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ORIGINAL

Limitation of life-sustaining treatment in patients with prolonged admission to the ICU. Current situation in Spain as seen from the EPIPUSE Study☆

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KEYWORDS
Bioethics;
Decision making;
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Abstract
Objective: Limitation of life-sustaining treatment (LLST) is a recommended practice in certain circumstances. Limitation practices are varied, and their application differs from one center to another. The present study evaluates the current situation of LLST practices in patients with prolonged admission to the ICU who suffer worsening of their condition.
Design: A prospective, observational cohort study was carried out.
Setting: Seventy-five Spanish ICUs.
Patients: A total of 589 patients suffering 777 complications or adverse events with organ function impairment after day 7 of admission, during a three-month recruitment period.
Main variables of interest: The timing of limitation, the subject proposing LLST, the degree of agreement within the team, the influence of LLST upon the doctor-patient-family relationship, and the way in which LLST is implemented.
Results: LLST was proposed in 34.3% of the patients presenting prolonged admission to the ICU with severe complications. The incidence was higher in patients with moderate to severe lung disease, cancer, immunosuppressive treatment or dependence for basic activities of daily living. LLST was finally implemented in 97% of the cases in which it was proposed. The decision within the medical team was unanimous in 87.9% of the cases. The doctor–patient–family relationship usually does not change or even improves in this situation.

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◊ The names of the investigators and participating centers are listed in Appendix A.

Conclusion: LLST in ICUs is usually carried out under unanimous decision of the medical team, is performed more frequently in patients with severe comorbidity, and usually does not have a negative impact upon the relationship with the patients and their families.

PALABRAS CLAVE
Bioética;
Decisiones al final de la vida;
Tratamientos de soporte vital;
Síndrome de disfunción multiorgánica

Limitación del tratamiento de soporte vital en pacientes con ingreso prolongado en UCI. Situación actual en España a la vista del Estudio EPIPUSE

Resumen
Objetivo: La limitación de tratamientos de soporte vital (LTSV) es una práctica recomendada en determinadas circunstancias. Las formas de limitación son variadas y su aplicación es diferente entre unos centros y otros. Conocer la situación actual de la LTSV en pacientes que presentan un ingreso prolongado en UCI y que sufren un empeoramiento es el objetivo de este trabajo.
Diseño: Cohorte, observacional, prospectivo.
Ámbito: Un total de 75 UCI españolas.
Pacientes: Se estudia a 589 pacientes que presentan 777 complicaciones o eventos adversos con repercusión orgánica a partir del séptimo día de ingreso, reclutados durante 3 meses.
Variables de interés principales: Estudiamos el momento en que se propone la limitación, el actor que la propone, el grado de acuerdo dentro del equipo, la influencia de este hecho en la relación médico-paciente-familia y sus formas de aplicación.
Resultados: Se plantea alguna limitación al tratamiento en el 34,3% de los pacientes con estancia prolongada en UCI que sufren complicaciones graves. La incidencia es mayor en pacientes con neumopatía moderada o grave, enfermedad oncológica, tratamientos inmunosupresores y en pacientes dependientes. En el 97% de los casos en los que se propone realizar la LTSV, finalmente se acuerda la misma. La decisión dentro del equipo médico fue unánime en el 87,9% de casos. Habitualmente la relación médico-paciente-familia no cambia o incluso mejora ante esta situación.
Conclusión: La LTSV en las UCI es una práctica que se suele llevar a cabo con la decisión unánime del equipo médico, se realiza con más frecuencia en pacientes con comorbilidad grave y no suele deteriorar la relación con pacientes y familiares.

Introduction

Intensive care units (ICUs) and life support measures with organ function replacement have contributed to prolong survival among patients with a broad range of diseases, but have also led to futile prolongation of the dying process, with an emotional and financial burden that is difficult to calculate.[1,2] In 1983, Bedell et al.[3] reported that although 44% of the hospitalized patients initially respond to cardiopulmonary resuscitation (CPR), only 14% are still alive at the time of discharge from hospital–this percentage in turn being far lower in individuals with certain disease conditions such as pneumonia or renal failure. The same authors found no patients with metastatic cancer, acute stroke, sepsis or pneumonia to survive following hospital admission due to cardiorespiratory arrest.[4] This led Symmers[5] to wonder whether the new technologies are truly able to maintain life or simply interfere with the dying process. Blackhall[6] in turn suggested that physicians should apply such technologies selectively, as is still recommended today.[7] Thirty-five years ago, most patients who died in the ICU were subjected to CPR.[8] However, now that the limited usefulness of the indiscriminate application of CPR is known, its massive indication has given way to the limitation of therapeutic effort or the limitation of life-sustaining treatment (LLST).[9]

A joint document drafted by intensivists and specialists in palliative care[10] has underscored that the starting point of these discussions is the recognition that life should not be needlessly prolonged in patients with incurable or end-stage disease. Severity scales or mortality predictors can be used in this respect.[11] However, is it possible to predict the future with sufficient certainty to not risk depriving a patient of potential cure?

The Medical Deontological Code of the Spanish General Council of Official Medical Colleges,[12] in its article 12, recognizes the right of the patient to reject a treatment and frees the physician from having to apply a treatment which he or she considers inadequate or inacceptable. On the other hand, in article 36, the mentioned Code obliges physicians to adopt the measures required to ensure patient wellbeing when healing or improvement is no longer possible. In 2002, the Spanish Society of Intensive and Critical Care Medicine and Coronary Units (*Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias*, SEMICYUC) published a