

WHAT'S NEW IN INTENSIVE CARE



Eight things we would never do regarding end-of-life care in the ICU

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Introduction

As intensivists from three distinct regions of the world with different cultural backgrounds, we believe it relevant in this rapidly emerging period of healthcare to share thoughts among clinicians providing end-of-life care in the intensive care unit (ICU). Intimate encounters with patients near the end of their lives [1] form a foundational aspect of our vocation as intensivists. This article is our vision of eight top-tier concepts that should be embraced to usher in the best end-of-life care for all patients. We realize that not everyone will agree with these points and anticipate that our “eight things” will stimulate healthy discussion and debate. Furthermore, there might be caregivers throughout the world dealing with different cultural, legal, political, and ethical preconditions that make implementation of the approach presented within this manuscript difficult in some respects. The joint American Thoracic Society (ATS)/American Association for Critical Care Nurses (AACN)/American College of Chest Physicians (ACCP)/European Society for Intensive Care Medicine (ESICM)/Society of Critical Care (SCCM) policy statement [2] and a complementary publication [3] on responding to potentially inappropriate treatment requests provide very helpful references for us in such difficult situations as well as a seven-step procedure for resolution of conflict.

1. I would not provide a non- or no longer beneficial treatment if requested by a patient and/or family or when the medical team recommends

something that the patient legitimately wishes to forgo or considers overly burdensome

Non- or no longer beneficial treatments are frequently requested and received in the ICU [4, 5]. These treatments are not restricted to devices or invasive procedures such as extracorporeal membrane oxygenation (ECMO); they include antibiotics, transfusions, or even diagnostic tests. Decisions must be patient specific, and judgments about the risks and benefits of any given treatment must be made by a well-informed patient or surrogate. First a physician must provide a professional opinion affirming that a treatment is indicated, then the patient/surrogate provides judgment as to whether or not in the patient's eyes it is proportionate/ordinary care for her/him. It is both the physician's “indication” of a medically sensible therapeutic aim with a distinct probability and the patient's personal judgment that legitimize treatment. Thus, for one patient, mechanical ventilation might be proportionate, beneficial, acceptable, and used; for another patient the ventilator might be considered overly burdensome (i.e., judged by the patient or surrogate to be extraordinary and disproportionate treatment) and avoided. While risk and benefit are subjective and determined by the patient or surrogate, they must be understood in the context of the medical professional's assessment of risk versus benefit.

2. I would never intentionally allow ongoing pain, anxiety, dyspnea, or other forms of suffering without doing all I can to relieve that suffering unless the patient specifically refuses such treatments in favor of ongoing suffering to allow some element of benefit (e.g., full consciousness to optimize communication with a loved one)

Palliation of suffering is a major goal of ICU care, yet it is too often undervalued or inadvertently unattended amidst the myriad of possible interventions considered

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by the ICU team. To provide the best ICU care, we must continue to ramp up collaboration with our palliative care colleagues. Indeed, forgoing or withdrawing treatment (as opposed to the incorrect and never-to-be-used term “forgoing or withdrawing care”) can relieve the suffering from overly burdensome interventions. Palliation can also be effected in many ways, both pharmacological and through non-pharmacological strategies such as massage, music, family presence, or even by reading to a patient [6–8].

3. I would not apply restricted visitation policies

Expanded family visitation hours in ICUs is now widely recognized as good medicine. Consider how important it is for a patient and his/her family to connect intimately in the final days of life. To do that, a major goal should be to have an attentive and non-delirious patient whenever possible. We now know that expanding family visitation accomplishes a reduction in delirium onset and duration [9, 10].

4. I would not assign bedside care and communication about shifting from cure to comfort to subsets of team members

We must model the “whole team” approach in the ICU. When we shift from aggressive interventions to palliation of suffering, every team member must embrace good end-of-life care as part of the continuum of care. The entire ICU team of clinicians makes decisions surrounding end-of-life, not a subset of members. Essentially, they must hear and feel the plural we will never leave you (the *we* being the entire scope of personnel).

5. I would never ask the patient “do you want everything done?”

The reason this wording is unhelpful and even dangerous in end-of-life care is that the list of “everything” depends on the patient’s situation. “Everything” for one patient might be aggressive therapy whereas for another patient “everything” would be palliative care. Perspectives may be different for the patient, family, and/or medical team. The word “everything” must be replaced with a careful and well-thought-out list of options that are indicated and provide the right balance of risk–benefit of the available treatment options according to the patient’s life goals.

6. I would never make an end-of-life decision and implement it without discussing it with the patient and/or family as well as other medical team members

Family and all members of the patient’s team are vital for best care of the patient. We strive to reach consensus or

near-consensus regarding goals of care among family and healthcare providers. This applies both to making good end-of-life decisions and to prevention of moral distress/burnout or the perception of inappropriate care by ICU clinicians [11].

7. I would never tell the patient and/or family how long the patient will live

In the ICU, overestimation of how long someone will live is particularly problematic. Predicting the patient will live for a few months and then having him/her die within a week is surely an error on the wrong end of uncertainty. Much preferred is to prepare the patient or loved ones for the potential that an earlier death is possible or even likely. We call this “flipping” the question. When asked, “How long can Momma live,” the answer could be something along these lines: “I am not sure how long she can live, and I certainly hope it is weeks or months, but let me flip your question and talk about how quickly she might die. With all of her ongoing problems, it would not be surprising to us if she were to die today or tomorrow.” Ask yourself the “surprise question” [12]. This means asking whether you or your team would be surprised if the patient were to die within the next few days or weeks. If the answer is “No, I would not be surprised,” then it is appropriate end-of-life care to discuss this possibility. Such decisions and their timing should be determined on a patient-by-patient basis to establish appropriate code status in accordance with a patient’s wishes.

In the Eldicus study [13, 14], physicians triaging patients into the ICU were notoriously inaccurate with their assessments of how long patients will live. On the basis of large study populations we can get some idea about patient mortalities, but these predictions are not valid for the individual patient. In Ethicus [15], patients who had the withholding and withdrawing of life-prolonging therapies had respective 24-h, 48-h, and 72-h mortalities of 50%, 61%, and 68% (withholding) and 80%, 89%, and 93% (withdrawing).

8. I would never intentionally shorten the life of a patient by withdrawing treatment to cause death or intentionally administer a lethal drug or toxin

This point is best understood in relation to point 1. We often forego non- or no longer beneficial treatments that allow the patient’s death to occur. This is qualitatively different than intentional or active killing. Foregoing or withdrawing therapy that is no longer beneficial (i.e., judged by the patient or surrogate to be extraordinary and disproportionate treatment) is not done with intent to kill but rather to allow the natural duration of a person’s life to unfold without artificial technological intervention. Intentionally ending the life of a patient through a lethal dose of medication or a toxin, no matter what the patient’s disease

or circumstances, must never be part of a healthcare professional's activities [16, 17]. Active shortening of the dying process (i.e., euthanasia) is not only unethical, it is unnecessary once we actively address and palliate the needs of ICU patients and their family in the last days of life [15].

In conclusion, to paraphrase an oft-quoted mantra, we who have answered the vocation of healthcare must “cure sometimes, relieve often, and comfort always.” The evolution of ICU medicine continues to bring many extraordinary life-saving interventions. This is wonderful, but it does not at all supplant the priority of the last two aspects of our job, to relieve suffering and comfort our patients and their families. The take-home message could simply be to focus more resolutely on accomplishing these two: relief of suffering through better palliative care and, in so doing, ushering in the “comfort always” piece of ICU medicine.

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