is our opinion that most critical care physicians would agree that essentially all patients who have life support purposefully withdrawn die shortly (minutes to days) thereafter.

Advocating a prolonged wean on the grounds that it promotes survival, moreover, confuses the nature of a terminal wean decision. While the possibility of survival can rarely be ruled out with absolute certainty, entertaining survival as a possible goal of terminal weaning can only lead to confused decision making in which half-hearted attempts are made to provide some intermediate level of care. Further, survival may be meaningless or even undesirable if the patient would be unable to regain a reasonable quality of life. When physicians implement a decision to withdraw life support, the goal of medical care changes from prolonging life to facilitating a dignified and peaceful death. We hope for death to occur in the least traumatic manner for the patient and for the family and loved ones.

In this regard, Gianakos' argument that prolonging a terminal wean diminishes the emotional difficulty experienced by physicians during withdrawal appears misguided. The argument hinges on the proposal that physicians find terminating life support easier if they can focus on the patient's comfort needs rather than on the imminence of death. We believe that physicians are better served by maintaining a clarity of purpose and a frank admission that death is the goal of withdrawing care. We do not want to minimize the distress and guilt that some physicians experience when they remove life support, but these feelings are best addressed directly rather than by denying the anticipated outcome of their actions. Moreover, we find it problematic from an ethical perspective to advocate that physicians commit acts that cannot be acknowledged in

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a forthright manner. If terminating life support cannot be candidly accepted as a deliberate and ethically proper decision to allow a patient to die, then how can we justify the decision at all? A dignified death is sometimes the best care we have to offer a patient. There is no shame in such an admission.

Gianakos raises an important issue when he argues that a slower withdrawal of ventilatory support allows the physician more time to comfort the patient and family. The decision to withhold life support and to allow a patient to die can be one of the most difficult a physician has to face; the temptation to stay away from patients under such circumstances can be great. It is essential that physicians not yield to this temptation but remain physically and emotionally present with the patient and loved ones when care is withdrawn. Being present, however, does not require a prolonged wean. Indeed, once a patient or family decides to end advanced life support, prolonging the process of dying may simply add to the family’s anguish. The time to go slow is not during the wean but during the discussions that lead up to the decision to withdraw care.

This last point is important. In considering how best to withdraw ventilatory support, we must not forget that our justification for taking such measures depends largely on the manner in which the withdrawal decision was reached. A careful decision-making process provides a moral foundation for withdrawing care and reduces the emotional difficulty of the terminal wean. Allowing a patient to die represents an enormous turning point for everyone involved. The transition from aggressive interventions aimed at prolonging life to an active withdrawal of care can feel like “suddenly slamming on the brakes of a moving vehicle.” The physician, patient, and loved ones alike may perceive the withdrawal decision as a failure. There may be sharp differences of opinion among the various parties over the most appropriate course of action. It is imperative that all involved have an opportunity to express their views and their feelings. Physicians must give their best and most honest assessment of the patient’s condition and prognosis. Patients and loved ones must, wherever possible, understand the most likely outcomes of alternative medical decisions. Only under these circumstances can patients or their surrogates make reasonable decisions regarding terminating life support. Only then can physicians justifiably assert that they are acting in accord with what their patient would want.

Beyond Gianakos’ argument, prolonged terminal weaning is also objectionable because it infringes on two basic tenets of medical ethics: the principles of nonmaleficence, more colloquially cited as “first do no harm,” and justice. We violate the principle of nonmaleficence whenever we provide patients with non-indicated therapies that result in increased suffering or morbidity. Living as an intubated patient in an ICU ranges from merely degrading to positively miserable. Prolonged terminal weaning extends the languishing of hopelessly ill patients and threatens to wrench patients back from a swift and painless death merely to live out a few additional hours or days in pain and indignity.

Justice, on the other hand, demands a fair allocation of medical resources. Expending limited resources where there is no reasonable hope of benefit violates the principle of justice, for it amounts to wasting services from which other patients could have benefited. In an era in which a growing proportion of health-care dollars are being transferred to the profit margins and shareholders of health-care corporations, we are not prepared to argue that our society cannot afford to provide a little more care for the dying. However, if prolonged terminal weaning offers no benefit to the patient, then there can be no justification for the associated expenditure.

We advocate the rapid withdrawal of life support, a technique that provides a dignified and peaceful death for the patient without traumatizing the patient’s family. Withdrawal of life support represents a major event and demands a careful and rigorous decision-making process marked by truth-telling and open, sensitive communication. Once a decision is reached, however, further delay is undesirable. Drawing out the process of dying during a terminal wean threatens to prolong a patient’s distress and further strain families that have often already spent too many days and nights in the hospital.

REFERENCES
3 Cook DJ, Gayatt BJ, Reeve J. Determinants in Canadian health care workers of the decision to withdraw life support from the critically ill. JAMA 1995; 273:703-08.