

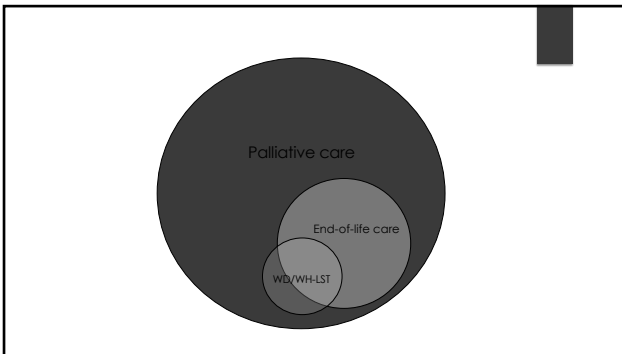
Withholding and withdrawing of life “sustaining” support

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WHO's definition of palliative care for adults

"Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual"

<http://www.who.int/en/news-room/fact-sheets/detail/palliative-care>



The difficults

- ▶ **"Palliative"** care in the **"Intensive"** care unit, where primary goal is **"life sustaining"** to **"recovery"**
- ▶ **"Mindset"** and **"perception"** about withholding and withdrawing of LST do vary
- ▶ **"Optimistic"** vs. **"Pessimistic"**

Life sustaining treatment

- ▶ Fluid
- ▶ Medications: antibiotics, vasopressors/inotropes
- ▶ Blood products
- ▶ Nutrition
- ▶ Artificial support: artificial airway, mechanical ventilation, dialysis, ECMO etc.
- ▶ CPR, defibrillator
- ▶ Etc.

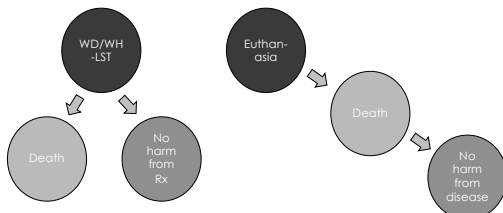
LST: double-edged sword echnology

- ▶ Every treatment in ICU is meant to support "life", more or less
 - ▶ But might not always "worthful"
- ▶ **Worthful:** minimal harm and more benefit and most likely high potential for success and meaningful outcome
- ▶ **Worthless:** Futile, more harm, unpleasant, more pain/disorfort, less likely to success with meaningful outcome

ตายดี (good death)

- ▶ พุทธ: ตายดี มีสติ ไม่หลงตาย
- ▶ คริสต์ และ อิสลาม: die peacefully with dignity

WH/WD-LST and Euthanasia



Factors influencing DLST

- ▶ Medical reasons
- ▶ Personal/Psycho-social reasons
- ▶ Ethical reasons
- ▶ Cultural
- ▶ Religion
- ▶ Legislation

Some problems with end-of-life care in ICU

- ▶ Variability in EOL practice
- ▶ Elusive knowledge of patients' preferences
- ▶ Poor communication between ICU staffs and surrogates
- ▶ Insufficient training in EOL care

Thompson BT. Crit Care Med 2004; 32:1781-1784

Decision-Making on Withholding or Withdrawing Life Support in the ICU
A Worldwide Perspective



- ▶ Observational study
- ▶ 730 ICUs, 84 countries
- ▶ 9,524 pts, died 2,076 (24%)
- ▶ Decision to WH/WD of LST (DLST) was taken during ICU stay in 1,259 (13%)
 - ▶ 820 (40% of non-survivors)
 - ▶ 439 (5% of survivors)
- ▶ ICU (56% vs 11%) and hospital (69% vs 17%) mortality was higher in group with than without DLST

ICON investigators. CHEST 2017; 152(2):321-329

TABLE 1 | Characteristics of the Study Cohort on Admission to the ICU Stratified According to Whether a DLST Was Made

Parameter	All Patients	No Decision	Decision	P
No. of patients	9,524 (100)	8,265 (86.8)	1,259 (13.2)	
Age, y	60.1 ± 18.1	59.4 ± 18.0	64.4 ± 17.5	< .001
Male ^a	5,659 (60.1)	4,936 (60.4)	723 (58.2)	.13
Severity scores				
SAPS II score	40.1 ± 18.3	38.2 ± 17.4	52.1 ± 19.6	< .001
SOFA score at admission	6.0 ± 4.4	5.6 ± 4.2	8.3 ± 4.7	< .001
Max SOFA score ^b	7.5 ± 4.9	7.1 ± 4.7	10.7 ± 5.2	< .001
Type of admission ^c				< .001
Surgical (nontrauma)	3,246 (36.0)	2,957 (37.7)	289 (24.8)	
Medical	5,107 (56.6)	4,323 (55.0)	784 (67.3)	
Trauma	608 (6.7)	522 (6.6)	86 (7.4)	
Other	57 (0.6)	51 (0.6)	6 (0.5)	
Source of admission				< .001
Other hospital	922 (9.7)	787 (9.5)	135 (10.7)	
ED/ambulance	3,632 (38.1)	3,084 (37.3)	548 (43.5)	
OR/recovery room	1,724 (18.1)	1,602 (19.4)	122 (9.7)	
Hospital floor	2,457 (25.8)	2,073 (25.1)	384 (30.5)	
Other	789 (8.3)	719 (8.7)	70 (5.6)	

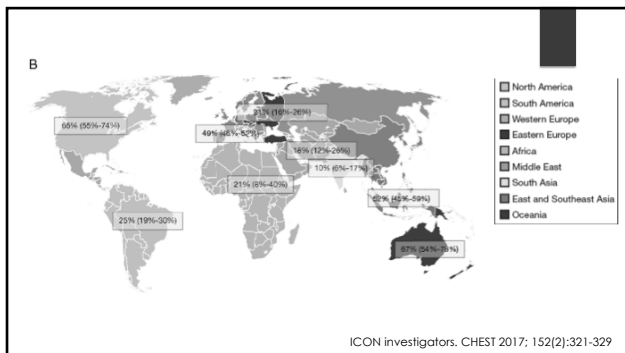
ICON investigators. CHEST 2017; 152(2):321-329

Comorbidity				
COPD	1,171 (12.3)	943 (11.7)	208 (16.5)	< .001
Cancer	989 (10.4)	820 (9.9)	169 (13.4)	< .001
Metastatic cancer	318 (3.3)	240 (2.9)	78 (6.2)	< .001
Hematologic cancer	206 (2.1)	165 (2.0)	41 (3.2)	.07
Stroke	919 (9.6)	770 (9.6)	129 (10.2)	.5
Heart failure, NYHA functional class III/IV	978 (9.2)	704 (8.5)	174 (13.8)	< .001
Chronic renal failure	864 (9.1)	726 (8.8)	138 (11.0)	.01
HIV infection	66 (0.7)	56 (0.7)	10 (0.8)	.64
Obesity	339 (3.6)	274 (3.3)	65 (5.2)	< .001
Immunosuppression	328 (3.4)	271 (3.3)	57 (4.5)	.02
steroid therapy	331 (3.5)	272 (3.3)	59 (4.7)	.01
Chemotherapy	254 (2.7)	209 (2.5)	45 (3.6)	.03
Infectious status				< .001
Infection	3,428 (36.0)	2,825 (34.2)	603 (47.9)	
Sepsis	1,187 (12.5)	994 (12.0)	193 (15.3)	
Septic shock	1,539 (16.2)	1,184 (14.3)	355 (28.2)	
No. of organ failures				< .001
None	2,366 (24.8)	2,221 (26.9)	145 (11.5)	
1 organ	2,627 (27.6)	2,436 (29.5)	191 (15.2)	
2 organs	1,843 (19.4)	1,602 (19.4)	242 (19.2)	
3 organs	1,309 (13.7)	1,039 (12.6)	270 (21.4)	
> 3 organs	1,379 (14.5)	968 (11.7)	411 (32.6)	
Procedures				< .001
Mechanical ventilation	5,058 (53.1)	4,166 (50.4)	892 (70.8)	
Renal replacement therapy	1,135 (11.9)	908 (11.0)	227 (18.0)	

ICON investigators. CHEST 2017; 152(2):321-329

Parameter	All Patients	High GNI	Upper-Middle GNI	Low/Lower-Middle GNI
Total No. of patients	9,524	6,004	2,355	1,165
DLST (%) in the whole cohort	1,259 (13.2)	816 (13.6)	374 (15.9) ^a	69 (5.9) ^a
DLST (%) in the hospital nonsurvivors	820 (39.5)	621 (48.4)	161 (26.6) ^a	38 (20.2) ^a
Age, y	64.4 ± 17.5	68.0 ± 15.1	57.7 ± 19.7 ^a	58.9 ± 18.8 ^a
Severity scores				
SAPS II score	52.1 ± 19.6	55.0 ± 19.1	46.9 ± 19.6 ^a	45.7 ± 17.8 ^a
SOFA score at admission	8.3 ± 4.7	8.8 ± 4.7	7.6 ± 4.5 ^a	6.6 ± 4.2 ^a
Septic shock	355 (28.2)	264 (32.4)	76 (20.3) ^a	15 (21.7)
Length of ICU stay, median (IQR), d	4.0 [2.0-8.0]	4.0 [1.0-8.0]	4.0 [2.0-8.0]	3.0 [1.0-6.0]
Length of hospital stay, median (IQR), d	6.0 [2.0-14.0]	6.0 [2.0-14.0]	7.0 [3.0-16.0] ^a	3.0 [1.0-6.0] ^a
ICU mortality	682 (55.6)	515 (63.7)	135 (38.4) ^a	32 (49.2) ^a
Hospital mortality	820 (68.7)	621 (77.2)	161 (49.2) ^a	38 (60.3) ^a

ICON investigators. CHEST 2017; 152(2):321-329



ICON investigators. CHEST 2017; 152(2):321-329

- ▶ Multivariable analysis, independent predictor of DLST were
 - ▶ Greater severity of disease
 - ▶ Presence of solid or metastatic cancer
 - ▶ Presence of ≥ 2 organ failures
 - ▶ COPD
 - ▶ CHF – NYHA III/IV

ICON investigators. CHEST 2017; 152(2):321-329

US Physicians' Opinions about Distinctions between Withdrawing and Withholding Life-Sustaining Treatment

Grace S. Chung¹ · John D. Yoon¹ · Kenneth A. Rasinski² · Farr A. Curlin³

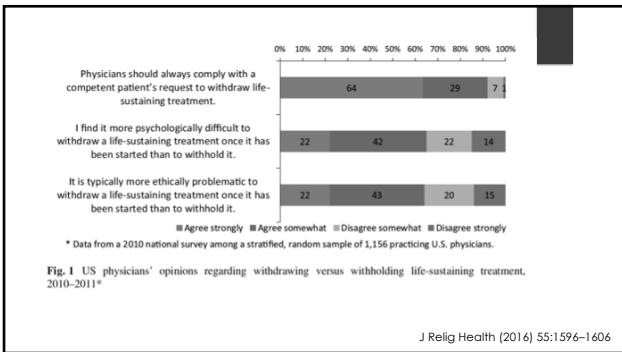
- ▶ Survey US physicians about withdrawing and withholding LST
- ▶ Assessed level of agreement with 3 statements
 - ▶ Physicians should always comply with a competent patient's request to withdraw LST
 - ▶ I find it more psychologically difficult to withdraw a LST once it has been started than to withhold it
 - ▶ It is typically more ethically problematic to withdraw a LST once it has been started than to withhold it

J Relig Health (2016) 55:1596–1606

	Physicians N (%) ¹	1156 physicians
Demographic characteristics		
Age	45.9 ± 0.3	
Gender		
Female	400 (35)	
Male	756 (65)	
Region		
Northeast	279 (24)	
South	378 (33)	
Midwest	283 (24)	
West	216 (19)	
Race/ethnicity		
White, non-Hispanic	758 (66)	
Black, non-Hispanic	43 (4)	
Asian	237 (21)	
Hispanic or Latino	47 (4)	
Other	65 (6)	
Immigration history		
Born in the USA	721 (63)	
Immigrated to the USA	424 (37)	
Religious affiliation		
Protestant, non-Evangelical	256 (23)	
Hindu	80 (7)	
Jewish	109 (10)	
Muslim	110 (10)	
Roman Catholic	295 (26)	
Protestant, Evangelical	85 (8)	
None	129 (12)	
Other	55 (5)	

J Relig Health (2016) 55:1596–1606

Practice characteristics	
Care of dying patients (in past 12 mos)	
4 or fewer	288 (25)
5-10	304 (26)
11-30	294 (25)
31 or more	270 (23)
Specialty	
General specialties	700 (61)
End-of-life specialties	456 (39)
Religious characteristics	
Attendance at religious services	
Never	159 (14)
Once a month or less	559 (50)
Twice a month or more	408 (36)
Importance of religion	
Not very important/not applicable	307 (27)
Fairly important	351 (31)
Very important	331 (29)
Most important	139 (12)



Other results

- ▶ Religious measures were **not** associated with agreement to patient's request
- ▶ Religious doctors more likely to indicate "ethical problematic" with WD-LST **but not** "psychologically difficult"
- ▶ Doctors with **more experience** in caring of dying patients were **less likely** to report both "psychological" or "ethical" distinction between WD and WH-LST
- ▶ Doctors working in **end-of-life specialties** (hospice and palliative care/geriatrics, oncology, and pulmonary/critical care) also reported **less distinction** between the two compared to general specialties

J Relig Health (2016) 55:1596-1606

Burden on doctors and nurses

- ▶ Grief and human suffering
- ▶ Anxiety
- ▶ Depression
- ▶ Difficulty balancing professional role and personal feelings
- ▶ Emotional exhaustion
- ▶ Burn out

ORIGINAL ARTICLE

End-of-life care in intensive care unit: Family experiences



Leah C. Kisorio¹, Gayle C. Langley¹

17 families

Findings: Five major themes emerged: "most of the time we are in darkness", "emotional support", "involvement", "family presence" and "spiritual support".

Conclusion: The findings reflect inadequate care to the families who had dying relatives in the intensive care unit. Negative experiences expressed by the families outweighed their positive experiences, as most families were not happy with the care observed or personally received while their relatives were in the intensive care unit.

Intensive and Critical Care Nursing (2016) 35, 57–65

Advance directives/care planning

- ▶ Associated with
 - ▶ Care received matching with patient's preference
 - ▶ Less aggressive care at end-of-life
 - ▶ Better family satisfaction

พระราชบัญญัติสุขภาพแห่งชาติ พ.ศ.2550

▶ มาตรา 12

“บุคคลมีสิทธิทำหนังสือแสดงเจตนาไม่ประสงค์จะรับบริการสาธารณสุขที่เป็นไปเพียงเพื่อยืดการตายในวาระสุดท้ายของชีวิตตน หรือเพื่อยุติการทรมานจากการเจ็บป่วยได้ การดำเนินการตามหนังสือแสดงเจตนาตามวรรคหนึ่งให้เป็นไปตามหลักเกณฑ์และวิธีการที่กำหนดในกฎกระทรวง เมื่อผู้ประกอบวิชาชีพด้านสาธารณสุขได้ปฏิบัติตามเจตนาของบุคคลตามวรรคหนึ่งแล้วมิให้ถือว่าการกระทำนั้นเป็นความผิดและให้พ้นจากความรับผิดทั้งปวง”

▶ ร่างพระราชบัญญัติสุขภาพแห่งชาติ ว่าด้วยสิทธิการตาย มาตรา 24 ระบุไว้ว่า

▶ “บุคคล มีสิทธิแสดงความจำนงเกี่ยวกับวิธีการรักษาพยาบาลหรือปฏิเสธการรักษาที่เป็นไปเพื่อการยืดชีวิตในวาระสุดท้ายในชีวิตของตนเอง เพื่อการตายอย่างสงบและมีศักดิ์ศรีของความเป็นมนุษย์” โดยมีคำชี้แจงว่าเพื่อให้บุคคลมีสิทธิเลือกตายอย่างสงบ และมีศักดิ์ศรีของความเป็นมนุษย์ ในบั้นปลายของชีวิต โดยไม่ยืดชีวิต หรือถูกแทรกแซงการตายเกินความจำเป็น และเพื่อให้เป็นภาระทุกๆ ด้าน โดยให้มีสิทธิแสดงความจำนงล่วงหน้า (Living will) ในร่าง พ.ร.บ. นี้ ไม่ได้กล่าวถึงการให้แพทย์มีสิทธิฆ่าผู้ป่วยด้วยความสงสาร (การุณยฆาต) และไม่ได้กล่าวถึงการให้แพทย์ช่วยให้ผู้ป่วยฆ่าตัวตายด้วยการจัดหาอุปกรณ์ลิดชีพให้ผู้ป่วย

Who make decision?

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    graph TD
      A[Assess prognosis and certainty] --> B[Assess family preference for role in decision making]
      B --> C[Adapt strategy according to patient and family factors]
      C --> D[Family's roles in decision making]
      D --- E[Parentalism or clinician decides]
      D --- F[Shared decision making]
      D --- G[Autonomy or family decides]
  
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Curtis JR. Lancet 2010; 375: 1347-53

Communication is a key to success

- ▶ Interdisciplinary collaboration and communication
 - ▶ Doctors
 - ▶ Nurses
 - ▶ Varies across countries and hospital settings
 - ▶ Poor collaboration → increase burn-out, anxiety, depression, post traumatic stress and conflicts between providers and family
- ▶ Communication between clinicians and family

Panel 2: Proposed best practices for ethics and end-of-life care in the intensive care unit (ICU)

ICU policies

- Explicit policy for admission and transfer criteria
- Explicit policy for delivery of palliative and end-of-life care
- Training for ICU clinicians in ethics, communication, and end-of-life care

Interdisciplinary communication

- All patients included in daily interdisciplinary rounds
- Daily interdisciplinary communication about the goals of care

Curtis JR. Lancet 2010; 375: 1347-53

Communication with families

- Open visiting hours for family members
- Allow family presence during ICU rounds
- Routine interdisciplinary family conferences within 48-72 h for family of patients at high risk of death or prolonged stay

Withholding or withdrawing life support

- Explicit policy about withholding and withdrawing life support
- Protocol for withdrawing life support
- Train clinicians from all disciplines regarding ethics and communication about withholding and withdrawing life support
- Staff support programmes about end-of-life care, and withholding or withdrawing life support

Curtis JR. Lancet 2010; 375: 1347-53

Panel 3: Key stages for improvement of communication during interdisciplinary family conferences in the intensive care unit

Before

- Plan the specific details of location and setting: quiet, private place²⁷
- Do a preconference with the clinicians to develop consensus and ensure consistency of information provided

During

- Use active listening and provide family adequate time to speak²⁸
- Use empathic statements to provide support for families:²⁹ difficulty of having a critically ill loved one; difficulty of surrogate decision making; impending loss of a loved one
- Acknowledge and address family emotions³⁰
- Explore and focus on patient values and treatment preferences³⁰
- Affirm non-abandonment of patient and family³¹

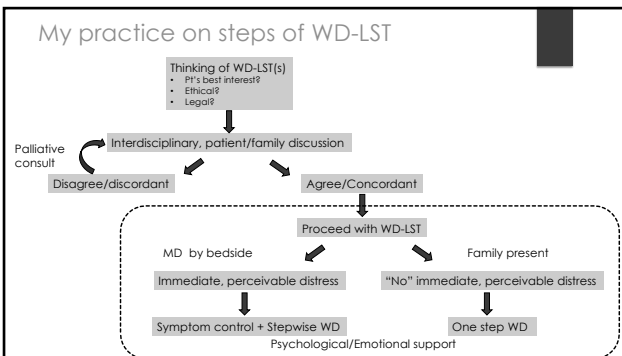
Completion

- Summarize information and decisions
- Ask for questions, and allow family time to consider questions³²
- Reaffirm and support family with respect to their decisions³³

Curtis JR. Lancet 2010; 375: 1347-53

Good WH/WD-LST practices

- ▶ Document of rationale to WD/WH-LST
- ▶ Develop explicit plan for procedure
- ▶ Patient should be in appropriate setting, unnecessary monitor removed
- ▶ Document detailed process of WH/WD
- ▶ Assess outcomes of WH/WD
- ▶ Some WD process need tapering to allow time to treat discomfort ie. mechanical ventilation



Panel 4: An eight-step approach to terminal withdrawal of mechanical ventilation

- 1 Communicate withdrawal process with patient (if able to communicate), patient's family, and intensive care unit team, and document decision making and communication in the medical record
- 2 Explain to patient and family the likely time course, uncertainty of that time course, and possible symptoms and treatment plan for symptoms when withdrawing life-sustaining treatment
- 3 Assess patient comfort and treat discomfort as necessary, often with opiate or benzodiazepine drugs, depending on the symptoms identified
- 4 Remove positive end expiratory pressure, and turn inspired oxygen fraction to room air
- 5 Reassess patient's comfort, and treat discomfort as necessary
- 6 Reduce ventilatory support by about 50%
- 7 Repeat steps 5 and 6 until ventilator support has been discontinued
- 8 Remove mechanical ventilator, and extubate patient or attach T-piece with humidified air

Curtis JR. Lancet 2010; 375: 1347-53

Symptom management

Symptoms

- ▶ Pain
- ▶ Dyspnea
- ▶ Anxiety
- ▶ Depression
- ▶ Delirium
- ▶ Thirst
- ▶ GI intolerance
- ▶ Constipation
- ▶ Spiritual distress

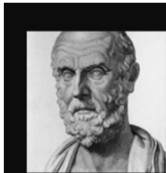
Assessment

- ▶ Asking
- ▶ Exam
- ▶ Observation
- ▶ Assessment scales/tools

Treatment

- ▶ Pharmacologic – opioid, anxiolytic, antipsychotic, antidepressant, palliative sedation
- ▶ Non-pharmacologic- counseling.

Thank you



Cure sometimes, treat often, comfort always.

~ Hippocrates
