Management of Withholding and Withdrawing Futile Interventions and Instituting End of Life Care

ICU Retreat
March 2009

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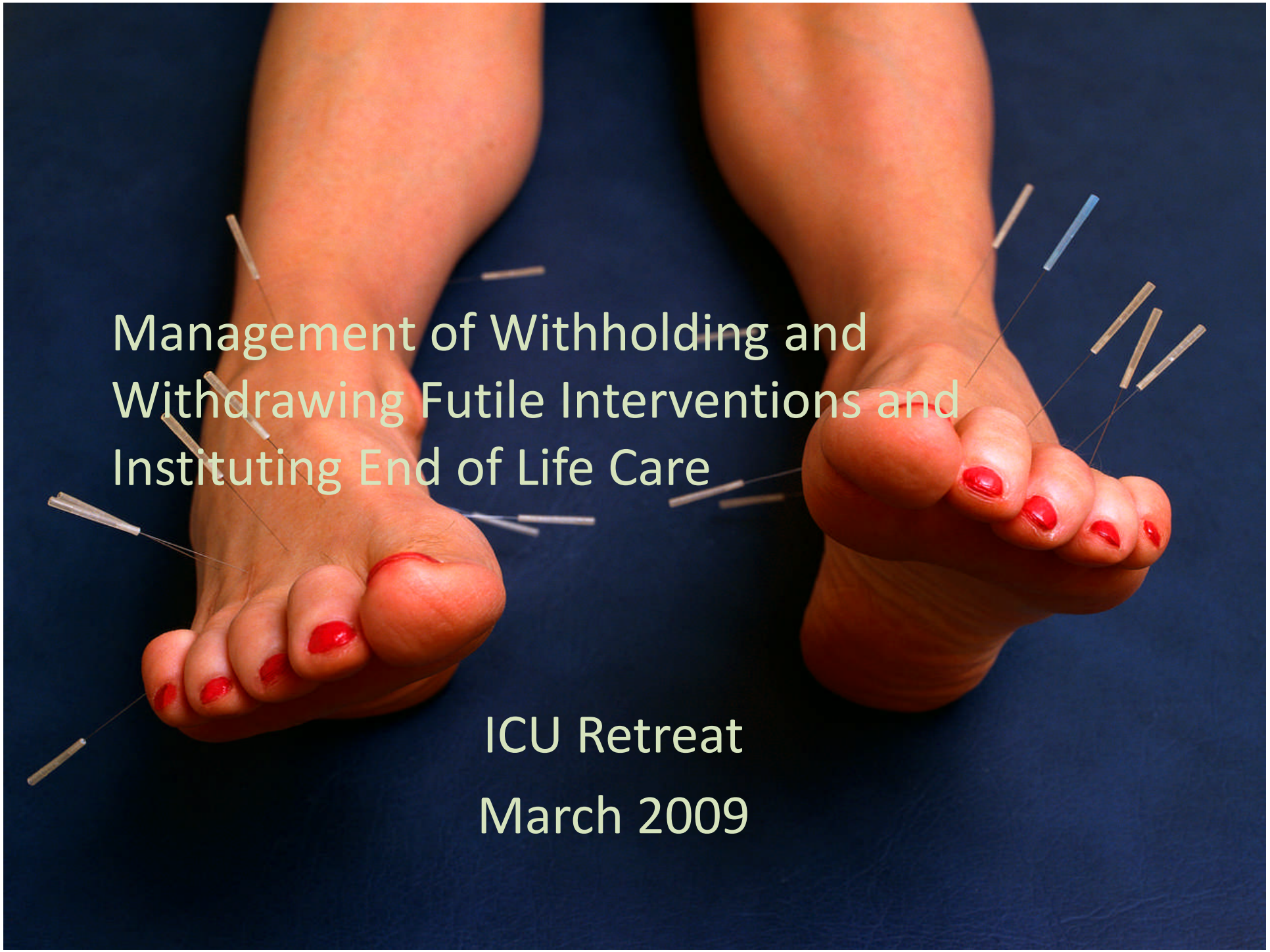
Management of Withholding and Withdrawing Futile Interventions and Instituting End of Life Care
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Aims

- Increase frequency of non-futile admissions to ICU
- Expedite recognition of interventions that are futile
- Improve communication with families and patients around the available limits of care and end of life decisions
- Resolve disagreements between families and caregivers over futility of care and end of life decisions
- Adopt a best practices approach to transitioning from interventional care to comfort focused care

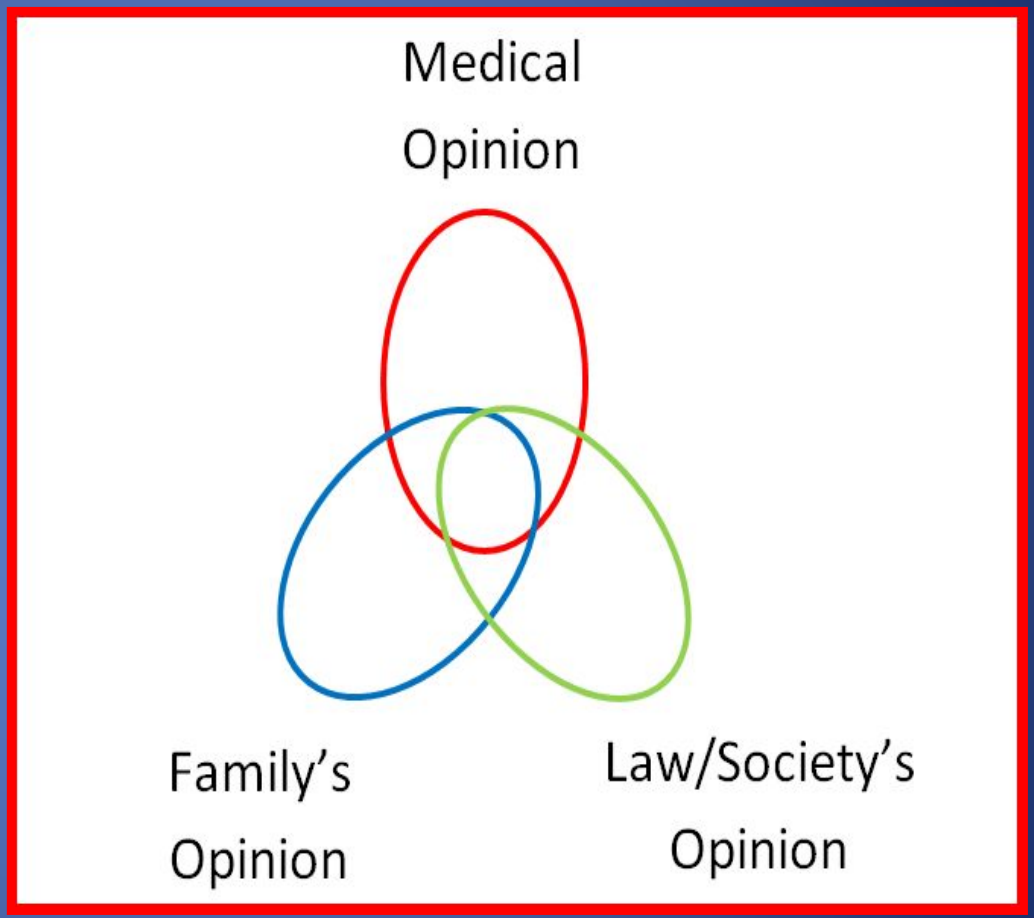
Foci

- Criteria for admission to the Intensive Care Unit
- Decision Making around Futility of New or Current Interventions
- Informing Families of Limits and Changing Care Plans
- Resolving Disagreements between Care Providers and Families
- Best End of Life Practices

Criteria for admission to the Intensive Care Unit

- Often strongly held feelings that some patients should not be admitted to intensive care for reasons of futility
- Powerful source of moral distress in caregivers
- “We should predict who will not survive and refuse to make them undergo intensive care”

- Where does our moral authority to limit care come from?



Winnipeg man in life support controversy dies

By RHONDA SPIVAK, Prairies Correspondent Wednesday, 02 July 2008

WINNIPEG — Sam Golubchuk, the man at the centre of a legal battle involving the question of who has the right to make end-of-life decisions for medical patients, died in hospital June 24 of natural causes while still on life support.

At Golubchuk's funeral, Dr. Joel Zivot, a critical care specialist who is Jewish, came forward to say that he had contacted Golubchuk's children and agreed to care for Golubchuk in his remaining days after three doctors at Winnipeg's Grace Hospital had refused to do so.

Zivot told those in attendance: "After I heard other physicians had concerns about treating Mr. Golubchuk, I called Mr. Kravetsky [the family's lawyer], and I told him that I wanted to meet with Mr. Golubchuk's children, and I met with them… I told them that it was my obligation as a physician to honour the wishes of my patients… There are doctors who believe that it is a duty to care for our patients. I was honoured and privileged to care for him [Mr. Golubchuk] in the last few days of his life."

- On February 13, a Manitoba judge sided with the Golubchuk family and extended an interim injunction preventing doctors from withdrawing care until a full trial could be heard in September.
- "This is grotesque. To inflict this kind of assault on him without a reasonable hope of benefit is an abomination. I can't do it."

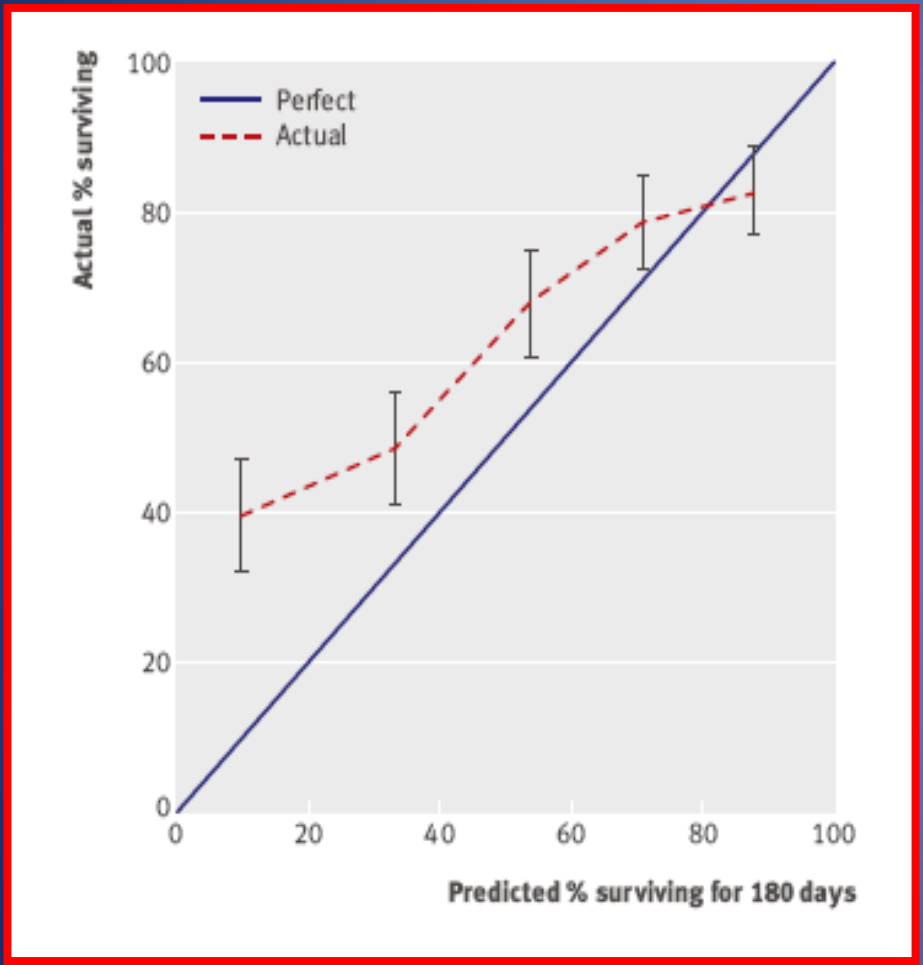
- "If the [Golubchuk] case goes against the hospital on the grounds that once you plug in you can't unplug, I think people will be a lot slower to plug in, and some people may die who should have been plugged in," Arthur Schafer, director of the University of Manitoba's Centre for Professional and Applied Ethics told the *Globe and Mail*. "So the social implications of a victory for Mr Golubchuk, his children and their lawyer would, I think, make Canadian hospitals deviate from good medical ethics."

National Review of Medicine, Feb 2008

- Jocelyn Downie, PhD, a lawyer at the Health Law Institute at Dalhousie University, isn't convinced. "These decisions are frequently moral ones not medical ones, or are at least medical and moral," she argues. "I don't believe that physicians have special knowledge or skills in terms of assessing what's in the best interests of patients."

National Review of Medicine, Feb 2008

- But surely there are some medical cases where it's obvious that survival is impossible?
- What about COPD and cancers?
- What about the elderly?

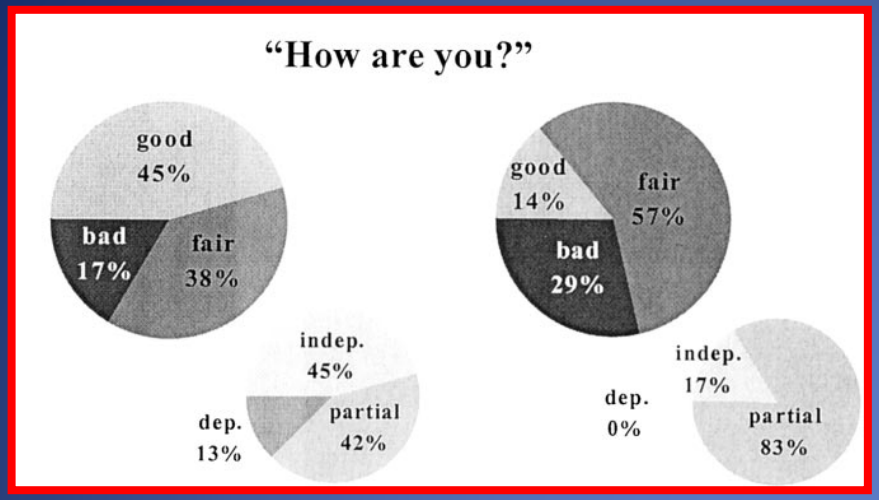


"Clinician pessimism was particularly marked for the patients in the lower fifth of the distribution of prognosis. In fact, the tenth of patients with the poorest clinician prognosis had a predicted 180 day survival of around 3% and an actual survival of around 36%."

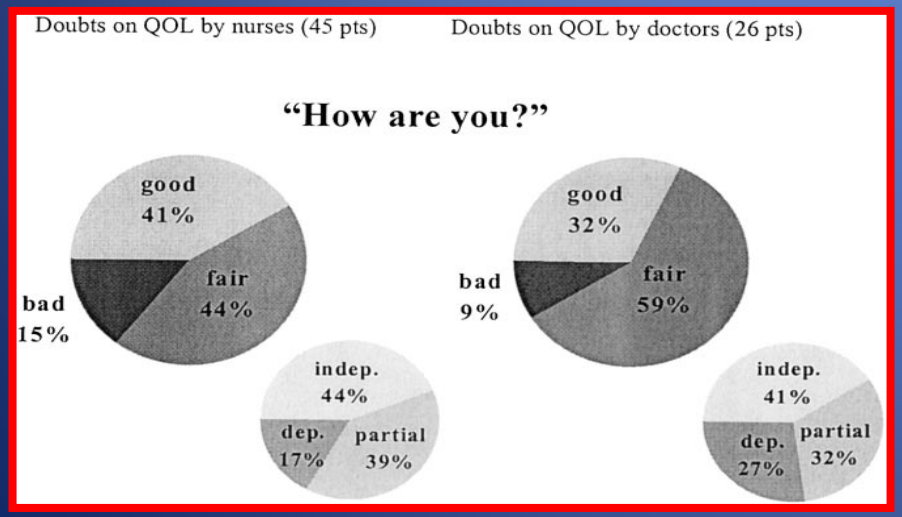
Wildman MJ, Sanderson C, Groves J, Reeves BC, Ayres J, Harrison D, et al. Prognostic pessimism for patients with chronic obstructive pulmonary disease (COPD) or asthma admitted to intensive care in the UK: multicentre observational cohort study. BMJ 2007

- However, prognosis shouldn't be the only end point on which we base decisions
- It is clear that caregivers, families and patients all feel that quality of life is an important consideration in making therapeutic decisions

Dowdy DW, Eid MP, Sedrakyan A, Mendez-Tellez PA, Pronovost PJ, Herridge MS, et al. Quality of life in adult survivors of critical illness: a systematic review of the literature. Intensive Care Med 2005;31:611-20.
Frick S, Uehlinger DE, Zuercher Zenklusen RM. Medical futility: predicting outcome of intensive care unit patients by nurses and doctors—a prospective comparative study. Crit Care Med 2003;31:456-61.



Answers of survivors 6 months after intensive care unit discharge for whom treatment had been considered futile or questionable in regard to survival by nurses or doctors



"Disagreement between nurses and doctors was frequent with respect to their judgment of futility of medical interventions. Disagreements most often concerned the most severely ill patients. Future quality of life cannot reliably be predicted either by doctors or by nurses"

- Given the lack of medical, legal and social clarity around restricting admission to critical care services, it seems unlikely that a single “policy” will be possible
- Decisions will continue to need to be made on a case by case basis.
- However, there may be room for improvement with respect to clarifying wishes prior to ICU admission

- Possibilities include:

- Provide early information on EOLC to all families
- “Preadmission Clinics” – Pre Operative Consults
- Mandatory Consults with High Risk Diagnoses

Decision Making around Futility of New or Current Interventions

- Once patients are admitted to the ICU it may become evident that specific interventions of care plans are not reasonable or ethical
- Significant caregiver distress occurs when different team members believe that there are different (or no) plans
- Once decisions to limit aspects of care have occurred, it can take families time to comprehend

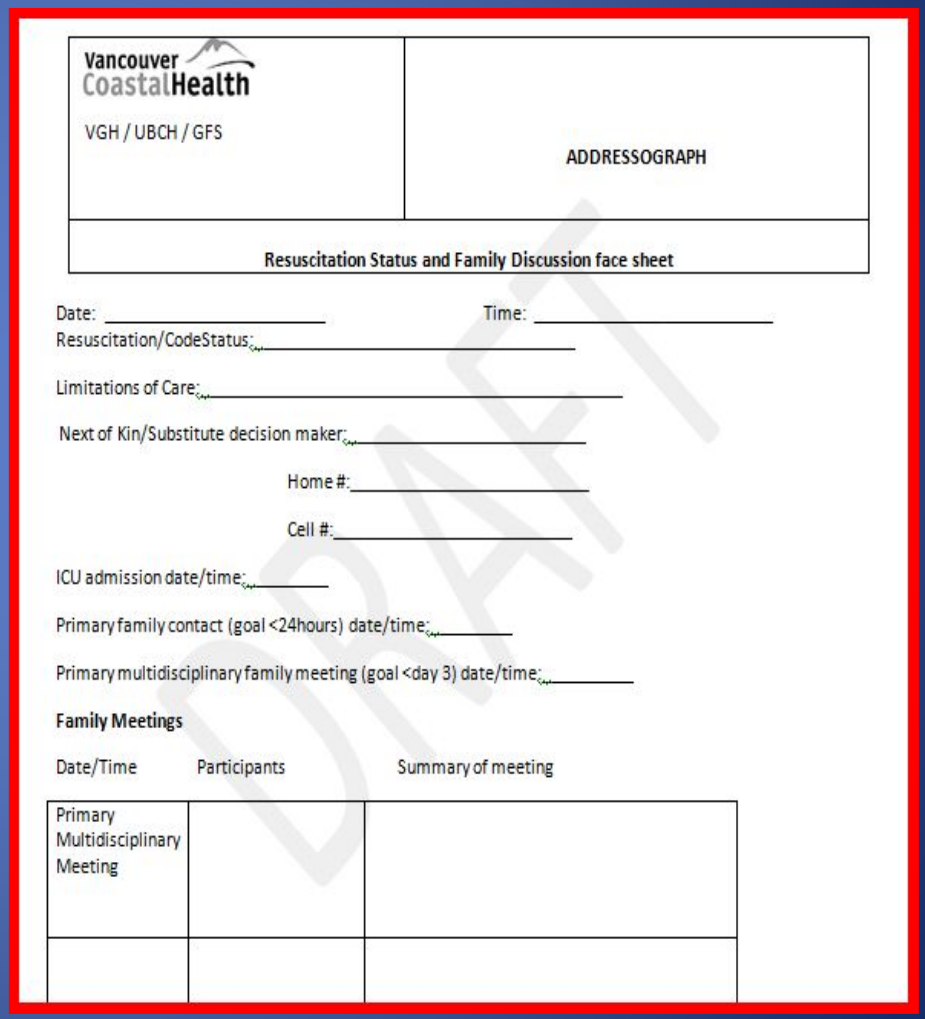
- Strategies that may help decrease the time from admission to the decision to withold or limit treatment options include:
    - Early communication
    - Institution of a facesheet
    - Setting goals for patient care

- **Early communication:** Ideally the time to discuss EOLC issues, especially in patients with chronic illness, is in the outpatient setting: quality of death was seen as improved in those patients who had an advance directive prior to entering the hospital or intensive care environment .

Glavan, BJ., Engelberg, RA., Downey L., & Curtis, JR. Using the medical record to evaluate the quality of end-of-life care in the intensive care unit. Critical Care Medicine. 2008; 36(4): 1138-1146.

Millner, P., Paskiewicz, ST., & Kautz, D. A comfortable place to say goodbye. Dimensions in Critical Care Nursing. 2009; 28(1):13-17.

- **Institution of a facesheet:** with resuscitation/code status, limitations of care, next of kin contact, times of primary contact with family and finally several boxes to record summaries of family meetings.



Vancouver Coastal Health

VGH / UBCH / GFS

ADDRESSOGRAPH

Resuscitation Status and Family Discussion face sheet

Date: _____ Time: _____

Resuscitation/CodeStatus: _____

Limitations of Care: _____

Next of Kin/Substitute decision maker: _____

Home #: _____

Cell #: _____

ICU admission date/time: _____

Primary family contact (goal <24hours) date/time: _____

Primary multidisciplinary family meeting (goal <day 3) date/time: _____

Family Meetings

Date/Time	Participants	Summary of meeting
Primary Multidisciplinary Meeting		

Resolving Disagreements between Care Providers and Families

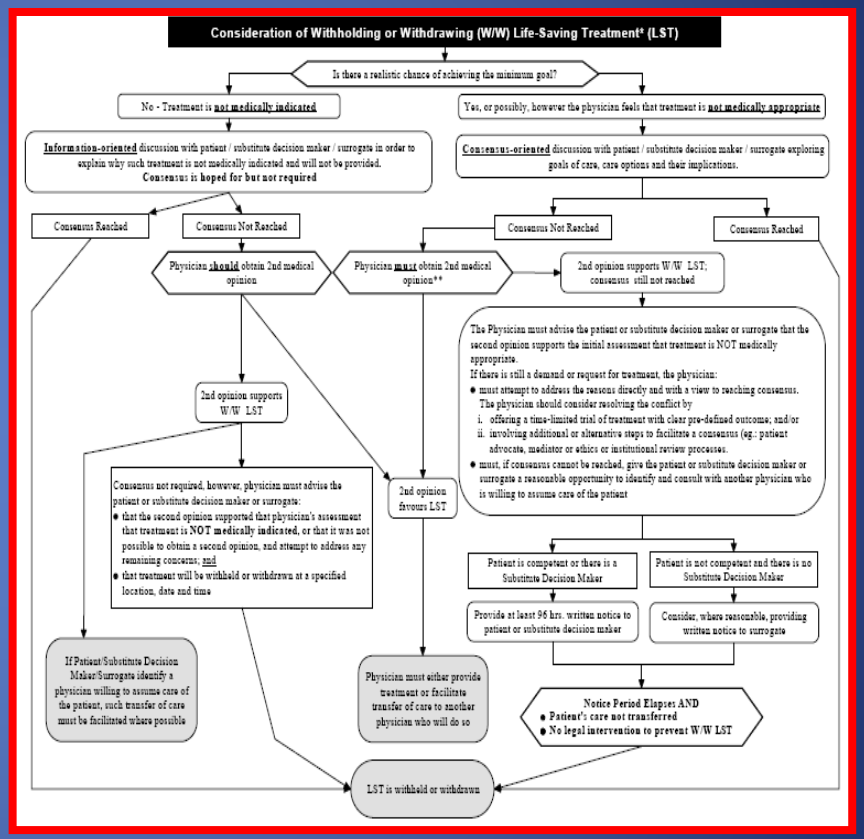
- Family based communication
- Clear communication
- Statement of prognosis and issues
- Documentation

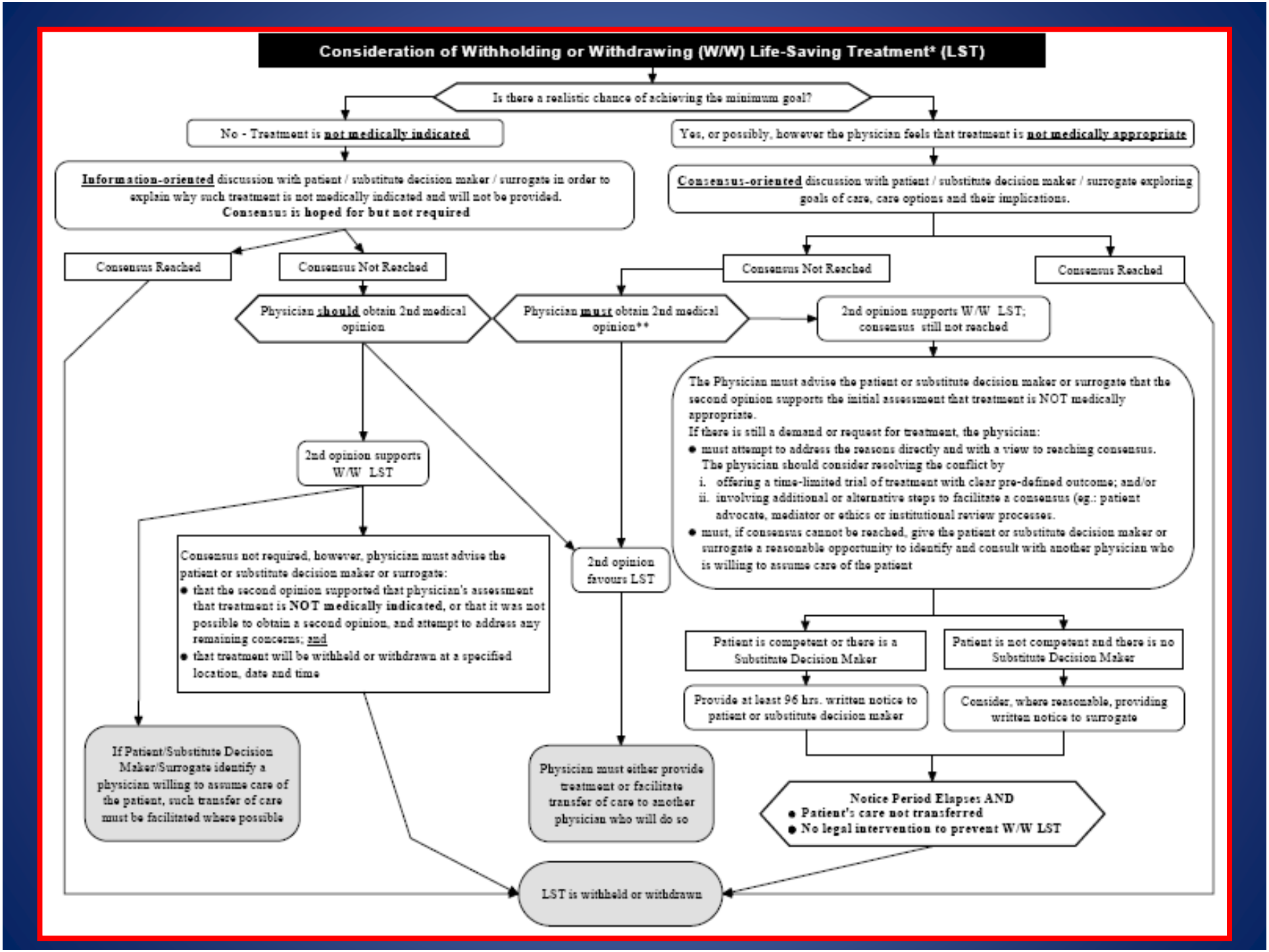
- Important to establish trust and rapport with families and surrogates so that they feel supported in their information gathering and their decision making.
- Misunderstandings regarding the diagnosis and prognosis, coupled with high expectations of the medical system lead to conflict between families and staff.

Badger, JM. Factors that enable or complicate end-of-life transitions in critical care. American Journal of Critical Care. 2005;14(6): 513-521.

- In situations where these conflicts are irreconcilable, it is imperative that objective opinions and careful documentation are maintained.
- There is immense moral distress felt by physicians who feel it ethically warranted to withdraw or withhold interventions in the face of family disagreement. There is also concern that this may place caregivers at legal risk.

- We suggest using an objective system of documentation and family notification coupled with a second opinion process to mitigate these risks.




Consideration of Withholding or Withdrawing (W/W) Life-Saving Treatment* (LST)
Is there a realistic chance of achieving the minimum goal?
No - Treatment is not medically indicated
Yes, or possibly, however the physician feels that treatment is not medically appropriate
Information-oriented discussion with patient / substitute decision maker / surrogate in order to explain why such treatment is not medically indicated and will not be provided. Consensus is hoped for but not required
Consensus-oriented discussion with patient / substitute decision maker / surrogate exploring goals of care, care options and their implications.
Consensus Reached
Consensus Not Reached
Consensus Not Reached
Consensus Reached
Physician should obtain 2nd medical opinion
Physician must obtain 2nd medical opinion**
2nd opinion supports W/W LST; consensus still not reached
The Physician must advise the patient or substitute decision maker or surrogate that the second opinion supports the initial assessment that treatment is NOT medically appropriate.
If there is still a demand or request for treatment, the physician:
must attempt to address the reasons directly and with a view to reaching consensus. The physician should consider resolving the conflict by
i. offering a time-limited trial of treatment with clear pre-defined outcome; and/or
ii. involving additional or alternative steps to facilitate a consensus (eg.: patient advocate, mediator or ethics or institutional review processes.
must, if consensus cannot be reached, give the patient or substitute decision maker or surrogate a reasonable opportunity to identify and consult with another physician who is willing to assume care of the patient
2nd opinion supports W/W LST
Consensus not required, however, physician must advise the patient or substitute decision maker or surrogate:
that the second opinion supported that physician's assessment that treatment is NOT medically indicated, or that it was not possible to obtain a second opinion, and attempt to address any remaining concerns; and
that treatment will be withheld or withdrawn at a specified location, date and time
2nd opinion favours LST
Patient is competent or there is a Substitute Decision Maker
Patient is not competent and there is no Substitute Decision Maker
Provide at least 96 hrs. written notice to patient or substitute decision maker
Consider, where reasonable, providing written notice to surrogate
If Patient/Substitute Decision Maker/Surrogate identify a physician willing to assume care of the patient, such transfer of care must be facilitated where possible
Physician must either provide treatment or facilitate transfer of care to another physician who will do so
Notice Period Elapses AND
Patient's care not transferred
No legal intervention to prevent W/W LST
LST is withheld or withdrawn

NOTICE OF INTENTION TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING TREATMENT
(please print)

PATIENT INFORMATION:

Name: _____

Location: _____
(identified by name and address of facility and location within facility)

Diagnosis: _____

TREATMENT INFORMATION:

Description of treatment
to be withheld or withdrawn: _____

_____

_____

Location at which
treatment will be
withheld or withdrawn: _____
(identified by name and address of facility and location within facility)

Date and time at which
treatment will be withheld
or withdrawn: _____

PHYSICIAN INFORMATION:

Name: _____

Address: _____

Telephone
Number: _____

NOTIFICATION INFORMATION:

Name of person to whom
notice has been given: _____

Date and time notice given: _____

Name of the person who
provided the notice: _____

Best End of Life Practices

- Once the decision has been made to change treatment modality from one of aggressive treatment to EOLC, the primary goal becomes ensuring that the patient remains comfortable and is treated with dignity in his/her final hours of life
- There is wide variation in how the transition to comfort measures only/end of life is managed by members of the care team

- Nursing and EOLC: Incorporating EOLC discussions into new staff orientation would ensure that all team members have a clear image of what EOLC looks like in our ICU
- It has also been suggested that continuity of care when patients are approaching end of life is extremely important to both patients and their families

•Millner, P., Paskiewicz, ST., & Kautz, D. A comfortable place to say goodbye. Dimensions in Critical Care Nursing. 2009; 28(1):13-17.

- There have been several groups in the ICU collaborative that have instituted the use of Bereavement cards that are sent to the family after their loved ones has died during their ICU stay.
- It is worth exploring whether we should revise our Comfort Care Orders. Many centres have a specific section on the management of removal of ventilatory support.

Thinking Outside the Box?

Journal of the New Zealand Medical Association, 18-June-2004, Vol 117 No 1196

Caring for patients and families at the end of life: withdrawal of intensive care in the patient's home

Sue Mann, David Galler, Pamela Williams, Paul Frost

Abstract

Aim To describe our experience of transporting 17 intensive care patients home to die.

Design A brief report.

Setting Mixed medical/surgical intensive care unit (ICU).

Results After discussions with their families, 17 adult patients in whom ongoing care was deemed either inappropriate or futile were transported home. Once there, intensive care modalities of ventilation and vasopressor therapy were withdrawn. The patients were sedated initially with intravenous morphine and if death was not immediately imminent, subcutaneous morphine was administered. In these cases where death took longer than 2 hours, the patients were managed with the assistance of district nurses, the family general practitioner, or staff from the South Auckland Hospice.

Conclusions All the patients in this report were Maori or Polynesian and all families reported this as a positive experience. Since completion of this report, we have taken our first European patient home to die.