End of Life Care in Critically Ill Patients

Hospital Authority Convention
Convention and Exhibition Centre
Hong Kong
May 7, 2014
DEATH IS MOST COMMON HEALTH EVENT

2.5 million die/year in the USA

JAMA 2012; 307:997-1098

MEDICALISATION OF THE DYING PROCESS
CONVEYOR BELT TO INTENSIVE CARE

- Ambulance
- Emergency Department
- Hospital ward
- Intensive care

Important for Intensivists to understand the source of EOL care
SOME DRIVERS

- Dying is frightening
- Lack of community support for dying
- Societal expectations (media)
- Reluctance of medicine to discuss death
- Specialisation of medicine
- Difficult to be 100% certain
- Because we can, we do
- “they want everything done”
- Litigation
HOSPITAL DOCTORS

- Single organ specialists
- Reluctance to discuss death/dying
  - Cure orientated
  - Time consuming
  - Defeat/embarrassment
  - Don’t understand limits of my specialty and therefore

CANNOT MAKE THE DIAGNOSIS OF DYING
USA

70% of Americans want to die at home
75% die in medical institutions
> 30% spend at least 10 days in ICU
> 30% bankrupt families in the process of dying

Time September 2000
DEMAND FOR CRITICAL CARE SERVICES INCREASING WORLD WIDE

Int Care Med 2011; 37:377

Lancet 2010; 376:1339
INCREASING NUMBERS OF PEOPLE DYING IN ICUS

JAMA 2013; 309:470
FUTURE

AGE

1950

2040
OBJECTIVES ARE CHANGING

- “…. To save lives of salvageable patients with reversible medical conditions and offer the dying a peaceful and dignified death”
  - Kollef and Schuster 1994

- “…. To use public health care resources in an efficient and equitable way on the basis of transparent decidability”
  - Dowie 1998

- “…. To facilitate recovery of organ dysfunction/failure to a level that results in discharge from the hospital with a quality of life that is acceptable to the patient”
  - 2014
DIAGNOSING AND MANAGING DYING WILL BECOME AN INCREASINGLY IMPORTANT AND CRUCIAL ROLE IN THE ICU PRACTICE
Most patients die in the ICU as a result of withholding and/or withdrawing treatment.

Diagnosing dying is part of our core business.
REALITY OF THE PROBLEM

- 73% of European and 87% of Canadian ICU physicians frequently admitted patients with unrealistic expectations
  - Palda et al. J Crit Care 2205
  - Giannini et al Br J Anaesthesia 2006

- Prevalence study: 27% of ICU physicians and nurses cared for at least one patient receiving disproportionate care; 60% indicated this was common in their unit
  - Piers et al. JAMA 2011
Moral framework

- **Do well – do no harm**
  - Intensive care treatment is almost always accompanied by intentional harm to the patient with the sole justification that the patient might benefit from this and that this “harm” is proportional to the benefit. When there is no benefit (anymore) or disproportionate benefit, “harm’ is not justified and is ethically questionable.

- **Respect autonomy**
  - A competent patient may always refuse treatment or request treatment is to be withdrawn

- **Do justice**
Use of ICU resources

- Inappropriate not proper - untimely
  - Treatment has no pathophysiologic basis (anymore)
  - Patient is not or minimally responding to treatment

- Disproportionate excessive, too much, more than enough
  - Patient is suffering from multiple severe co-morbidity and chronic organ dysfunction
  - Patient is not critically ill anymore but cannot survive outside ICU

- Unlawful – against the will of the patient, goals not met
Why not use ‘medical futility’?

‘futile care’ is unidirectional whereas ‘disproportionate use of ICU resources’ entails a bidirectional discrepancy between the administered care and the prognosis (‘not enough’) but also ‘too much – more than enough’

- ‘disproportionate as not enough’ rare in Western ICUs
- Disproportionate is determined by many factors (severity of illness, co-morbidity, response to previous treatment, life expectancy, quality of life, cost of use of ICU resources, cost of long term follow up for society) where the burdens outweigh the benefits
Why not use ‘medical futility’?

- Only one factor involved (patient’s (estimated) prognosis)
- Regards a high degree of certainty regarding the prognosis
  - Use of life sustaining technology (e.g. mechanical ventilation, vasoactive drugs, ECMO, CVVH) virtually excludes patients spontaneous death
  - Possibility of a self-fulfilling prophecy: treatment was futile justified from the fact the patient died after withdrawal
- Does not take into account that physicians and nurses have an evolving opinion concerning a patient’s prognosis and burden
- There can be no futility when the goal of treatment for patients/family changes to “not being dead”
AGEING = CO-MORBIDITIES

- Type 2 DM
- Hypertension
- Increased cholesterol
- IHD
- Decreased kidney, liver and genital function

- Dementia
- Skin cancers
- Muscle bulk loss and falls
- Osteoarthritis
- Heart failure
- Lung diseases
The diagnosis of dying often reflects the sum of all the other “diagnoses” that come with age

No longer allowed to write ‘old age’ as a cause of death
Some medical DIAGNOSES are inconsistent with life
  e.g. end-stage cancer, COPD, and CCF

Some medical CONDITIONS are inconsistent with life
  e.g. unresponsive hypoxia and hypotension
DYING

Often not the acute ‘diagnosis’ which determines the outcome but the underlying sum of the chronic conditions – as yet unclassifiable

e.g. urinary tract infection
     lung infection
     ‘The old person’s friend’
FRAILTY

Collecting diseases
(or age related conditions)
FUTILITY

- FRAILTY – (RESERVE)
- Interacting with acute disease largely defines FUTILITY
- Which defines DYING
DIAGNOSING DYING

Withholding and Withdrawing treatment
DIAGNOSIS OF DYING

- Severity of the acute illness
- Response to treatment
- Therapeutic options
- Co-morbidities
- Scores e.g. APACHE and SAPS
- QOL post hospital
- Patient/relative wishes
THE DIAGNOSIS OF IMMINENT DYING (1-5 days) PREDICTORS

- pH
- Respiratory rate
- GCS
- PEEP level
- Systolic BP
- Specialist opinion - BEST

CCM 2013; 41:2677
WHO DECIDES

- Autonomy
  - Right to make decisions
- Beneficence
  - Should benefit
- Non-malfeasance
  - Do no harm
- Distributive justice
  - Equitable distribution of resources
EXTREME MODELS

- Autonomy – individual, patient, family choice
- Right of health professionals to not deliver futile EOL care
UNCERTAINTY

- Uncertainty is part of medicine
- Scientific certainty
- Practical certainty - Aristotle
PATIENT AUTONOMY AT THE EOL

- Choices are not a smorgasbord
- Physicians are not waiters
- Doing exactly what the patient wants is not patient autonomy
- Should not permit preferences, fear, guilt and fantasy to substitute for autonomy
“SHARED DECISION” MODEL

COMMUNICATION IS CRUCIAL
SEEKING CONSENSUS WITHOUT ASKING FOR PERMISSION
DIAGNOSING DYING OUTSIDE THE ICU
HOSPITAL CPR

- Most die in hospital
- Half of all survivors have significant decrease in functional status

Arch Int Med 2000; 160:1969
DNR (NFR)

- Pretends medicine has something to offer
- That we are withholding something from the dying
DNR (NFR)

= Diagnosis of dying
= Medicine has no more to offer
= Change thrust of care

HONESTY AND PALLIATION
DNR (NFR)

At best – basis for the beginning of an honest dialogue
PROBLEM WITH DIAGNOSING DYING IN ACUTE HOSPITALS

- Multicentre, international study
- One-third of all emergency calls in hospitals are for previously not addressed EOL issues

CCM 2012; 40:98-103
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<th>Jun</th>
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<td><strong>Not Suitable for ICU Admission</strong></td>
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HOSPITAL MEDICINE

- Hospital specialists are very poor at diagnosing dying
- Diplomacy, politics and conformity with the medical hierarchy usually trumps patient care
FAILURE TO DIAGNOSE DYING

- Suffering of patients and loved ones
- Frustration of treating physicians
- Unsustainable health care costs
DYING – diagnosed by:

- Family practitioner
- General hospital specialist
- Intensive care specialist
HOSPITAL SPECIALISTS CAN NO LONGER DIAGNOSE DYING OR RECOGNIZE PATIENTS AT THE END OF LIFE
Intensivists are becoming the specialists who diagnose ‘dying’

- ICU Consultations
- In ICU

“When the ICU has no more to offer”
PATIENTS DO NOT SUDDENLY DIE IN ICU!
MANIPULATION OF THE DYING PROCESS

- Death is a transitional process

INTENSIVE CARE
- MANIPULATE UP – prolonging dying by temporarily supporting some of the dying organs
- MANIPULATE DOWN – withdrawal and withholding when no progress is being made
SOME PERSONAL LESSONS
REMEMBER PEOPLE MAY BE RELUCTANT TO WANT ACTIVE TREATMENT

- It depends on the way the information is presented
“There is little hope. I think to continue active treatment would be cruel and futile”

“There is a small chance of recovery. I think I would give him a chance”
SUPERMARKET MEDICINE

- “He/she is deteriorating, do you want everything done?”
- “What would you like us to do?”
- “The relatives want everything done”
  - Intubation
  - Ventilation
  - Dialysis
  - Heart lung transplants
  - Cryogenics
- Learn to say “WE CAN’T OFFER ANY MORE, YOUR LOVED ONE IS DYING”
This is a very serious situation. We are doing everything possible, but I’m afraid that he/she may die during this illness.
1. Facilitate switching from curing to caring
2. Consider family rounds
3. Emphasize privilege to care for the patient
4. Emphasize to relatives we are not there for them
5. Never ask “Do you want everything done?”
7. Never say care is a burden
8. Emphasize we will not abandon you - physically say this
9. What prediction of death – how short NOT how long i.e. “flipping it” – not boxed into a corner
10. Take a spiritual history
Conclusions

- Conveyor belt to intensive care – multiple drivers
- Hospital doctors cannot make the diagnosis of dying or recognize patients at the end of life
- Demand for critical care services increasing worldwide
  - Diagnosing and managing dying will become an increasingly important and crucial role in the ICU practice
- Most patients die in the ICU as a result of withholding and/or withdrawing support
  - patients do not suddenly die in ICU
  - manipulation of the dying process
- Often not the acute ‘diagnosis’ which determines the outcome but the underlying sum of the chronic conditions – as yet unclassifiable