Worcestershire Acute Hospitals NHS Trust

GUIDELINES FOR THE LIMITATION OF TREATMENT FOR ADULTS REQUIRING INTENSIVE CARE

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Key Amendments

Date	Amendment	Approved by
8th October 2019	Document extended with no changes as part of Disease Management section in critical care	Dr Nick Cowley/ Dr Andy Burtenshaw
24th February 2022	Document edited by owner to include RESPECT form	
14th October 2022	Document reviewed with no changes	Intensive Care Forum

INTRODUCTION

This guideline is largely transcribed from the document "Guidelines for limitation of treatment for adults requiring intensive care" published by the Intensive Care Society. The authors of the source document were S.L. Cohen; J.S Bewdley; S. Ridley; D. Goldhill; and the Members of the ICS Standards Committee.

For the purposes of this guideline, an adult is defined as age 18 years old and over.

In light of the SUDIC policy all patients admitted to critical care who are under the age of 18 are to remain under the care of a Consultant Paediatrician.

This guideline does not apply to patients under 18 and all withdrawal decisions in this age group should be guided by the Consultant Paediatricians in consultation with advice from the Regional Paediatric Intensive Care Unit.

These are basic guidelines solely intended to provide a framework for approaching a highly sensitive subject.

Further documents are available from the British Medical Association and the General Medical Council.

All medical treatment must be founded on compassion and the best interests of the patient. Good communication, collaboration and agreement between colleagues, patients and families are essential.

Accurate documentation of these aspects of care is essential from a governance point-of-view.

A significant proportion of hospital deaths occur within a critical care environment and these deaths need to be properly managed. Studies on end of life decisions show the vast majority of deaths in the ICU occur following decisions to withhold or withdraw treatment. Death needs to be a managed process in the ICU.

Competent adults have an absolute right to refuse treatment, even if that refusal results in their death. The vast majority of ICU patients are not competent but occasionally have valid advance directives. The assessment of competency should include an assessment of mental capcity in accordance with the principles laid out in the mental capacity act code of practice, noting specifically the principles of the 2 stage test. In particular, it may be necessary to carefully consider the impact of medication, sleep deprivation or other features of critical illness on a patient's capacity to make life-determining decisions.

Many factors are involved in making decisions to withhold or withdraw therapy. The decision is normally taken after consultation with other members of the nursing and medical team. Ideally, there should be consensus among the entire clinical team who have been heavily involved in the patient's care, that it is appropriate to withhold or withdraw aggressive treatment. Usually two or more senior doctors, one of whom must be an ICU Consultant, will agree on the decision.

Unanimity is desirable but may be unobtainable. The final decision and responsibility for that decision is vested in the consultant in charge of the ICU, but it is essential that the views of the family are taken into consideration and attempts are made to avoid conflict at this sensitive time. The nurses may be more familiar with the family and the patient's views, which if known, are of paramount importance. Usually, in ICU patients, these views are not available. A recent Swedish study demonstrated that the general public wanted the patient and family to be involved in such decisions, with only 5% supporting a physician only approach. We do not know British patients' views on this subject, but the law allows a competent and experienced physician to make the decision.

In the UK, with the exception of Scotland, there is at present no established role for surrogate decision makers, although their input might be helpful in making decisions for patients who are not competent. In England and Wales, no adult can give consent on behalf of another adult; however Scotland passed a law encompassing surrogacy in April 2001.

Uncertainty in prognosis in critical illness may lead to problems in communication with patients, family and caring team. There is increasing societal awareness of medical matters. Decision-making should be open and accountable to the patient, family and all concerned. All discussions and decisions should be recorded in the notes.

The legal issues surrounding treatment limitation are discussed in the BMA booklet on withholding and withdrawing life-prolonging treatment. The second edition also gives specific guidance on the Human Rights Act that came into force in October 2000. The spirit of the Act aims to promote human dignity and transparent decision making, and it is these principles that should be applied in decisions to limit intensive are treatment.

DETAILS OF GUIDELINE

Principles:

Medical treatment should only be withdrawn on clinical grounds because the treatment will not benefit the patient or the expected benefits are outweighed by the burdens of treatment.

Every withdrawal decision should be made upon its own merits and must not be made on the basis of either cost or medical convenience

The need for an ICU bed for another patient should not be a reason for withdrawing support.

There is a need to know, if possible, the wishes of the patient and their treatment goals. If the patient is not competent to communicate their wishes, their family and friends should be consulted. Attempts must be made to discover the patient's wishes in this situation. Advance directives, if available and relevant, may be helpful. In the case of incompetent patients without family or close friends, the doctor has the responsibility of determining the best interest of the patient. Ultimate responsibility remains with the consultant in charge of the ICU.

When patients are admitted to the ICU there needs to be a clear management plan encompassing the limits, if any, of invasive interventions. This plan requires accurate documentation and regular review.

Limitation of treatment should be regarded as a formal ICU procedure subject to the same preparation, thought, care and consent as for any other aspect of care.

A RESPECT form should be completed for each patient admitted to ICU. This form contains a summary of diagnosis, prior planning, personal preferences and clinical recommendations for emergency care and treatment. Further detail can be provided on the RESPECT form concerning interventions that are and interventions that are not appropriate. The RESPECT form incorporates sections stating whether CPR attempts are or are not recommended.

Ethics:

Almost all ethical authorities agree that there is no moral difference between withholding and withdrawing treatment. In practice though, many doctors feel more comfortable with withholding, rather than withdrawing treatment. When outcome is uncertain, it is worth considering a trial of intensive care treatment on the understanding that it will be withdrawn if ineffective.

Some doctors and nurses, as well as patients, may have conscientious objections to treatment withdrawal. Their views should be respected and they should be allowed not to participate in such procedures if these are against their principles. They should, however, be prepared to transfer care to other clinicians.

Training:

Training in communication skills and in breaking bad news for all ICU personnel should be improved with the emphasis on the importance of good contemporaneous written records.

Communication & Records:

Good communication with the patient and/or family as well as all colleagues in the caring team and the referring clinicians is essential. If the patient is competent, the patient's wishes and preferences for treatment must be obtained.

Methods of Withholding & Withdrawing:

It is the duty of the consultant in charge of the ICU to recognise a dying patient and to know when palliative care should over-ride more aggressive treatment. There needs to be

agreement among patient, family and the entire caring team, especially in the case of the patient who is not competent, but the ultimate responsibility for the decision should rest with the ICU consultant in clinical charge. The significance of poor prognostic factors must be explained. Families may need time to come to terms with their impending loss.

In the cases of disagreement, either among the family or physicians, or between them, suitable second opinions may provide objective assessment and support.

Basic Guidelines for Withdrawal of Life-Sustaining Treatment (WLST):

Patients and families should be given the maximum possible access and privacy at this time. If possible a side room should be made available otherwise the bed space curtains should remain drawn and unnecessary monitoring and alarms removed.
It is important to communicate to all of the unit staff that a highly-sensitive stage of patient care is unfolding and extraneous noise on the unit should be kept to a minimum. Signs and candles are available on both units to facilitate this communication.

The patient's management should continue to be compassionate and caring. To this end, it is important to relieve the patient's pain and distress. Suitable drugs might include potent opioid analgesics such as diamorphine or benzodiazepines such as midazolam. Such drugs are often given by infusion. The dosage needs to be adjusted to relieve the patient's suffering but not to intentionally hasten death.

Treatments aimed at primarily maintaining organ function but which may prolong death should be withdrawn. Examples may include vaso-active drugs, antibiotics and intravenous fluids. Respiratory support may be withdrawn. This may involve reducing fractional inspired oxygen concentration towards 21%, lessening the ventilatory support and eventually where appropriate extubating the patient. Adequate analgesia and sedation are essential, but paralysis must always be avoided.

It is vital that whichever drugs or combination of drugs are used, the aim is to relieve the patient's pain and distress. Clinicians need to ensure that the drugs and the doses they use could not be regarded as excessive by others responsible for similar patients. Euthanasia is illegal in the United Kingdom and plays no part in the withdrawal of treatment from critically ill patients.

REFERENCES

The document "Guidelines for limitation of treatment for adults requiring intensive care" includes this list of suggested further reading.

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