IMA

EMERGING TRENDS IN MEDICINE

AN ETHICAL GUIDE TO END-OF-LIFE DISCUSSIONS

Dr. Joseph Varon
IMA President and Chief Medical Officer

INDEPENDENT™ MEDICAL ALLIANCE

EMERGING TRENDS IN MEDICINE

AN ETHICAL GUIDE TO END-of-LIFE DISCUSSIONS

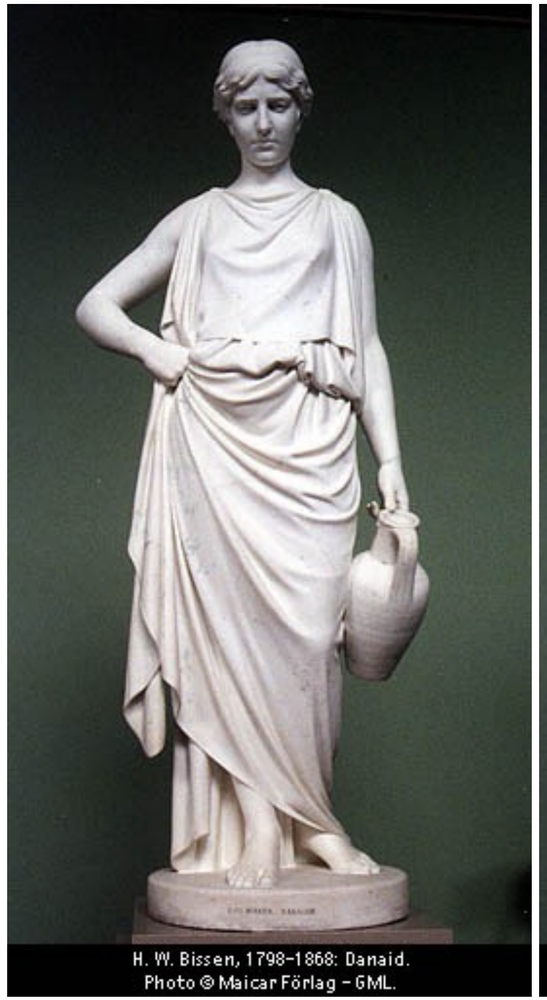
With

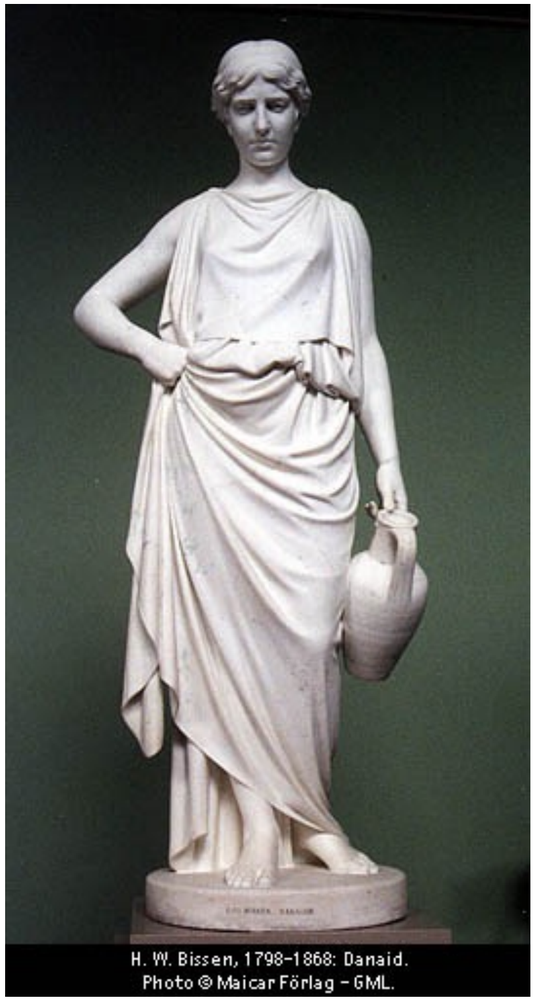
Dr. Joseph Varon

MD, FCCM,
FCCP

The Danaides

- Aegyptus and Danaus were brothers and Aegyptus decided that his fifty sons would marry Danaus' fifty daughters.





The Danaides (Cont..)

- Danaus, king of Argos, wasn't fond of the idea, so he *told his daughters to kill their husbands on their wedding nights* and supplied them with ruby tipped poisoned pins to stick into their hearts.

- All of the Danaides did so (except one, who fell in love with her husband).

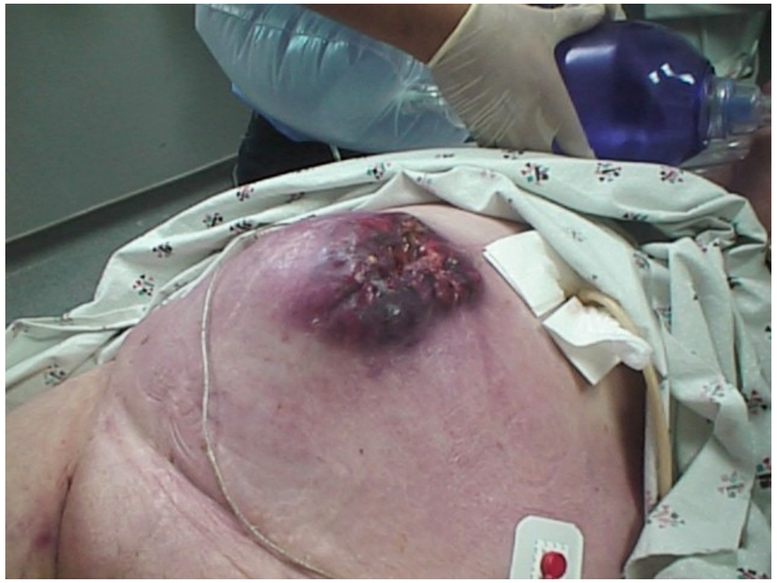
Futility

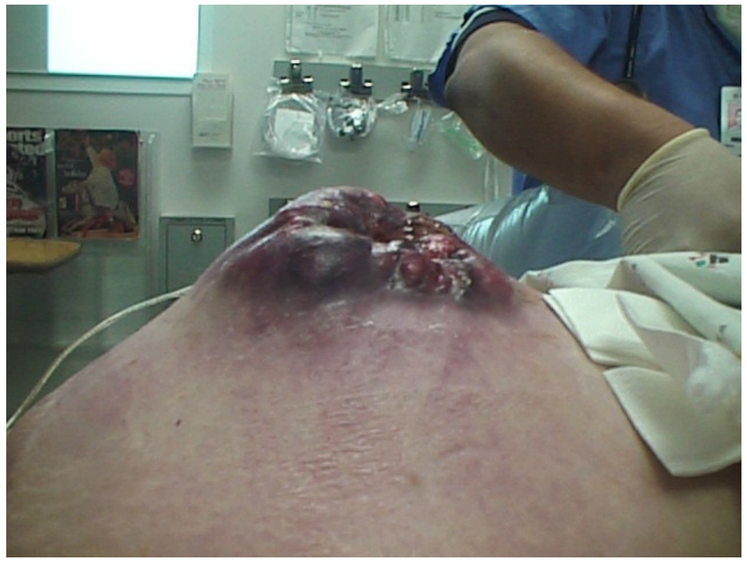
- Condemned by Hades to fetch water from leaky sieves, thus *doomed to fail forever*.
- From the Latin word for leaky (*futilis*) we acquire “futile”

Luce J, Alpers A.: End of life care: What do American courts say? *Crit Care* Med 2001, **29**; N40-N45

Concept of Futility

- Futility means useless or incapable of being achieved.
- The most limited form of futility is physiologic futility, which is present when a certain treatment cannot achieve a desired physiologic effect.





Luce J, Alpers A.: End of life care: What do American courts say? *Crit Care* Med 2001, **29**; N40-N45

Medical Futility

- The concept of medical futility is a broader term that is difficult to quantify.
- Some physicians would argue that mechanical ventilation is futile if it can only keep patients alive but cannot restore health.
- Physicians frequently cite this concept in recommending to patients or their surrogates that life support be withheld or withdrawn.

Schneiderman L, Jecker N, Jonsen A.: Medical futility: Its meaning and ethical implications. *Ann Intern Med* 1990: **112**: 949-954

When are our Treatments Futile?

- The decision not to provide a useless therapy requires 2 sets of value judgments:
  - Any assertion that a therapy will be useless is a matter of probability, not certainty.
  - Uselessness and futility are judged only relative to an end that should be focused on the unique situation and needs of a patient.

Frick S, et al. Medical Futility:Predicting outcome of intensive care unit patients by nurses and doctors-A prospective comparative study. *Crit Care Med*. 2003; **31**: 456-461.

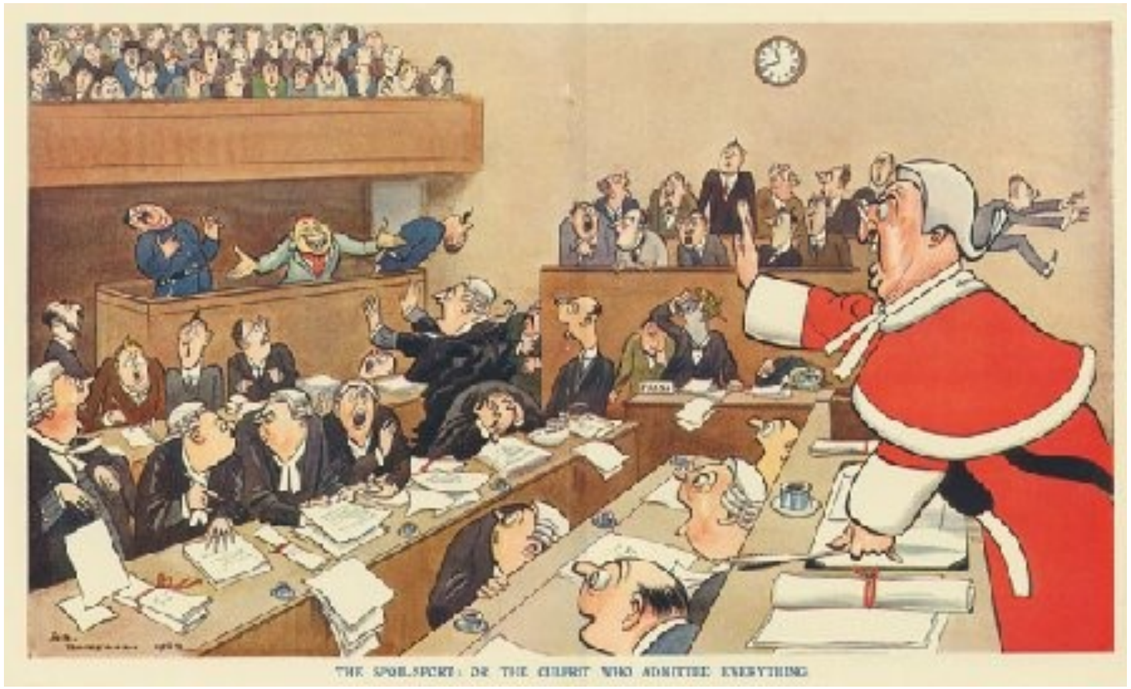
When are our Treatments Futile? (Cont..)

- Judgment that further treatment would be futile is not a conclusion, it would initiate the task of discussing the situations with patients and families

Asch D, Hansen-Flaschen J, Lanken P.: Decisions to limit or continue life-sustaining treatment by critical care physicians in the United States: conflicts between physicians' practices and patients' wishes. *Am J Respir Care Med* 1995; **151**:288-292.

When are our Treatments Futile? (Cont..)

- Judges and juries seem *reluctant to punish physicians who act carefully and within professional standards* in refusing to provide treatment they consider inappropriate.



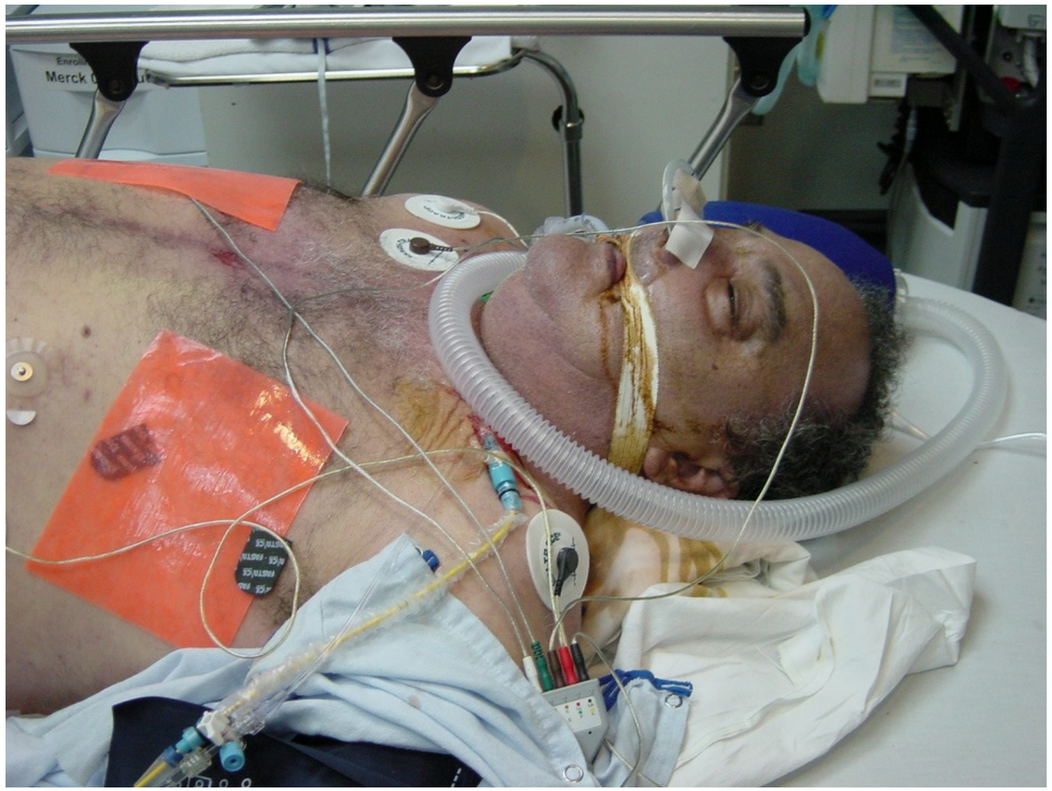
Luce J, Alpers A.: End of life care: What do American courts say? *Crit Care* Med 2001, **29**; N40-N45

When are our Treatments Futile? (Cont..)

The only clear legal rule on medically futile treatment is the traditional malpractice test, which measures treatment decisions against the appropriate standard of medical care and then requires that any substandard care cause the patient injury.

Luce J, Alpers A.: End of life care: What do American courts say? *Crit Care* Med 2001, **29**; N40-N45

Withholding-Withdrawing



- Withholding and/or withdrawing of life-support is a process(es) through which various medical interventions are either not given to a patient or removed from the patient with the expectation that the patient will expire from their underlying illness.

Luce J, Alpers A; Legal aspects of witholding and withdrawing life support from critically ill patients in the U.S. and providing paliative care to them; *Am J Respir Crit Care Med*. 2000; **162** (6): 2029-32

Palliative Care

- Palliative care is the *prevention and treatment of pain, dyspnea and other kinds of sufferings in terminally-ill patients.*

Smedira N,Evans B, et al: Withholding and withdrawal of life support from the critically ill. *N Engl J Med* 1990: **322**: 309-315

Definitions and Categories

Withholding of Life-Support

- Decision not to institute a medically appropriate and potentially beneficial therapy.

Withdrawal of Life-Support

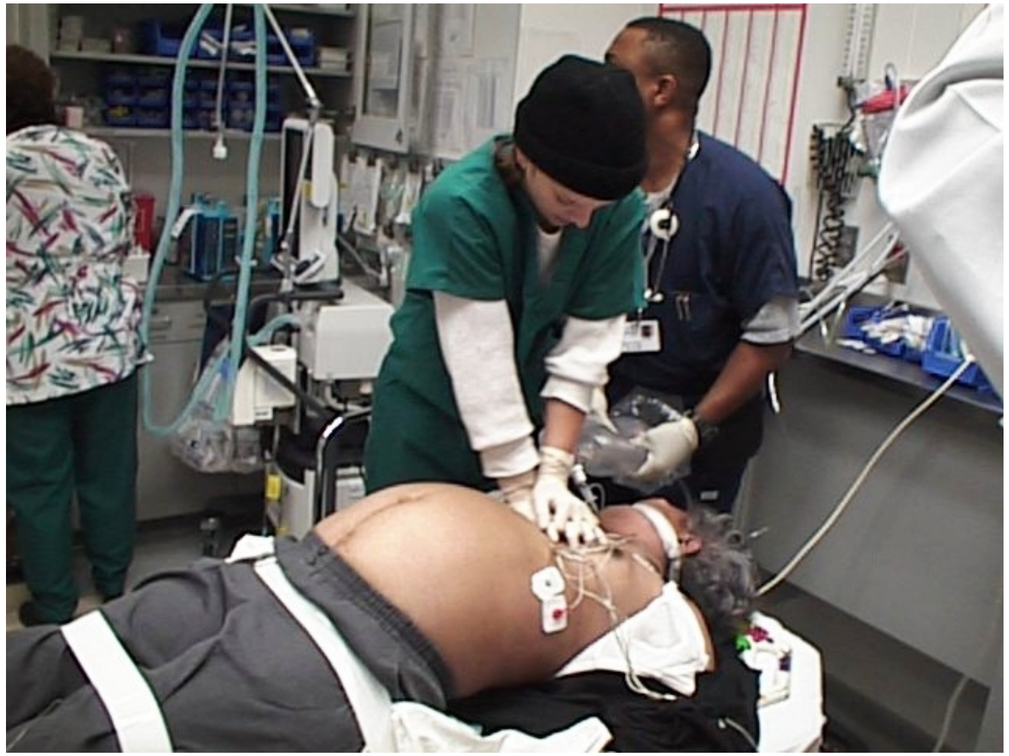
- Cessation and removal of and ongoing medical therapy with the explicit intent not to substitute an equivalent treatment.

Prendergast T, Claessens M, et al.: A national survey of end-of-life care for critically ill patients. *Am J Respir Crit Care Med* 1998; **158**: 1163-1167

Definitions and Categories

- Full Resuscitation
  Aggressive management including full resuscitative attempts.

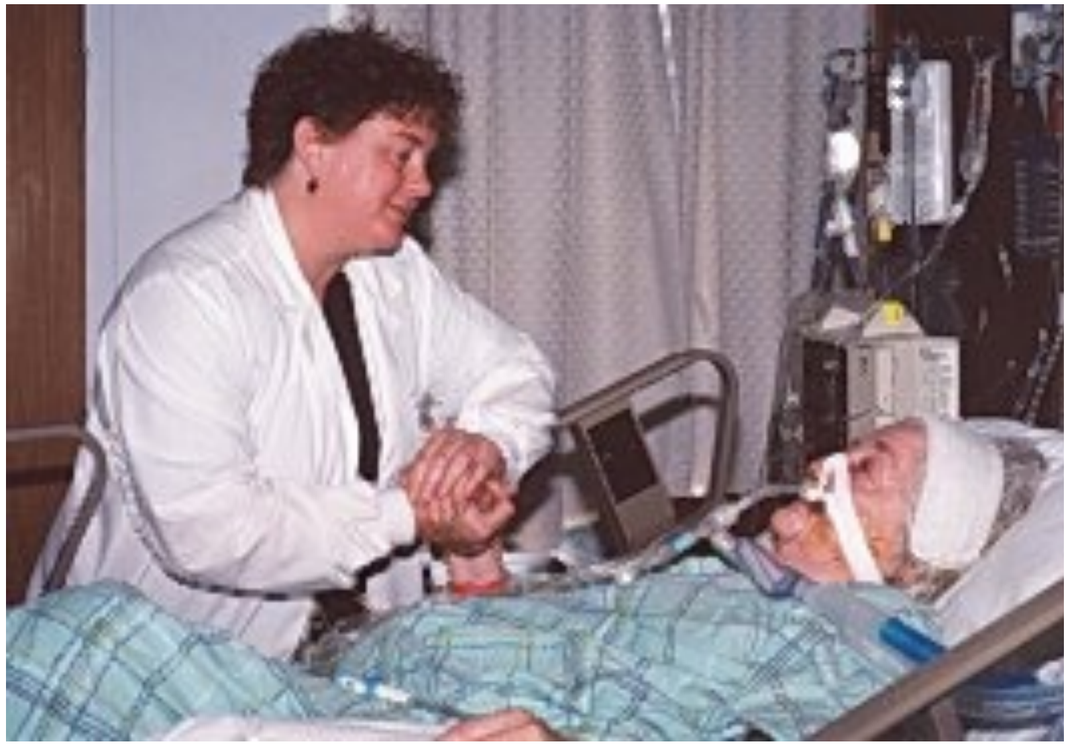
- Withholding Resuscitation
  Aggressive ICU management up to but not including CPR.



Prendergast T, Claessens M, et al.: A national survey of end-of-life care for critically ill patients. *Am J Respir Crit Care Med* 1998; **158**: 1163-1167

What does the data show?

- Of 2926 patients, 11% had an explicit resuscitation directive.
- *50% had a do not resuscitate (DNR) directive*.
- Directives were established by residents in 46% of cases.



Cook DJ, Guyatt G, Rocker G, Sjokvist P, Weaver B, Dodek P, Marshall J, Leasa DJ, Levy M, Varon J, Fisher M, Cook R: CPR directives on admission to intensive-care unit: *Lancet*: 2000; December;**358** (9297):1941-5

The Costs of Dying in The ICU

End-of-life care consumes 10% to 12% of all healthcare expenditures, and 27% of Medicare expenditures.

The use of hospice and advance directives could save 25% to 40% in the last months of life, but the savings decreased to 10% to 17% over the last 6 months and 0% to 10% over the last 12 months.

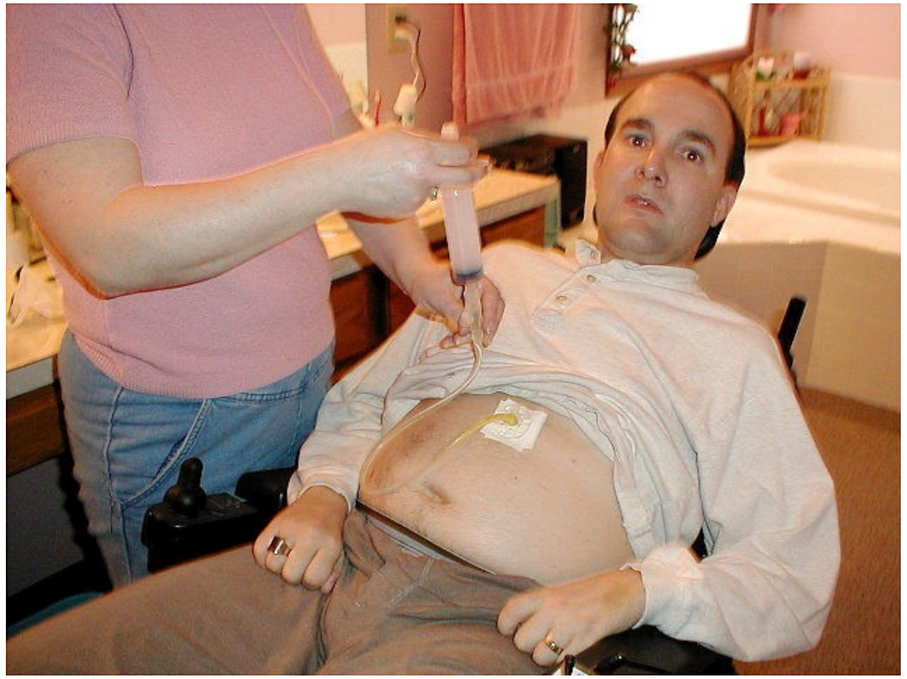
Emanuel, E, Fairclough D.: Understanding Economic and Other Burdens of Terminal Illness. *Ann Intern Med.* 2000; **132**: 451-459

Economics of Dying

- The amount that might be saved by reducing the use of aggressive life-sustaining interventions for dying patients is at most 3.3 percent of total national health care expenditures. In 1993, with $900 billion going to health care, this savings would amount to 29.7 billion.

Emanuel, E: Cost savings at the end-of-life. What do the data show? *JAMA* 1996; **275**; 1907-1914

Legal and Ethical Concerns Regarding Withholding or Withdrawal of Potentially Life-Sustaining treatments



- *Physicians are **not** required to provide all life sustaining possible*
- Patients, on the other hand, have a right to refuse any medical treatment, even life-sustaining treatment such as medical ventilation, or even artificial hydration and nutrition

Ackerman R.:Withholding and Withdrawing Life-Sustaining Treatment. *Am Fam Phys* 2000: **62** (7):1555-1564

Legal and Ethical Concerns Regarding Withholding or Withdrawal of Potentially Life-Sustaining Treatments (Cont..)

- *Withdrawal and withholding of treatment is **not** equivalent to euthanasia.*
- It is not a decision to seek death and end life.
- **Euthanasia** actively seeks to end patient's life

Ackerman R.:Withholding and Withdrawing Life-Sustaining Treatment. *Am Fam Phys* 2000: **62** (7):1555-1564

Legal and Ethical Concerns Regarding Withholding or Withdrawal of Potentially Life-Sustaining Treatments (Cont..)

- *You are not killing the patient when you remove the ventilator and treat the pain.*

- The *intent and sequence of actions* are important, as are the means chosen.
- The intent is to secure comfort not death.

Ackerman R.:Withholding and Withdrawing Life-Sustaining Treatment. *Am Fam Phys* 2000: **62** (7):1555-1564

What do the American courts say?

In the United States, withholding and withdrawing life support are legally justified primarily by the principles of informed consent and informed refusal.

Both principles have a strong roots in the common law, which reflects the American regard for self-determination.

Luce JM, Alpers A, End of life care: What do American courts say? *Crit Care Med* 2001; **29**, (2) N40-N45

What do American Courts Say? (Cont..)

The application of the principles of informed consent and informed refusal to the care of incompetent critically ill patients began with *Quinlan* case .

In re Quinlan, 775 A2A 647 (NJ), cert denied, 429, 429 US 922 (1976)

What do American Courts Say? (Cont..)

In this case the Supreme Court of New Jersey held that a patient had the right to refuse mechanical ventilation, and that because she was vegetative and could not exercise that right directly, her parents could act as surrogates and make a “substituted judgment”.

In re Quinlan, 775 A2A 647 (NJ), cert denied, 429, 429 US 922 (1976)

What do American Courts Say? (Cont..)

- The issue of withholding and withdrawal of life support was first addressed by the U.S. Supreme Court in the mentioned *Cruzan* case, which involved a parents' request to have a feeding tube removed from their vegetative daughter in a Missouri nursing home.

Cruzan v Director, Missouri Department of Health, 497 DS 261 (1990)

What do American Courts Say? (Cont..)

- As for rules regarding what surrogates can decide, all states agree that such decisions should be guided by the wishes of the patient.
- It is often difficult to prove what kind of treatment a patient would desire in a given situation.

Luce JM, Alpers A, End of life care: What do American courts say? *Crit Care Med* 2001; **29**, (2) N40-N45

Surrogates

When surrogates make decisions for a patient they should use the following criteria:

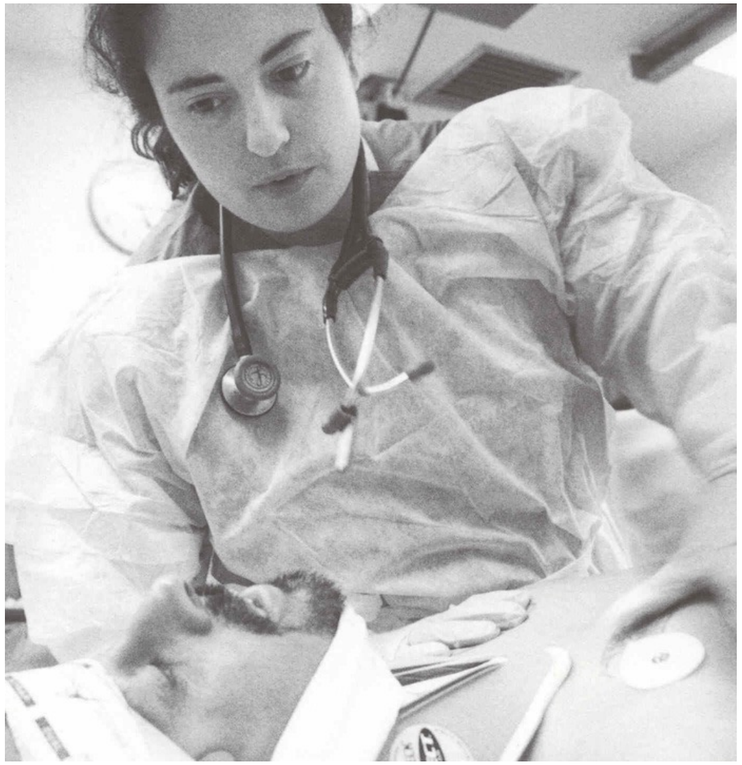
Subjective standard: advance directive, what did the patient say in the past.

Substituted judgment: who best represents the patient, what would the patient say.

Quill T, et al: The rule of double effect- a critique of its role in end-of-life decision making. *N Engl J Med* 1997; **337**: 1768-1771

"Medical ethics do not allow me to assist in your death. I am, however, permitted to keep you miserable as long as possible."

Factors Involved in the Decision-Making Process



- Poor prognosis for acute survival
- Poor prognosis for long term survival
- Poor quality of life

Street K, Ashcroft R, Henderson J: The Decision Making Process Regarding the Withdrawal or Withholding of potential Life-Saving Treatment in a Children's Hospital. *J Med Ethics* 2000; **26**: 346-352

Factors Involved in the Decision-Making Process (Cont..)

Family expressed wishes

Patients expressed wishes

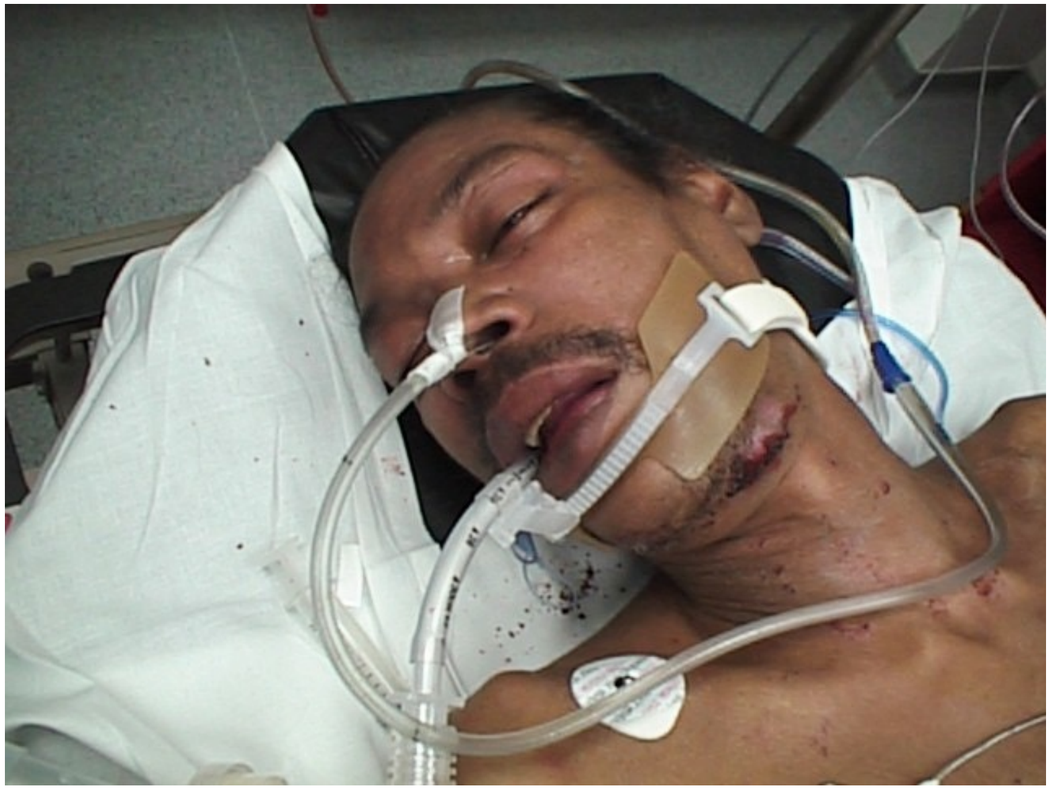
Dissent between parties

Physical health prior to admission

Intolerable suffering of the patient long term illness.

Street K, Ashcroft R, Henderson J: The Decision Making Process Regarding the Withdrawal or Withholding of potential Life-Saving Treatment in a Children's Hospital. *J Med Ethics* 2000; **26**: 346-352

Factors Involved in the Decision-Making Process (Cont..)



- Family perception of unbearable acute suffering.
- Family perception of poor quality of life long term.
- Intolerable suffering during acute illness.
- Hospital resources

Street K, Ashcroft R, Henderson J: The Decision Making Process Regarding the Withdrawal or Withholding of potential Life-Saving Treatment in a Children's Hospital. *J Med Ethics* 2000; **26**: 346-352

The Four Principles of Dealing with Terminal Patients include:

Beneficience: the obligation to provide benefits.

Non-maleficence: the obligation to avoid the causation of harm.

Respect for autonomy: the obligation to respect the decision making capacities of autonomous persons.

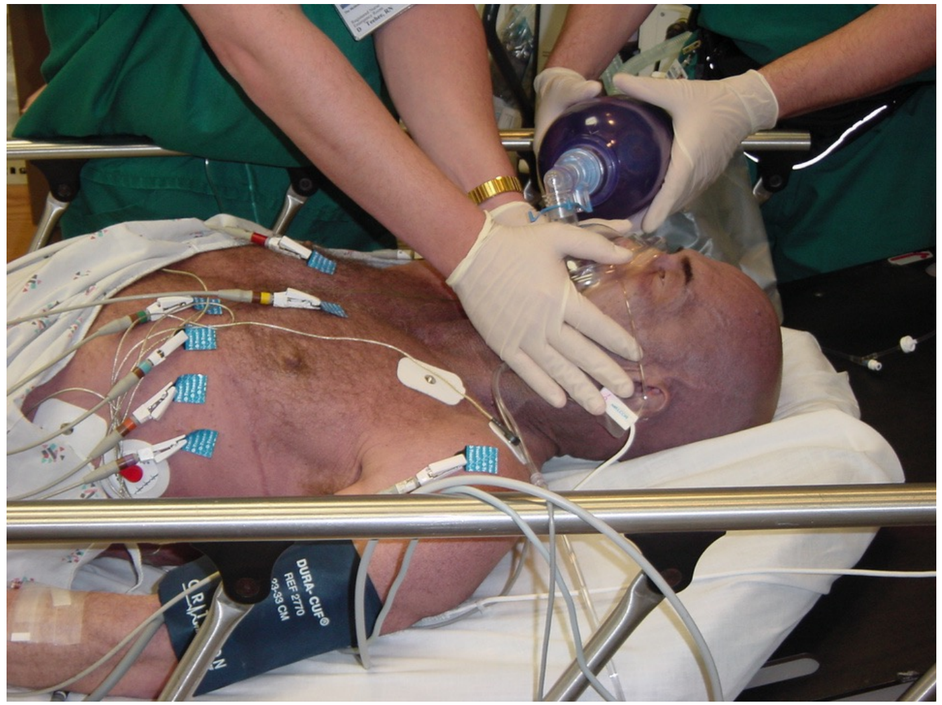
Justice: obligations of fairness in distribution of benefits and risk.

Beauchamp T. The four principles Approach. In: Gillon R, ed. Principles of Health Care Ethics. New York: *John Willey and Sons*, 1994, 3-12

How much do we really want to be done?

- In the event of a cardiac arrest *less than 20% of physicians would want to undergo cardiopulmonary resuscitation* in the setting of chronic end stage organ failure.

- If death was imminent, 87% of physicians indicated they would want treatment withdrawn.



Marik P, Varon J.: Physicians, own preferences to the limitation and withdrawal of life-sustaining therapy. *Resuscitation* 1999**: 42**: 197-201

How much do we really want to be done? (Cont..)

- 95% of physicians indicated that they would want treatment withdrawn should they be in persistent vegetative state.

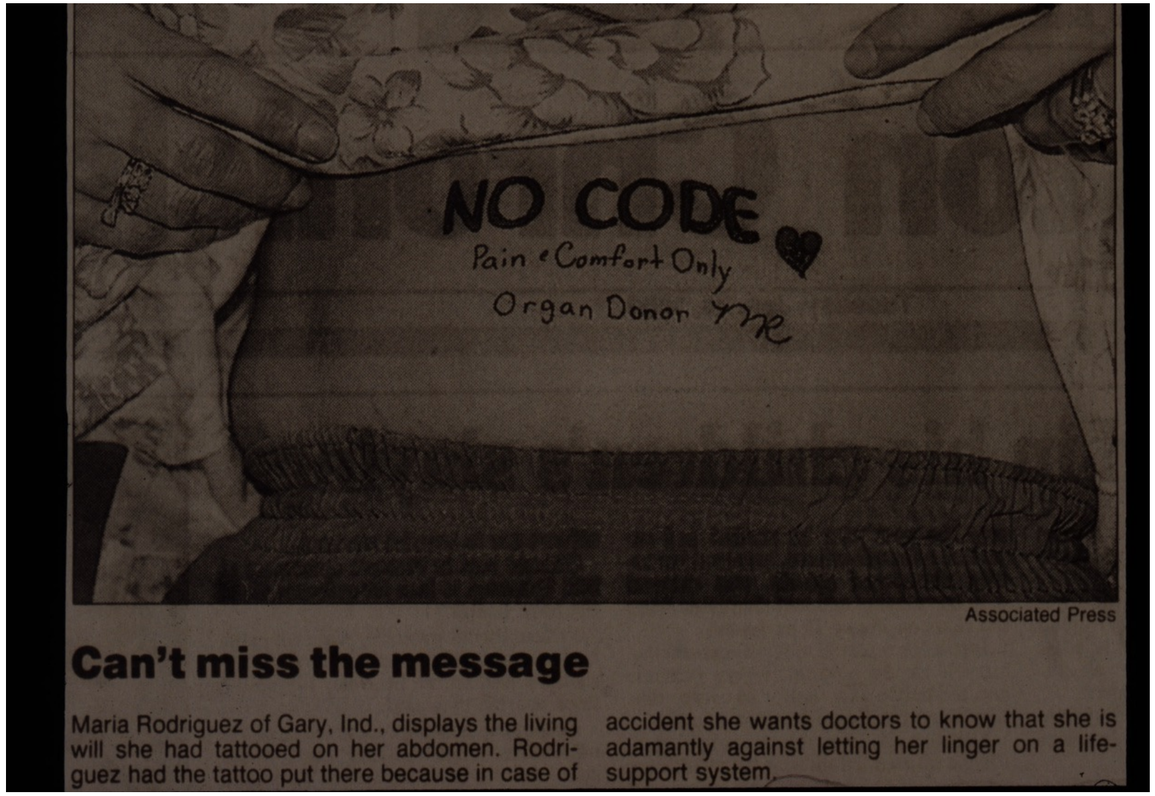
- Only 1% of physicians believed that health care providers should never remove or withhold life-sustaining therapy.

Marik P, Varon J.: Physicians, own preferences to the limitation and withdrawal of life-sustaining therapy. *Resuscitation* 1999**: 42**: 197-201

How much do we really want to be done? (Cont..)

- The most of the medical professionals favored resuscitation in a university hospital over other sites.

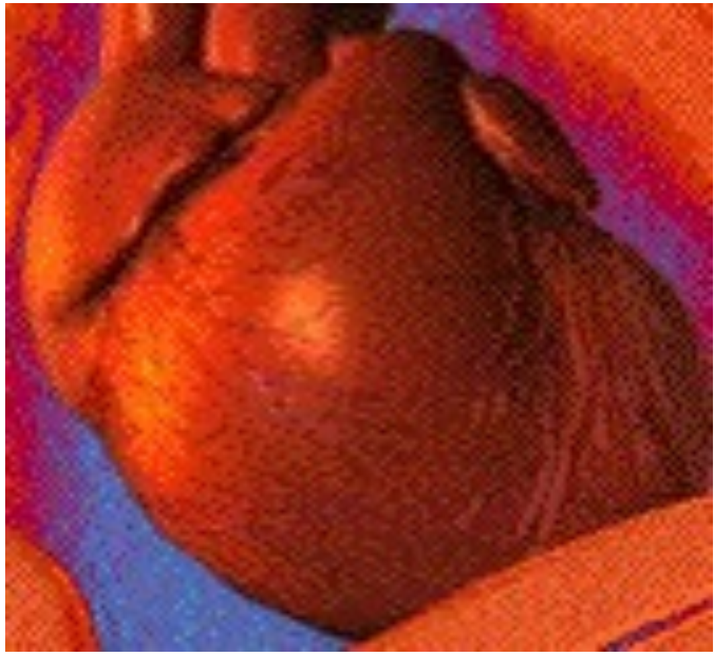
- More nurses requested to be “no code” compared with other professionals.



Varon J, Sternbach G, Rudd P, Combs A: Resuscitation attitudes among medical personnel: How much do we really want to be done? *Resuscitation* 1991; **22**: 229-235.

How much do we really want to be done? (Cont..)

- Attending physicians requested that CPR attempts be terminated after less time than any other group.
- Medical students requested resuscitation more than any other group.



Varon J, Sternbach G, Rudd P, Combs A: Resuscitation attitudes among medical personnel: How much do we really want to be done? *Resuscitation* 1991; **22**: 229-235.

Are There Any Guidelines?

Respect for patient autonomy is the primary basis for withholding and withdrawing life sustaining therapy.

When a patient lacks decision-making capacity, a surrogate decision maker should be identified to help make decisions on the patient's behalf regarding life-sustaining therapies.

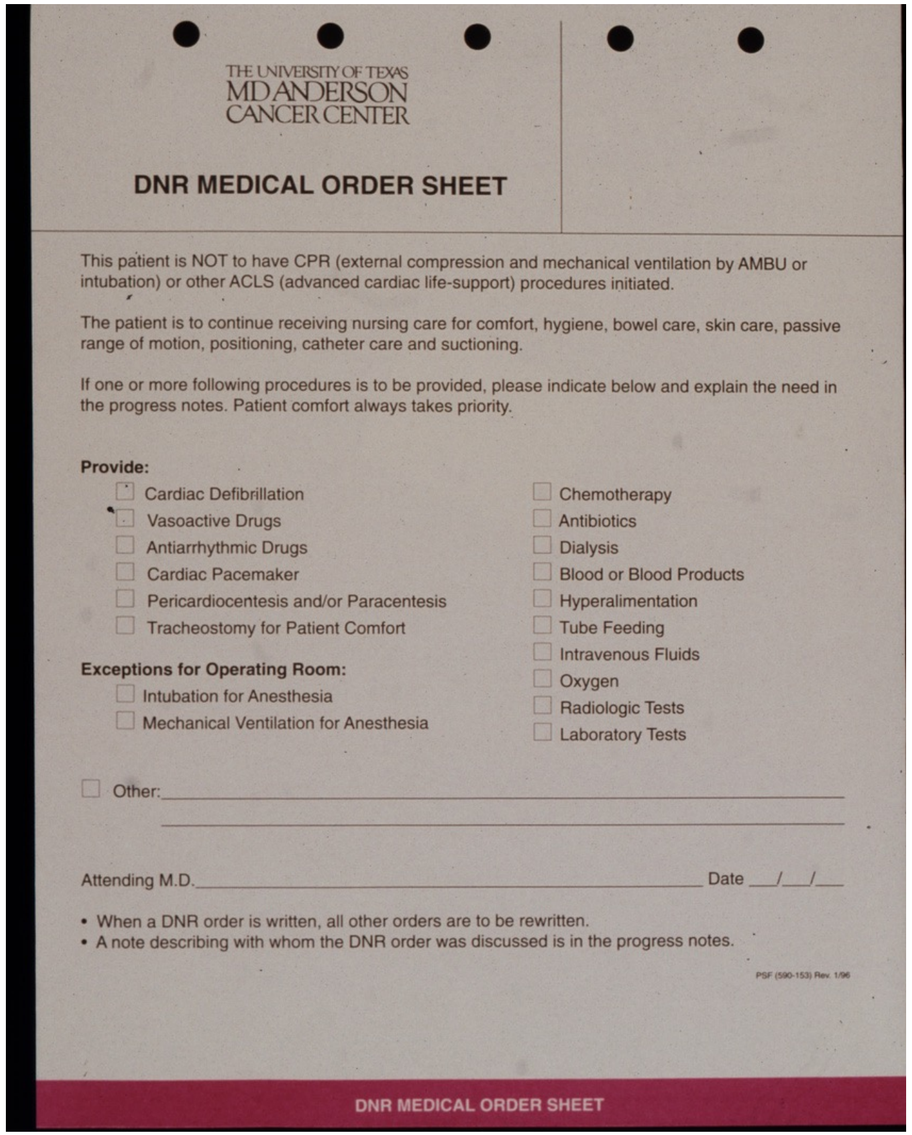
Ruark, J, et al: Initiating and withdrawing life support. Principles and practice in adult medicine. N Engl J Med 1988; 318: 25

Are there any Guidelines? (Cont ..)

A life-sustaining medical intervention can be limited without the consent of the patient or surrogate when the intervention is judged to be futile.

Health care institutions have a responsibility to promote ethical sound decision making regarding life-sustaining therapy.

ATS guidelines: www.utdol.com 2003



THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER

DNR MEDICAL ORDER SHEET

This patient is NOT to have CPR (external compression and mechanical ventilation by AMBU or intubation) or other ACLS (advanced cardiac life-support) procedures initiated.

The patient is to continue receiving nursing care for comfort, hygiene, bowel care, skin care, passive range of motion, positioning, catheter care and suctioning.

If one or more following procedures is to be provided, please indicate below and explain the need in the progress notes. Patient comfort always takes priority.

Provide:

- ☐ Cardiac Defibrillation
- ☐ Vasoactive Drugs
- ☐ Antiarrhythmic Drugs
- ☐ Cardiac Pacemaker
- ☐ Pericardiocentesis and/or Paracentesis
- ☐ Tracheostomy for Patient Comfort

Exceptions for Operating Room:

- ☐ Intubation for Anesthesia
- ☐ Mechanical Ventilation for Anesthesia

- ☐ Chemotherapy
- ☐ Antibiotics
- ☐ Dialysis
- ☐ Blood or Blood Products
- ☐ Hyperalimentation
- ☐ Tube Feeding
- ☐ Intravenous Fluids
- ☐ Oxygen
- ☐ Radiologic Tests
- ☐ Laboratory Tests

☐ Other:_____

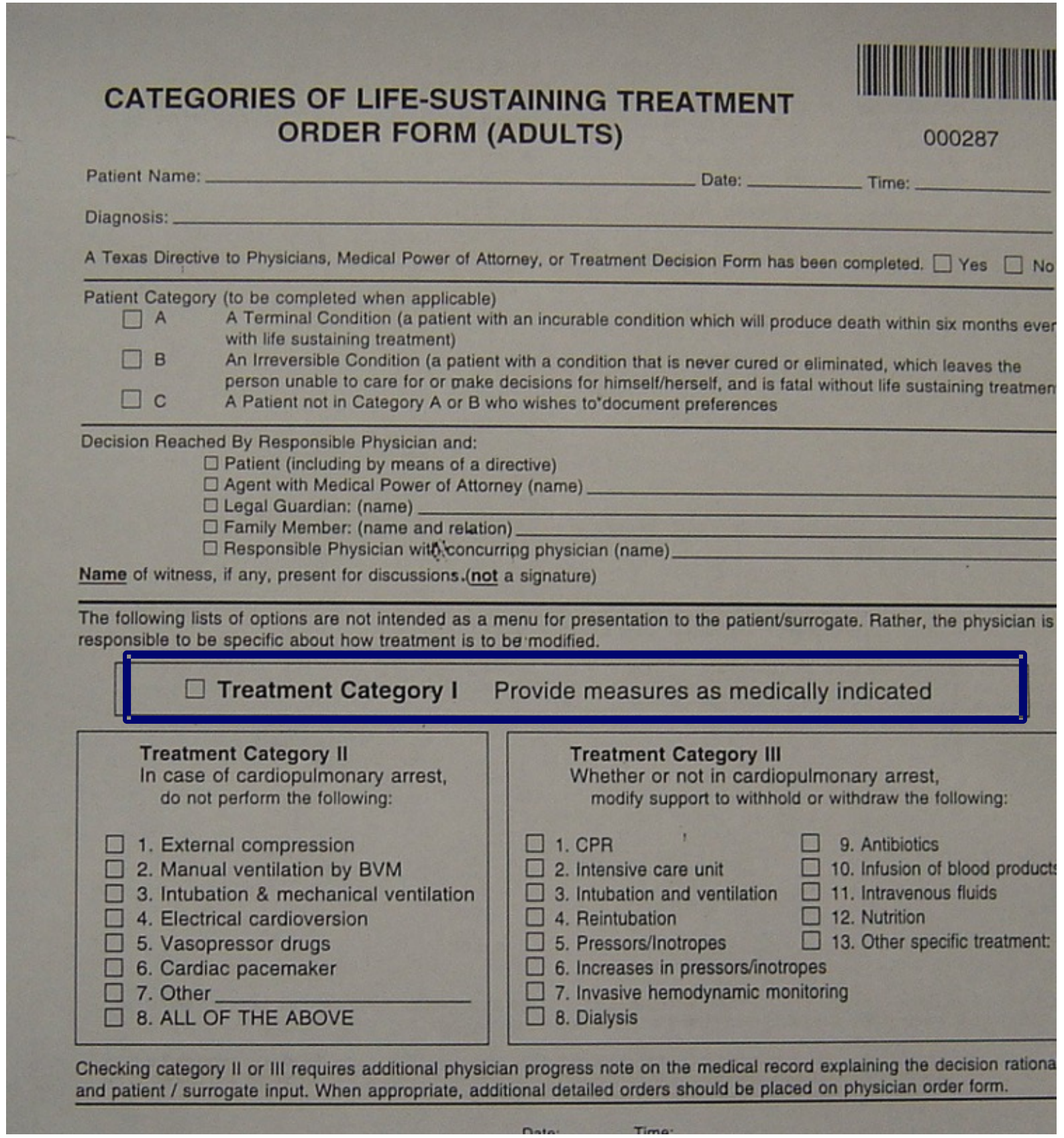
_____

Attending M.D._____ Date ___/___/___

- When a DNR order is written, all other orders are to be rewritten.
- A note describing with whom the DNR order was discussed is in the progress notes.

PSF (590-153) Rev. 1/96

DNR MEDICAL ORDER SHEET



CATEGORIES OF LIFE-SUSTAINING TREATMENT ORDER FORM (ADULTS)

000287

Patient Name: _____ Date: _____ Time: _____

Diagnosis: _____

A Texas Directive to Physicians, Medical Power of Attorney, or Treatment Decision Form has been completed. ☐ Yes ☐ No

Patient Category (to be completed when applicable)

- ☐ A — A Terminal Condition (a patient with an incurable condition which will produce death within six months ever with life sustaining treatment)
- ☐ B — An Irreversible Condition (a patient with a condition that is never cured or eliminated, which leaves the person unable to care for or make decisions for himself/herself, and is fatal without life sustaining treatmen
- ☐ C — A Patient not in Category A or B who wishes to document preferences

Decision Reached By Responsible Physician and:

- ☐ Patient (including by means of a directive)
- ☐ Agent with Medical Power of Attorney (name) _____
- ☐ Legal Guardian: (name) _____
- ☐ Family Member: (name and relation) _____
- ☐ Responsible Physician with concurring physician (name) _____

Name of witness, if any, present for discussions. (not a signature)

The following lists of options are not intended as a menu for presentation to the patient/surrogate. Rather, the physician is responsible to be specific about how treatment is to be modified.

☐ **Treatment Category I** Provide measures as medically indicated

Treatment Category II
In case of cardiopulmonary arrest, do not perform the following:

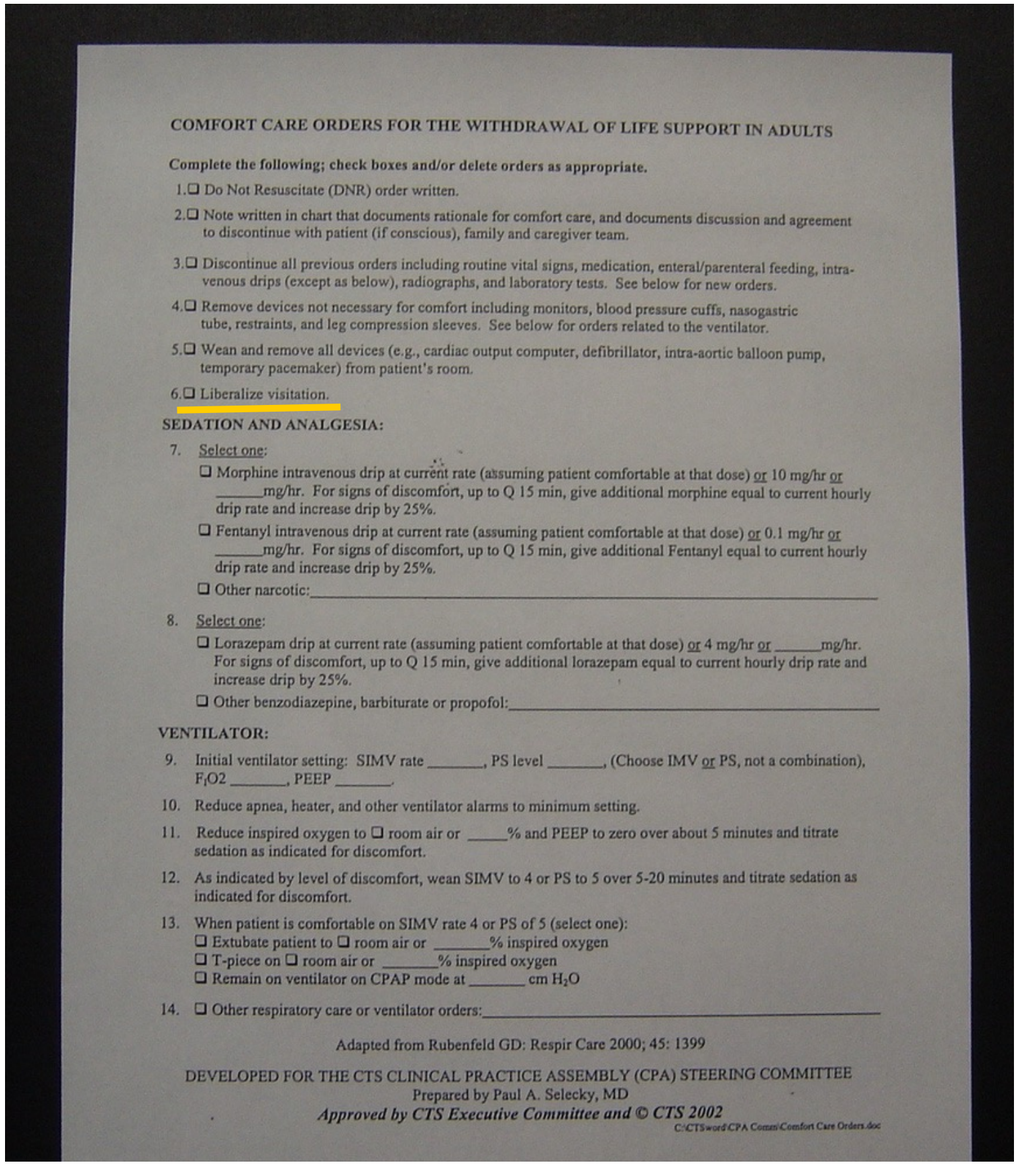
- ☐ 1. External compression
- ☐ 2. Manual ventilation by BVM
- ☐ 3. Intubation & mechanical ventilation
- ☐ 4. Electrical cardioversion
- ☐ 5. Vasopressor drugs
- ☐ 6. Cardiac pacemaker
- ☐ 7. Other _____
- ☐ 8. ALL OF THE ABOVE

Treatment Category III
Whether or not in cardiopulmonary arrest, modify support to withhold or withdraw the following:

- ☐ 1. CPR
- ☐ 2. Intensive care unit
- ☐ 3. Intubation and ventilation
- ☐ 4. Reintubation
- ☐ 5. Pressors/Inotropes
- ☐ 6. Increases in pressors/inotropes
- ☐ 7. Invasive hemodynamic monitoring
- ☐ 8. Dialysis
- ☐ 9. Antibiotics
- ☐ 10. Infusion of blood products
- ☐ 11. Intravenous fluids
- ☐ 12. Nutrition
- ☐ 13. Other specific treatment:

Checking category II or III requires additional physician progress note on the medical record explaining the decision rationa and patient / surrogate input. When appropriate, additional detailed orders should be placed on physician order form.

Date: Time:



COMFORT CARE ORDERS FOR THE WITHDRAWAL OF LIFE SUPPORT IN ADULTS

Complete the following; check boxes and/or delete orders as appropriate.

1. ❑ Do Not Resuscitate (DNR) order written.
2. ❑ Note written in chart that documents rationale for comfort care, and documents discussion and agreement to discontinue with patient (if conscious), family and caregiver team.
3. ❑ Discontinue all previous orders including routine vital signs, medication, enteral/parenteral feeding, intravenous drips (except as below), radiographs, and laboratory tests. See below for new orders.
4. ❑ Remove devices not necessary for comfort including monitors, blood pressure cuffs, nasogastric tube, restraints, and leg compression sleeves. See below for orders related to the ventilator.
5. ❑ Wean and remove all devices (e.g., cardiac output computer, defibrillator, intra-aortic balloon pump, temporary pacemaker) from patient's room.
6. ❑ Liberalize visitation.

SEDATION AND ANALGESIA:

7. Select one:
   - ❑ Morphine intravenous drip at current rate (assuming patient comfortable at that dose) or 10 mg/hr or _____mg/hr. For signs of discomfort, up to Q 15 min, give additional morphine equal to current hourly drip rate and increase drip by 25%.
   - ❑ Fentanyl intravenous drip at current rate (assuming patient comfortable at that dose) or 0.1 mg/hr or _____mg/hr. For signs of discomfort, up to Q 15 min, give additional Fentanyl equal to current hourly drip rate and increase drip by 25%.
   - ❑ Other narcotic:_____
8. Select one:
   - ❑ Lorazepam drip at current rate (assuming patient comfortable at that dose) or 4 mg/hr or _____mg/hr. For signs of discomfort, up to Q 15 min, give additional lorazepam equal to current hourly drip rate and increase drip by 25%.
   - ❑ Other benzodiazepine, barbiturate or propofol:_____

VENTILATOR:

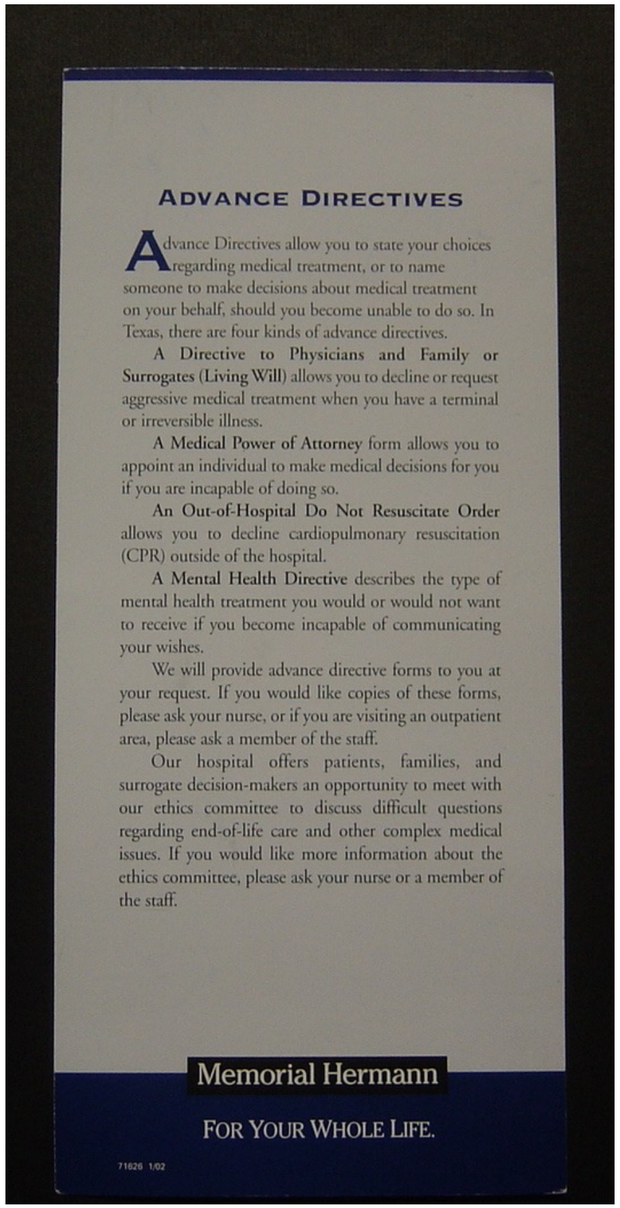
9. Initial ventilator setting: SIMV rate _____, PS level _____, (Choose IMV or PS, not a combination), F_iO2 _____, PEEP _____.
10. Reduce apnea, heater, and other ventilator alarms to minimum setting.
11. Reduce inspired oxygen to ❑ room air or _____% and PEEP to zero over about 5 minutes and titrate sedation as indicated for discomfort.
12. As indicated by level of discomfort, wean SIMV to 4 or PS to 5 over 5-20 minutes and titrate sedation as indicated for discomfort.
13. When patient is comfortable on SIMV rate 4 or PS of 5 (select one):
    - ❑ Extubate patient to ❑ room air or _____% inspired oxygen
    - ❑ T-piece on ❑ room air or _____% inspired oxygen
    - ❑ Remain on ventilator on CPAP mode at _____ cm H_2O
14. ❑ Other respiratory care or ventilator orders:_____

Adapted from Rubenfeld GD: Respir Care 2000; 45: 1399

DEVELOPED FOR THE CTS CLINICAL PRACTICE ASSEMBLY (CPA) STEERING COMMITTEE
Prepared by Paul A. Selecky, MD

Approved by CTS Executive Committee and © CTS 2002

C:\CTS word\CPA Comm\Comfort Care Orders.doc



ADVANCE DIRECTIVES

Advance Directives allow you to state your choices regarding medical treatment, or to name someone to make decisions about medical treatment on your behalf, should you become unable to do so. In Texas, there are four kinds of advance directives.

A Directive to Physicians and Family or Surrogates (Living Will) allows you to decline or request aggressive medical treatment when you have a terminal or irreversible illness.

A Medical Power of Attorney form allows you to appoint an individual to make medical decisions for you if you are incapable of doing so.

An Out-of-Hospital Do Not Resuscitate Order allows you to decline cardiopulmonary resuscitation (CPR) outside of the hospital.

A Mental Health Directive describes the type of mental health treatment you would or would not want to receive if you become incapable of communicating your wishes.

We will provide advance directive forms to you at your request. If you would like copies of these forms, please ask your nurse, or if you are visiting an outpatient area, please ask a member of the staff.

Our hospital offers patients, families, and surrogate decision-makers an opportunity to meet with our ethics committee to discuss difficult questions regarding end-of-life care and other complex medical issues. If you would like more information about the ethics committee, please ask your nurse or a member of the staff.

Memorial Hermann

FOR YOUR WHOLE LIFE.

71626 1/02

Initiating End-of-Life Discussions With Seriously-Ill Patients

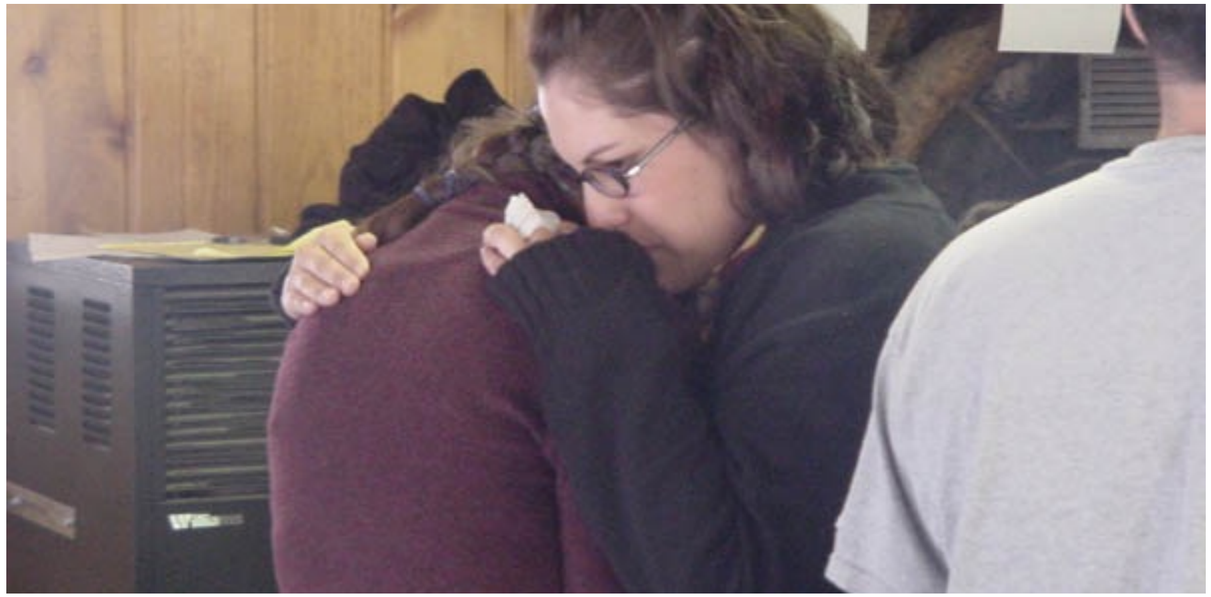
Eight Step Protocol:

- Be familiar with institutional policies and state law.
- Choose an appropriate, private setting for the discussion.
- Ask the patient and family what they understand.

Ackerman R.Withholding and Withdrawing Life-Sustaining Treatment. *Am Fam Phys* 2000: **62** (7):1555-1564

Initiating End-of-Life Discussions With Seriously-Ill Patients (Cont..)

- Discuss the patient's values and general goals of care.
- Establish context for the discussion.
- Discuss specific treatment preferences.
- Respond to emotions.
- Establish and implement the plan.



Ackerman R.Withholding and Withdrawing Life-Sustaining Treatment. *Am Fam Phys* 2000: **62** (7):1555-1564

Forgoing Life Support

When several interventions are in use, a somewhat predictable pattern of withdrawal often occurs.

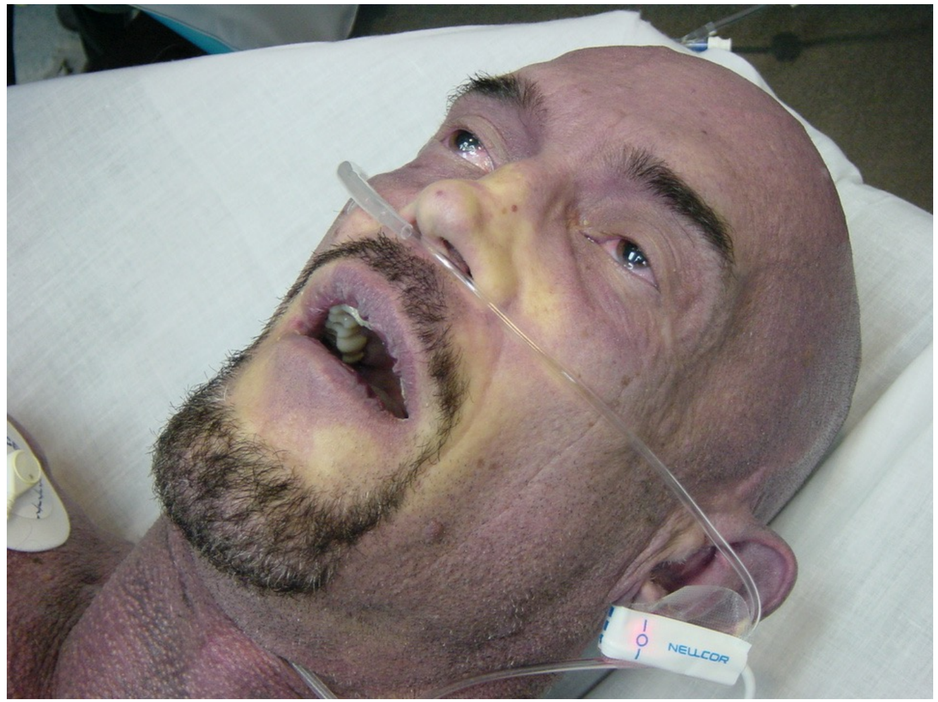
First, dialysis, further diagnostic workups, and vasopressors are discontinued.

Next, intravenous fluids, hemodynamic and electrocardiographic monitoring, laboratory tests, and antibiotic treatment are stopped, and finally artificial feedings and mechanical ventilation are withdrawn.

Faber-Langendoen K, Spomer A, Ingbar D.:A prospective study of withdrawing mechanical ventilation from dying patients. *Am J Respir Care Med*. 1996; **153**: 4S

Forgoing Life Support (Cont..)

- Surrogates may find it easier to decide to avoid beginning new interventions or to withhold antibiotics or dyalisis because in these cases, the link between forgoing the intervention and death is not so obvious.



Christakis N, Asch D.: Medical specialists prefer to withdraw familiar technologies when discontinuing life support. *J Gen Intern Med.* 1995; **10**: 491-494

Methods of Withdrawing Ventilator Support

Method	Positive Aspects	Negative Aspects
Prolonged terminal weaning	Allows titration of drugs to control dyspnea Maintains airway for suctioning Create more “emotional distance” between ventilator withdrawal and patient’s death	May prolong the dying process May mislead family to think that survival is still a goal or therapy Interposes a machine between family and patient Precludes any possibility of verbal communication

Gianakos D.:Terminal weaning. *Chest*. 1995; **108**: 1405-1406

Methods Of Withdrawing Ventilator Support (Cont..)

Method	Positive Aspects	Negative Aspects
Extubation	Allows patient to be free unwanted technology Is less likely to prolong the dying process	Family may interpret noisy breathing caused by airway secretions or agonal breaths as discomfort May cause dyspnea at time of extubation, especially if anticipatory sedation is not given

Gilligan T, Raffin T.: Withdrawing life support: extubation and prolonged terminal weans are inappropiate. *Crit Care Med*. 1996; **24**: 352-353

Methods Of Withdrawing Ventilator Support (Cont..)

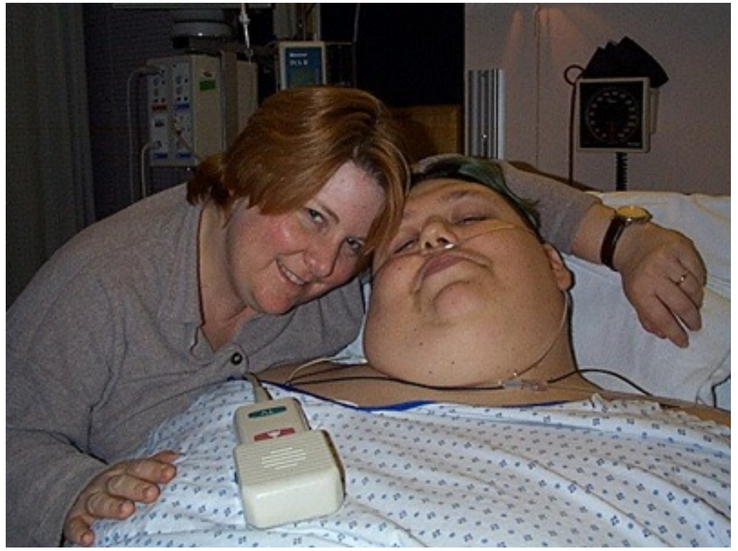
Method	Positive Aspects	Negative Aspects
Rapid terminal weaning	Maintains airway for suctioning Is less likely to prolong the dying process	Interposes machine between family and patient Precludes any possibility of verbal communication

Gianakos D.:Terminal weaning. *Chest*. 1995; **108**: 1405-1406

Ways in Which the ICUs can Simulate a Home Environment for Dying Patients

Transportable Aspect of a Patient's Home	Ways To provide This Aspects in the Intensive Care Unit
Privacy	Provide a private room Close doors and curtains
Ready access to family	Suspend restrictive visiting hours Provide comfortable chairs, recliners, and cots for family members in the patient's room
Access to patient's own possessions and amenities	Allow family to bring in favorite music, clothes, religious icons, food and pets
Family serving as personal caregivers	When appropriate, allow family to assist with patient care
Access to religious rituals and spiritual support	Provide religious and spiritual resources Encourage religious and other family rituals at the bedside before and after death

Miller F, Fins J.: A proposal to restructure hospital care for dying patients. *N Engl J Med*. 1996; **334**: 1740-1742.



Conclusions

Respect patient autonomy provided that request are reasonable

Communication

Dignified death must include NO PAIN or SUFFERING

Thank you

For more medical education visit
www.IMAhealth.org

IMA 2026
EMERGING TRENDS IN MEDICINE

INDEPENDENT™
MEDICAL ALLIANCE