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Ethics

The Durban World Congress Ethics Round Table Conference Report: I. Differences between withholding and withdrawing life-sustaining treatments ☆

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ABSTRACT

Introduction: Withholding life-sustaining treatments (WHLST) and withdrawing life-sustaining treatments (WDLST) occur in most intensive care units (ICUs) around the world to varying degrees.
Methods: Speakers from invited faculty of the World Federation of Societies of Intensive and Critical Care Medicine Congress in 2013 with an interest in ethics were approached to participate in an ethics round table. Participants were asked if they agreed with the statement "There is no moral difference between withholding and withdrawing a mechanical ventilator." Differences between WHLST and WDLST were discussed. Official statements relating to WHLST and WDLST from intensive care societies, professional bodies, and government statements were sourced, documented, and compared.
Results: Sixteen respondents stated that there was no moral difference between withholding or withdrawing a mechanical ventilator, 2 were neutral, and 4 stated that there was a difference. Most ethicists and medical organizations state that there is no moral difference between WHLST and WDLST. A review of guidelines noted that all but 1 of 29 considered WHLST and WDLST as ethically or legally equivalent.
Conclusions: Most respondents, practicing intensivists, stated that there is no difference between WHLST and WDLST, supporting most ethicists and professional organizations. A minority of physicians still do not accept their equivalency.

1. Introduction

Forty years ago, patients typically died in intensive care units (ICUs) after failed cardiopulmonary resuscitation (CPR). Over the ensuing years, foregoing of life-sustaining treatments has become a more common way for ICU patients to die. Studies around the world have demonstrated that forgoing of life-sustaining treatments occurs in 1.5% to 22% of patients admitted to ICUs [1-11] and that forgoing of life-sustaining treatments occurs in 23% to 93% of patients who die [2,4,6,10-16]. In these studies, death was preceded in 8% to 70% of patients by withholding of life-sustaining treatments [4,6,9,13,15-19] and in 3% to 69% of patients by withdrawing of life-sustaining therapies [4,6,8,9,13,15-19]. Among individual ICUs within countries and regions, withholding life-sustaining treatments (WHLST) may range from 0% to 67% [2], whereas withdrawal of life-sustaining

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therapies may range from 0% to 96% [2,6,8]. Clearly, there is a significant variation in practice among the different ICUs not only in different countries but also in different parts of a country [2,6,8]. In addition, there is evidence that limiting life-sustaining treatments has become more frequent in recent years [13].

The experience in neonates and children is extensive and reveals differences in approaches in neonatal and pediatric critical care units as well as regional variations within and between countries. For instance, in North America, Northern Europe, and Australia, it is rare in neonatal intensive care for infants to die while receiving CPR and uncommon in pediatric ICUs (PICUs). Generally, 18% to 65% of pediatric ICUs practice withdrawing or withholding of life-sustaining therapy or institute do-not-resuscitate orders with higher rates (30%-65%) in North America and Northern Europe, whereas in Eastern Central Europe, decisions to forego life-sustaining therapy are almost nonexistent [20,21]. There are also regional differences worldwide on how decisions regarding withholding or withdrawing life-sustaining decisions are made and to what extent families are involved. In most cases, decisions are made after discussion among the medical team, and parents may be informed of the decision and may or may not be asked for their permission [20-25]. In addition, difficulty in reaching consensus is usually resolved over time [26,27], and the approach to the use of sedatives and neuromuscular blockers is subject to individual preferences [23,28,29]. There are also differences in approach depending on race and resources in that limiting therapy is less likely if the patient is black or in units with no trainees [30].

There are a number of reasons for these considerable differences in practices in the various ICUs. These may include legal and regulatory issues and legal precedents within the country; the religious and/or cultural beliefs and practices of both the health care professionals and the patients and their families; the speciality of the attending physician; and the patient profile, which may include the medical condition itself as well as race/ethnicity and socioeconomic factors [31-39].

Recognizing the different worldwide contexts and practices, during the World Federation of Societies of Intensive and Critical Care Medicine Congress in August and September 2013 in Durban, South Africa, an ethics round table was convened as a component of the scientific program. Round table participants were polled as to whether they believed there was a moral difference between withholding and withdrawing mechanical ventilation. This article reports their opinions and attempts to delineate the issues and discuss the reasons why withdrawing therapies is equivalent or better than withholding them or whether withholding therapies is superior to withdrawing. In addition, official statements relating to withholding or withdrawing life-sustaining treatments from intensive care societies, professional bodies, and government statements were sourced, documented, and compared.

To highlight the differences between withholding or withdrawing mechanical ventilation a clinical example where those who support equivalence of withholding and withdrawing therapy or reject equivalence would reach different answers is provided. An 86-year-old man with diffuse non-Hodgkin lymphoma relapsing after a third course of chemotherapy with a cerebral *Aspergillus* infection undergoes a cardiac arrest in the emergency department (ED). Not being aware of the patient's advance directive, the ED physician intubates, ventilates, and transfers the patient to the ICU. When the intensivist on call (who supports the equivalence of withholding and withdrawing therapy) discovers that the patient has an advance directive stating that he would not want to be intubated or ventilated or to undergo CPR, she extubates the patient and continues other medical and palliative care. She reasons that, if the ED physician would have been aware of the advance directive, he never would have intubated the patient in the first place and the patient's wishes should now be respected by withdrawing the endotracheal tube and ventilation. Another ICU physician (who does not support the equivalence of withholding and withdrawing therapy) states that the endotracheal tube and ventilation should not be withdrawn, although the patient would not have been intubated and ventilated if there would have been knowledge of the advance directive and, currently, the patient is receiving treatment he does not desire. He reasons that despite the fact that the intubation and ventilation could have been withheld, once started it cannot be withdrawn.

2. Methods

Speakers from the invited faculty list of the World Federation of Societies of Intensive and Critical Care Medicine Congress with an interest in ethics were approached to participate in the ethics round table. Round table participants were asked to identify their 3 most pressing specific worldwide ethical issues that the group should address. Most responded that they were interested in end-of-life issues including withholding life-sustaining treatments (WHLST) and withdrawing life-sustaining treatments (WDLST). Seventy questions were sent to participants regarding practice in their hospitals and countries. There were 20 responses with variations from different countries, which seemed the most interesting. The summary of the responses was sent to participants. Respondents were asked to identify the most interesting topics for further work and discussion at the Congress. Based on the responses, the 5 topics with the greatest differences between centers and countries were chosen. They included questions related to WHLST and WDLST at the end of life for age, health care professional end-of-life decision making, patient/family end-of-life decision making, how to withdraw mechanical ventilation, and differences between WHLST and WDLST. Before the Congress meeting, potential questions for the 5 issues were distributed. At the meeting and several weeks later, 76 questions were finalized using a Likert scale (strongly agree, agree, neutral, disagree, and strongly disagree), and the round table participants answered the questions. The present article summarizes opinions of participants and elaborates on 1 of the 76 questions the differences between withholding and withdrawing a mechanical ventilator.

3. Results

Respondents' answers to the statement "There is no moral difference between withholding and withdrawing a mechanical ventilator" are outlined in Table 1. Sixteen respondents stated that there was no moral difference between withholding or withdrawing a mechanical ventilator, 2 were neutral, and 4 stated that there was a moral difference. The round table participant country laws or intensive care society statements regarding differences between WHLST and WDLST are shown in Table 2.

4. Organizations and government statements on the differences between WHLST and WDLST

It is increasingly recognized that, in certain circumstances, limitations of life-sustaining therapies in the critically ill may be both medically and ethically appropriate, and to achieve this limitation of therapy, treatment may either be withheld or withdrawn. *Withholding life-sustaining treatments* is defined as a decision not to start or increase a life-sustaining intervention, whereas *withdrawing life-saving therapies* is defined as a decision to actively stop a life-sustaining intervention being given [6].

To guide and direct the clinical practice of health care professionals regarding limitation of life-sustaining therapies, a number of professional bodies, associations, and societies have drawn up recommendations to assist in the understanding and processes [40,56,58-63]. Most ethicists, the President's Commission [64], and several medical organizations [40,56,58-63] have stated that there is no moral difference between withdrawing life-sustaining treatments and withholding them. A review of life support guidelines noted that all but 1 of 29

Table 1
Durban Ethics Round Table participant responses to the statement "There is no moral difference between withholding and withdrawing a mechanical ventilator"

	Country	Name	Institution	Response
1	Australia	Jeff Lipman	Royal Brisbane and Women's Hospital, Brisbane	Agree
2	Belgium	Jean-Louis Vincent	Erasme University Hospital, Brussels	Agree
3	Canada	Niranjan (Tex) Kissoon	BC Children's Hospital and Sunny Hill Health Centre, Vancouver, BC	Agree
4	China	Bin Du	Peking Union Medical College Hospital	Agree
5	France	Bertrand Guidet	Hopital Saint-Antoine	Agree
6	France	Elie Azoulay	Hopital Saint-Louis, Paris	Neutral
7	Germany	Christiane Hartog	Jena University Hospital, Jena,	Disagree
8	Hong Kong	Gavin Joynt	Prince of Wales Hospital, Hong Kong	Agree
9	Israel	Charles Sprung	Hadassah Hebrew University Medical Center, Jerusalem	Disagree
10	Saudi Arabia	Khalid Shukri	International Pan-Arab Critical Care Society, Jeddah	Neutral
11	South Africa	Eric Hodgson	Inkosi Albert Luthuli Central Hospital, Durban	Agree
12	South Africa	Andrew Argent	Memorial Children's Hospital, Cape Town	Disagree
13	South Africa	Fathima Paruk	Charlotte Maxeke Johannesburg Academic Hospital	Agree
14	South Africa	Rudo Mathivha	Chris Hani-Baragwanath Hospital, Johannesburg,	Agree
15	South Africa	Charles Feldman	Charlotte Maxeke Johannesburg Academic Hospital and University of the Witwatersrand, Johannesburg,	Agree
16	South Korea	Younsuck Koh	Asan Medical Center, Seoul	Agree
17	The Netherlands	ABJ Groeneveld	Vrije Universiteit Medical Centre, De Boelelaan	Agree
18	USA	Chris Farmer	Mayo Clinic, Rochester	Agree
19	USA	Mitchell Levy	Rhode Island Hospital, Providence	Agree
20	USA	Janice Zimmerman	The Methodist Hospital, Houston,	Agree
21	USA	Edgar J. Jimenez	Orlando Regional Medical Center, Orlando	Agree
22	USA	J. Randall Curtis	University of Washington, Seattle	Disagree

considered withholding or withdrawing life support as ethically or legally equivalent [65].

The dominant ethical opinion favors the equivalence of withholding and withdrawing therapy, using the Equivalence Thesis [66]. The Equivalence Thesis states that, if there is no moral difference between withholding and withdrawing treatment, there are no cases where it would be permissible to withhold treatment, but it would not be permissible to withdraw the same treatment (if it had already been started but all other relevant factors are equal) [66]. Despite these philosophical equivalencies, some physicians and nurses have more difficulties withdrawing than withholding life-sustaining therapies [67-70], and a substantial number believe that they are not equivalent [67,69,70].

5. Reasons why WDLST is equivalent to or better than WHLST

As noted above, most professional opinions are that withholding and withdrawing life-prolonging therapies are ethically equivalent. In fact, several of the major religions permit both the withholding and the withdrawing of nonbeneficial life-sustaining treatments in terminally ill patients. This includes Christians (Roman Catholics and Protestants), Muslims, and Buddhists [71]. Interestingly, the Greek Orthodox Church equates withholding with withdrawing therapy but prohibits both as it condemns medical acts that do not prolong life [71]. There remains, however, a diversity of views within each of the religions, and there may be different opinions regarding withholding and withdrawing based on the country of origin of the patient and family or acculturation [71].

In addition to noting the lack of a difference between WHLST and WDLST, it has been suggested that withdrawing them may be more ethically sound [64,72]. In the first instance, if withdrawal of therapy were not permitted, then many ICUs would be filled with patients who are hopelessly ill and who are receiving ongoing treatment that is not likely to benefit them and is contrary to the 4 ethical principles [72]. A common additional reason given for the soundness of withdrawal is that, if physicians are unable to withdraw therapies, there is a danger that they will not provide treatment, particularly in the acute situation, fearing that, once started, they will not be able to discontinue it [61,64,66,72]. This approach may deny a patient the chance of receiving a potentially beneficial treatment. As a consequence, patients who could have benefited may be denied potentially life-prolonging treatment [66]. By allowing a trial of a therapy rather than withholding it, the patient will be given every chance there is of possibly benefiting from the treatment. In addition, after the therapeutic trial, there will be less uncertainty and also a better assessment of the patient's prognosis [66,72]. By permitting a trial of treatment, the patient is at least given a chance and only if the treatment is not effective is it withdrawn. If the physician's assessment is incorrect (which occurs not infrequently) [73], then by withholding, no allowance is made for an error of judgment [72]. By permitting a trial of treatment, the patient is at least given a chance [72]. Adopting this approach, the withdrawal of life-sustaining therapies is not considered the cause of the patient's death, as although patients may die sooner, the actions of physicians are considered "allowing the patient to die" from the underlying illness [61]. In addition, some national societies have explicitly stated that shortening the dying process using analgesics/sedatives may sometimes be appropriate even in the absence of discomfort [74].

6. Reasons why WHLST is not equivalent to WDLST

Although most organizations and ethicists believe that there is no moral difference between WHLST and WDLST, some clinicians and, specifically, a few in the round table do not share that view [75]. One of the suggested reasons is that withholding is passive and withdrawing is active. Although some experts [64] state that there is no moral difference between actions and omissions, the fact that patients die much more frequently and quicker after the withdrawal of therapy is associated with a greater sense of causing the patient's death, responsibility, and even guilt. In the Ethicus study [6] of deaths or limitations of life-sustaining treatments in 4248 ICU patients, patients died more frequently within 72 hours after withdrawing treatments (93%) than withholding therapies (68%) and more quickly. Some philosophers have supported this view, arguing that because *killing* is defined as an act that is the proximate cause of a death, then withdrawal of life support is also an act of killing, although one that may be justified [61].

Another reason suggested for the nonequivalence between withholding and withdrawing therapy relates to the physician's duty of care [66]. Physicians take on a duty of care to patients once they start to treat them. Therefore, although it may sometimes be ethical to withhold therapy in a critical medical situation, it may not be ethical to withdraw therapy. According to Nozick's principle of original acquisition of holdings, once a person has started on a treatment and has a holding in accordance with the principle of justice in acquisition, they may be entitled to that holding [76,77].

Table 2
Durban Ethics Round Table participant country law or intensive care society statement regarding differences between WHLST and WDLST

Australia—The Australian and New Zealand Intensive Care Society and College of Intensive Care Medicine of Australia and New Zealand have a statement on withholding and withdrawing treatment [40]. It states that although intensive care treatment may be life-saving for patients with reversible critical illness, medical intervention can cause considerable suffering for patients and their families with little or no benefit. The withholding or withdrawing of specific treatments is appropriate in some circumstances. Withholding treatment and withdrawing treatment are legally and ethically equivalent. Decisions to withhold treatment should involve the same principles and processes as decisions to withdraw treatment. When death follows the withdrawal or withholding of treatment in accordance with the principles outlined in this statement, the cause of death is the medical condition that necessitates the treatment that is withheld or withdrawn.
Austria and Germany—Austrian and German national societies point out that, for decisions to limit life support, withholding or withdrawing life support is regarded as ethically equivalent [41,42]. There are also no legal differences [43]. In practice, however, ICU physicians and nurses often find it more difficult to withdraw than to withhold mechanical ventilation, possibly because of the psychological "advantage" to keep the airway accessible.
Belgium—The Belgian Society of Intensive Care Medicine states that there is no ethical or moral difference between withholding and withdrawing life-sustaining therapy [44].
Canada—Canadian law and ethicists make no distinction between WHLST vs WDLST. Clinicians often do feel that there is a difference in practice. The Canadian Critical Care Society position paper on WHLST and WDLST [45] states that, from a traditional ethical point of view, there is no difference between the withholding and withdrawing of life support. If life support can be withheld, it can also be withdrawn. Nonetheless, it is generally better to provide treatment, with a strategy in place for later withdrawal if it is either of no medical benefit or proves too burdensome, than to withhold treatment altogether because of unfounded fears about treatment withdrawal. When it is not clear if treatment will be effective, the choice should be made on the side of life, and treatment should be provided, if this treatment is in accord with the patient's goals. On the other hand, when it is clear that treatment will not be effective and is not in accord with standard medical practice or norms, the physician is not obliged to begin, continue, or maintain the treatment.
China—Although there is no local or national legislation governing the withdrawal of life-sustaining treatments, in clinical practice, withdrawal of life-sustaining treatments is not uncommon due to the wish of the patient or family for the patient to die at home or because of financial issues [46]. The final decision for withdrawal is always made by the family after discussion with the physicians.
France—A first law defining end-of-life treatment in France was issued in 2005 [47]. It was updated in 2008. The ethics committee of the French Society of Intensive Care issued several recommendations. The last version was updated in 2010 [48]. The document was produced by intensivists, nurses, psychologists, and specialists in ethics and law. It was endorsed by the French Society of Intensive Care. It defined the circumstances together with the practical aspects of treatment limitation. It provided a guideline for deciding and applying end-of-life decisions. There were no formal differences between WHLST and WDLST given that all preliminary steps are followed and that in any case there is no pain or discomfort for the patient.
Israel—The Dying Patient Act 2005 [49]. The law prohibits stopping continuous life-sustaining treatments, which is viewed as an act shortening life. It does allow stopping intermittent life-sustaining therapies. Terminating intermittent life-sustaining therapies is regarded as omitting the first or next treatment as opposed to an act of withdrawing a treatment. The withdrawal of a ventilator (which is considered a continuous treatment) is an act that shortens life and is, therefore, forbidden. This is rooted in the Jewish legal concept that not only must the end be morally justified (allowing a suffering terminally ill patient to die) but in addition the means to achieve that end must be morally correct. The law, however, allows the possibility of changing the ventilator from a continuous treatment to an intermittent one by connecting a timer to the ventilator thereby allowing the ventilator to stop intermittently [50]. There was disagreement on these issues by the committee developing the law and a majority opinion believed that there is a difference between withholding and withdrawing a life-sustaining treatment. The practical disagreement was minimized by accepting the concept of a timer attached to a ventilator [50].
South Africa—The law does not expressly permit physicians to withdraw life-sustaining treatments or make a pronouncement on the equivalence or not of withholding and withdrawing therapy or recognize an advance directive ("living will") [51]. However, the National Health Act, 61 of 2003, section 6(1)(d) gives a competent patient the right to refuse treatment and in section 7, where the patient is incompetent, a surrogate may do so on his behalf. Withholding life-sustaining therapy is supported by legal precedent. In 1 case [52], the judge did not find it necessary to draw a distinction between withholding and withdrawing treatment but applied the same approach to both possibilities which was to accept that, where a person's prospects of recovery and quality of life are nil, such as in a persistent vegetative state, the withdrawing/withholding of treatment would not invariably be wrongful, based on the legal convictions of society. In a more recent case, it was held that the constitutional right of access to health care was dependent on the resources available and, therefore, also limited by a lack of resources [53].
In South Africa, withholding therapy is a decision required regularly in State-funded practice due to resource constraints [54]. Decisions tend to be made earlier in State-funded practice due to the presence of intensivists, occurrence of regular multidisciplinary ward rounds, and significant resource constraints [12]. In contrast, in the private practice settings, resources are less constrained, and there are very few intensivist-led closed ICUs so intensive therapy may tend to persist longer [55].
Fortunately, the Health Professions Council of South Africa, which is the controlling body for medical practitioners, does have an ethical guideline booklet to guide and direct the practice of withholding and withdrawing treatment [56]. The guideline recognizes that "life has a natural end" and that there are life support techniques that may sustain life artificially for many years even in patients in whom there is little hope of recovery [56]. It indicates that the health care professional may alleviate the suffering of a terminally ill patient by withholding treatment and does not appear to differentiate withdrawal from withholding of treatment [56]. Furthermore, it does indicate that the patient's wishes need to be considered and that when a patient does not have the capacity to decide for themselves that the health care provider must respect any valid advance refusal [56]. With regard to the processes of treatment, it recommends that a decision regarding withdrawal or withholding of life-sustaining treatments should be made by the senior clinician in charge of the patient's care with consideration of obtaining a second opinion and that there should be consultations between the clinician, the health care team, and those close to the patient to aim to achieve consensus on what course of action would be in the best interest of the patient [56].
The Netherlands—The Dutch Intensive Care Society formulated end-of-life guidelines for withholding or withdrawing treatment in the critically ill in accordance with Dutch legislation [57]. This entails that intensivists, preferably in a multidisciplinary meeting decide on futility on the basis of which it is permissible to abstain from or stop treatment. There is no difference between withholding and withdrawing life-sustaining treatments. This is done preferably, in agreement with the family, but they do not have "the last word." In clinical practice, the aim is to obtain consensus.
United States—1. Society of Critical Care Medicine [58]. A decision to withdraw a treatment already initiated should not necessarily be ethically regarded as more problematic than a decision not to initiate a treatment.
2. American College of Chest Physicians [59]. A legal and ethical consensus has developed in the United States stating that there are no differences between WHLST and WDLST. The President's Commission and leading ethicists have stated that no moral difference exists between withholding and withdrawing life-prolonging therapies. Despite this fact, health care providers have traditionally had greater difficulty withdrawing than WHLST.
3. American Thoracic Society [60]. Physicians and other health care providers have a responsibility to respect patient autonomy by withholding or withdrawing any life-sustaining therapy as requested by an informed and capable patient. In this regard, there is no ethical difference between withholding and withdrawing. Helping a patient forgo life support under these circumstances is regarded as distinct from participating in assisted suicide or active euthanasia, neither of which is supported by this statement.
4. American College of Critical Care Medicine [61]. Withholding and withdrawing life support are equivalent.

A third reason for the lack of equivalence relates to differences between the means vs ends. Although the end may be the same for a dying critically ill patient, the means as to how a patient dies also has significance. According to some religions, actions that hasten a patient's death are prohibited [71]. According to halacha or Jewish religious law, the value and sanctity of human life are infinite and beyond measure. Therefore, any part of life is of the same worth and an act that hastens a patient's death, no matter how laudable the intentions, is equated with murder. The omission, withholding, or the termination of an intermittently given life-sustaining treatment is permitted, whereas the withdrawing or termination of a continuously given life-sustaining therapy is prohibited [49,50]. The above deontological concepts are probably the reason that Jewish health care workers are more likely to withhold than to withdraw therapy [78]. Although withdrawing ventilators and other life-sustaining treatments are the most common methods of limiting therapies, there are some countries such as Israel where the withdrawal of a mechanical ventilator from a terminally ill patient is illegal based on

The Terminally Ill Law [49]. Finally, although not a moral argument, many physicians are more concerned about legal liability for withdrawing than withholding treatments and patients dying shortly after the withdrawal [79].

7. Limitations and strengths

The present study has strengths. A group of intensivists from around the world with divergent cultures, religions, and professional opinions and many with a specific interest in ethics researched; evaluated the literature, law and professional statements; voted; and discussed issues related to withholding and withdrawing life-sustaining therapies. The present study also has limitations. Although the small number of respondents represents a diverse group of intensivists from around the world, they cannot be regarded as representative of their country. The review of guidelines, law, and literature was not systematic. The study does not propose to contain data generalizable to the entire world because many countries, cultures, or religions were not represented.

8. Conclusion

Although most ethicists and professional organizations have stated that there is no moral or legal difference between WHLST and WDLST, some health care professionals still do not accept their equivalency in practice. Several authors have proposed that health care professionals be further educated so they can accept their equivalence [66] and others have made proposals for implementing equivalence [66]. Most intensive care clinicians in previous surveys and at the round table believe that there is no moral difference between WHLST and WDLST other things being equal. Some clinicians find treatment withdrawal more difficult, possibly because of the influence of personal religious and other values and some jurisdictions prohibit treatment withdrawal. It may be justifiable to prefer treatment withholding over treatment withdrawal if (*a*) the patient would have preferred withholding to treatment withdrawal or (*b*) legal frameworks limit or prohibit treatment withdrawal. It may be justifiable to prefer treatment withdrawal over treatment withholding if (*a*) the patient would have preferred withdrawal to treatment withholding or (*b*) provision of a trial of treatment would yield greater certainty about prognosis.

One way around the equivalence dilemma that has been recommended is that there should be a change in emphasis of the guidelines regarding end-of-life decisions. Some authors recommend that the possible ethical differences between withholding and withdrawing therapy should be avoided. Rather, the particular situation and consequences of withholding or withdrawing treatment should be taken into account [80]. Other authors have stated that a more useful framing for this question is whether either or both WHLST and WDLST are morally and ethically preferable to continuing life-sustaining treatments in certain circumstances, such as when the burden of treatment outweighs the potential for benefit. The rephrasing of these common terms focuses on the important issues of assessing the potential burdens and benefits of the treatments physicians offer [81].

Unfortunately, it is unlikely that these proposals will have any effect when the reasons for not accepting the equivalence of withholding and withdrawing life-sustaining therapies are religious and deontological. Despite the differences between physician opinions, agreement can be reached that treatment should be compassionate and caring meeting the needs of the patients and their families [75].

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