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End-of-life decisions in Austria's intensive care units

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Introduction

Intensive care physicians are often confronted with decisions to withhold or withdraw life-sustaining care in critically ill patients. Such decisions have become more frequent during the past decade and currently are involved in the majority of deaths in intensive care units (ICUs) in Western countries [1]. In most of these cases the patients are incompetent, but physicians and families usually agree to limit care.

Moreover, critical care providers face difficult decisions about how to allocate limited resources to patients with competing needs. Most ICU physicians refuse to make choices based on estimates of who might benefit most [2]. Certainly, this aspect must become a major issue for discussion within intensive care medicine and for legislation in the near future.

As in other European countries, end-of-life care decisions and the use of critical care resources in Austria are taking place within a legal framework which is poorly adapted to these special situations and the demands of modern medicine. Currently, there are few circumstances in which current legislation really supports the physician in decision making at the bedside. Thus, a growing number of countries have tried to modify legislation to better meet the needs of modern critical care medicine (see, for example, [3, 4]).

Limitation of life-sustaining therapy in Austrian ICUs

Intensive care medicine in Austria differs little from that in other European countries with regard to the problems associated with decisions of withholding, limiting or withdrawing intensive care in patients often unable to consent and unable to participate in the decision-making process [5, 6]. As demonstrated in a recent German survey [7], also in Austria the opinion predominates that these problems should be an integral part of medical decision making and not delegated to legal guardians and/or authorised representatives. The German survey revealed considerable uncertainty on the part of physicians regarding the application of various measures at the end of life.

Unfortunately, the debate on euthanasia has dominated the public arena and media headlines [8]. It should be stressed at this point that this media hype on euthanasia has clouded the issue of withholding or withdrawing support in ICU, which conceptually presents a different spectrum of problems that has little in common with the ongoing euthanasia debate. The above-mentioned German survey also showed rather limited knowledge of different types of euthanasia, and many physicians do not comprehend the juridical differentiation between active and passive and/or direct and indirect euthanasia [7].

Medical decision making is directed by ethical principles, by (poorly specified) legal frameworks, and by

guidelines and recommendations from professional bodies [9, 10]. Professional statements and recommendations should be comprehensive, unambiguous and compatible with the law [11]. As in most European countries there is no formal legislation in Austria governing end-of-life care. Thus, this perspective on end-of-life decisions in Austria must present an amalgam of law, various statutes, professional statements and everyday medical experience and practice.

Legal aspects

Under current Austrian law the ultimate authority for medical care of the incompetent adult rests with the treating physicians rather than the next-of-kin, and this is at variance with the situation in other countries such as the USA. Presence of an "indication for treatment" creates the basis for the physician's obligation to treat, and vice versa, absence of an indication the obligation to withhold or withdraw treatment [14]. Consequently it is not only the patient's refusal that prevents treatment but also medical futility. This legal foundation forms a broad and actually rather liberal but ill-defined basis for end-of-life decision making. As patients in intensive care are often unable to consent, consent to treatment must be given by a legal representative (for a child) or a power of attorney (for an adult) except under certain circumstances defined by urgency and necessity of treatment (Austrian Penal Law § 110). Frequently, a formal power of attorney is not involved under the assumption by physicians of "presumed patient will".

In May 2006, Austria's parliament passed an advance health care directive law that covers specific directives on treatment decisions to be taken by caregivers, in particular with regard to preventing treatment modalities in the event that the principal is unable to give informed consent due to incapacity [15]. This advance health care directive is legally binding when it fulfils the law's formal requirements but also must be respected when not fully fitting legal criteria. In this case it contributes to recognition of the patient's will, which the treating physician aims to respect. Moreover, the new law does not imply that in the absence of such a formal advance directive the "presumed patient will" is not to be followed.

Any type of active euthanasia, as well as assisted suicide, is forbidden in Austria. About 10 years ago, Austrian lawmakers decided not only to prohibit euthanasia but – in contrast to Germany and Switzerland – explicitly also not to allow assisted suicide under any circumstances. The arguments included fundamental concerns about the value of life "per se", the fear of misapplication and of abuse, and finally, about the lack of "freedom of decision" of the patient in such situations. In addition, Austrian citizens are prohibited to assist suicide outside of Austria in countries where it is allowed under certain conditions.

Nevertheless, very recently, the trial of an Austrian citizen accused of assisting his wife's suicide ended without a conviction. The 56-year-old man had travelled in 2003 with his wife, who was terminally ill, to Switzerland, where euthanasia is allowed under certain circumstances. The man could have faced up to 5 years in prison if convicted but was found not guilty at his trial in Klagenfurt, Austria, in October 2007 (http://oe1.orf.at/inforadio/82041.html?filter=1; accessed 12 October 2007). The court's conclusion, which was appealed by the state prosecutor, was substantiated by the assumption of an exculpating act of necessity (Austrian Panel Law, § 10). After the trial, the vice-president of the Austrian Association of Judges criticised Austrian lawmakers for not having updated the political and legal position on active and passive euthanasia (http://kaernten.orf.at/stories/227900/, accessed 12 October 2007). Given the lack of explicit legislation, so he claimed, judges have the burden of deciding each individual case, and their decisions may even contradict existing law, as happened in the case of assisted suicide presented here.

The case certainly is not applicable to the ICU situation but might signify a change in the public discussion and a softening of a rather strict legal position with a more secularised point of view.

Optimisation of professional care, of palliative measures for mental conditions, depression and pain were proposed by Austrian lawmakers as alternative to any type of euthanasia, and the development of palliative medicine has received more attention and funding recently.

Consensus recommendations on therapy limitation and therapy discontinuation in ICUs

Decisions regarding intensive medical care should be based on the fundamental ethical principles of respect for the autonomy and dignity of the patient and of fostering the well-being of the patient, while avoiding harm as the highest priority, with fair use of available means and resources, a principle which will receive much attention in the near future [14]. These decisions are and must be intrinsically medical decisions that have to be made in a responsible manner and cannot be delegated to others. Recognition of the finiteness of life and the limitations of medical interventions is indispensable in intensive care medicine that is oriented towards human beings [15]. On this basis, the Austrian Associations of Intensive Care Medicine have published their joint national consensus recommendations with the goals, among others, of (1) addressing the problem of therapy limitation and discontinuation; (2) describing the conditions under which a decision of this nature can be made; (3) describing the circumstances that can lead to a decision of this kind; (4) providing helpful arguments during conversations with

relatives and when confronted by professional superiors and referring physicians; (5) supporting elaboration of local ward-specific procedures; (6) promoting attention and care on the issues of the dignity, anxiety and freedom from pain of dying patients in ICUs; and (7) developing uniformity in the expression of views of the Austrian Associations of Intensive Care Medicine [16]. One of the basic conclusions states that the institution or prolongation of any type of therapy (including ventilation, artificial nutrition) is not ethically justified if this intervention is not or no longer indicated or not desired by the patient.

In many ICUs there has developed a culture of support and concern in relation to the care of the dying and their relatives. In countries where intensive care medicine is relatively well developed, however, considerable differences remain in physicians' attitudes towards end-of-life care in the ICU [17]. Recommendations that have been elaborated in Austria unconditionally encourage an open discussion of these issues and efforts to harmonise end-of-life care in ICUs and to develop the appropriate resources. Hospital administrators may not be aware that for the fulfilment of the eminently important and desirable tasks of critical care medicine, it is necessary to have not only adequate personnel but also appropriate infrastructure [16].

The combination of laws that avoid "over-regulation" of terminal care, practical recommendations from the professional societies, and the care-providers' high medical expertise and moral competence may well contribute to the low number of legal cases regarding end-of-life care that have attracted media attention in Austria. Such decisions must remain fundamentally medical decisions by the physicians in charge and can and should not be delegated to hospital-based clinical ethics committees or legal bodies [18]. When critical care medicine reaches its limits, all available energies and experience must be concentrated on enabling the patients in care to die in dignity and peace, with their relatives at the bedside. To ensure such a "good death" has become a central commitment also for intensive care medicine.

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