

What are the ethical aspects surrounding the collegial decisional process in limiting and withdrawing treatment in intensive care?

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Abstract: The decision to limit or withdraw life-support treatment is an integral part of the job of a physician working in the intensive care unit, and of the approach to care. However, this decision is influenced by a number of factors. It is widely accepted that a medical decision that will ultimately lead to end-of-life in the intensive care unit (ICU) must be shared between all those involved in the care process, and should give precedence to the patient's wishes (either directly expressed by the patient or in written form, such as advance directives), and taking into account the opinion of the patient's family, including the surrogate if the patient is no longer capable of expressing themselves. A number of questions still remain unanswered regarding how decisions to limit or withdraw treatment are taken in daily practice, especially when this decision can be anticipated. We discuss here the collegial procedure for decision-making, in particular in the context of recent French legislation on end-of-life issues. We describe how collegial decision-making procedures should be carried out, and what points are covered in shared discussions regarding decisions to limit or withdraw life-sustaining therapies.

Keywords: Intensive care unit (ICU); shared decisional process; end-of-life; ethics

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Introduction

The decision to limit or withdraw life-support treatment is an integral part of the job of a physician working in the intensive care unit (ICU), and of the approach to care (1-3). However, this decision is influenced by a number of factors, such as resource availability and the surrounding environment, the use of intensive communication strategies (4,5), multidisciplinary care teams (6), institutional culture (7), cultural differences between countries (8), religious beliefs of the physicians (9), ICU family conferences (i.e., VALUES approach) (10), the presence or not of surrogate decision-makers (11), the use of ethics consultations (12) and ICU capacity strain (13). Despite the many factors

that enter into play in the decision, it is nonetheless widely acknowledged around the world that a medical decision that will ultimately lead to end-of-life in the ICU must be shared between all those involved in the care process, and should give precedence to the patient's wishes [either directly expressed by the patient or in written form, such as advance directives (AD)], and taking into account the opinion of the patient's family, including the surrogate if the patient is no longer capable of expressing themselves (3,14).

Although there is an abundant literature in the area of end-of-life in the ICU, position papers from professional societies around the world (3,15,16) and legislative texts from numerous countries (3), a number of questions still remain unanswered regarding how decisions to limit or

withdraw treatment are taken in daily practice, especially when this decision can be anticipated. This latter aspect is addressed in a separate article in this issue on advance care planning.

From shared decision-making to the collegial procedure: the Worldwide Professional Consensus (WPC) (14) and recent French Legislation (17)

The decision to limit or withdraw treatment is frequent in the ICU setting. Around 20% of patients die in the ICU (18) and these deaths in the ICU are preceded in 53% to 90% of cases by a decision to withhold or withdraw life-sustaining therapies (5,10,19). The most common reasons justifying this decision include the patient's age, previous autonomy, comorbidities, expected future quality of life, diagnosis at admission, non-response to maximal therapy and multi-organ failure (5,9,19). In a recent paper, Sprung *et al.* reported a study seeking to reach a broad, worldwide, multidisciplinary professional consensus on multiple end-of-life (EOL) issues across barriers of geography, culture, religion and medicolegal systems (14). Using a modified Delphi process, a steering committee developed 35 definitions and 46 consensus statements for 22 issues, which were also distributed to the coordinators of 32 participating countries (16 European countries, the USA, Australia, South Africa, Saudi Arabia, South Korea, Cyprus, China, Canada, India, Turkey, Hong Kong, Israel, and 4 countries in South America).

In summary, the study found significant support for the use of advance directives as a mechanism for assuring patient wishes in decision-making (93% agreement). Advance directives include living wills or designation of health care proxies. The statement affirmed that physicians should determine whether their patients have advance directives, respect them and incorporate them into their decision making (91% agreement). Secondly, in making health care decisions, the surrogate decision maker who knows about the patient's preferences should use the standard of substituted judgment (making the decision that the patient would have made in the particular situation), whereas, if the patient's preferences are unknown, the best interests standard should be used (the course of action that a reasonable, competent person would choose in the incompetent patient's situation) (85 % agreement). A third major point was that health care professionals should communicate important medical information to patients

and families (92% agreement). This information should include the names of key staff members caring for the patient, the diagnosis, diagnostic and therapeutic options planned, prognosis, and visiting hours (88% agreement). Fourth, health care professionals should attempt to use shared decision-making procedures when deciding about end-of-life care for critically ill patients (88% agreement). Fifth, 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 (decision not to start or increase a life-sustaining intervention) (88% agreement) or withdrawn (decision to actively stop a life-sustaining intervention presently being given) (82% agreement). Life-sustaining treatment should generally be withheld or withdrawn only after obtaining agreement of the patient and/or the surrogate decision maker or family. Finally, the goal of palliative care is to anticipate, prevent, and relieve suffering and to optimize quality of life for patients with terminal illnesses (95% agreement).

The findings of this consensus by Sprung *et al.* (14) are in line with the recent recommendations by the Task Force of World Federation of Societies of Intensive and Critical Care Medicine (3), who also underline the variations in practice between countries in terms of limitation and withdrawal of care in ICUs, with for example, the use of "terminal sedation" being allowed in some countries (20), whereas, in others, the withdrawing of a ventilator is prohibited (21).

Recent French legislation (17)

While a number of countries have integrated decisions to limit or withdraw therapy in the context of shared-decision making as outlined above (14), France recently enshrined this principle in its legislation, with the publication of the so-called "Claeys-Leonetti" law dated 2 February 2016 (17). This is an adjunct to previous legislation regarding patients' rights at the end-of-life dating from 4 March 2002 (22) and 22 April 2005 (23). The paternalistic model (24,25) that was predominant in the European context has progressively given way to a more autonomous model (15,26), in particular with the integration of advance directives (AD). When they exist, AD must be consulted if the patient is no longer capable of making their wishes known, and the physician in France is now legally obliged to adhere to the wishes of the patient as outlined in the AD. Contrary to the provisions of the previous legislation from 2005, the new

law now stipulates that AD have no expiration date, and remain valid indefinitely. In addition, under the new legal framework, the officially designated surrogate has a more important role, as they are entrusted with the knowledge of the patient's AD.

The dispositions of the 2005 law introduced the idea of a “collegial procedure” for making decisions to limit or withdraw life-sustaining therapies. This procedure was deemed to be obligatory for patients who were unable to express their own wishes, in particular in two situations, namely: (I) when the limitation or withdrawal of life-sustaining therapy was likely to put the patient's life in danger; and (II) for a person at the advanced or terminal phase of a serious and incurable disease, regardless of the cause, a decision to limit or withdraw life-sustaining therapy can be made when this therapy is disproportionate, useless, or aims solely to artificially prolong the life of the patient. Regarding the context of AD in France, the new legislation introduced in 2016 now allows for two important derogations, namely: (I) emergency situations, including attempted suicide, because it is difficult to examine AD calmly and attentively in this context. This derogation is temporary, and is applicable during the time required to make a complete evaluation of the situation; (II) AD that are inappropriate to the patient's clinical situation. If the physician refuses to respect the dispositions of the AD in this context, the new law allows for a procedure whereby the opinion of a second physician is sought, and the opinions of both physicians are recorded in the patient's medical file. The new French law also provides two models for the preparation of AD, according to whether or not the person writing the AD is already diagnosed with a chronic disease at the time of writing (27). In any case, both versions are recorded in a national database. The new legislation from 2016 also allows for the initiation of continuous deep sedation when a decision to limit or withdraw therapy is made in a collegial manner, and in the sole aim of minimizing the patient's suffering. Similarly, the new law stipulates that artificial nutrition and hydration may be discontinued or maintained, according to the patient's wishes, which allows for interruption of artificial nutrition to be considered as a possibility, and no longer an obligation.

Unanswered ethical questions regarding the collegial decision-making process

There are three distinct situations in which the collegial decision-making process can be implemented, although

the timing differs between the three situations. Firstly, when therapy fails, despite a well-conducted therapeutic strategy and optimal management. Second, in patients with unfavourable outcome (in terms of survival and/or quality of life) and for whom pursuit or intensification of life-support therapies would be unreasonable, and disproportionate with regard to the therapeutic objective of the patient's actual situation. And thirdly, if the patient directly or indirectly refuses the introduction or intensification of life-support therapies.

How is the collegial process initiated?

While it is established that the final decision to limit or withdraw therapy is the responsibility of the physician (14,17), the question arises as to the situation of the physician in charge of the patient in the ICU. Usually, in the ICU setting, there are several physicians taking care of any given patient, sometimes simultaneously or on a rota, with complex and varying questions arising during the patient's stay with respect to the course of disease and the likely outcome. These questions arising from a range of different competences, knowledge, experience and work cultures, are a unique feature of the critical care physician's job (see also the article on the different dimensions of the profession of ICU physician in this issue). In the ICU, more than in other medical disciplines, the meaning of a medical and caregiving team is highly significant. The team aspect is evident in daily practice through the many decisions that are discussed at length and always shared between all the members of the team, and this illustrates the collegial facet that guides a project for curative care. This collegial approach also makes it possible to prevent over-involvement or varying motivations, to which all healthcare professionals may be exposed, but it also prevents gaps in knowledge of the therapeutic issues when the workplace organisation (i.e., obligatory time off after night duty) results in the absence of a key player in the patient's care (28). In this context, identifying the main physician(s) in charge of the patient is not an easy task, but the fact that the patient is being managed by a team is likely reassuring for the patient themselves, and for their family; family being defined here by the patient themselves, or in the case of minors or those without decision-making capacity, by their surrogates. In this context, the family may be related or unrelated to the patient.

It was shown in a recent qualitative study that in 30% of deaths occurring after a decision to limit or withdraw

life-sustaining therapies, there was no discussion about the patient's previously expressed preferences or values (29). Pushing this reflection further, one could also raise the question of the family and/or loved ones, and ask who can best represent the interests of the patient if the patient is no longer competent. French legislation introduced, in 2002 the possibility for a patient to designate a surrogate for the duration of the hospital stay, the role of the surrogate being to report the patient's wishes and values, in case the patient was no longer able to communicate. In the particular situation of admission to the ICU, the emergency nature of the situation means that often, no official surrogate has been designated before hospitalisation, which compounds the difficulty of involving the family and/or loved ones in any collegial decision to limit or withdraw therapy. Often, the problem is that there is not one spokesperson from the family, but rather a "spokes group" (30). A recent article by Rigaud *et al.* (31) showed that in the ICU, caregivers use simple criteria to identify the most suitable surrogate. These criteria include knowledge of the patient's wishes, an emotional bond with the patient, adequate understanding of the clinical history, and designation as a surrogate prior to admission. In these delicate situations where the patient's life is in jeopardy, it is essential for the physician(s) to inform the entourage, without betraying any secrets, yet simultaneously allowing all those involved to have their say and make their opinions known without judgement, especially when there is the possibility of a decision to limit or withdraw therapy. Sometimes, no family members are present during ICU hospitalisation, either because they are geographically too distant, or because the patient has no surviving family (32).

The subsequent French law of 22 April 2005 stipulated, in line with legislation in other countries (14), that the discussions leading to limitation or withdrawal of therapy could be initiated by the patient him-/herself (if competent), the patient's family and/or loved ones, but also by any member of the medical team in charge of the patient. Identifying the most appropriate representative of the patient from among the entourage is particularly crucial in these situations. The decision is then made by the physician in charge of the patient after discussion (collegial decision-making procedure) with the caregiving team if one exists (almost always the case in the ICU), and on the basis of a reasoned opinion from a physician called in as a consultant (either a treating physician or specialist). The "ideal" time to initiate these discussions and make a decision is not specified in the law. In 2009, the French Intensive Care

Society (SRLF) proposed that regular meetings should be organised (weekly, for example) to allow reflection and discussion within the caregiving team regarding the level of therapeutic engagement (16). This may pose some organisational problems, by requiring medical staff to attend meetings during their time off, or by requiring those on duty to interrupt their work to attend the meeting. In the same vein, what about night-time or weekends, when the caregiving team is usually limited, sometimes with doctors on call who know little about the patient's medical history, and even less about the potential outcome. In such meetings, the whole team attending the collegial meeting would have to have a good level of knowledge of the patient's history, not only in terms of the previous healthcare pathway, but also in terms of the current clinical situation. Discussions could then focus on whether or not the therapeutic management was appropriate.

An alternative proposal is that discussions regarding the level of therapeutic engagements be initiated as soon as the patient is admitted to the ICU, and integrated into the daily rounds by the physician. This would enable greater reactivity as regards changes in the clinical situation, but would also allow deeper involvement of all those present (caregivers, family and/or loved ones) in decision-making procedures. Structured communication regarding the perspective of limitation or withdrawal of therapy makes it possible to improve the overall decision-making process and limit the utilisation of resources, in terms of mechanical ventilation, length of stay and healthcare costs (5,33).

The organisation of daily meetings is now an integral component of good clinical practice (34) and is associated with less frequent conflict (35), particularly when patients and families are of different ethnic backgrounds (36). The exact modalities of such meetings remain to be defined within each individual ICU.

What should the collegial meeting cover?

The French Intensive Care Society has issued a guide to collegial discussions surrounding the level of therapeutic engagement (16). This guide takes into account, on the one hand, the patient's ability to express their own desires (or not), and on the other hand, how proportionate the proposed therapeutic engagement is with regard to the patient's prior or future situation. This consequently requires sufficient time to obtain all the necessary information about the patient's history, in order to include them adequately in the healthcare project. Every time such

a discussion is held, it is noted in the patient's medical file with chronological follow-up. A level of consensus among the caregiving team is also proposed, that can lead to one of several conclusions, such as: plan another meeting (specifying the timeframe for the next meeting); plan to involve the patient and/or family; plan to obtain the opinion of other practitioners from outside the unit.

Once a consensus has been reached on a common decision, it is proposed that the modalities of limitation or withdrawal of therapy be clearly identified, with the exact treatments that will be limited (e.g., do not introduce catecholamines, do not intubate, do not initiate renal replacement therapy...) or withdrawn (interrupt mechanical ventilation, for example). The modalities for the discontinuation of mechanical ventilation have also been the object of debate (37).

Following a guide for discussions regarding limitation and withdrawal of therapy is attractive, but what role does each individual participating in the meeting truly play? The term "collegial" was coined in the French law of 22 April 2005 undoubtedly to avoid physician omnipotence, while at the same time, relieving the physician of the responsibility of the decision. Conversely, the word "collegial" in its French language signification, implies the guiding principles of action of a college, itself defined as a group of persons of similar rank or having the same function. The term "collegial" therefore seems to be somewhat inappropriate to describe the decision-making process for the limitation or withdrawal of therapy as proposed for end-of-life situations in intensive care, since health professionals have widely differing functions, status, hierarchical levels, competences, and cultures. Alternatives such as "interdisciplinary" or "multidisciplinary" would appear to be more suitable than "collegial", as underlined by the National Consultative Ethics Committee for health and life sciences (CCNE) (38), which advocates moving from a "collegial procedure" towards a "collective and interdisciplinary deliberation". The most appropriate term is probably "multidisciplinary team meeting", which best reflects what truly happens in daily practice at the bedside. The advantage of interdisciplinary discussion is the multiple viewpoints, with exchange of perspectives and confronting of opinions, where all the participants can have their say, regardless of their status or job title. The quality of debate would be all the more enhanced when the objective of the discussion is clearly defined: i.e. discuss the patient's healthcare project, or discuss whether the treatment proposed is unreasonable, unjustified or disproportionate, etc.

Finally, the question of the family's role in the decision-making process is also very important for the majority of medical staff, even though the reality may not reflect this, with reportedly only 40% of families involved in such decisions (19).

Evaluation of practices in terms of collegial procedures for shared decision-making regarding limitation and withdrawal of life-sustaining therapies in the ICU

In 2009, the French Intensive Care Society proposed that end-of-life practices should be evaluated in all ICUs, through their published guide to collegial discussions surrounding the level of therapeutic engagement (16). The evaluation of collegial decision-making covers three aspects: (I) a review of the organisational and practical conditions in which the therapeutic project for a patient at the end-of-life is discussed; (II) an evaluation of the patient's medical file and the traceability of the ethics procedures; and (III) evaluation of the caregivers' experiences through the use of questionnaires.

Within our own research unit, we have evaluated the utility of this guide in the management of patients and the evaluation of caregivers' experiences. We showed that the implementation of collegial decision-making procedures regarding the therapeutic project for each patient on a daily basis led to decisions to limit or withdraw therapy being made more quickly, and improved palliative care (5). It also helped to reduce the incidence of burnout among caregivers in the ICU (39). Indeed, it is now recommended that every ICU in France should evaluate practices in the area of end-of-life on a regular basis.

Conclusions

The procedures that lead to a decision to limit or withdraw therapy should be carried out in a collegial manner, or rather, during collective and interdisciplinary deliberation, in order to ensure that the discussions fully take account of the opinions and reflections of all those involved in the patient's management, and obtaining the patient's opinion (where competent, or through instructions laid down in advance directives) or that of the patient's family.

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Footnote

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