End-of-Life Issues in Critically Ill Cancer Patients

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KEYWORDS

• End-of-life • Intensive care unit • Cancer
• Advance directives • Management

"To cure sometimes, to relieve often, to comfort always"
15th Century French proverb

Over the past decade, the probability of surviving an admission to the ICU for a cancer patient has improved. This trend can be attributed to three factors. First, improvement in the treatment of solid tumors and hematological malignancies has led to a 20% overall decrease in mortality from 1978 to 1998. Second, earlier admission to the ICU has resulted in better survival rates. Third, there has been some improvement in selecting patients likely to benefit from ICU admission.[1]

Despite the above factors, some critically ill cancer patients will die during a hospital admission that includes an ICU admission. A review of an epidemiologic study demonstrated that one in five patients will die during a hospitalization that included an ICU admission.[2] This number includes all patients, not just cancer patients, and does not necessarily indicate a death in the ICU. One may conclude that this percentage may be higher or lower depending on the type of ICU—medical, surgical, open or closed, rural or urban, and their respective admission criteria for cancer patients. Most of the deaths in the ICU will follow withholding or withdrawing of life support.[3] Before discussing end-of-life issues in critically ill cancer patients it is beneficial to review those factors or barriers that may lead to a greater probability of death in a critically ill cancer patient admitted to the ICU.

ADMISSION CRITERIA TO ICU AND TRANSITIONING TO PALLIATION AFTER A TRIAL OF AGGRESSIVE SUPPORT

The first factor to consider is the criteria used in determining admission of a cancer patient to an ICU. The criteria may vary depending on the type of hospital: community,

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tertiary, or a comprehensive cancer center. In general, most physicians will admit cancer patients to the ICU if their condition is medically reversible, but will not admit cancer patients with only palliative care treatment options. However, a great deal of variation exists between these two admission options. This variation can, in part, be explained by the uncertainty of the reversibility of the condition. Thus, some cancer patients are admitted to the ICU with the intent to give a trial of aggressive support.

The timing of the transition from cure to palliation after a trial of aggressive support is seemingly straightforward; however, this decision is delayed at times for different reasons. Depending on the type of ICU administrative model—closed, semi-closed, or open—the intensivist's role may be that of a consultant to the primary oncologist and he or she may not be willing to discuss end-of-life issues. In a survey of oncologists attending a meeting of the American Society of Clinical Oncology, 18% of the respondents stated that they would have a discussion about do-not-resuscitate (DNR) orders "a few days or few hours before the patient's death."[4] Based on these findings, approximately one in five oncologists potentially may not discuss DNR status until after the patient has had a cardiac arrest or has been on life support for some time. On the other hand, when the ICU is a closed unit with the intensivist serving as the primary attending, he or she may feel that it is not his or her role to discuss end-of-life issues. Also changing from one intensivist to another affects the timing of the decision because of varying viewpoints and approaches between intensivists.

USE OF ADVANCE DIRECTIVES IN CRITICALLY ILL CANCER PATIENTS

Confounding the decision of when to transition from intensive care to palliation is the lack of patients' advance directives as to when to limit or withhold aggressive support. The Patient Self Determination Act (PSDA) signed into law on November 5, 1990, and effective December 1, 1991, was to have addressed the increased use of advance directives. The law was in response to the US Supreme Court case *Cruzan v Director, Missouri Department of Health and Human Services*.[5] In brief, Ms Cruzan was a 26-year-old who was rendered comatose after a motor vehicle accident in 1983. In 1986, after not recovering and remaining in a persistent vegetated state, her parents asked that artificial nutrition be stopped. However, the Missouri State Hospital insisted that a court order was needed to stop enteral feeding. The trial court ruled to stop enteral feeding, but the Missouri Supreme Court reversed the lower court's ruling. Subsequently, in 1990, the US Supreme Court reviewed the Missouri Supreme Court ruling and upheld the ruling in regard to incompetent patients, but also added that competent patients would be allowed to refuse unwanted medical treatment. Furthermore, in incompetent patients, like Nancy Cruzan, the US Supreme Court allowed individual states to determine requirements for surrogate decision making regarding withdrawal of life-sustaining therapy. In response to this ruling, Senator Danforth of Missouri sponsored the PSDA.[6]

The purpose of the PSDA was to give patients the right to make decisions regarding their medical care, including the right to accept or refuse treatment, and to make an advance directive. The law also requires that health care facilities and agencies discuss advance health care directives with patients when they are admitted.[5]

Soon after the PSDA went into effect, research was conducted to evaluate its impact on completion of advance directives and decision making with regards to end-of-life decisions. The studies on the impact of PSDA on decision making for the most part have demonstrated negative results. The most widely known of these studies is the Study to Understand Prognosis and Preferences for Outcomes and Risk of Treatments (SUPPORT) which demonstrated that the intervention did not