

EDITORIAL



Making good death more accessible: end-of-life care in the intensive care unit

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Despite advances in critical care medicine, decisions and communications about withholding or withdrawing life-sustaining interventions are routine for intensive care unit (ICU) physicians who attend critically ill patients [1]. Nonetheless, the quality of the dying process and ICU physicians' comfort in discussing end-of-life issues with families vary not only across the globe but also within a region. In a large-scale study on the practices of ICU physicians in Asia who manage critically ill patients [2], respondents reportedly often withheld but seldom withdrew life-sustaining treatments at the end-of-life, although variations in attitudes and practice exist across countries and regions. Using the data from that study, Phua et al. [3] report in a recent article how regional economic status in particular has a significant impact on ICU physicians' attitudes regarding withholding or withdrawing life-sustaining interventions for end-of-life patients. Physicians in low-middle income countries were less likely to withhold and withdraw resource-intensive and invasive interventions (e.g. cardiopulmonary resuscitation, mechanical ventilation and vasopressors and inotropes, tracheostomy and haemodialysis), although they were more likely to forego less aggressive interventions (e.g. enteral nutrition, intravenous fluid therapy, oral suctioning). These physicians, who are more inclined to accede to families' requests to withdraw life-sustaining treatments on financial grounds, are nevertheless more agreeable to follow families' demands to continue these interventions, possibly out of their perceived legal risks associated with a lack of policies and ethical guidance on limiting and overriding family requests for non-beneficial treatments [3].

The interesting, albeit somewhat counterintuitive, finding of physicians' relative comfort in foregoing less invasive interventions while continuing aggressive artificial life support in a family-driven environment begs the question of how well families understand these different interventions, and how information regarding these interventions is being communicated. While death in the ICU is common, less than half of the ICU physicians in the study [3]—40.6 % of those from high income countries and 46.3 % from low-middle income countries—feel comfortable in having end-of-life discussions with patients' families. Such discomfort highlights the possibility that even well-intended clinicians may miss valuable opportunities to address and clarify families' misunderstandings and concerns regarding goals of care at the end of life [4].

While Phua et al.'s [3] regional focus may invite East–West comparisons on cultural attitudes and decision-making processes regarding death and dying [5], culture is only meaningful when analysed and interpreted in particular local sites and contexts [6]. Socio-economic, legal, professional, religious, educational and technological factors intersect and frame not only families' expectations but also clinicians' contribution and responses to these expectations. Higher income countries, many of which have relatively more democratic structures, established legal and institutional frameworks, and educational curricula regarding patient rights, generally have greater emphasis on respect for patient autonomy compared to low-middle income areas [7]. Various healthcare team members may also have different perceptions given their educational background, roles and experiences. Monolithic claims regarding “Asian culture” or “Western culture” may thus be too simplistic in guiding end-of-life care discussions and decisions. More importantly, critical care medicine also has a unique culture that intersects with various end-of-life norms. Its heroic rescue mission

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[1] may frame physicians' experiences, hopes and fears in treating severely ill patients and discussing end-of-life planning. Change in attitude and behaviour can thus be mentally and emotionally challenging in the ICU, especially when legal guidelines and institutional support may be lacking.

Professional education, ethical guidelines and institutional policies regarding end-of-life care thus need to consider such multidimensional factors. They need to address the intricate and nuanced contexts that frame patients', families' and clinicians' respective expectations, including how these expectations may coincide and diverge. Even among countries/regions with a high proportion of Chinese populations (e.g. China, Taiwan, Hong Kong, Singapore), Phua et al.'s study [3] shows that different education in and access to palliative care were associated with varying attitudes towards withholding and withdrawing life-sustaining interventions.

Indeed, different attitudes regarding end-of-life interventions may also exist within one country. In Taiwan, which passed the Hospice and Palliative Care Act in 2000 and Patient Self-Determination Act in 2015, the rate of do-not-resuscitate (DNR) practice in terminally ill patients gradually increased in the last 10 years (2001–2011) [8] as more education and guidelines became available. Nevertheless, academic medical centres, which generally have more elaborate guidelines and training regarding end-of-life care, practised DNR more frequently than local and regional hospitals. Studies in the USA [9], France [10] and other parts of Europe [11] also reported provider and institutional variations on the use of life-sustaining interventions in the ICU within a region.

As palliative care is increasingly recognized as an essential component of comprehensive care for critically ill patients around the world [12, 13], clinicians' preparedness to hold end-of-life discussions that consider patients' and families' respective wishes will be key to facilitating clinically and ethically appropriate care. Some physicians' recognition of the importance of offering palliative services in the acute and critical care arenas takes the form of deferring end-of-life conversations to palliative care teams rather than developing one's own skills in holding these discussions [14], suggesting the need to incorporate end-of-life and ethics education in not only medical school or residency training but also in postgraduate continuing education [15]. In considering effective and efficient allocation of healthcare resources as well as physical and psychological harm that can be incurred in prolonging the dying process, there is a critical need to reframe end-of-life care planning in the ICU. Many clinicians and families equate withholding or withdrawing life-sustaining interventions as giving

up or abandonment. Nonetheless, even Confucian ethics, which values family relationships and is often adopted by many rooted in Chinese culture, does not prioritize life extension over good death [16]. Helping clinicians and families to understand how end-of-life planning is an active rather than a passive form of care to facilitate the best outcome—a well-coordinated and interprofessional care experience that corresponds with the patient's and family's values and priorities given the clinical realities—is thus important [14]. Communication and intervention withdrawal practice guidelines that highlight end-of-life care as part of rather than separate from critical care and education regarding how to implement such practice [17] may be crucial in supporting ICU teams to help make good death more accessible.

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Compliance with ethical standards

Conflicts of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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