Attitude of the Macedonian Intensivists Regarding Withdrawal of therapy in Intensive Care Patients: Curriculum for Policy Development

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Ethical confusion regarding withdraw of therapy led to the aim of the study in which the knowledge and attitude of the Macedonian Intensive Care Unit (ICU) doctors and their impact on decision making process were assessed. **Methods:** Knowledge, Attitude and Practice (KAP) study has been conducted on a national sample of 217 ICU doctors (response rate 83.87%), applying restructured EURELD 2002 questionnaire as study instrument. CHI-square test was used for cross tabulations. **Results:** 103 responders were females and 79 males with mean age 40.2 years ±3 y. Significant percent of the doctors didn’t know what is withdraw of therapy, chi-square 34.47 (p<0.0001) and for most there was no difference between withdraw of therapy and euthanasia, chi-square 41.482 (p<0.0001). Most of doctors didn’t have any formal training (67%) and didn’t know whether they had experience with withdraw or withhold. Similarly to other countries, for significantly higher percentage of the Macedonian intensivists patient’s wishes and patient autonomy have to be main criteria for decision. Significantly higher group of doctors (p<0.0001) would prefer to leave their own advanced directives. **Conclusions:** Legal principles in end of life care must be established in the country. Courts should have drawn a distinction between intentionally causing a patient’s death (euthanasia) and allowing a patient to die as a result of the withdrawal of life support treatment. There is a need of additional improvement of postgraduate curriculum and continuous professional development of ICU doctors working with end-of-life patients. **Key words:** withdraw of therapy, ICU doctors end-of-life decisions, quality of life, advanced directives

**1. INTRODUCTION**

Modern Intensive Care Unit (ICU) is very efficient in treatment of critical ill patients and for a long period the resources were used to preserve life in any costs. During the past two decades, however, there has been an increased awareness that ICU can help many patients back to a respectable life, but in other cases causes horror and a prolonged process of dying. Growing interest in medical ethic leads to an increased concern among doctors that life-sustaining therapies should only be employed when there are likely to produce real benefits while in situations in which they prolong the dying process violates the ethical principles of beneficence and non-maleficence.

Nowadays modern medicine and developing technology have expanded abilities to cure, or at least to treat previously “incurable” diseases. This has resulted in increasing financial burdens and ethical dilemmas in society on a time when resources for medical care are becoming more and more limited and when they are used to provide unwanted and useless life-sustaining medical treatment for the patients at the end of their life. Therefore, difficult decisions need to be made regarding who to treat and for how long, resulting in ethical, legal and economical dilemmas.

Objective evaluation of the existing literature and daily practice in lot off countries shows that considerable differences exist in opinions between patients, doctors, politicians and lawyers regarding end of life decisions as forgoing therapy, do not resuscitate orders, withdrawal of therapy, pain treatments even euthanasia are.

Withdrawal of therapy is an issue in Intensive care medicine with enormous challenge regarding end-of-life decisions, because it is now possible to maintain life for long periods without any hope of recovery. Withdrawal of support does not equate with withdrawal of care. Care to ensure the comfort of a dying patient is as important as the preceding attempts to achieve cure. Improving the process by which life-sustaining treatments are withheld or withdrawn is an important aspect of improving the quality of end-of-life care (1). To avoid confusion
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of terminology, practice of withholding or withdrawing life-supportive care should be guided by a thorough understanding of the goal: to remove treatments that are no longer desired or indicated and that do not provide comfort for the patient. It can be achieved by performing "Withdrawal of life support order form" for use in ICU developed by Treece in 2004 (2). Published data show that 40-90% of deaths in ICU's in many western European countries are preceded by decisions to withdraw or withhold therapy (3, 4, 5, 6).

What is also important is that the legal status of withdrawal of therapy is anything but uniform. There are a number of countries which standards of medical care are comparable but where relevant law and legal practice differ greatly. Recently, the ETHICUS study showed that decisions to withdraw treatment were less common in southern European countries, where cardiopulmonary resuscitation (CPR) was more often used and ICU stays were longer than in northern countries (7). These differences have been attributed in part to different case-mix, differences in culture and religion, differences in physician values and practices, as well as variability in the ongoing evolution of end-of-life practices. However all ICU doctors think or feel that withdrawal of therapy is an issue in Intensive care medicine with enormous challenge, so ethical and legal dilemmas arise about it.

2. THE AIM OF THE STUDY

The aim of the study was to assess the knowledge and attitude of the Macedonian ICU doctors and their impact on decision making process regarding withdrawal of therapy in their practice. Trying to assess the opinion and attitude of the Macedonian intensivists regarding withdrawal of therapy, first it was important to know are they familiar with end-of-life decisions, how would doctors defined withdraw of therapy, why is this issue important, how should they approach the issue of withdrawal of therapy in practice and what are the policies of withdraw of therapy.

3. MATERIAL AND METHODS

Knowledge, Attitude and Practice (KAP) study has been conducted on a national sample of 217 doctors working in ICU through Macedonia. CHI-square test was used for cross tabulations and significance of difference was accepted for p<0,0001. Anonymous written questionnaire with restructured questions adapted from EUREL 2002 (questions regarding experiences and statements) was used as study instrument. A total of 217 questionnaires have been sent and 182 (response rate of 83,87%) were returned with complete answers from May to September, 2010. Questionnaire comprised two main parts of questions: questions pertaining statements; and additional questions about professional experience and knowledge with end-of-life care. Personal characteristics (age, gender) of the responders were followed by 6 statements regarding withdraw of therapy and doctors were asked to answer with "yes, no, or I don't know" to this: 1. Does a person have the right to decide whether or not to hasten the end of life; 2. Should the relatives be allowed to decide whether or not to withhold or withdraw therapy; 3. Is there a difference between withdraw and withhold of therapy; 4. Is there a difference between withdraw of therapy and euthanasia; 5. Consideration regarding quality of life (is it acceptable for you to promote life at all costs); and 6. Would the doctor himself want to leave advanced directives. Questions about professional experience and knowledge with end-of-life care were as follows: 1. Have you had any specific formal training in palliative care; 2. How often do you have patients at the end of life; 3. Did you ever withhold treatment (e.g. dialysis) at the terminal patient; and 4. When would you implement withdraw of therapy.

On the end of the questionnaire there was place for comments to the questions.

4. RESULTS

From number in our sample 103 of the responders were females and 79 were males. The mean age was (40,2 ±3 years).

There is significant difference in the knowledge about patient rights and difference between withdraw and withhold of therapy and euthanasia as presented in Table 1. Significantly higher percentage of doctors (85.7%) think that the patients have the right to decide about their end of life (chi-square 223.095, p<0,0001). Though higher percentage of the doctors recognize the difference between withdraw and withhold of therapy (49.5%), there is still high percentage of those who do not make any difference. It is an impressive finding that a very high percentage of doctors do not make difference between withdraw of therapy and euthanasia (chi-square 41.482, p<0,0001) (Table 1).

The major part of doctors stated that the relatives should be allowed to decide about the withhold or withdraw of therapy. Significantly higher percentage of doctors stated that there is no reason to promote the life at all costs (Table 1)

Significantly higher group of doctors (p<0.0001) would prefer to leave their own advanced directives.

In regard to the second part of the study linked with the level of experience and knowledge, though the majority of the doctors interviewed had very often contact with the terminal patients (93% of them, Chi-square = 3.604, p=0.0576), most of them did not have any formal training 67% (Chi-square=5.23, p=0.0731) nor they know whether they had so far experience with withdraw or withhold treatment since they do not know the difference between these two issues (72 % of the interviewed, Chi-square = 10.749, p=0.0295). However, most of them know how to apply this treatment (over 95%).

Different comments with qualitative differences regarding end-of-life treatment are extracted and presented in bellow:

"Some quoted answers, comments, suggestions from respondents:

"Doctor has no obligation to offer, begin, or maintain a treatment which in his honest judgment, will be physiologically futile..."

"I would never want to live as a vegetable"

"If I have to be in a situation that irrevocably leads to death, I don't want to suffer pain..."

"...it is ethically permissible to provide withhold or withdraw of therapy if it is..."
5. DISCUSSION

Limiting treatment is unusual in Macedonia. Macedonian healthcare legislation does not provide any guidance on withholding and withdrawing of therapy. Even when the treatment is regarded as futile, limiting treatment is unusual. Not even case law exists in Macedonia. National guidelines are not developed. In this moment there is a progress in ethical discussion between professionals about when to withhold and when to withdraw life support treatment.

One of the ethical questions discussed in the context of forgoing life-sustaining treatment is whether there is any ethically relevant difference between withholding and withdrawing of therapy (8).

General guidelines have been developed (9, 10) to aid doctors in deciding when life support may be withheld or withdrawn and several studies have described the procedure by which do not resuscitate orders should be written (11). Such guidelines and statements generally state that there is no difference between withdrawing and withholding of therapy. From a medical point of view, there is no difference, because if the aim of therapy is to improve the patient’s condition and it cannot be achieved with a certain intervention, then it is irrelevant whether it is withheld or withdrawn. From a legal point of view in some countries (e.g., Germany), there is also no difference between withholding and withdrawing. The same, from the viewpoint of Christian ethics, withholding and withdrawal is equivalent measures of forgoing life support.

In contrast to the “official” guidelines, which state that there is no difference, many ICU doctors think or feel that there are ethical and legal, at least psychological and practical differences (12). Our results showed that great percent of the doctors did not know what is withdrawal of therapy, and for most of them there was no difference between withdrawal of therapy and euthanasia, although it was evident that half of them did not know the answer. Because the terms “active” and “passive” euthanasia do not respect the distinction between direct euthanasia and withdrawal of treatment and that they are profoundly different, it emanates that they should be avoided when discussing about withdrawal of therapy.

However it is often easier to withhold a treatment than to withdraw it once it has been instituted. This is not euthanasia. Though it was evident that half of them did not respect the distinction between withholding and withdrawing of therapy. From a medical point of view, there is no difference between withholding and withdrawing of therapy, even if the patient’s death may be unintentionally hastened in the process…” is supported by World Society of Critical Care medicine and many other medical professional organizations (14).

Another question associated with withdrawal of therapy is who is competent in decision making? For significantly higher percentage of the Macedonian intensivists patient’s wishes and patient’s autonomy are the main criterion of decision. This is the same as in United States, first country where a number of options have been developed to enable competent people to plan for their medical decision-making (Federal patient-self-determination act). The choices known as “advanced directives”, or what would the patient desire are acceptable for Macedonian intensivists as in France where personal directives are adopted in a law which bring new rights to patients and clarifies medical practices regarding end of life care: “granting terminally ill patients the right to end their life” (Leonetti’s Law 2005-370 of April 22, 2005). The Act allows doctors to stop giving medical assistance when it “has no effect other than maintaining life artificially”. This new law prohibits unreasonable obstinacy in investigations or therapeutics and allows the withdrawing or withdrawal of treatments when they appear “useless, disproportionate or having no other effect than solely the artificial preservation of life”. It stops short of permitting euthanasia, because the Act does not allow the doctor actively to end a patient’s life. (Art. 7). This is opposite to the example of attitude in other coun-

Table 1. Significance in the differences in the knowledge attitudes and practices of Macedonian intensivists in withdrawal therapy

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>Chi-Square</th>
<th>P&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does a person have the right to decide whether or not to hasten the end of life</td>
<td>156 (85.7%)</td>
<td>9 (4.9%)</td>
<td>17 (9.4%)</td>
<td>223.095</td>
<td>0.0001</td>
</tr>
<tr>
<td>Is there a difference between withholding and withdrawal of therapy</td>
<td>90 (49.5%)</td>
<td>26 (14.3%)</td>
<td>66 (36.5%)</td>
<td>34.47</td>
<td>0.0001</td>
</tr>
<tr>
<td>Is there a difference between withdrawal of therapy and euthanasia</td>
<td>21 (11.5%)</td>
<td>89 (48.9%)</td>
<td>72 (39.6%)</td>
<td>41.482</td>
<td>0.0001</td>
</tr>
<tr>
<td>Should the relatives be allowed to decide whether or not to withhold or withdraw therapy</td>
<td>127 (69.8%)</td>
<td>38 (20.9%)</td>
<td>17 (9.3%)</td>
<td>110.899</td>
<td>0.0001</td>
</tr>
<tr>
<td>Is it acceptable for you to promote life at all costs</td>
<td>47 (25.8%)</td>
<td>130 (71.4%)</td>
<td>5 (2.8%)</td>
<td>131.679</td>
<td>0.0001</td>
</tr>
<tr>
<td>Would the doctor himself want to leave advanced directives</td>
<td>165 (90.6%)</td>
<td>17 (9.4%)</td>
<td>0 (0%)</td>
<td>269.049</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

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tries in Europe where advanced directives do not represent legal binding and do not relieve doctors of their liability. Relatives are empowered to give consent on behalf of incapacitated patient (15, 16). As presented, the major part of doctors in our study stated that the relatives should be allowed to decide about the withhold or withdraw of therapy. The doctor is ethically obligated not to promote life at all costs, but rather to enable patients to choose what kind of life represents a “good life” to them and what kind of life does not. In most cultures, over the past three decades, QOL (Quality of Life) has become a preoccupation that overrides length of life. The scale to measure QOL may vary between individuals and cultures and may be subjective, although some scales of QOL are widely accepted. In our study significantly higher percentage of doctors stated that there is no reason to promote the life at all costs. In regard to the issue of leaving advanced directives for the end of life, as presented significantly higher group of doctors (p< 0.0001) would prefer to leave their own advanced directives which can be judged as a relevant message and proposal for appropriate amendments in the regulations.

6. CONCLUSIONS

It is obvious that the Policy can make a significant progress in the area of end-of-life treatment. The first thing to do is to legally justify withholding and withdraw of therapy by the principles of informed consent and informed refusal, both of which should have strong roots in the common law. Whether by active or passive euthanasia means, the moral basis enjoin the need to clarify the inherent differences between these terms and these, both to the biomedical community and the general public, remains a major challenge.

The principles will held that treatment may not be initiated without the approval of patients or their relatives excepting in emergency situations, and that patients or relatives may refuse any or all therapies. The second and very important thing is to develop processes to allow doctors, patients and families a forum for the discussion of end-of-life decision-making through the ethics committees. At least legal principles in end-of-life care must be established: courts should have drawn a distinction between intentionally causing a patient’s death (euthanasia) and allowing a patient to die as a result of the withdrawal of life support treatment. Legal consensus that both withdrawing and withholding treatment, if not wanted by the patient or ineffective, can be justifiable. The decision to withdraw treatment is never made hastily and is never easy. At this very moment many discussions are ongoing regarding these topics. According to some quoted comments listed in the box (especially comments No.9 and 10) there are still issues which must be taken into account while making the proper regulations. However still the main goal to achieve is the doctors to face with this issue and to learn how to bear this burden during their practice in ICU. Last but not least, our study also confirmed the need of additional improvement in the curriculum of the postgraduate trainings of the doctors working in ICU with end-of-life patients.

REFERENCES