

When death is imminent, can life be improved?

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Intensive care provides patients with treatments which sustain life despite severe organ dysfunction. Provision of life sustaining treatment is thus the primary aim of admission to the intensive care unit (ICU). However despite the technologically advanced care provided, data from the UK reveal that 15-25% of those admitted will die in the ICU and 10-20% of the general population will also die in ICU.¹ Furthermore, the Ethicus study showed that 70% of patients who die in ICU do so following the withdrawal or withholding of treatment.² These figures indicate that a majority of deaths in ICU are 'expected deaths' highlighting the importance of providing high standards of care aimed at an improved quality of life up until the time of death.

In the ICU we encounter patients who are curable, at the end of life or actively dying. Management of the former is what we have all been trained to do. The patient at the end of life is by definition 'likely to die within the next 12 months'.³ A patient who is actively dying is in 'the hours and days preceding imminent death during which time the patient's physiological functions wane'.⁴

In the curable patient, clinical management targets physiological goals and definitive treatment of the underlying pathology. Patients who are at the end of life however need entirely different targets focusing on patient and family centered care, which forms the basis of palliative care. The definition of palliative care by the WHO states that it is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of

suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'.⁵ The emphasis of palliative care is to relieve suffering in patients with any serious illness. It can be commenced in conjunction with life sustaining therapies and aims to provide the best possible quality of life whether or not the patient is going to die from this episode of illness. Contrary to the view that palliative care hastens death, high quality palliative care sometimes prolongs life.⁶

The WELPICUS (Consensus for Worldwide End-of-Life Practice for Patients in ICUs) study sought to develop worldwide professional consensus for key end-of-life issues. The authors felt that 'by being mindful of similarities and differences in end-of-life attitudes, health care professionals might provide better care to their patients and families with different opinions, cultures, and religions. This study showed clear support from clinicians worldwide on the vital importance of palliative care in patients at the end of life and this management approach is now gaining ground in ICU as patients near the end of their lives'.⁶

The WELPICUS study also states that "treatments should only be used if they are consistent with the patient's goals and preferences, and if they offer a benefit to the patient and do not merely prolong the dying process".⁶ There was consensus for initial life-sustaining therapies for patients in the ICU, but that intensivists should not use therapies that only prolong the dying process or offer no benefit. Similarly, the position taken regarding cardiopulmonary resuscitation (CPR) stated that CPR should not be offered if not indicated".

Furthermore there was consensus that, "if a patient's chances of surviving are extremely low or the patient would not want continued life-sustaining treatment, therapy may be

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withheld or withdrawn". As such a patient with capacity can refuse life-sustaining treatments but cannot force doctors to provide life-sustaining treatment where the doctor feels that this is not in their best interests. In Sri Lanka, the former situation is clear, we must uphold the patients wishes. However in the latter there is no current legal provision for a medical practitioner to withhold or withdraw treatment. Limiting life-sustaining treatments therefore remains an ambiguous and contentious topic in Sri Lanka.

In order to provide palliative care services in the subset of patients at the end of life, patients must be correctly identified as being so. Despite the availability of validated prognostic tools clinicians often are unable to accurately prognosticate or identify the dying patient. In the UK and the USA one method adopted is to ask the surprise question – ‘Would you be surprised if this patient died within the next 12 months?’.⁷ The answer ‘no’ triggers a detailed assessment of the patient’s condition followed by referral to palliative care services if deemed necessary. In Sri Lanka, not all hospitals have a formal palliative care service. Thus until such time as these services are widely available a palliative care approach to management should be followed in appropriate patients by all doctors.

The tenets of palliative care include the following:⁸

1. Elucidating the patients goals of care
A conversation to find out the patient’s goals is necessary. A suggested structure for such a conversation is as follows– Ask patients how much they know about their condition, find out what their goals are, find out what their fears are and finally find out how much they would be willing to sacrifice in order to achieve their goals.⁹ This knowledge then can be used as a framework on which to formulate decisions and provide multi disciplinary care for the patient.

2. Symptom management
Common symptoms in the ICU include pain, dyspnoea, thirst, anxiety and sleep disturbances.⁸ Care should be taken to assess these symptoms and to manage them whilst ensuring that the patient’s goals are met, fears

alleviated, values upheld and dignity maintained.

3. Sustained and consistent communication
Prior to communicating with patients or relatives, a consensus should be reached on the clinical management of the patient amongst the multidisciplinary team.¹⁰

The concept of shared decision making should be aspired to where agreement is reached with the patient or surrogate decision maker taking into account the patients values.¹⁰

In patients who have capacity, all communication should be with the patient in the presence of relations or friends whom the patient wishes to be present.¹⁰ In patients who do not have capacity to make decisions, communication should be with the patient’s next of kin and decisions should be made in the patients best interests taking into consideration the advanced directives that may be in place, the patient’s values and wishes.³ Unless a surrogate decision maker has been formally appointed, next of kin, other family members or carers cannot give consent on behalf of the adult lacking capacity.³ However, it is always advisable to consult with them and keep them informed and in some countries it is a legal duty to do so.

In Sri Lankan culture communication with family members may prove to be complex due to large numbers of close relatives. The appointment of one or two designated family representatives agreed upon by the patient early in their illness or by the majority of family members may help to avoid conflict.

4. Spiritual support for patient and family
Attending to the spiritual needs of the critically ill patient is associated with improved quality of life and many patients view this as an important part of their overall medical care.⁸ In Sri Lanka, religious arrangements are often made by the patients’ family and the ICU staff should accommodate this as far as possible.

5. Coordination across sites of care
In patients who are to be transferred out of the ICU meticulous handover of all relevant

information should be done and appropriate care arranged in advance at the destination. The Sri Lanka Medical Association and Ministry of Health, Nutrition and Indigenous Medicine of Sri Lanka have set up committees on palliative care to formulate guidelines and protocols for the incorporation of palliative care to everyday practice in Sri Lanka. These guidelines will hopefully also provide a legal framework for making key end of life care decisions including limitation of treatment, do not attempt CPR, consent, surrogate decision makers and assessing mental capacity.

As anaesthetists and intensivists we must develop a model on how best to implement a palliative care pathway within critical care to ensure enhanced care aimed at providing an improved quality of life for our patients as death becomes imminent.

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