The EMJ podcast: Withholding and withdrawing care

Janos Peter Baombe: **Professor Jean-Louis Vincent, on behalf of the Emergency Medicine Journal, thank you for these few minutes here today in Brussels during the 31st International Symposium on Intensive Care and Emergency Medicine.**

During your opening speech, you mentioned a few rather fascinating topics like the weather and the political situation in Belgium. Another interesting topic, more medical this time, was the decision of withholding and withdrawing medical care. This is a difficult question for medical staff and also the family. Death in the intensive care unit is rarely premature or unexpected; the caring team are often prepared for it.

What is the situation today in Europe and in Belgium in particular?

Professor Jean-Louis Vincent: When we admit a patient to the intensive care unit (ICU), we sometimes have to admit that despite our best efforts things do not improve enough, and that quality of life will not be the best or death is unavoidable. In this context, I think it is important to understand that we need to put an end to our therapeutic efforts. It is not something we can do; it is something we must do.

I have insisted on this moral duty. There are several reasons for this: the first and most important one is we have to respect the dignity of the individual, and it is pointless to apply treatments that represent purely therapeutic relentlessness ('futile therapy' as English speakers call it).

On the other hand, in terms of distributive costs, it is not good as it costs society money and we know that the budget of healthcare has its limits. What we would invest here unnecessarily, we would not be able to spend on other treatments more important for society.

Furthermore, we would feel forced to put all our efforts into trying to save all lives because we would be too scared to stop, if, for example, we had started the mechanical ventilation or renal support.

Personally, I very much like the concept of the 'ICU test': when we admit a patient to ICU we hesitate about the appropriateness of this admission. In other words, we give the patient a chance and see in the next few days if there is any amelioration. If there is no improvement we will stop, but we will have to stop treatment or one should not use such-described strategies.

In Europe, the situation is rather heterogeneous. Generally in the northern countries, including Belgium and France, we can usually stop treatment when we realise that treatment leads nowhere, with the involvement of the family. In the southern countries, I mean Spain, Portugal, Italy or Greece - very orthodox, these aspects of end-of-life are not common practice, and could even lead to legal prosecution and serious problems for the doctors stopping the treatments.

JPB: **In which context do you think it is appropriate to withhold or withdraw treatment, in the emergency department or the intensive care unit?**

JLV: This is very good question! It can obviously already take place in the emergency department and it is not unusual that, for example, for a patient known to have advanced cancer we decide not to admit to the ICU and maybe even start them on morphine to alleviate pain.

Sometimes we just do not know. We often just do not have the information or we might think this is just a temporary complication like a pulmonary infection. We probably can still treat their infection and if we do not have the full information or we are still unsure about their future, we can then admit to the ICU. We will hope that the situation will improve. If not, we will have to stop.

JPB: **We are in Brussels today, capital of Europe, capital of diversity. You mentioned earlier religious and cultural diversity plays a major role in the process. Do you think one day we will see a pan-European legislation on this topic?**

JLV: I think that a French-like legislation would be quite useful. One that recognises the proportionality of treatment, one that recognises that active and palliative treatments are very often mixed: I very much like the notion of 'proportionality of care'.

In Belgium, like in the Netherlands, we have a law on euthanasia but this law is not really a law for the intensivist. It is a law that states one can request euthanasia when one does not support the progression of his disease, and this means signing a document asking for euthanasia. This concerns a minority of patients with advanced cancer or with evolution of a non-treatable disease, but this does not help the situation in the ICU where patients often cannot sign such a document. I do not see why they would sign it anyway because we have to continue to be humane (and we should not sign a document just to stop all this.)

JPB: **One last question Professor. The impact of such a decision on the nursing and medical staff is an area not really discussed. It does however have a certain impact on them. Have you got a personal opinion on this?**

JLV: I think it is very important that these discussions are done at a team level so everyone can be involved. The concept of a team is therefore very important as everyone has to voice their opinion. Far gone are the times when withdrawal of care was done in the middle of the night because one was alone with a patient. Today these decisions take place at ten o'clock in the morning when the whole team is present and this is how it should be. There is nothing to hide and if we do good, there is no need to hide it!

JPB: **Professor Vincent, thank you once again. I'll let you go, I am sure that you have other important tasks. On behalf of the editorial board, thank you very much.**

JLV: It was my pleasure, thank you!