End of life decision in Indian Armed Forces hospitals

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INTRODUCTION

Death is frequent in the critical care unit. For many, life support interventions have not helped to mitigate their sufferings, but rather increased the agony and burden of a prolonged dying process. Modern technology can lead to the patient being kept alive with little regard to the quality of living as well as dying. Death, which can be a peaceful event and can occur in the presence of loved ones, has become artificial, away from the family surrounded by the paraphernalia of modern critical care. The Economist Intelligence Unit (EIU) ranked India's end-of-life (EOL) care last out of 40 countries.¹ The EIU also rated each of the 40 countries on the availability of painkillers on a scale of one to five (where 1 = little or no awareness and 5 = high awareness). Again, India scored one—the lowest score of all since every other country received at least a score of two. It showed that dying in India means a lot of sufferings.

In India, 90% of the patients were uninsured. Prolonged and futile life support has imposed enormous economic strain on patients and families. Potentially salvageable patients can be denied intensive care unit (ICU) care when scarce beds and resources are consumed in a futile search of cure where death appears inevitable.

Decisions to limit support in terminal illness have become routine in American and European ICUs.^{2,3} In a recent publication, European physicians were reported to have had no difficulty in making these decisions in 81–93% of cases.⁴ These decisions have been perceived to be difficult in India due to a number of barriers: non-awareness of ethical issues, culture of 'fighting till the end', lack of palliative care orientation, and legal issues. Despite these barriers, a recent study from Delhi had reported that 49% deaths were preceded by EOL decisions.⁵ The EIU, besides condemning India for poor palliative care system, also highlights Kerala as a successful model for the rest of world to follow. Kerala takes a uniquely community driven, holistic approach to EOL care. Rather than relying solely on the Governmental and medical sectors to deliver services, Kerala has instituted a program called the Neighbourhood Network for Palliative Care (NNPC). The NNPC incorporates trained community volunteer who give the dying moral support and financial advice—the idea being that companionship can be just as relieving during a person's last days as medicine.

The debate on EOL care has been going on in civilian medical fraternity. Since in Indian Armed Forces hospitals, conditions are slightly different from those in civilian institutions as

all patients admitted in our hospital are insured. To implement EOL care, we need legally valid guidelines on whether, under specified circumstances—such as the presence of widespread malignant cancer or a mercilessly progressive disease that paralyses the patient and will eventually render him/her unable to breathe or swallow so that he/she may choke to death—the doctor can be empowered to follow the patient's order to stop any further treatment. This is not termination of life, but a decision to prevent tragic and soul deadening prolongation of a life that has lost all meaning and in any event is soon to end. Moreover, technologically prolonged dying process takes away the serenity and dignity accorded to it by the established cultural traditions and beliefs and will also relieve the dying person from unnecessary sufferings given to him by these modern interventions.

The Indian Society of Critical Care Medicine Ethical Position Statement⁶ has already taken significant steps towards EOL care in India. This statement aims to minimise inappropriate treatment and optimise palliative care for terminally ill patients in Indian ICU by standardising the process of forgoing life support. It also provides clinicians a set of practical recommendations for providing palliative care to patients with critical illnesses.

WHEN TO INITIATE END-OF-LIFE DISCUSSIONS

Identifying situations where EOL discussions can begin needs expertise and experience. Decision is not to be based merely on the below mentioned criteria. Clinical assessment and pre-admission functional status of the patient should also be taken into consideration along with these proposed criteria. At time of prognostic uncertainty, physician should wait for the disease process to unfold. The following list can be used as an aid to recognise when to start EOL discussions.

1. Advanced age along with poor functional status due to chronic debilitating diseases, e.g. advanced chronic obstructive pulmonary disease (COPD) requiring home oxygen and/or bi-level pressure support or with disabling dyspnoea at rest; advanced interstitial lung disease on oxygen therapy and unresponsive to medical treatment, chronic liver disease, advanced congestive heart failure.
2. Catastrophic illnesses with multiple organ dysfunctions refractory to aggressive treatment for a reasonable period.
3. Prolonged coma due to acute non-reversible causes, chronic vegetative state, chronic neurological states rendering meaningful life unlikely, e.g. progressive dementia, quadriplegia with ventilator dependency.
4. Progressive metastatic cancer where treatment has failed or patient refuses treatment.

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5. Postcardio-respiratory arrest nonrestoration of comprehension after a few days.
6. Comparable clinical situations along with a physical prediction of low survival probability.
7. Patient/family preference to limit life support or refusal to accept life support.

FOR PAEDIATRIC PATIENTS

The ethics advisory committee of the Royal College of Paediatrics and Child Health (EAC-RCPC) guidelines⁷ cite the following situations as justification for limitation and withdrawal of interventions:

1. The permanent vegetative state.
2. The 'no chance' situation where imminent death is expected despite aggressive treatment.
3. The 'no purpose' situation where there is decrease in quality of life despite potentially extended survival.
4. The 'unbearable' situation where further treatment of progressive illness is more than can be borne.

RECOMMENDATIONS FOR LIMITING LIFE SUPPORT INTERVENTIONS

1. The physician prognostication is important to patients and families. Physician has a moral duty to disclose about the patient's poor prognosis with honesty and clarity when further aggressive support appears non-beneficial.
2. If the patient or family wish for limiting life support interventions, the available options should be offered:
 - (a) *Do not resuscitate/intubate*: If despite aggressive management, patient had cardiac arrest, do not attempt at CPR (DNR) or endotracheal intubation (DNI).
 - (b) *Withdrawal of life support*: The cessation and removal of an on-going medical therapy without substituting an equivalent alternative treatment.
 - (c) *Withholding of life support*: Do not institute new treatment or escalate existing medical treatment (inotropes, vasopressors, dialysis, antibiotics, intravenous fluids, enteral, or parenteral nutrition).
3. Family conferences should be held periodically with the physician to discuss the implications of forgoing aggressive interventions and work towards a shared decision-making process.
4. During conflicts between the physician's approach and the patient's/family's wishes, all existing supportive interventions should continue. The physician may not subject a patient to a particular therapy, even if he is pressurised by the family, if it is against his professional judgement.
5. The proceedings of the physician prognostication, family conferences, and the final decision should be clearly documented in the case records, to ensure transparency and to avoid future misunderstandings.

6. The overall responsibility for the decision rests with the attending physician/intensivist of the patient, who must coordinate with other members of medical team to follow the same approach for the care of the patient.
7. If the family/capable patient consistently demand withdrawal of life support interventions and the physician also considers aggressive treatment as nonbeneficial, the treating physician is ethically bound to consider withdrawal within the limits of existing laws.
8. In the event of withdrawal or withholding of support, physician should provide compassionate and effective palliative care to the patient as well as attend to the emotional needs of the family.

To conclude, when critical care is unlikely to restore a patient to a meaningful existence, then life supporting devices must be withdrawn so as to avoid the inappropriate use of aggressive interventions. This will benefit the organisation and country too. The responsibility of bringing the necessary changes in our law and practices falls upon the intelligentsia of our organisation, who must come together to arrive at a consensus on this issue after honest, practical, and soul searching deliberations.

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