

# End-of-Life Care in ICU: A Practical Guide

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## Abstract

Proper critical care training and management rests on 3 pillars—evidence-based patient care, proficient procedural skills, and compassionate end-of-life (EOL) management. The purpose of this manuscript is to provide a practical guide to EOL management for all bedside practitioners. The manuscript outlines not all but some fundamentally important ethical concepts and provides helpful rules and steps on end-of-life management based on my own personal experience and practice. Moreover, nowhere in the rigorous training of critical care or hospitalist physicians do we teach the procedure for removal of life-sustaining measures. Like any other procedure in medicine, it requires preparation, implementation and conclusion, as well as supervision and repetition to become proficient. Therefore, at the conclusion of this paper, an attempt is made to correct this lack of training by providing such outline and a guide.

## Keywords

end-of-life care, futility, resuscitation, communication, withholding treatment, withdrawing treatment, death

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## Introduction

Proper critical care training and management rests on 3 pillars—evidence-based patient care, proficient procedural skills, and compassionate end-of-life management. The last of these 3 continues to be the weakest. There are several reasons explaining this. One, we are concerned that the patient's death will get us into administrative or legal trouble, not realizing that a wrongful life could be as much of a legal problem as a wrongful death.<sup>1</sup> Two, we dislike talking about death. We rarely use the word *death* in conversations with patients and families. Many of us feel stressed and uncomfortable with the topic.<sup>2</sup> And three, formal training in end-of-life skills for critical care physicians is rare, and most postgraduate training programs do not have educational curricula for this training process.<sup>3</sup> As a result, end-of-life management in an intensive care unit (ICU) is sometimes considered an additional or an optional but not an integral part of critical care management. The misconception is that discussion about end-of-life choices is abstract, and therefore anyone can engage in such abstract discussion. But in an ICU setting, discussions about end-of-life are no longer abstract or intangible. Death may be imminent, and facing that fact becomes a key component of treatment plan.

This paper attempts to provide the reader with some fundamental ethical concepts of bedside end-of-life management as well as provide a practical guide of steps and processes I have been using in my practice that have proven quite successful in our setting.

## Concepts

### *Medical Futility vs Inappropriate Treatment*

One of the more important clarifications is to understand the difference between “medical futility” and “inappropriate treatment.”

The definition of the term “medical futility” comes from the translation of the Latin word *futilis*, which means *failing of the desired end through intrinsic defect*. In other words, the inability to conquer the disease is not due to extrinsic problems such as inappropriate technology or physician's ability, but is the result of the irreversible changes caused by the disease process. In 1990s, attempts were made to clarify medical futility even further by dividing futility into 3 categories: qualitative, quantitative, and physiologic.<sup>4</sup>

“Qualitative” futility, which is based on a quality-of-life judgment, declares futility when the quality of benefit an intervention will produce is exceedingly poor. “Quantitative” futility, which involves a judgment about what probability of success is reasonable, declares futility when the likelihood that

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an intervention will benefit the patient is exceedingly poor. And “physiologic” futility describes treatments that will not achieve physiologic goals, for example, mechanical ventilation would be deemed as futile only when it could no longer achieve blood gas values compatible with life. Each of these approaches has limitations. To minimize these inconsistencies in the definition of futility, the Society of Critical Care Medicine’s Ethics Committee made the following consensus statement in 1997—*only treatments that offer no physiologic benefit to the patient thus will not accomplish their intended goal, should be labeled “futile.”*<sup>5</sup> In summary, if the treatment does not or could not meet the goal, it is deemed futile, no matter what the goal is. To make this point clearer, let us use an example of an elderly patient with debilitating dementia requiring 24/7 assistance who developed a severe pneumonia requiring mechanical ventilation support. If the goal for the hospitalization, expressed by the next of kin, is to return him to a fully functional and independent living, then any treatment—eg mechanical ventilation, antibiotics, hydration, nutrition—can be declared to be futile since it will not meet the desired outcome. But if the family’s goal is to merely keep him alive irrespective of his quality of life, then declaration of futility cannot be made, because those interventions would be effective in achieving the goal. Nevertheless, the treatments maybe deemed inappropriate, because they represent inappropriate use of scarce resources, not to mention the harm they will cause to the patient.

The study case above has been simplified to make clear differentiations between futility and rationing. But frequently, the task of differentiating the 2 becomes daunting.<sup>6</sup> Clear-cut futility cases remain infrequent. The key difference lies in the question they ask. Futility asks the question “will the intervention work?” whereas rationing concerns the question “is the intervention worth it?” Whether inappropriate treatment is family or physician driven, it ultimately contributes to ever more increasing health care costs. Total health care costs in the United States (US) reached \$2.2 trillion in 2007, 16.2% of the Gross Domestic Product (GDP), even though the average annual percentage growth has been steadily decreasing since 2002.<sup>7</sup> Knowing that 35% of all health care expenditure is due to hospital care and assuming that at least 10% of hospital care is provided in ICU, the conservative estimate is that ICU cost is close to and may exceed \$220 billion a year.<sup>8</sup>

There are several explanations to the high cost of critical care in the United States. First of all, it is characterized by a very high ratio of resources used per patient treated. Second, ICU utilization has steadily risen in recent decades, driven by an increase in beds and occupancy.<sup>9</sup> Some of the resource overutilization can be explained by the fear of litigation on the part of the physician and defensive medicine. It is estimated that malpractice costs, including defensive medicine, account for at least \$100 billion a year in health care costs.<sup>10</sup> And lastly, it is because ICUs have transformed to become the expected place for the sick to die. The culture of dying, especially for the elderly, has changed from death being a family event to becoming a hospital and frequently an ICU routine. The high cost of ICU then could be deemed acceptable if the death was

comfortable and dignified. The alarming truth was uncovered by the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT). This landmark study followed a large cohort of critically ill patients with a predicted 6-month survival probability of only 52%. The SUPPORT investigators found that despite an intervention designed to improve end-of-life care, many patients who died did so not only at great expense but also after spending at least 10 days in the ICU comatose, receiving mechanical ventilation, with do-not-resuscitate (DNR) orders written 2 days before death, and in pain.<sup>11</sup> This further demonstrates the need in end-of-life education not only to avoid unnecessary cost but more importantly, unnecessary pain and suffering.

### Resuscitation vs Treatment

The second end-of-life concept in need of clarification is the difference between resuscitation and treatment.

Resuscitation implies certain measures undertaken at the time of arrest to restore vital functions. In discussing resuscitation, a particular emphasis must be made on the all-encompassing nature of cardiopulmonary resuscitation (CPR) measures. These include chest compressions, intubation and mechanical ventilation, defibrillation, and the full arsenal of Advance Cardiac Life Support (ACLS) medication. The rule to follow during in-house resuscitation, and to explain to the patients and their families, is “All or Nothing.” For example, the family cannot request to have all measures be applied except for chest compressions (some families describe it as brutal). All the measures will have to be taken as medically determined by the physician at the time of resuscitation or no resuscitation will be offered. As Miller and Brody stated, “physicians in clinical practice have a duty to promote the medical best interests of patients by offering optimal medical care.”<sup>12</sup> And such selective, fractured, and limited resuscitation will not be consistent with the duty of the physician to provide competent care. The same way, the physician cannot provide competent care while denying a septic patient fluid resuscitation, because the family requested so, and only continuing with antibiotics and pressors.

A true representation of the CPR process and survival probability should be provided to families to make an informed decision, understanding that the families have a fictitious perspective of the CPR process and unreasonable expectations, both promoted by our modern culture and more specifically by television. From 60 occurrences of CPR in the 1997 television episodes on 3 major medical programs—*ER*, *Chicago Hope*, and *Rescue 911*—only 28% were due to primary cardiac causes. Sixty-five percentage of the cardiac arrests occurred in children, teenagers, or young adults. Seventy-five percentage of the patients survived the immediate arrest, and 67% appeared to have survived to hospital discharge. These are the expectations of our public.<sup>13</sup> But the reality is much less optimistic. The data from the 2002 Canadian study shows that of already hospitalized patients whose arrests were witnessed, 48.3% were able to be resuscitated, 22.4% survived to discharge, and 18.9% were able to return home. Survival was

highest after primary respiratory arrest and lowest after pulseless electrical activity (PEA) or asystole. Of the patients with unwitnessed arrests, 21.2% were able to be resuscitated, but only 1.0% survived to hospital discharge and was able to return home. This patient survived an unwitnessed respiratory arrest. No patient who had an unwitnessed cardiac arrest survived to discharge. Survival was significantly decreased after pulseless ventricular tachycardia or ventricular fibrillation arrest and even more so after PEA or asystole arrest than after respiratory arrest.<sup>14</sup>

Death is unfortunately a common occurrence in the intensive care unit (ICU); a recent study suggests that approximately 20% of deaths in the United States occur after a stay in the ICU.<sup>15</sup> Families need to know these odds and understand that the goal of CPR should be to “reverse premature death and not prolong inevitable death.”<sup>16</sup>

Treatments are measures and procedures that are intended to relieve or ameliorate illness or injury at any time other than the time of arrest. Some of these measures can be used interchangeably as resuscitation or treatment. For example, intubation and mechanical ventilation initiated as part of ACLS on a patient who just suffered a cardiopulmonary arrest will be considered to be resuscitation, while the same intubation and mechanical ventilation becomes a treatment measure in a case of worsening respiratory distress or failure due to severe pneumonia. Hence, during end-of-life discussions with patients or their surrogates, a differentiation of the 2 must be made and discussed separately. For example, the fact that some patients will choose not to be resuscitated does not necessarily mean that they will also decline intubation as a treatment, if that treatment has a reasonable possibility of reversing the underlying problem. Moreover, the “health care professional has an obligation to allow a patient [or surrogate] to choose from among medically acceptable treatment options. . . or to reject all options.”<sup>17</sup> Medically acceptable treatment options are those that, given available medical evidence and expert clinical opinion, are consistent with the physician’s duty to provide competent care to the patient.

In cases when the treatment is medically acceptable and the probability of reversal is reasonable, it is advisable to establish the timeframe and duration of such treatment. For example, if in most cases the expected turnaround time on mechanical ventilation is 1 week, give the patient that information and inform of the alternatives in case the condition has not improved in that 1 week. One option to present will be prolonged mechanical ventilation and tracheostomy, while the other, withdrawal of mechanical ventilation and institution of comfort measures.

These wishes then can be differentiated into 3 levels of care. In my institution, the consensus is to use these levels for both adult and pediatric patients and describe them as: Maximal Care, Directed Care, and Comfort Care. Here are how they are defined:

**Maximal care.** The patient will receive all appropriate treatments and all appropriate resuscitation measures, including advance life support in the event of cardiopulmonary arrest.

**Directed care.** No resuscitation measures will be initiated in the event of cardiopulmonary arrest. Treatment measures to be initiated prior to cardiopulmonary arrest will be determined after discussions with the patient or patient representative.

**Comfort care.** No resuscitation measures will be initiated in the event of cardiopulmonary arrest. All treatments will be palliative, focused on pain relief and comfort.

For standardization and completeness sake, in addition to encouraging documentation of all conversations in the chart, a Level of Care order form was created and is now used city-wide in Bakersfield, California—see Addendum 1.

## Rules

### Seven Rules of Communication

Prior research focused on patients’ and families’ needs specifically in the ICU setting has established repeatedly that communication with caregivers is one of the most highly valued aspects of care,<sup>18-24</sup> particularly for dying patients and their families.<sup>25-33</sup> And despite this knowledge, training for such remains scarce.

In preparation for family meetings, there are 7 rules that I follow in my practice.

#### 1. Arrange to meet in a private room

Prepare an appropriate size room to accommodate all members of the family. Having the entire family present will eliminate the possibility of misunderstanding or misinterpretation of what was said, as well as misperception by the members of the family that were arbitrarily excluded that they are not important. This will also give the physician a good understanding of family dynamics and will help to anticipate problems before they arise. The room must provide privacy, be quiet, and be well-stocked with facial tissue.

#### 2. Identify next of kin

During the first meeting, introduce yourself and all the members of your team present in the room, then ask the family members to introduce themselves and their relationship to the patient. By doing this you will meet the necessary rules of civility as well as differentiate the immediate family from the extended one. You will then establish the legal (based on your state’s definition) next of kin. If the legal next of kin is not comfortable with this role, another may be appointed by the family instead. In some cases, a dilemma might arise when the legal next of kin had very little interaction with the patient over the years, and the only person who knew the patient well was let us say a friend. For especially these and all other cases, the physician must establish above all what the patient’s wishes were if known, or what the family believes their loved one would want to do in this situation. Thus, families should be asked, “what do you believe [your loved one] would choose

if she could speak for herself?” or, “If [your loved one] were sitting here now, what do you think he would say?”<sup>34</sup> Focusing on these questions will provide you and the legal decision maker with the necessary information from the person who knew the patient well. This is particularly important as, anecdotally, family members report feeling guilt over being asked to make life-and-death decisions for their loved ones. Asking, “what do you want us to do for your mom?” may intensify these feelings, as opposed to, “what would your mom want to do if she could choose?” Moreover, empirical data suggest that family members more accurately predict their loved one’s wishes when they are asked what their loved ones would want.<sup>35</sup>

It is not uncommon to be faced with situations when the legal and the moral surrogates disagree. The most effective measure in this conflict, based on my experience, is first, to keep reorienting the family on the importance of following the patient’s wishes, and second, to schedule daily meetings and provide continuous communication between the multidisciplinary ICU team members—RNs, RTs, house staff, social worker, to assure consistency in the message the family will be receiving from each and every member of the team, remembering that some family members of a dying patient need adequate time to prepare for the death of their loved one.<sup>36</sup> The goal is to reach a decision that all members of the family are satisfied with. The tragedy of critical illness and impending death must never become a reason for family conflict or feud but should bring the families closer. The duty of the physician at this time is not only to the patient but also to the family.

Family members who made a decision to withdraw life-sustaining efforts reported greater feelings of support during end-of-life decision making and higher satisfaction with end-of-life decision making. This finding suggests that being involved in this decision may be an important aspect of satisfaction with the decision-making process. These results could be related to the family accepting the inevitable, preparing for their loved one’s death, and having some sort of control in this situation.<sup>37</sup>

In most difficult cases, when this conflict becomes damaging to the patient—due to prolonged pain and suffering—mediations by ethics consultants or societal adjudication (eg, the courts) will be required to determine who is the most appropriate surrogate.<sup>38</sup>

### 3. Commit time

Communication successes and failures generate more gratitude and complaints than any other aspect of end-of-life care.<sup>39,40</sup> Therefore, the physician should first arrange his duties in such a way that will allow the ICU team to have at least 30 minutes of protected time to spend with the family, knowing that in some cases the conference may last over an hour.<sup>41</sup> And secondly, a consideration for the family should be paramount, since most of them probably work, have child-care responsibilities, are dependent on others for transportation, etc, and will not be able to come to the hospital at the drop of

the hat, without accruing even further financial or social difficulties. The time for the family conference, therefore, must be mutually agreeable for both parties.

During the end-of-life conferences, address the following 5 objectives, summarized by the mnemonic VALUE: to value and appreciate what the family members said, to acknowledge the family members’ emotions, to listen, to ask questions that would allow the caregiver to understand who the patient was as a person, and to elicit questions from the family members and confirm understanding. Longer meetings in which families had more opportunities to speak and to express emotions, felt more supported in making difficult decisions, experienced more relief from guilt, and were more likely to accept realistic goals of care, may lessen the burden of bereavement.<sup>42</sup> In summary, listen to them.

### 4. Do not intimidate

A recent survey on patients’ perspectives on ideal physician behaviors validated the following 7 themes. The ideal physician is confident, empathetic, humane, personal, forthright, respectful, and thorough.<sup>43</sup> There is clearly a desire by our patients to have a combination of a competent and at the same time a comforting physician. It is hard to appear comforting, when the physician does not take time to sit down and listen, discusses devastating news in a hallway, leaning on the wall, or talks down to the family by standing over them. Use all possible measures to make sure that your eye level is at least the same with the family’s. Make arrangements to have enough chairs in the room, or even kneel next to and hold the hand of patient’s elderly mother who is in a wheelchair, for example.

Moreover, I am in a complete agreement with Dr Ayan Panja, who wrote “Even though there is something instantly recognizable and predictably professional about a doctor in a white coat, it can act as a communication barrier between doctors and patients. Is there something intrinsically authoritarian, even intimidating, about such a uniform? I am not sure that the white coat makes doctors any more approachable.”<sup>44</sup> Though in many cases the white coat adds to the role of authority that a primary physician needs to hold to promote a healthier lifestyle in his patients, in an ICU, wearing a white coat creates a barrier. The families tend to open up easier when the intimidating factors are minimized. Let us remember that families have been experiencing emotions of pain, stress, guilt, and fear by seeing their loved ones become unrecognizably changed while intubated, ventilated, edematous, attached to numerous machines that constantly alarm. Not having a white coat anxiety adding to the overwhelming stress of the critical care environment I find to be a very positive contributor to good physician-family relationship.

### 5. Ensure quality interpretation

It is always advisable to employ a qualified translator for any communications with patients and families. This will ensure compliance with stringent regulatory laws, including

HIPPA, as well as will minimize further stress on the family, when one family member, who happens to speak both languages, is placed in a terrifying position of becoming the bad news bearer. And, moreover, it should never be a child. Very commonly, the first generation immigrants do not speak English well or at all, but their children are bilingual and fluent in both. Avoid the temptation of using a 10-year-old child as your messenger of impending death, especially when the dying person is his parent. Furthermore, be on your guard for using another health care provider who is bilingual but not a credentialed interpreter. Once, when I was using a native Spanish-speaking resident to translate for me, I realized that the translation of my word “death” was fudged around. I have enough Spanish to expect to hear the word “muerte,” but did not. The resident stated that she felt the word “death” was too cruel and changed it to, in her opinion a more appropriate phrase, “heart will stop.” The interpreters you use must understand that you require a verbatim translation, and that they have no artistic license to change the intended meaning of your statement.

#### 6. Solicit spiritual support

Religious faith may be an essential part of coping with illness and death for many patients and families, affecting the quality of life if not medical outcomes.<sup>45</sup> In ideal circumstances, the hospitals will ensure a partnership between physicians and professional chaplains. Board-certified chaplains have graduate-level theological and clinical training that enables them to assess a patient’s faith system and religious practice and help the patient use that faith in coping with illness.<sup>46</sup> In all other cases, where no hospital chaplain is available, invite the family to bring their own religious/spiritual leader to the end-of-life conferences. Having the spiritual support from the beginning will ensure that the care provided is truly patient and family centered, respecting the beliefs and customs of patients and families. It might help you better understand when a conflict might occur between goals of medical treatment and patient values/beliefs, and more importantly, help patients and families draw upon resources that might help them cope with unrelieved physical pain or other symptoms and/or to identify nonphysical causes of this pain. And finally, it will help bring comfort and meaning, and facilitate closure or transition at the time of death.

#### 7. Affirm nonabandonment

One of the biggest fears that our patients and their families have is based on a misconception that a Do Not Resuscitate order equals a Do Not Care one. This notion must be clearly and loudly repudiated. Even when modern medicine is helpless to provide a cure, the care will and should continue. At all cost, avoid phrases such as “there is nothing more we can do for you.” Even in most tragic cases, when we cannot address the cause of the devastating illness, we can do a lot to address its consequences—pain, nausea, constipation, etc. The families need to know the truth about the prognosis of the disease, but

they must be assured that they will not be left alone, abandoned. The better phrase to use is “even though we cannot do much to reverse the problem and cure your loved one, we can do a lot to make sure that he is not in pain, and that he is comfortable.”

### **Withdrawal of Life-Sustaining Measures: How to do it?**

Since medical school, we have been taught clinical exams and procedures in a most methodical and organized manner. Some of us with more gray hair practiced percussion and peripheral line placements on our classmate, and the younger generation has gotten more sophisticated simulation manikins to practice pelvic and breast exams, central line placement, and pericardiocentesis. But nowhere in this rigorous training do we teach the procedure for removal of life-sustaining measures. Like any other procedure in medicine, it requires preparation, implementation, and conclusion, as well as supervision and repetition to become proficient.

#### *Step 1: Preparation*

By now you have prepared the family about the poor prognosis and have identified the patient’s wishes. It will help to outline to family in most simple terms what will be done and how, as well as what the expected length of survival will be. In some cases, the survival time is very easy to predict. If the patient is on 100% oxygen, difficult to ventilate, on 3 vasopressors, and is still hemodynamically unstable, you may confidently state to the family that the time will be brief. Short of these terminal cases, avoid making rigid predictions. Give families a wide time range to avoid the feeling of guilt on the part of the family about the decision they made as well as of distrust for the medical profession, if your prediction fails. The family might consider that they did not give their loved one the opportunity to survive if the patient expired on day 3 after withdrawal of treatment and not after 20 minutes as the doctor predicted. Next time they will not be so trusting.

It is advisable to obtain a unanimous agreement on withdrawal of treatment measures from the entire family. All conversations with family should be well-documented in the medical record. Accommodate the patient’s last wish if known and possible, and provide the family with a reasonable timeframe for the withdrawal to take place. It is acceptable to postpone the withdrawal by 1 day, for example, to allow a brother to arrive from another town.

In the beginning of the preparation stage, your local Organ Procurement Organization (OPO) must be contacted to evaluate the patient for a possible Donation After Cardiac Death (DCD). If the patient is deemed a candidate, the physician must introduce the OPO representative to the family during one of the meetings but not initiate the donation conversation or remain in the room for the fear of being perceived to have a conflict of interest.

## Step 2: Implementation

Families should be given ample time to spend with the patient; limitation for visitation rules, which some ICUs (mine included) still have, should be lifted for this purpose and as many family members as the room allows should be permitted in to see the patient. After all good byes are said and all spiritual requirements have been met, the family is asked to step out. All life-sustaining and nonpalliative measures such as mechanical ventilation, vasopressors, nutrition, and antibiotics are removed after providing appropriate comfort measures, and before the family is allowed back to the room. My personal preference is not to have families in the room during the withdrawal process. The act of removal of the endotracheal tube that has been there for 2 weeks, followed by a removal of an endogastric tube, followed by not so pleasant secretions and immediate noisy aspiration with a Yankauer suction device might turn many strong stomachs upside down. Minimize all stressful events during this procedure. I usually inform family members who wish to be present at withdrawal that “I want their last memory to be of the patient and not of the doctor removing tubes – it is a better memory to live with”.

It is most important during this stage that the patient receives appropriate pain control before life-sustaining measures are withdrawn. Discontinuation of mechanical ventilation should take place only after perceived comfort is achieved. If the patient is rapidly declining, bring the family in immediately to allow their presence at the time of death, if they so desire. Otherwise, if time allows, first prepare the room by removing unnecessary equipment and providing more chairs. Lower the side rails of the patient’s bed, dim the lights, and cover the patient with fresh sheets or blankets to emulate a family-friendly bedroom ambiance. Most close family members will hold the dying patient’s hands and kiss the face; therefore, wash the patient’s hands and face with a warm washcloth. Lastly, position the patient’s head in such a way as to minimize the rattle.

A question arises regarding this process: “Is allowing one to die the same as *mercy killing*? And which of these two do we routinely practice in our ICUs when life-sustaining care is

withdrawn?” Though the 2 actions are similar in result – death, they are not the same in process or in proximate motivation. In the case of allowing to die, the cause of death is an existing irreversible pathology, which is allowed to reach its natural effect without undue and painful prolongation. In mercy killing, the cause of death is a pathology induced by the mercy killer, be that an injection of air or a pistol shot. In other words, mercy killing can be viewed as an act of violence against another person. Undoubtedly, allowing a patient to die and making that process pain free carries no violence of intent or action.

## Step 3: Conclusion

When all above measures have been taken, guide the family back into the room with the nurse at the bedside. Observe the patient and provide comfort treatments and measures at the bedside. Even if the patient appears comfortable to you, confirm this perception of comfort with the family and address their concerns appropriately. After the ICU team and the family are in agreement about comfort, give the family the privacy they need. Usually, in the first step of this process, I indicate to the family that in the event the patient remains comfortable and stable for an extended period—say, several hours after removal of life-sustaining measures—we will make arrangements to find a private room on a regular medical/surgical floor in order to give families more flexibility and privacy. This arrangement also helps with appropriate ICU resource utilization. All these steps are intended to allow the patient to die the most dignified and painless death.

Irrespective of semantics on death and dying only this forever holds true:

*Of all the wonders that I yet have heard,  
It seems to me most strange that men should fear;  
Seeing that death, a necessary end,  
Will come when it will come.*

William Shakespeare, Julius Caesar

Make it come peacefully . . .

### Appendix I. Physicians Orders—Level Of Care Status

Only checked orders will be implemented:

<p><u>Required</u></p> <p><input type="checkbox"/> I have fully discussed level of care status with the patient and/or surrogate decision maker.</p>
<p>CHECK DESIRED LEVEL OF CARE STATUS</p>
<p><input type="checkbox"/> 1. MAXIMAL CARE STATUS All appropriate treatments and resuscitation measures to be provided, including Advanced Life Support (ACLS, PALS, NRP)</p>
<p><input type="checkbox"/> 2. DIRECTED CARE STATUS</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> NO RESUSCITATION: No resuscitation measures to be taken. No CPR or Advanced Life Support (ACLS, PALS, NRP)</p> <p style="margin-left: 20px;">TREATMENT: The treatments indicated with a check mark below may be provided at any time other than the time of arrest:</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Intubation  <input type="checkbox"/> Short-term mechanical ventilation – Specify time frame _____  <input type="checkbox"/> Mechanical ventilation (long-term)  <input type="checkbox"/> Drug treatment of dysrhythmia with pulse  <input type="checkbox"/> Electrical treatment of dysrhythmia with pulse  <input type="checkbox"/> Hypotension treatment with vasopressors  <input type="checkbox"/> Lab studies  <input type="checkbox"/> Blood products/transfusions  <input type="checkbox"/> Artificial nutrition  <input type="checkbox"/> Patient specific requests _____                 </p>
<p><input type="checkbox"/> 3. COMFORT CARE STATUS</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> NO RESUSCITATION: No CPR or Advanced Life Support (ACLS, PALS, NRP)</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Treatment: Comfort measures only</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Pain relief</p> <p style="margin-left: 20px;">Additional palliative measures will be provided as ordered:</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Artificial hydration  <input type="checkbox"/> Artificial nutrition                 </p>

Attending Physician's Signature: \_\_\_\_\_

Date                      Time

Noted by: \_\_\_\_\_

Date                      Time

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