ESRA Italian Chapter

XXVIII CONGRESSO NAZIONALE

Uno sguardo verso il Mediterraneo
Il Rischio Clinico

Withholding - Withdrawal in ICU

Prof. Andrea Cortegiani, MD
Di.Chir.On.S. University of Palermo
Department of Anesthesia Intensive Care and Emergency
University Hospital Policlinico Paolo Giaccone, Palermo, Italy

andrea.cortegiani@unipa.it

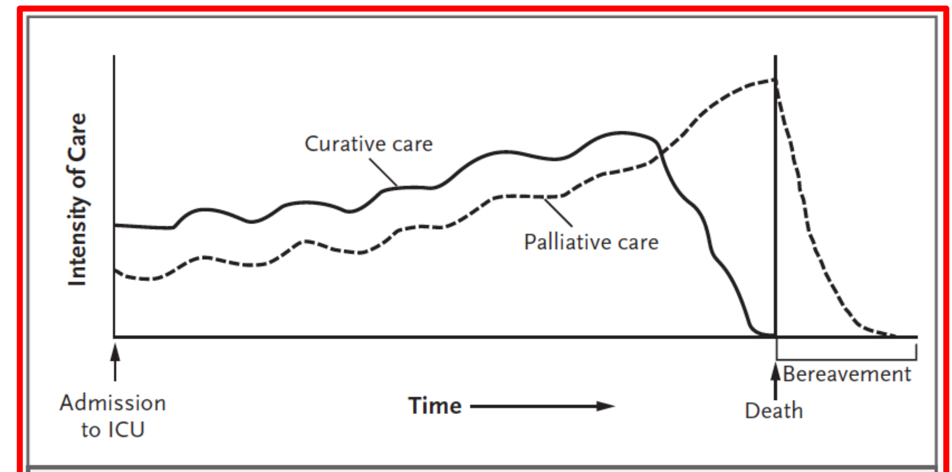
SIAARTI Scientific Committee 2022-2024 - Chair

Palliative Care in ICU Key Components

- Symptom assessment and management
- **Shared decision-making**
- Communication about prognosis and treatment options
- **High-quality End-of-Life Care**
- Post-ICU transition

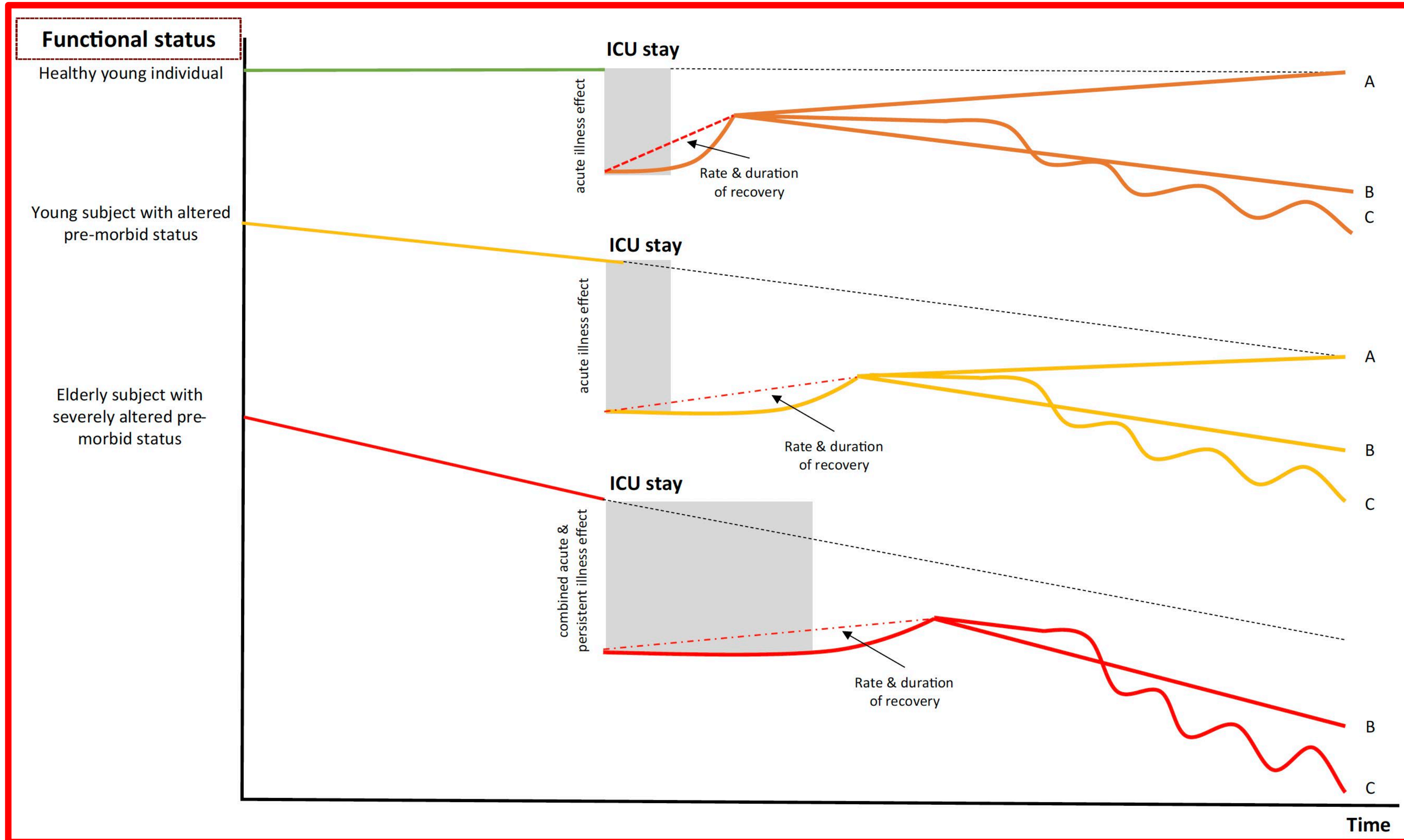
Curtis R et al ICM 2022
Edwards JD et al ICM 2016

*«The **coexistence** of **Palliative care** and **Critical Care** may seem paradoxical in the technological ICU. However, **contemporary critical care** should be as **concerned with palliation as with** the prevention, diagnosis, monitoring, and treatment of **life-threatening conditions.»***



Cook D et al NEJM 2015

Trajectories of recovery with Interaction between pre-ICU status



Trajectories of recovery

- Big Hit
- Slow burn
- Relapsing recurrencies

Latronico N et al Intensive Care Med 2017

Iwashyna T AJRCCM 2011

Seeking Worldwide Professional Consensus on the Principles of End-of-Life Care for the Critically Ill

The Consensus for Worldwide End-of-Life Practice for Patients in Intensive Care Units (WELPICUS) Study

Charles L. Sprung[1], Robert D. Truog[2], J. Randall Curtis[3], Gavin M. Joynt[4], Mario Baras[5], Andrej Michalsen[6], Josef Briegel[7], Jozef Kesecioglu[8], Linda Efferen[9], Edoardo De Robertis[10], Pierre Bulpa[11], Philipp Metnitz[12], Namrata Patil[13], Laura Hawryluck[14], Constantine Manthous[15], Rui Moreno[16], Sara Leonard[17], Nicholas S. Hill[18], Elisabet Wennberg[19], Robert C. McDermid[20], Adam Mikstacki[21], Richard A. Mularski[22], Christiane S. Hartog[23], and Alexander Avidan[1]

ICU Therapies

Definition

…CPR, endotracheal intubation, mechanical ventilation, vasopressor therapy, total parenteral nutrition, dialysis, blood products, antibiotics, and intravenous fluids.

Consensus

During end-of-life care of patients in the ICU, **interventional therapies may only prolong a patient's dying process without offering benefit to the patient. Under these circumstances, health care professionals should not use these interventional ther**apies, and should discuss with the patient and/or surrogate why these therapies should not be used.

- Modiphied delphi approach to evaluate consensus on 22 end-of-life issued
- 35 Definitions and 46 consensus statments
- 3.049 participants involving ICU physicians and nurses, hematologists, oncologists, gerontologists, hospice and palliative care specialists, ethicists, social workers, clergy, legal experts, media, and patient advocacy groups
- Consensus defined as 80% of 'agree' or 'strongly agree'-

Sprung C et al AJRCCM 2014

Withdrawing Life-sustaining treatment

Definition:
Decision **to actively stop a life-sustaining intervention** presently being given

93%

Consensus
A. If **a medical decision** is made that a patient's **chances of surviving are extremely l**ow or the patient under the present medical circumstances would not want continued life-sustaining treatment, life-sustaining treatment may be withdrawn.

82%

Revised consensus B.
Life-sustaining treatment should generally be withdrawn **only after obtaining agreement of the patient and/or the surrogate decision maker or family.** There are circumstances when withdrawing life-sustaining treatment is permissible (provided it is legal in a given location) **even though agreement cannot be obtained**

77%

Withholding Life-sustaining treatment

Definition:

Decision **not to start or increase a life-sustaining intervention** — 94%

Consensus:

A. If a medical decision is made that a patient's chances of surviving are extremely low or the patient under the present medical circumstances would not want continued life-sustaining treatment, life-sustaining treatment may be withheld. — 84%%

Revised consensus B.

Life-sustaining treatment should generally be withheld only after obtaining agreement of the patient and/or the surrogate decision maker or **family**. There are circumstances when withholding life-sustaining treatment is permissible (provided it is legal in a given location) even though agreement cannot be obtained. — 75%

Active Shortening of the Dying Process

Definition:

A circumstance in which someone performed an **act with the specific intent of hastening death or shortening the dying process**. <u>These acts do not include withdrawing or withholding life-sustaining treatment</u>.

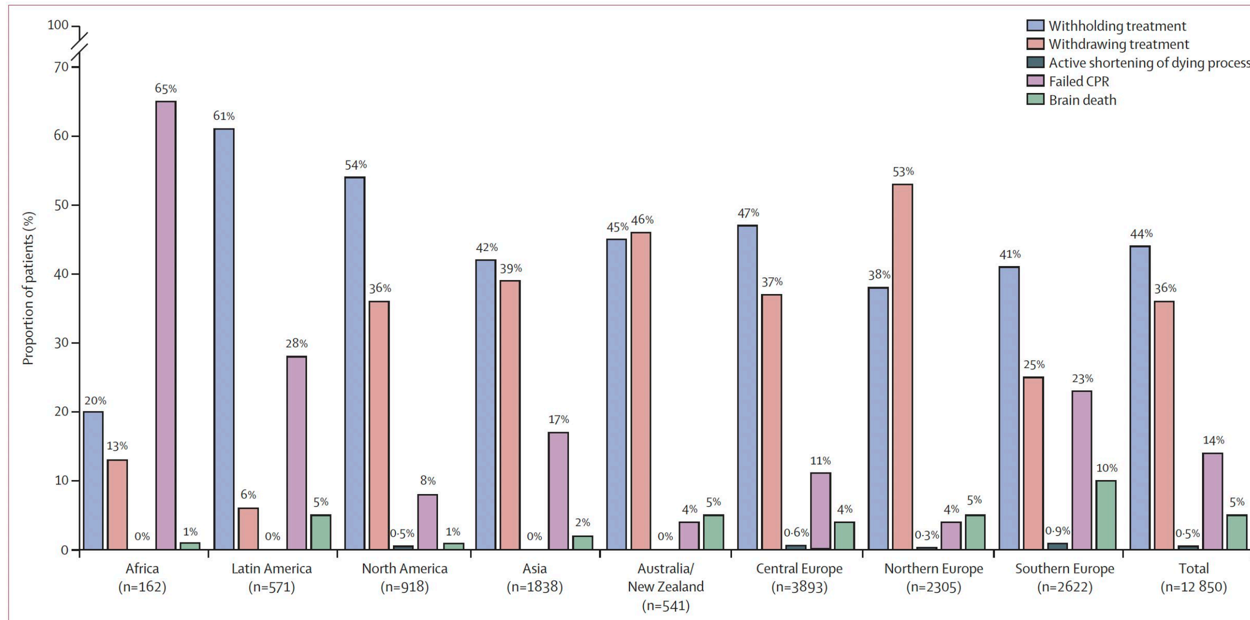
82%

Revised consensus:

When it is determined that a patient's chances of surviving are extremely low, a patient, surrogate decision maker, or family may request the physician to hasten the patient's death even after the physicians have ensured the provision of optimal palliative care. Under these circumstances, <u>**active shortening of the dying process with the intention to hasten death is not permissible even if allowed by law.**</u>

79%

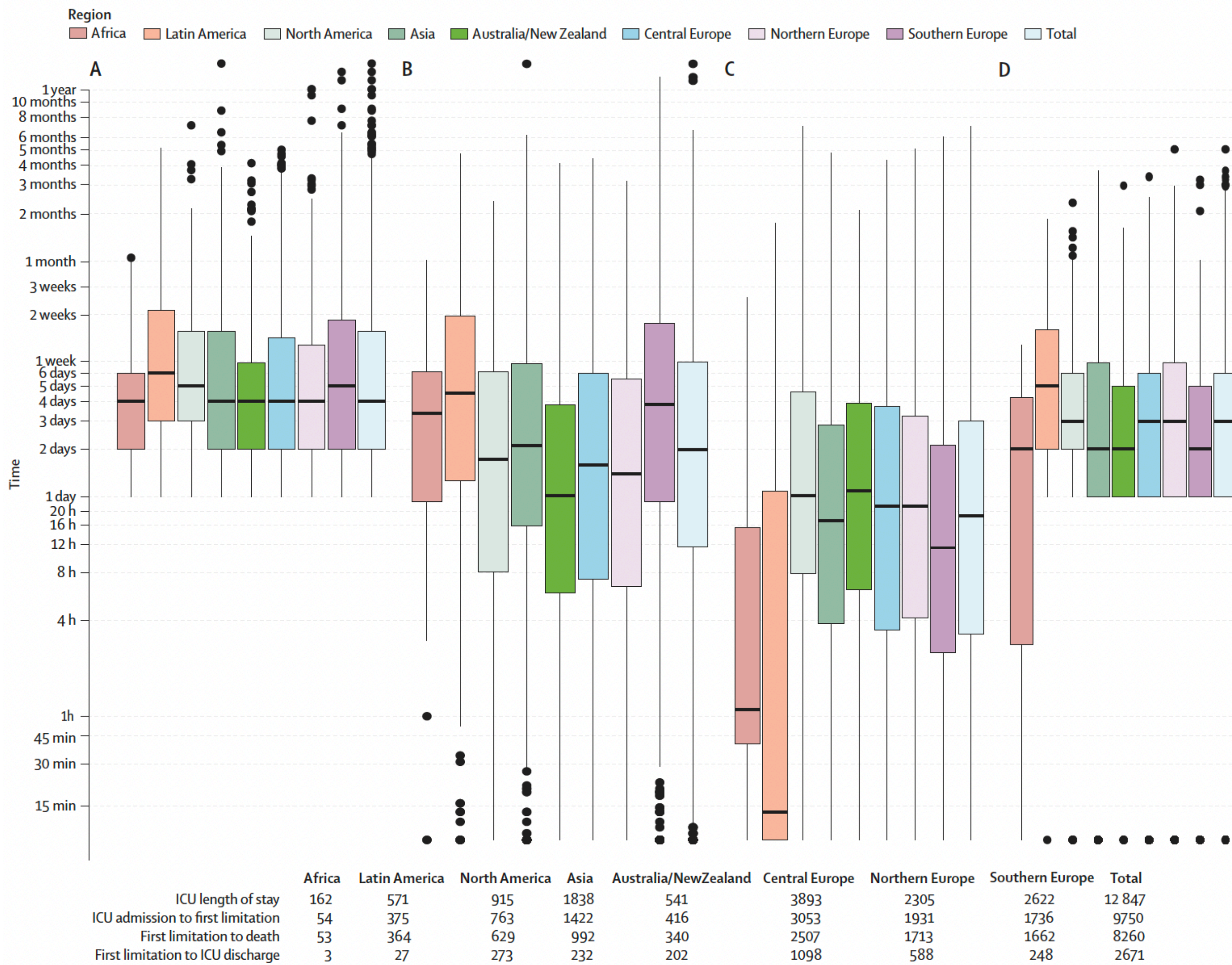
Variations in end-of-life practices in intensive care units worldwide (Ethicus-2): a prospective observational study



Avidan A et al Lancet Resp Med 2021

- Prospective, multinational, observational study performed in 199 ICUs in 36 countries
- **12.850 patients** who died of had limitation of life-sustraining treatments
- **81% of patients received limitation of life-sustaining therapies** (12% of all ICU admission)
- **The most common limitations was withholding life-sustaing treatment (44%),** followed by withdrawal (36%)
- Shortening of the dying process was uncommon across all regions (0.5%)
- Region, age, and diagnoses (acute and chronic), and country end-of-life legislation associated to limitation of life-sustaining treatments

Variations in end-of-life practices in intensive care units worldwide (Ethicus-2): a prospective observational study



- **Median time from admission to first limitation was 2 days**
- Treatment limitations much more common in Northern Europe, Australia/New Zealand, and North America than in Africa, Latin America, and Southern Europe.
- **One in five patients survived treatment limitations till hospital discharge**
- **Southern Europe and Latin America** had the **lower rates of withdrawing, and reluctance to apply limitations (particularly withdrawing)**

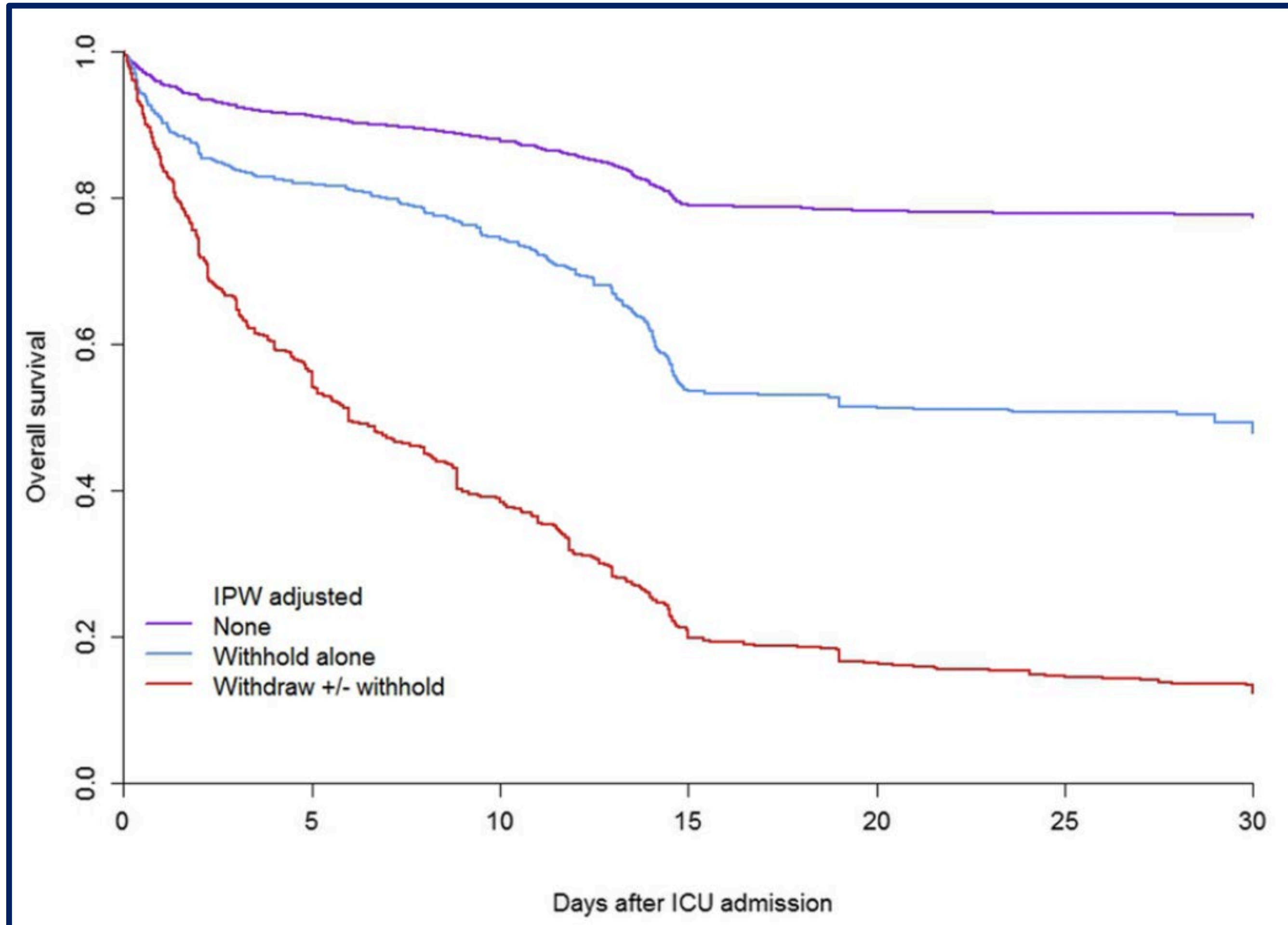
ORIGINAL

Withholding or withdrawing of life-sustaining therapy in older adults ($\geq$ 80 years) admitted to the intensive care unit

VIP-1 Study

- Prospective multicentre international study inclusing ICU patients ≥ 80 years in 309 ICUs from 21 European countries
- **LST** limitation identified in 1356/5021 (**27.2%**) of patients
- **15% had a withholding decision and 12.2% withdrawal decision**
- LST limitation was less frequent in eastern and southern than Northern Europe, lower in more religious countries
- Older age, higher frailty, acute admission and SOFA score significantly associated with more LST limitation

Guidet B et al Intensive Care Med 2018



ICU mortality

- 22 in the overall cohort
- **29% in withholding**
- 82% in withdrawal

30-day mortality

- 33% in the overall cohort,
- **53.1% in withholding**
- 93.1% in the withdrawal

Guidet B et al Intensive Care Med 2018

Withholding and Withdrawing of Life-Sustaining Treatment:
The Canadian Critical Care Society Position Paper

Bioethical Background

- ✓ **Western biomedical ethics does not distinguish between WHLST and WDLST**
- ✓ In some countries, WHLST may be permitted, but WDLST is considered unethical or illegal regardless of consent.
- ✓ There can be a **psychological difference between WHLST and WDLST**. Many patients, family members, and some HCPs are **uncomfortable** with the moral agency involved in withdrawing LST (an active act of commission) and **more accepting of withholding LST** (a passive act of omission)
- ✓ It is important **not to overstate the moral or legal distinction between WHLST and WDLST**, as there may be **no clinically meaningful distinction** between withdrawing a treatment and withholding the next dose or escalation

Bandrauk N et al Can J Anaesth 2018

Withholding and Withdrawing of Life-Sustaining Treatment: The Canadian Critical Care Society Position Paper

Decision-making considerations

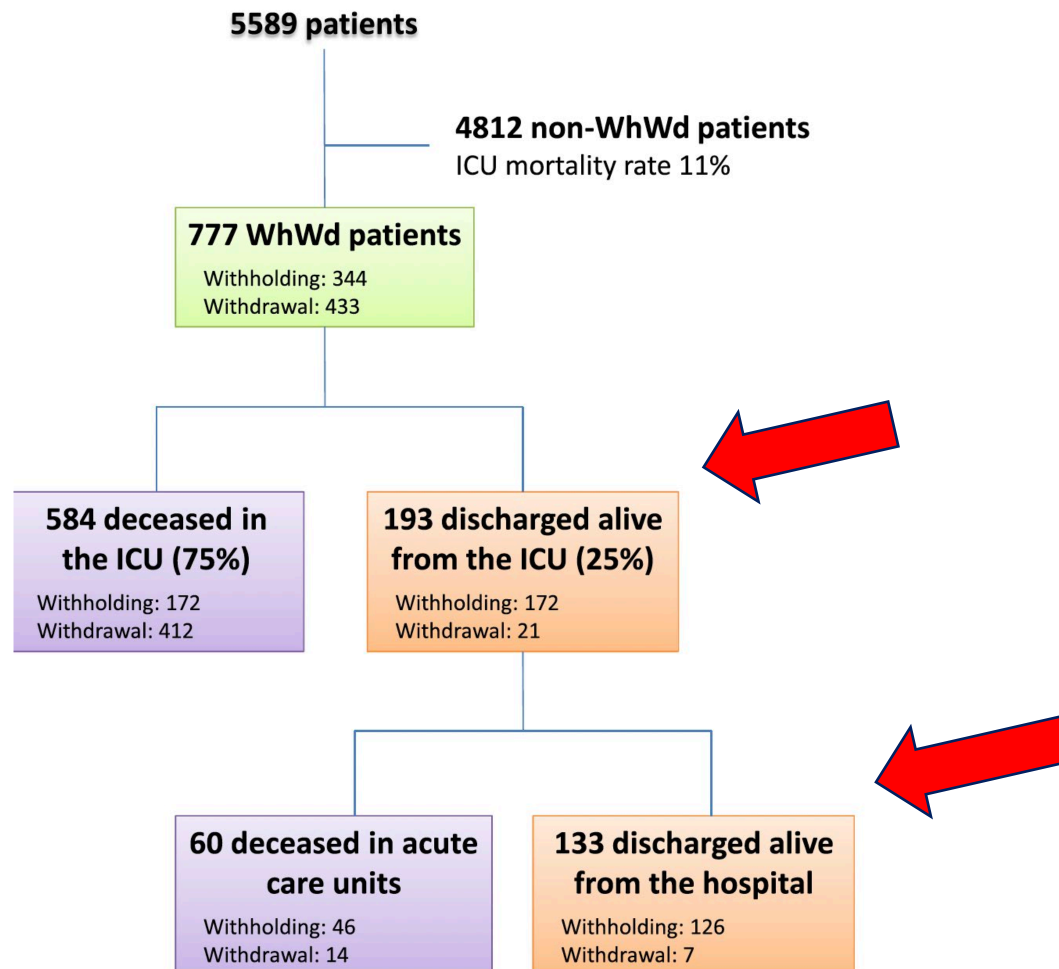
- **Life-sustaining treatment is not an all-or-none treatment plan**. A limit on LST should not be interpreted or represented as resulting in patient neglect (e.g. DNAR can receive other forms of LST)
- **If it is not clear whether individual patients could recover to a meaningful quality of life, a trial of LST could be offered but regularly reviewed for appropriateness**
- **There should be consensus among ICU team members** about the options (including palliation) and the recommended plan before anyone approaches the patient/SDM regarding WWLST

Bandrauk N et al Can J Anaesth 2018

RESEARCH Open Access

Withholding or withdrawal of treatment under French rules: a study performed in 43 intensive care units

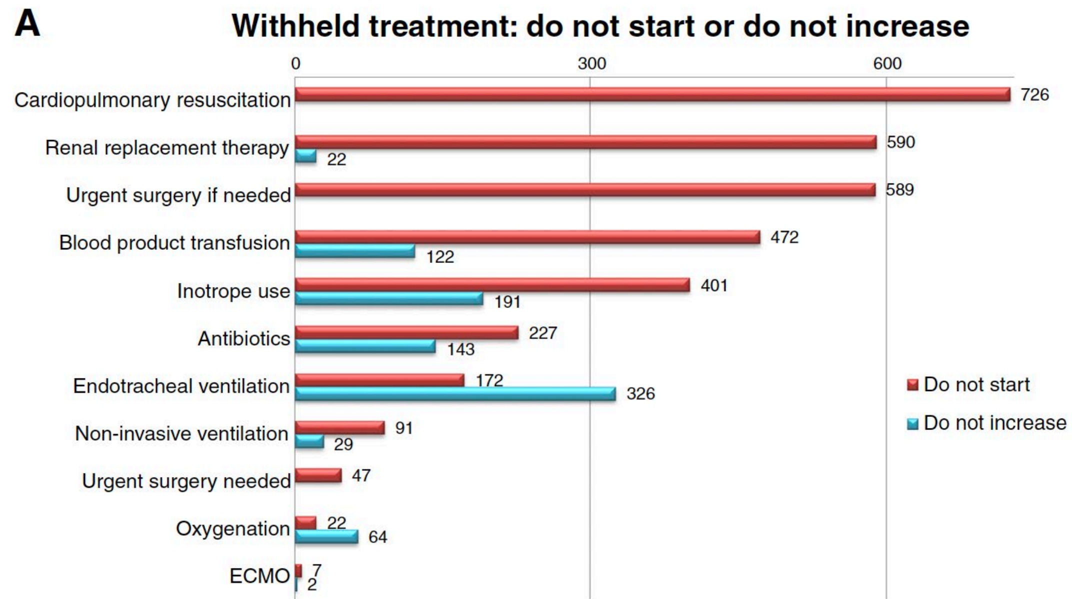
Olivier Lesieur[1,2*], Maxime Leloup[1], Frédéric Gonzalez[2,3], Marie-France Mamzer[2] and EPILAT study group



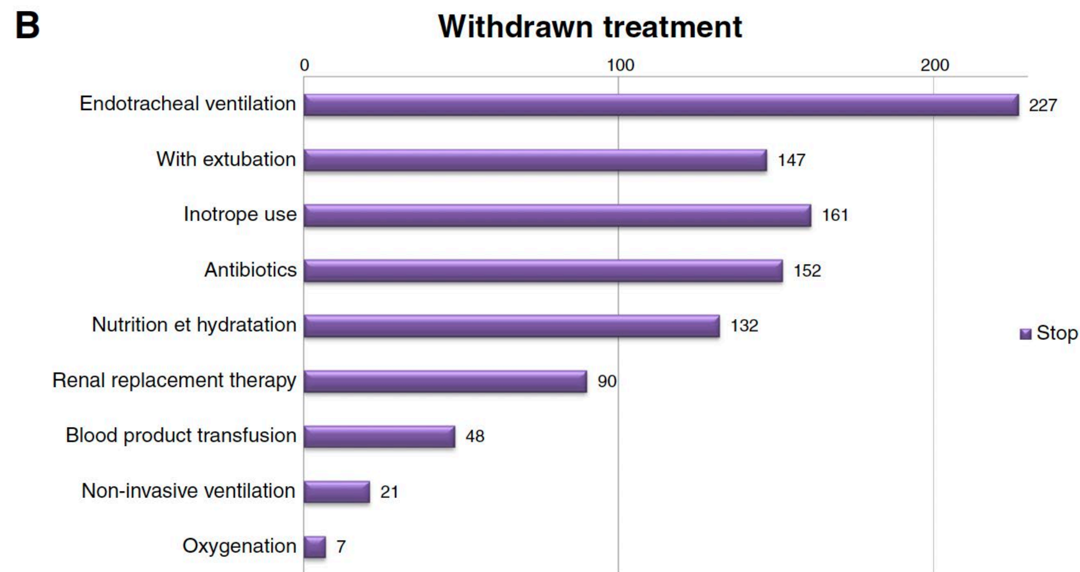
Rationales most often claimed to justify the WhWd decision

1) No additional information needed for decision-making: 602 patients (77 %)
2) Limited subsequent functional autonomy: 581 patients (75 %)
3) Absence of curative strategy: 559 patients (72 %)
4) Non-responsive to medical therapy: 516 patients (66 %)
5) Advanced or terminal stage of a severe and incurable disease: 474 patients (61 %)
6) Limited subsequent relational quality of life: 442 patients (57 %)
7) Limited functional autonomy before hospital admission: 317 patients (41 %)
8) Very advanced age: 210 patients (27 %)
9) Perception of disproportionate and non-beneficial treatment voiced by patient's relatives: 172 patients (22 %)
10) Wish to limit treatment voiced by patient: 110 patients (14 %)

Lesieur O et al Annals Int Care 2015



"Do not start" and "do not increase" orders are expressed as numbers of patients involved (of 777 WhWd)



"Stop" orders are expressed as numbers of patients involved (of 433 Wd)

- More than half of deaths in the study population occurred after a decision to **WhWd**
- **Brain-injured** subjects were more likely to undergo a **withdrawal** procedure
- **Chronic respiratory disease** and pre-existing disability affecting autonomy or cognition had preferentially **withholding**
- An **external consultant** was involved in **less than half** of all decisions
- Patients' wishes are rarely known
- **Limitations**, especially withholding of treatment, **did not preclude survival** and hospital discharge.

Attitudes towards end-of-life issues in intensive care unit among Italian anesthesiologists: a nation-wide survey

Andrea Cortegiani[1] · Vincenzo Russotto[1] · Santi Maurizio Raineri[1] · Cesare Gregoretti[1] · Antonino Giarratano[1] · Sebastiano Mercadante[2]

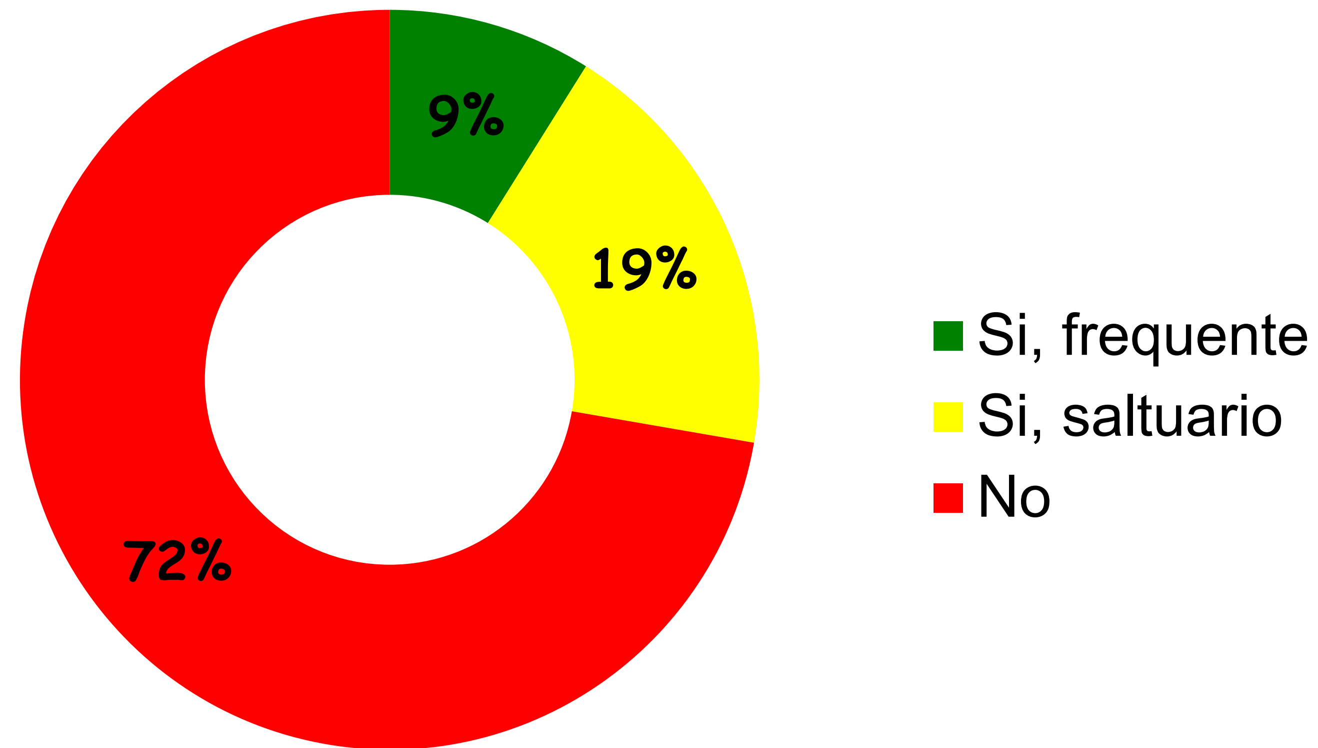
"Tra le seguenti, quali **Trattamenti** vengono **modificati/interrotti** in caso di decisione di sospensione e/o modifica delle cure intensive di supporto d'organo? "

Nessuno di questi
Trasfusioni
Antibiotici
Idratazione
Ventilazione meccanica (IMV o NIV)
Nutrizione
Trattamenti extracorporei (CRRT,…
Vasopressori/Inotropi
O2

0 10 20 30 40 50 60 70 80 90

Cortegiani A et al Supportive Care in Cancer 2018

“Esiste un rapporto di **collaborazione** con figure professionali esperte in cure **palliative/cure di supporto** in caso di decisione di sospensione e/o modifica delle cure intensive di supporto d’organo sulla base di futilità?”



Cortegiani A et al Supportive Care in Cancer 2018

Approaches to provide Palliative Care to ICU patients

Mixed Approach
(Generally the best approach)

Definition: ICU and palliative care teams work together to address palliative care needs

Key features for success
- Collaboration and communication between two teams
- Identify patients for specialty care based on needs

Primary palliative care by ICU team

Definition: ICU clinicians address all palliative care needs of patients and families without palliative care specialists

Key features for success
- Symptom assessment and management
- Communication with and support for families
- Shared decision-making with family and interprofessional team

Consultative palliative care by PC team

Definition: Palliative care team addresses all palliative care needs for all critically ill patients

Key features for success
- Understand practice and culture in each ICU
- Coordinate messages for patients and family with ICU team

Curtis R et al Intensive Care Med 2022

Early Palliative Care Consultation in the Medical ICU: A Cluster Randomized Crossover Trial

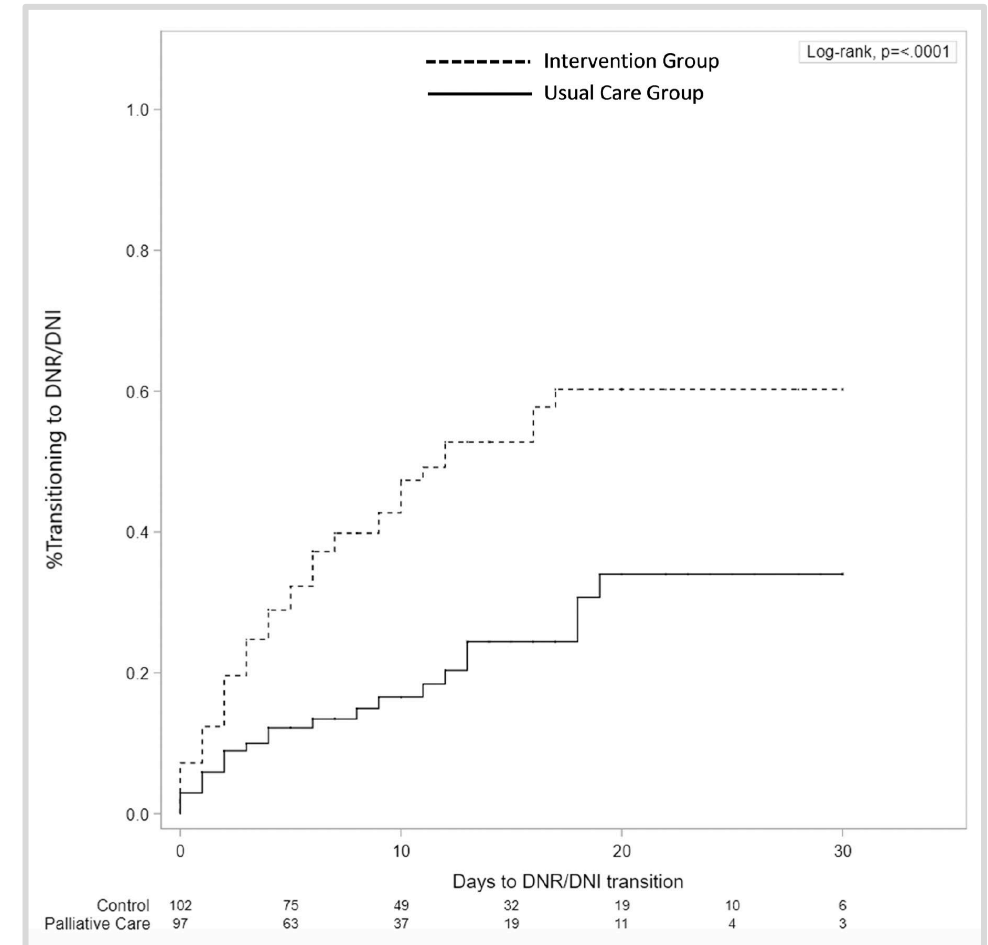
Design: Single-center cluster randomized trial in 2 ICUs in US

Participants: 199 patients admitted to the ICU at high risk of dying

Intervention: **Palliative care consultation** from an interprofessional team led by board-certified **palliative care providers** within 48 hours of ICU admission

Control: Standard care

Results: 1) DNR/DNI occurred earlier and significantly more often in the intervention group (50.5% vs 23.4%, p<0.0001); **2) More transfers to hospice care**, fewer ventilator-days, less tracheostomies, less ICU readmission



Ma J e al. Crit Care Med 2019

Consenso su procedure di donazione DCD controllata in Italia:

Position Paper e Documento di indirizzo della Rete Nazionale

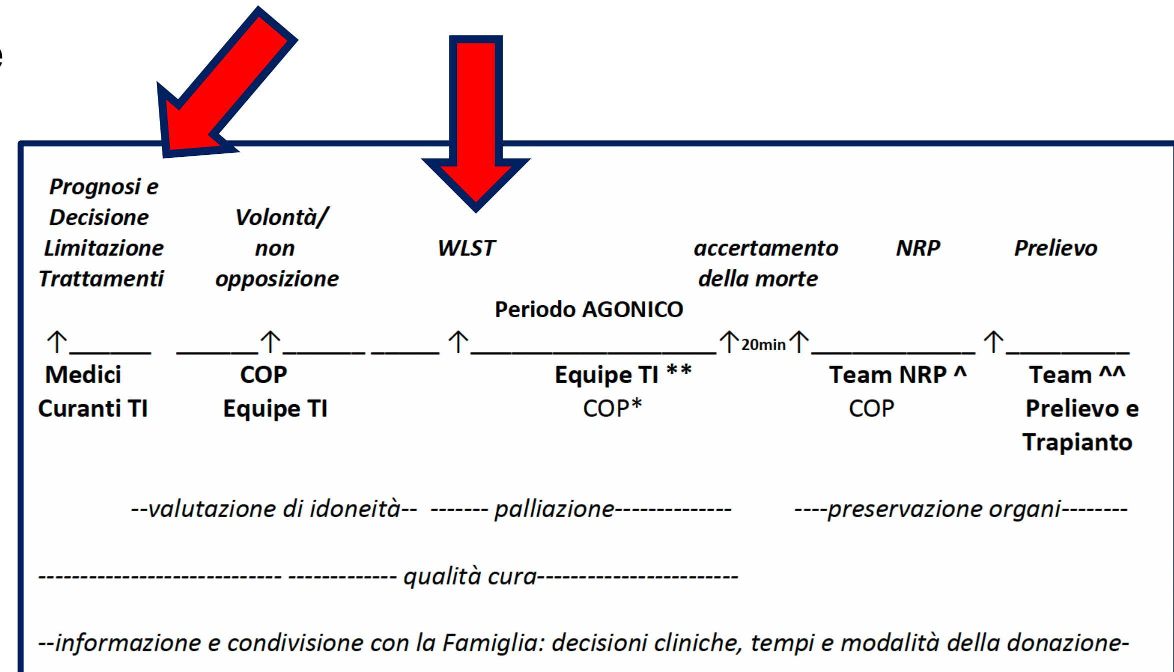
Centro Nazionale Trapianti
ISTITUTO SUPERIORE DI SANITÀ

Rete Nazionale Trapianti

La possibilità di donazione cDCD modifica le procedure di sospensione dei trattamenti di supporto vitale?

- Si raccomanda che la flessibilità dei tempi di sospensione dei trattamenti di supporto vitale, giustificata da ragioni cliniche ed organizzative finalizzate al miglior esito della donazione e mantenuta entro un limite definito, sia sempre rispettosa del miglior interesse del donatore e della sua famiglia. (raccomandazione)

- Si raccomanda che la scelta e la responsabilità di tali interventi, concordati con il Coordinamento ospedaliero e il Centro Regionale Trapianti, siano dell'equipe curante e che i familiari siano informati delle motivazioni e della finalità di tali interventi. (raccomandazione) (Ungraded Statement)



2 giugno 2021

revisione 25 gennaio 2023

Raccomandazioni

- **Ogni trattamento deve essere clinicamente appropriato e clinicamente proporzionato**
- **E' doveroso non prolungare il processo del morire ed intensificare precocemente un approccio palliativo**
- **Le volontà del paziente, anche anticipate, in merito alla limitazione dei trattamenti deve essere riportata in cartella e rispettata**
- Il paziente (quando possibile), i familiari e gli operatori sanitari devono essere coinvolti nel processo decisionale
- L'incertezza prognostica non deve diventare "**paralisi prognostica**"
- **Ogni trattamento intensivo deve essere considerato un *trial* di terapia, soggetto a rivalutazione degli obiettivi dei cura**

Take-home Messages

- The **vast majority of death in ICU** follow Withholding or withdrawal of LST
- **Patients can survive** treatment limitations to hospital discharge, especially withholding
- Patient's **wishes and sharing-goal-of-care** with family must **guide** the decision after clinical judgment
- **Every treatment in ICU** must be considered a «**trial**» that can eventually be suspended if not appropriate
- **Palliative Care** must follow along with ICU stay