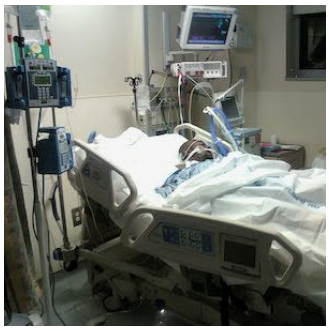
ICU
MANAGEMENT & PRACTICE

Withholding and withdrawing life-sustaining treatment: guide for ICU team



Guidance from the Canadian Critical Care Society aims to guide and educate the multidisciplinary intensive care unit (ICU) team and all involved in end-of-life decision making on the background to withdrawal or withholding of life sustaining treatment.

The authors emphasise that any form of life-sustaining treatment (LST) should be considered a trial that should continue as long as it is desired by the patient and involves a reasonable prospect of recovery to a meaningful patient-centred quality of life. They write:

"It is central to medical practice that all medical interventions, not just LSTs, are individualized to patient benefit, routinely reassessed, and open to discontinuation. This approach minimizes inappropriate suffering and distress for patients and caregivers, burnout in HCPs, and inappropriate use of finite resources."

The legality in Canada regarding decision-making in WHLST remains undetermined and only narrowly defined with regard to WDLST in the province of Ontario, note the authors.

The article includes detailed points to consider when making decisions about withholding and withdrawing life-sustaining treatment, summarised below:

- Does LST have a reasonable chance of restoring the patient to a quality of life that s/he would find meaningful?
- Life-sustaining treatment is not an all-or-none treatment plan.
- If it is not clear whether individual patients could recover to a meaningful quality of life, a trial of LST could be offered and regularly reviewed,
- 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.
- Healthcare providers should provide consistent communication with the patient or surrogate decision maker.
- The appropriateness/desirability for initiation or continuation of LST should be interpreted in the context of the patientâ€™s overall prognosis, values, and longer-term goals
- Discussions of WWLST should involve other members of the healthcare team and if agreed, a spiritual health provider and/or social worker.
- Good communication is central to decision-making.
- Every effort should be made for patients to be involved in discussions about their own medical decisions and treatment.
- The ICU team should respect patientsâ€™ wishes if they do not want to know their condition or be involved in treatment decisions.
- Recognise that patients may have cultural/religious/spiritual beliefs that have shaped their attitudes to life, illness, and death and will influence their feelings about WWLST.
- Any recommendation to withdraw or limit ICU care should be discussed respectfully and compassionately: discussions should be unhurried, avoid medical jargon, be calm, honest, respectful and compassionate.
- Discussions should be documented including plans and timelines.

The authors also advise how to handle disagreements and what to do when there is an impasse between the ICU team and the patient/ family.

In addition they provide guidance on withholding and withdrawing life-sustaining treatment at the request of a competent patient and when consulting with surrogate decision makers.

Ultimately, the goal is a respectful and dignified death and a reverent family experience, they say. Regarding use of sedatives and/or opiates, the authors write â€œThe doctrine of double effect holds that it is acceptable for comfort medications to potentially hasten death as long as that is not the intended effect of giving those medications.â€ it is important to be clear that WLST is not the same as euthanasia.

Source: Canadian Journal of Anesthesia
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