Module: Withdrawal of Life-Sustaining Treatments

Learning Objectives

Attitudes

- Decisions to direct care towards quality of life and comfort rather than extending life are supported by ethical and legal standards
- A "comfort-focused treatment" plan should be presented alongside "longevity-focused / surgical treatment" plans for critically ill/injured patients in several circumstances including:
  - High risk of death or significant disability
  - Existing documents or other indicators of previous selection of a comfort focused care plan
  - Pre-existing significant frailty or co morbid medical conditions
- The notion of "treatment" is often conflated with "care" by medical professionals. Surgeons sometimes withdraw life-sustaining treatments, surgeons always care for patients. We do not "withdraw care."

Knowledge

- Be curious when told "they want everything done." It is rare that patients / families want every invasive life-prolonging treatment in which the burden outweighs the benefit.
- Replace the notion/phrase of "withdrawal of care" with "transition to comfort-focused treatments."

Skills

- Avoid the use of pseudonyms for death (expired, passed away, lost). Instead use the definitive terms death, dying, and dead to improve communication with patients / families. Be authentic and empathetic and find language that feels comfortable to use.
- Describe a "comfort-focused treatment" plan starting with what will be done for the patient to improve the quality of remaining life, and finish with what interventions that will be avoided and are not beneficial.
- Recognize when patients are actively dying on life-sustaining treatments and explicitly disclose this information to the family with a recommendation to provide appropriate end of life care.

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Teaching Outline

Discussing medical treatments near the end-of-life can be uncomfortable for both patients/families and surgeons. Lack of understanding regarding the legality of these transitions can amplify the discomfort. As a result, longevity-focused treatment plans, including surgical interventions, are more often described. This module will provide guidance on discussing a comfort-focused treatment plan and withdrawal of life-sustaining treatments.

Care Transitions at End of Life

1. **What**?
    a. Life-sustaining treatments include blood product transfusion, artificial nutrition, intravenous fluids, dialysis / continuous renal replacement therapy, mechanical ventilation / non-invasive ventilatory support (BiPAP, CPAP), select medications (antibiotics, vasopressors / inotropes, insulin), pacemakers / defibrillators / heart pumps, extracorporeal membrane oxygenation, procedures / surgeries, and cardiopulmonary resuscitation.
    b. There are ethical and legal standards in all 50 states to support withholding and withdrawal of life-sustaining treatments under appropriate circumstances.

2. **Who**?
    a. Each surgical specialty interacts with different populations of patients that need support for care transitions in the context of serious injury or illness with poor prognosis for recovery. For example, evidence in the trauma patient population demonstrates that severely ill/injured patients at high-risk of life-altering disability or death should have a goals of care discussion within the first 72 hours of hospital admission and again with significant change in clinical status (new organ failure, admission to ICU, serious complication, unplanned surgery, etc.).
    b. The patient's values should be assessed along the spectrum of longevity-focused, independence-focused, or comfort-focused.
    c. In this context, life-sustaining treatments are recommended for patients whose goals of care are longevity-focused and for those who are independence-focused (with implementation of a "time-limited trial" for life-sustaining treatments).
    d. Surgeons should recommend a comfort-focused treatment plan (which includes stopping life-sustaining treatments that do not provide benefit for symptoms or quality of life) to patients
        i. who have not met the criteria of a "time-limited trial"
        ii. who prioritize comfort and have a life limiting diagnosis
        iii. who are actively dying

3. **When**?
    a. Early in the hospital course, a comfort-focused treatment plan should be presented as a viable treatment option alongside life-prolonging and surgical treatment plans for critically ill/injured patients believed to have low likelihood of recovery. Even if patients/families are longevity-focused, educating the family about comfort-focused treatments early gives them an alternative option for the future if things don't turn out the way they were hoping.
    b. Some families want information about comfort-focused treatments but don't have the language and/or feel guilty asking physicians about alternatives to longevity-focused treatments. The notion of "giving up" is shared by families and surgeons alike and fosters reticence to discuss comfort-focused treatments and withdrawal of life-sustaining treatments in a timely fashion. Acknowledging this perspective can help prevent it from interfering with sharing timely and appropriate information about treatment options.

4. **How**?
    a. Take the burden off the patient/family and make a recommendation for comfort-focused treatments when goals align with comfort and/or the patient is dying.
        i. "*Despite all our efforts with multiple life-sustaining treatments, your Dad is unlikely to recover to the point where he can participate in the activities you identified as meaningful to him. At this point, I recommend we transition to a comfort-focused treatment plan to make the most of the time he has left. Can I tell you more about what this would mean?"*
    b. When describing a comfort-focused treatment plan, develop an explanation that starts with what will be done for the patient, and ends with what will be removed / avoided.
        i. "It can be hard to predict what the end-of-life phase will look like for a particular person, how long it will last, and what types and doses of medications may help. What I can tell you is that our focus will be on providing comfort and allowing a natural death."
    c. Families may inquire about the process of discontinuation of mechanical ventilation. Explain that the patient's comfort is the priority. There are several different approaches for this process depending on institutional practices, patient factors and clinician experience.
    d. Another common question is regarding estimated life expectancy once life-sustaining treatments have been discontinued. To acknowledge the inherent uncertainty within this prognostication, provide the best estimate in ranges of duration (minutes to hours, hours to days, days to weeks, etc.). One rule of thumb is, if things are changing by the minute, the patient has minutes to live; if things are changing by the hour, the patient has hours to live, etc. Also, let the patient and family know that there are signs and symptoms of impending death that the team will relay when death is imminent. It is as important to prepare patients and families for a protracted dying process as it is a short one.

e. When discussing death with a patient / family, avoid using euphemisms for death (expired, passed, lost, etc.). Instead use the definitive "D words" such as dying, death, dead when appropriate to ensure clarity of communication.
f. Feeding and nutrition can be emotionally charged topics. Explain to patients and families that feeding, particularly when provided artificially, is not beneficial and can create burden at end of life due to the potential for aspiration, fluid overload and other adverse effects. Encourage families to wet their loved one's lips and provide other care as substitutes for feeding.

5. **Why**?
    a. Making a treatment recommendation for comfort-focused treatment does not infringe on patient autonomy and allows for patient focused care. The patient / family has the right to decide on treatment based on their goals and the surgeon's recommendation.
    b. Normalizing comfort-focused treatment in high-risk patients by discussing the option upfront, and making the treatment recommendations when appropriate, will reduce potentially inappropriate and non-beneficial surgical treatment near the end-of-life.

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Pre/Post Test

Questions

1. Which is a clearer delivery of serious news to a family member?
    a. "I truly wish I had better news. Your mom passed away this morning."
    b. "Unfortunately, your mom expired this morning."
    c. "There is no easy way to say this, but we lost your mom this morning."
    d. "I wish I had better news. Your mom died this morning."

2. What is the risk of a surgeon waiting until the family broaches the topic of comfort-focused treatments?
    a. Burden is put on families to request education for end-of-life treatment
    b. Infringing on patient autonomy
    c. The patient receives potentially inappropriate and non-beneficial life-sustaining treatments near the end of life
    d. The patient / family may think the surgeon is giving up

3. Describe the pros and cons of these phrases when they are used to describe treatment plans?
    a. "Comfort measures only"
    b. "Withdrawing care"
    c. "DNR / DNI"
    d. "On palliative care"
    e. "full care"

Answers

1. D. avoid using euphemisms when disclosing or discussing death

2. A & C. Families should not bear the burden of asking for information about transitioning to comfort-focused treatments in appropriate situations. It is a physicians' job to provide this information upfront as a reasonable treatment option. Surgical patients should not be subjected to goal-discordant life-sustaining treatments near the end of life because the surgeon is uncomfortable discussing comfort-focused treatments in a timely fashion.

3. "Comfort measures only" gives patients / families the impression that treatments are restricted. "Withdrawing care" gives the impression that the surgeons will no longer be taking care of patients. "DNR / DNI" is often conflated with comfort-focused treatments. Some patients / families are reticent to designate DNR / DNI for fear of receiving comfort-focused treatments when not goal concordant. Palliative care is a medical specialty that specializes in reducing suffering for seriously ill / injured patients. Palliative care is not synonymous with end-of-life, and is often provided alongside longevity-focused treatments. "Full care" is used by medical professionals as euphemism for life-sustaining treatments without limitations. "Full care", like "wants everything done" is used by families with variable intention. The patient / family's intention may very well be to receive all the treatments to get their father back to living independently, short of connecting him to life support machines.

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Case 1

An 81-year-old woman presents after a car collision with polytrauma including a traumatic brain injury, multiple bilateral rib fractures and pulmonary contusions resulting in respiratory failure and need for mechanical ventilation, pelvic fracture with active extravasation, and multiple orthopedic injuries. Her daughter arrives to the trauma bay and states "we want everything done."

Questions

1. Ask the daughter if her mother has advance directives like a living will or durable power of attorney for healthcare. This opens up the door to previous discussions regarding life sustaining treatments when seriously ill or injured.

2. Take note of the phrase "we want everything done" and plan to explore the meaning of this to the daughter.

Case 2

She receives blood transfusions for her hemorrhagic shock and goes to interventional radiology for embolization of her right internal iliac artery. The patient is admitted to the intensive care unit for resuscitation.

Questions

1. Determine the earliest time for a goals of care discussion. This should be conducted prior to going to the operating room and within the first 72 hours of hospital admission.

2. During the goals of care discussion, present a comfort-focused treatment plan as an option to the daughter. Even if she elects for longevity focused treatments early on, she has heard information about comfort-focused treatments and heard that her mother is sick enough to warrant this as a viable option.

Case 3

The patient goes to the operating room the following day for fixation of her pelvic fracture. On post-operative day #3, the patient develops tachycardia and hypoxia and is diagnosed with a pulmonary embolism. Continuous heparin is initiated. Two days later, the patient develops hemorrhagic shock from an upper gastrointestinal bleed. EGD reveals two very large duodenal ulcers not amenable to endoscopic treatments. The patient is requiring continuous massive transfusion and vasopressors to blood pressure and the option of major abdominal surgery is discussed amongst the ICU and surgery teams. When the daughter sees her mother and the intensive treatments, she tells the nurse “I’m not sure she would have wanted all of this…”

Questions

1. Disclose to the daughter that her mother is actively dying and end of life care is appropriate.

Assessment Form

Content Checklist: Make an “X” if the resident did this without prompting, mark with “✓” if the resident did this only after prompting and leave blank if this was not done.

______ Asks about advance directives and durable power of attorney for healthcare

______ Schedules a goals of care discussion within 72 hours of admission

______ Explores “we want everything done” or “full care”

______ Explores patient values along spectrum of longevity – independence – comfort

______ Presents treatment options including comfort-focused treatments early in admission

______ Uses “D” words when discussing dying, death, dead. Avoids euphemisms

______ Discloses to family when patient is actively dying. Provides a treatment recommendation for comfort-focused treatments including withdrawal of life-sustaining treatments and allowing natural death

Please provide your overall assessment

_____ Competent to perform independently

_____ Needs close supervision

_____ Needs basic instruction

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