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Chapter 2

Bioethics in Critical Care Patients

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Additional information is available at the end of the chapter

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Abstract

Intensive care unit is a special medial environment for many reasons (the severity of the patients, the important technological advances). In recent years, the medicine has changed to a more focused practice on the patient, leaving behind the paternalistic medical approach, with a transparent new relationship with the patient and his family. The ethical principles-autonomy, beneficence, non-maleficence and justice-and the possibility of conflicts between them make decision-making very complex. The admission of these patients in our unit is justified based on a triangle-acute, severe, and recoverable disease-trying to optimize their treatment. Unfavorable later evolution is possible; a palliative management can often be considered, changing the patient's approach from the cure of his illness to the relief of his symptoms. Decisions about patient's future must be jointly made by the health care team, the patient and his family. We must look for documents about previous instructions and/or opinion of a substitute decision-maker. We must humanize our units, thinking about the best care for the sick person and his family, and improve the support to the family after his death. Therefore, the development of practice guidelines on palliative care should be promoted by the hospitals.

Keywords: bioethics, intensive care unit, patient's best interests, withdrawal treatment, withholding treatment

1. Introduction

The important advances made over the last decades in the field of critical care have led to an increase in survival and an increase in prevalence of chronic diseases. This in turn has focused growing attention on end-of-life care.

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A significant number of patients (a value close to 10%) die in the intensive care units (ICU) [1]; in many of them, the so-called limitation of life support therapy (LLST) is carried out either because it is not possible to offer a curative treatment or because the patient expressly refuses to undergo further tests or treatment.

Spanish studies indicate that the limitation of life support is made between 10 and 12% of the patients admitted to the ICU [2, 3]. The current vision of intensive medicine is more focused on the patient's well-being and autonomy, in contrast to the older, more paternalistic one, that is, focused on the doctor and his decisions [4].

2. Ethical principles and decision-making

According to the principles of good medical practice that emanate from the recommendations of the Collegiate Medical Organization [5], the doctor must act in the best interest of the patient. The ethical framework for decision-making includes four basic principles, and religious and cultural issues are intimately related to their interpretation.

2.1. Principle of autonomy

Autonomy is the right that people have to make their own decisions regarding their health and illness in the absence of coercion and with the necessary information. It means knowing all the available treatments options and the possible consequences of their use of the fact of inhibiting their use. Underlying this principle is the importance of informed consent (IC) for any procedure.

This principle does not oblige the doctor to administer a treatment against his opinion due to the fact that the patient requests it. The intensivist on the other hand must administer the treatment that offers the greatest benefit to the patient, the least harmful, providing all the necessary information and obtaining the IC.

If there are doubts about the patient's ability to refuse treatment and there are no anticipated decisions, life support should be offered until the issue is clarified.

Consent for a treatment may not be sought in an emergency situation, if this treatment is necessary to save the life of the patient or if it prevents or can prevent serious harm.

2.2. Principles of beneficence and non-maleficence

It refers respectively to benefit the patient in the first place and to avoid physical, psychological, or moral damage in the second. All these followed the old Latin aphorism "primum non nocere". The risks and the potential benefit or each intervention should also be weighted in intensive therapy. In case of doubt, the intervention of the family could clarify what are the best interests of the patient. If still, there is no agreement, the participation of the Bioethics committee may be useful to define the case.

The intensivist must always pursue the best interest for the patient, and this does not necessarily mean saving his life, in cases where, for example, the prognosis is bad and the "cost to pay" is extremely high in time, resources and suffering of the patient [6].

2.3. Principle of justice (distributive)

Health professionals, patients, and their families share responsibility for the distribution of community resources for health problems. These resources are limited and should be used judiciously. The medical staff and the patient, and their family, should keep in mind that responsibility also concerns them. The management of the services provided by the health system must be careful, it must include respect for the individual decisions of the patient, and resources must be maximized. Resources should not be so scarce as to justify preventable deaths. The population should be aware that ICU beds are limited.

2.4. Principle of patient's best interests

It constitutes the sum of the principles of beneficence, non-maleficence, and autonomy; i.e., the patient's best interest is pursued if the doctor acts to benefit the patient, avoids the damage, and takes into consideration, together with the apparent prognosis of the patients and his favorable or not favorable response to the treatment, his wishes, values, and objectives, depending on the clinical circumstances of the case. This is paramount because the patients′ perception of what is best for them sometimes differs from the doctor's opinion. Every patient whose decision-making capacity is intact has the right to accept or refuse the treatment proposed by the medical team. Sometimes the best interest of the patient will be achieved with the withdrawal or not starting (withholding) treatment.

The role of the intensivist doctor is also relevant in end-of-life situations, because they are well acquainted with the natural history of critical pathology, such as the treatment options available in the ICU, as well as the risks and complications.

The sources of information that the intensivist doctor reviews for this transcendent decision-making are the medical history, anticipated decision-making, or the point of view of the parents, relatives, or legal guardian. In emergency situations, in which the wishes of the patient are unknown and there is no other source of information available, the available support maneuvers must be initiated until the situation is clarified.

2.5. Conflicts between bioethical principles

Bioethical principles have two levels: first level, public or collective (Justice and Non-Maleficence) and second level, private or individual (Beneficence and Autonomy). If there is a conflict between these principles, first level principles have priority; that is, the second level principles are mandatory if they do not conflict with those of the first level [7]. There may be conflict between bioethical principles from the point of view of patients between what they expect as a population (Distributive Justice) and what they expect at the personal level (Beneficence and Autonomy).

The intensivist also experiences conflict between his duties toward different patients outside and inside the ICU. The limitation of resources (available beds) may mean that the treatment that is desired to be administered or that is believed to be beneficial for the patient cannot be administered. Health resources must be localized so that they provide the greatest benefit to a greater number of patients. If the ICU is full, it may be necessary to transfer the patient to another hospital. When the intensivist must choose between patients, the priority should be those patients with the highest probability of benefit for admission to the ICU. The intensivists must perform reasonable actions (with the capacity to justify them) and with responsibility (clear knowledge of their obligations and knowing that the consequences of the decisions fall on them).

2.6. Cultural and religious issues

The relationship between the four bioethical principles can be modified by religious and cultural views of the patient and the doctor. The intensivist must respect the perspective and values of the family, and even sometimes he/she should look for someone with the capacity to interpret these topics that help to solve problems that fit in the perspective of the patient and his/her family. For example, it must be explained in a brain death situation that the brain has died, although the different point of view of the family should be accepted, and must explain that the heart will stop shortly afterward.

2.7. Removal of the treatment (withdrawal) and non start (withholding)

From a philosophical and ethical standpoint, there is no difference between these two options. This means that, if all the circumstances to be assessed in the decision-making are equal and if it is ethical not to initiate a treatment to patients, it would be equally ethical to withdraw it if already begun. Not initiate or withdraw a treatment, which the intensivist thinks is not helping the patient, is not killing the patient, but the evolution of the disease is influencing the poor prognosis. In spite of everything, many doctors consider that not starting a treatment is different from withdrawing.

If the patient has expressed clearly (though not in writing) his desire not to continue or initiate a particular treatment, the intensivist is obliged to follow the evolutionary course of the patient as a continuation of that desire [8]. When the wishes of palliative care by the patient agree with good medical care, there are sure reasons to withdraw the treatment.

Some circumstances surrounding the decision of withdrawing or withholding may be different; i.e., the first option is more frequent with the ICU, while the second one is usually outside the ICU. Sometimes, the chosen option may be a trial of treatment of limited time, proposing from the beginning to withdraw it if ineffective in this period; this plan allows collecting additional information about the patient's situation. If the intensivist does not have a clear option to withdraw a treatment, he should ask a question: knowing what he knows about the patient, would he enter the patient in the ICU and start an invasive treatment? If the answer is negative, the treatment should be withdrawn.

If the family is reluctant to withdraw a treatment, it may be useful to negotiate an initial agreement on not escalating the treatment if there is no improvement or to continue treatment

for a limited period with defined expectations for certain outcomes (consensus building), insisting on interrupting painful and unpleasant treatments because they do not cause benefits. It is useful to redefine the objective of treating the patient in a positive way, insisting on treatments that can help him/her more than those that do not help him. The best way to establish the patient's best interest is the doctor's conversation with the patient (when he/she can express him/herself) and his family [9].

This point is crucial because it constitutes the cornerstone in determining the best interest of the patient, especially if he has no ability to express himself. In short, if the doctor thinks that a certain treatment will not bring significant benefits to the patient, the one that does not initiate or suspend is irrelevant. What is really happening is that the natural history of the disease is acting.

There may be different points of view about what life means. Some people think that the value of life is infinite; others think that life has value only if it has quality. For those who have the first point of view, the agreement on withdrawing or not initiating a treatment may be difficult to achieve.

3. Legal framework: End of life care

The juridical international framework focuses on two reference elements in Bioethics: the Agreement on Human Rights and Biomedicine (Council of Europe 1997) [10] and the Universal Declaration on Bioethics of the UNESCO in 2005 [11]. Both standards recognize the right to decide, after appropriate information, by people, who can voluntarily decide for themselves which treatments or interventions they accept or reject. Legality has evolved to give priority to the principles of autonomy freedom, equality, and respect for sanctity—inviolability of human life. Adults able to decide can refuse treatment even if this is danger to their life. On the other hand, they have the right to effective communication to make the decisions they consider appropriate and to an informed choice.

The planning of early decisions, or advanced care directives (ACD), and a substitute decision-maker could also help to a patient that cannot make a decision.

The options of withholding and/or withdrawing supportive therapy are considered legal and appropriate in circumstances in which there is a valid recess of such treatment, either because the patient requests it or because the doctor considers that such treatment does not pursue the best interest of the patient. On the other hand, euthanasia, or assisted death, defined as those situations in which the doctor administers or removes substances in order to end the life of the patient or shorten it, is not legal under any circumstance in our current legal framework. An act is criminal according to the underlying intention. If a treatment is administered, a foreseeable shortening of the patient's life may occur, although that is not its purpose, and it is legal if its goal is not to shorten life (doctrine of "Double Effect"). That is, death is expected but not persecuted by that action. Intensivists should not use the term Euthanasia, and they should accurately describe the actions they carry out, such as removing ineffective and burdensome treatment and initiating palliative treatment.

It is essential for intensivists to familiarize themselves with the legislation in force in each territory in which they practice medicine. In some places, it is mandatory to have consensus with the patients or with the substitute decision-maker, to withdraw or not initiate a treatment, when it is thought that these do not pursue the best interest of the patient. The doctor who ignores a patient's desire to suspend a certain treatment (even if thus puts his life at risk) risks criminal prosecution.

By the other side, it is not true that the patient has the right to demand a certain treatment that he considers appropriate if the doctor does not agree with him.

When there is no agreement between intensivist and relatives, the case may be referred to the court or to the Supreme Court. The decisions made in accordance with the patient, especially if they are directed to their own benefit, must be well documented and sometimes even commented with a psychiatrist. If there are early decisions, in the sense of refusing a treatment, they must be followed. If the patient has appointed a substitute decision-maker, what he says must be respected.

Children and young people who have not reached a minimum age to make decisions; the best interest of the children is supreme, and usually intensivists rely on their parents to make the best decision in their favor. Sometimes, adolescents and older children are considered "mature" to make decisions, without the need for parental permission. If the child has his own point of view, he should be given the opportunity to express himself, and it will be given importance in relation to the development of the child's capacity and circumstances. For example, Jehovah's Witnesses who refuse to be transfused in situations of life-threatening anemia, despite the apparent maturity and intelligence of the adolescent, may be considered to have no ability to reject potentially life-saving measures; in these circumstances, the principle of the child's best interest may prevail over the principle of Autonomy.

The shared decision is the best model to follow in situations at the end of life and there is no room for unilateral decisions. The intensivist must be very careful about projecting their own point of view when it comes to assessing the quality of life of each patient, particularly when it comes to degenerative and chronic diseases, avoiding pejorative terms such as futility, very expensive, not beneficial, etc. Occasionally, medical interventions that cause suffering may be acceptable to the patient if a benefit in terms of prognosis or health status, or other objective value, can be achieved. If the treatment causes suffering, it should be avoided if it clearly does not bring any benefit [12]. The best interest of the patient assumes that the treatment should not be continued only to prolong life in any way.

It is very probable that a thoughtful, meditated, and consensual decision finds support in the legal framework. The laws recognize that in some circumstances, the mere prolongation of life does not follow the best interests of the patient. The withdrawal of life support treatment can shorten life, but not extending it to delay an inevitable end can follow the best interests of the patient.

4. Criteria for admission to the ICU

The success of intensive care should be measured by the quality of life preserved and not only by survival statistics. It should also be taken into account the quality of the process of death of

patients who end up dying and the quality of the human relationships involved in each death [13]. In general, admission to the ICU should be reserved for patients with reversible diseases whose prognosis can be improved with the human material and available technology. There may be other reasons: a treatment attempt limited in time when the degree of irreversibility is unknown, difficult management of symptoms (including palliative care), and consideration of organ donation.

At any time during admission, the goal of treatment can be changed from curative to palliative (**Figure 1**). The assessment of the suitability of the admission is based on the fact that the probable prognosis is acceptable for the patient, and that the burdens/risks of the treatment exceed its benefit. In patients with advanced age, frail, and with significant comorbidity, it is difficult to identify the possible benefits of their admission to the UCI. The prognosis scores are of limited value when applied to individual cases, especially in older people with comorbidities. The so-called "surprise questions" are useful when it comes to clarifying the picture: questions such as "Would you be surprised if the patient died in the following 6-12 months?" as well as others of functional character (more than 50% of time in bed, frequent hospital admissions, little autonomy in basic activities, loss of more than 10% of weight in the last 5 months).

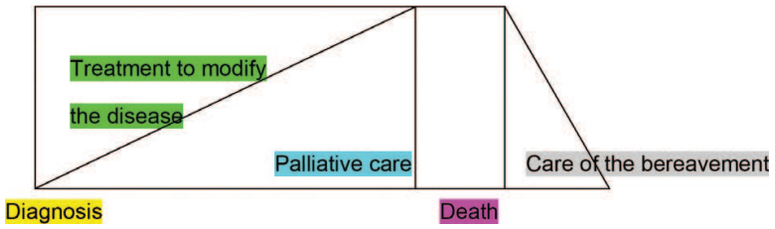

Figure 1. Continuity of the care of the patients at the end of life.

The decisions not to admit a patient to the ICU, as well as a limited time of treatment in the ICU, are ways of LLST. A deliberative process should be carried out by the treating team of the patient, with a collegial decision that allows offering other options than nonadmission, as admission with agreed treatment measures, assessing a response time, etc. This decision should be shared with other members of the team, as well as with the family and the patient. All these processes must be recorded in the clinical history.

The admission of patients with terminal or intractable diseases would not be considered, although exceptionally the admission of patients requiring palliative care to better manage end-of-life care could be considered.

5. Palliative care in ICU

The determination of the patient's prognosis before and during admission is extremely difficult. It involves integrating several data: current clinical assessment, information from other medical teams, impact of ICU treatments on life expectancy, and the chronic diseases of the patient.

As we have seen before, age should not be an exclusive factor when deciding to enter the ICU. Comorbidities, degree of dependency, chronic diseases in advanced stage, and dementia frequently occur with increasing age should be valued as a whole. Talking and mobility are also factors to be assessed. Baseline quality indicators of the patient, together with specific disease markers, may indicate that the patient has started an inexorable path toward death.

It is important to assess other failures such as terminal heart failure, respiratory failure with home oxygen, renal failure in hemodialysis, or advanced cancer.

When it has been decided to move from the goal of intensive to palliative care, efforts must be made to achieve its main objectives. The WHO definition of palliative treatment is [14]: "treatment approach that improves the quality of life of the patient and their families, and maintains the comfort and dignity of the patient, with prevention and alleviation of suffering, and assessing and treating physical, psychosocial and spiritual problems".

The intensivist frequently takes a leadership role in end-of-life discussions with patients admitted toward different to ICU, along with their doctors and their nurses (who have a key role in ensuring the continuity of care and goals), and the patients and their families. Other medical teams should be encouraged to take a leadership role in these discussions and to establish early advance care plans (ACP) and its written part (ACD). Discussion about the end of life should not be too fast or carried out with incomplete information.

Attention to these situations is complex. The intensivist must handle the symptoms, and in complicated cases, ask for help to a palliative care specialist. Detailed instructions of withdraw this or that treatment should be made. Care to the family is also difficult is also difficult; unrestricted family visits should be obtained, and if it is possible, an individual room for the patient and his family can be provided. The intensivist who has been involved in the decision-making should visit the patient and his family during the process of death of the patient. Religious support should be given when deemed appropriate. When family asks to intensivist if children can say goodbye to their family member, they (children) can be asked, explaining them carefully what they will see.

The Australian and New Zealand Intensive Care Society (ANZICS) describes the principles of end-of-life care [15]. The goal of ICU treatment is to return the patient to a quality of life acceptable for him, and if this is not possible, to compassionately support the death process; suffering must be minimized in all circumstances. All patients receive treatments for therapeutic purposes and symptom relief measures. This balance of treatments varies throughout the critical illness, reaching only measures of symptomatic relief and comfort at the end of life (Graph). The medical team and their patients and families should make a shared decision about treatment options. If there is disagreement, which cannot be resolved with discussion and time, an additional medical opinion or opinions of nondoctors (religious advisors, spiritual counselors, lawyers, etc.) can be sought. All decisions related to the withdrawal or withholding of treatment measures should be included in the medical record, including the reasons for making the decision, who participated, and the treatments to be withdrawn/withheld. The same principles govern the withdrawal and withholding of a treatment, and each ICU and each hospital must develop and implement clinical guidelines according to these principles, promoting the evaluation of end-of-life care as a measure of quality.

The quality of life at the end of life can be defined in several ways. Smith [16] gives us a definition that is based on 12 principles (**Table 1**):

It is difficult to evaluate the quality of end-of-life care. The main judge on this process, the patient, dies in a high percentage of occasions. The delivery of a long questionnaire to the family can be understood as intrusive by them. Attention may be paid to other indicators that things have been done well: expressions of gratitude from the family at the time of death, other indirect expressions of gratitude (such as financial donations to the hospital), absence of complaints about external interference, etc.

- know that death is coming, and understand what can be expected;
- be able to maintain control of what happens;
- ensure dignity and privacy;
- have control over pain relief and control other symptoms;
- control and choose where death occurs;
- have access to information and experience about what is necessary;
- have access to proximity care, not just hospital care;
- have access to any spiritual and emotional support required;
- control who is present and with whom we share the end;
- be able to direct the advance care directives that ensure that the wishes are respected;
- have time to say good-bye, and control other aspects of time;
- be able to leave when it is time, and not prolong life indefinitely.

Table 1. Definition of quality of end of life.

6. Consensus building, communication: Documentation

Consensus is an opinion or decision reached by a group as a whole, and it can be followed by all group members even if it is not the preferred option of each individual. This decision of shared decision makes the decision less subject to complaints or legal review than decisions reached by other methods (paternalistic exclusively by the doctor, majority vote, identification of a family member with the right to make any important decision in the patient). This consensus should ideally be achieved between the different medical teams before meeting with the patient, his family, or his decision-making substitute.

The relations between intensivists and other specialists, in order to build a common option, must be constructive.

The discussion must take place at different stages over time, and the meetings must be planned. They must include ICU nurses, social workers, chaplains, and patient families. Communication skills and the proper use of language are very important. Words such as "do everything," "do nothing," "futility," "uselessness" should be avoided, and the "value of treatment options" should be avoided, rather than "the value of the person." The documentation of the decision-

making process must provide transparency and ensure that the health professional fulfills his professional and legal obligations.

There may be misunderstood cultural themes or linguistic nuances that may introduce small changes of meaning in the discussion. The careful use of translators is recommended. Informal use of untrained interpreters, like other family members, should be avoided, because they may confuse their roles as a translator and as a family member and may misinterpret clinical information.

The determination of what therapeutic options may be clinically indicated and the recommendation of a plan that is the most appropriate considering the wishes of the patient are responsibilities of the intensivist. The intensivist must have leadership in the end-of-life discussions in the ICU and must respect the fact that each patient and each family differ in the discussion process: many families want to have weight in the discussions [17, 18] and described that some families involved in end-of-life decisions may experience long-term psychological harm [19]. It is important that families do not feel an unwanted responsibility or weight associated with these decisions. The careful use of language can limit that feeling of personal responsibility; consensus also serves to share that burden.

Rarely, ICU patients are able to participate in decisions about the end of life. Medication, illness, delirium, dependence, and dementia can alter your ability to make decisions. The formal evaluation of decision-making capacity is important in daily practice and must be applied to the decision to be taken in concrete. The intensivist should assess if the patient is capable of understanding the facts involved in the choices to be made, if he is capable of weighing the consequences, and if he has the ability to communicate his decision.

The agreement with the family is best achieved when they are helped to reach a conclusion by themselves, not when they are confronted with a medical decision previously made. Also when emergency treatment begins with doubts about whether it is appropriate, the family must be informed that a reassessment will occur and that the treatment plan may change.

Understanding the expectations of the decision process is important to avoid misunderstandings. Some patients want their decisions to be made, others prefer to delegate to others (a member of the family), others prefer to delegate to the doctor, etc. There may also be degrees of delegation: full responsibility for the decision process or only specific wishes.

When "devastating damage" occurs in the discussion process, it can be understood that family members want "everything to done," which can include a transfer to a tertiary hospital "with more resources." As a result, you should try to restore trust. The treatment in a tertiary hospital can be carried out by consultation, but not necessarily the patient must move to tertiary hospital, especially if the transfer has no benefit and may pose a risk, or harm, to the patient.

The presence of the social worker and the chaplain in the discussions is recommended, because both can dedicate more time to the family, and because they can be perceived by the family as a more neutral opinion to medical treatment. Also, the presence of cultural leaders is important if there are cultural or tradition issues not fully understood by the doctor.

If a patient professes a religion, he may have a fundamentalist or more superficial position. In each case, religion has an impact on decision-making, and the patient's beliefs should be explored.

It is recommended that a doctor speaks on behalf of the medical teams, since small differences in the explanation of the condition or progress of the patient can be seen as major disagreements in the medical teams. This physician must be experienced and veteran in carrying out these discussions, and he should have achieved the confidence of the patient and his family before discussing the limitation. It should be clarified what the family has heard from previous information; it can happen that what families understand is different from what doctors believe they have said. Additional assurances should also be given, such as that the medical team will remain involved in the treatment and will support the family.

If patients and their families are involved in decisions, the information on which decisions are based must be accurate. The recognition of the possibility of death allows families to understand the severity of the disease and assesses that prolonging life should not be the only objective. The word "die" should be used if death is a possibility. Sometimes the doctor avoids giving a realistic prognosis to patients and family for the belief that this will keep their hope. The overestimation of the prognosis by the patient or his family can lead to being misinformed, with inappropriate treatment choices.

The relevant elements of a meeting are listed in **Table 2**.

The reached agreement must be noted in the clinical history. This documentation should provide transparency and responsibility. It should include date and duration of the meeting; people involved in the meeting; medical facts that lead to the decision; written notes about the wishes of the patient, including the ACD/ACP; discussed options, agreed objectives treatment, and agreed consensus; which treatments are going to be withdrawn/withheld and which treatments have to be continued, including medications and symptomatic relief.

- update the situation of the patient with recent data, also from other medical teams, before the meeting;
- meetings must take place in a private room designated for this purpose;
- appropriate time for the meeting should be allocated; during it the family must receive nonfragmented information from the doctor, without interruptions;
- the medical team must always have an intensivist and a bed nurse;
- ensure that all members of the medical team have a consistent message before the start of the meeting, and that each member understands their role;
- ensure that all important members of the family are present at the meeting before initiating it;
- it is necessary to find out what the family has understood up to now of the evolution of the patient; provide new information with simple language;
- emphasize continuous patient care when treatments have been limited or not offered;
- show empathy, active listening, and allow silences as a form of respect and compassionate communication;
- encourage asking the family, and answering completely.

Table 2. Important elements to fulfill in a meeting with families of a patient.

7. Conflicts with family and among professionals

7.1. Basic ideas

Disagreements can arise in several aspects: patient's prognosis and wishes; points of view about what is a successful outcome or a good prognosis; understanding of cultural and religious values; the family fell responsible of the death of the patient; emotional overlap of previous unsatisfactory interactions between health personnel and the patient or their family. These disagreements can also arise at different levels: between family members, between family and doctors, and even between different medical teams. The desire to avoid a painful treatment or dependency is often as important for the patient as the possibility of survival; therefore, the probable prognosis should be included in the discussion. The disagreement taken to the extreme, or extreme disagreement, is the conflict.

7.2. Conflicts between family members and medical team

An open and early communication about the risk of death is a priority in critical situations. The patient and his/her family will be offended and will resist the withdrawal of the treatment if the death expectancy is discovered at the end of the course of the disease.

The possible outcomes should be early discussed with the patient and his family, especially if the patient is seriously ill. An honest and sensitive communication, from the beginning of the disease, on the risk of death makes all parties aware of the possible evolutionary courses, and creates the confidence necessary for joint decision-making and preventing most disagreements.

As already mentioned, doctors consider an appropriate treatment according to the possibility of survival, but the treatment burden, the expected duration of the treatment and the probable prognosis are important aspects for the patient and his family.

The communication must be early and proactive, it must clarify the objectives of the treatment and guide the treatment plan to the patient's values. Listening and empathizing with the opinions of the other party is a way to handle any disagreement. The conflict can be harmful for all parties, and it is better to prevent or treat it early to avoid the negative effects [20].

When detecting these behaviors, a plan should be drawn that prevents the progression of these behaviors. The family that experiences a conflict should receive adequate support. Health personnel should provide clear information, thus avoiding the deterioration of relationships. Finally, threats to health personnel should not be tolerated.

Despite good communication training and proper family management, there may be families with a different perspective of intensive care and management of the patient's end of life. Some sensitive families may not assimilate the information. Families may not be aware of the patient's wishes. The explanation that the treatment plan is made based on your wishes can help resolve the conflict.

Several indicators of conflict regarding end-of-life care can be recognized (**Table 3**).

• circular conversations: the family avoids discussing withdrawal of treatment and revisits previous discussions repeatedly. The solution to this problem is to stop and announce the discussion topic (ensure that the discussion is focused)
• request for second opinions: can be sought in the ICU or out of it, including people without medical knowledge, or religious beliefs
• request to see the medical records, with the help of a member of the team to clarify doubts
• avoidance behaviors of medical or ICU personnel,
• criticism or rejection of individual members of the team, especially nurses, and accusations of not attending properly or incompetence; in a extreme case, transfer requests to another ICU
• request that a specific treatment be administered or interrupted (for example, withdrawal of opiates by the belief that they have been deliberately administered to shorten life). Petitions and demands can be increasingly inappropriate if the process continues, until attempts to control medical decisions.

Table 3. Elements that are associated with end of life conflicts.

The advantages of the medical consensus decision are important, but if this can't be achieved, both options should be presented to the patient and family. Patients and family members may find themselves confused if the treatment options and the possibility of interrupting any of them are carried out at a late stage in the evolution. Honest, sincere, and precocious communication is always the best option.

The word "die" should be used if death is a nonremote possibility. Here is an example: "It is very likely that you will die from this disease, we are doing the indicated treatment, we would like to talk again tomorrow in the morning and tell you if this situation has changed or not, we are offering you the best treatment available".

Conflict prevention is an essential part of communicating with patients, family and nonmedical staff. Here are some key points:

- take the appropriate time (unless it is an emergency); families need time to understand at their own pace, often with discussion at home, rather than being forced by the medical team;
- if this is the case, explain to the family that the decisions about the interruption of a treatment are based on consensus;
- facilitate a second opinion if the family requests it and that this "external opinion" has access to all available information; Sometimes, a general practitioner (GP) in whom the family has confidence, with their own ethnic values, will probably understand the medical situation and may communicate it to the family in an appropriate manner. Others, however, as alternative healers, may not make progress in understanding the case.
- in some circumstances, the presence of an involved third party (facilitator) can clarify and address the concerns of the patient and their family.

When the aforementioned steps have not resolved the dispute, and although rarely effective, the possibility of transferring the patient to another ICU should be considered. Finally, the courts and the Supreme Court can intervene in situations with no way out. If an organization

experiences repeated conflicts about the end of life, the established protocols on this matter should be reviewed.

7.3. Conflict between medical teams

There may also be a lack of agreement between two medical teams and may be due to several factors.

- disagreement about the prognosis;
- different concepts about what "treatment success" represents;
- different understanding of what the patient wants;
- personal refusal to accept death as a result, including feelings of guilt (frequent in the case of iatrogenic complications);
- doubts about administrative or legal requirements;
- emotional overload, frequent in situations of previous unsatisfactory interaction with the patient.

Respect must be shown to the other doctor, and if necessary, involve a veteran colleague to help resolve the conflict. It is important that doctors respect the disagreement that may exist between them, and recognize the need for consensus, accepting it. There must be a desire to negotiate and to remain objective, and on all occasions, to maintain the focus on the patient's best interests.

Conflict is considered a burden on all sides, and has been associated with symptoms of post-traumatic stress and burn-out syndrome [21]. Disagreement among the treatment objectives is the most common source of conflict among ICU staff [22], although disagreement about prognosis is also frequent. Occasionally, doctors and nurses may be forced to apply treatments at the request of the family or other medical teams, and that they do not believe follow the best interests of the patient. This can make them feel undervalued and lead to a moral conflict with short- and long-term consequences. Active professional support programs should be part of the routine functioning of the ICU, with professional advice and supervision for those with exposure to complicated end-of-life decision-making situations.

There is a general belief that the intensivists are downright pessimistic and that the doctors of other teams are too optimistic [23, 24]. All specialties must be aware of the prognostic uncertainty of the critical patient and of the primacy of the personal values and the quality of life of the patients facing the burden and the benefit of the treatment. Misunderstandings can be avoided if the other medical teams visit the ICU frequently and keep informed of the patient's progress. No doctor has the right of veto over other doctors. Although it is useful to consider how much weight, it is reasonable to have the point of view of each specialist when reaching an agreement. A specialist who has taken the patient for a long time, or who has special knowledge about the prognosis of the disease in particular, can provide useful information.

In case of increased difficulty, over the years between medical teams, the doctors involved should take further measures to get an acceptable consensus for the medical team and may involve the hospital's medical administration or human resources.

Conflicts in relation to end-of-life decisions may reappear. When an intervention or procedure has been developed, the other specialist may find it difficult to withdraw the treatment, especially if he has invested a lot of time and effort in that solution. Empathy with the family has traditionally been emphasized, but the relationship with other doctors is also important. Without empathy, problems may reappear.

Doctors must always adhere to the Code of Good Medical Conduct [5]. These good behaviors require doctors to communicate effectively with other team members, and the consequences of bullying and aggression must be made clear. Some doctors can maintain a position of conscientious objection in relation to end-of-life management; in these cases, the doctor should stop evaluating the aspects related to the patient's care.

7.4. Conflict between family members

Sometimes conflicts arise between the family members, and health personnel must help by providing clear information and helping to minimize the breakdown and damage of relationships. Long relationships are tested by emotion, fatigue, or interest in the patient. The ICU environment can generate positive emotional responses and unmask previous tensions, for example, unrecognized sentimental relationships, habits, practices or orientations of the patient, etc.

There is no single solution to these situations. It may be necessary the support of social workers, priests, family counselors, and even security guards. First of all, UCI staff cannot lose sight of their primary responsibility for the patient, although the duty of care can be extended to the interests of the patient's family.

7.5. Conflict between the patient and his/her family

There may be serious disagreements involving patients and their families. The wishes of a patient who maintains their ability to make decisions are supreme and remain so when they have been expressed in advance. If the wishes about acceptance or rejection of active treatment are known, the wishes of the patient should prevail over those of his family. It is important to explore why the family wants to disobey the patient's wishes or believes that their wishes are not valid.

The request of the family that the patient should not be informed should be managed with great care. On these occasions, the family should be informed that the patient has the right to choose if they are going to be fully informed. The family should be told that most patients want to be informed, and that the intensivists are very careful and compassionate in their explanations. The family will be notified that the patient will be asked, with the family present, if he wants that the family is informed. Most patients do not want to be excluded and the patient's preference for the inclusion of their family in the information must be respected. Few patients want to be protected

from information, and expect their family to take a decision-making role; this is acceptable if the intensivist perceives that the decision is taken freely and without coercion, clarifying that in addition to delegating the information, decision-making is delegated.

8. Decision-making, advance care planning, advance care decision

The treatment of critically ill patients has two objectives: intensive treatment, which tries to restore the health and functionality of the patient to a level acceptable to him, and the control of symptoms, which tries to reduce the burden of suffering caused by the disease and by your treatment. In certain cases, in the face of poor clinical evolution, pursuing the best interest of the patient is to change the treatment approach from intensive treatment to palliative care, rather than extending life in any way [25]. Applying the principles of palliative care means maintaining comfort and dignity, attending to psychological and spiritual needs, and supporting the family.

Doctors and family members must make decisions based on the wishes of the patient. He has sometimes made ACP or formal opinion heard. But those desires can also be deduced in other ways: extrapolation of how he has led his life, general statements during his life, and sometimes appointment of a substitute decision-maker (who will inform the medical team of their preferences regarding this point if the patient cannot).

ACP allows the patient to plan and make clear his preferences and to take care of his health in case he gets sick. They usually include end-of-life decisions (although not necessary). It is based on the principle of Autonomy, and on the right to be fully informed about the treatment options of their pathology, and to be treated in a way that respects their dignity and avoids their suffering. ACP improves end-of-life care, meets the preferences expressed by the patient, improves family satisfaction, and reduces anxiety depression and the post-traumatic effect on survivors. It should be reflected in writing (ACD) and included in the medical report, with an adequate alert system. The intensivists must be familiar with their inclusion in the decision-making of patients, especially in end-of-life treatments.

However, the ACP may be inadequate to provide the degree of certainty necessary to support the end-of-life decision, for example, to include generic phrases such as "no reasonable possibility of cure." It can be established an order of reliability about the validity of the patient's wishes:

- 1st, ACP that is relevant in the current situation;
- 2nd, ACP that does not mention the current situation of the patient, although it allows conclusions to be drawn "by analogy";
- 3rd, informal discussions of the patient with his family and friends about his wishes;
- 4th, belief of the family and friends of the patient's knowledge about what the patient would like to do;

- 5th, evaluation of the doctor, based on the limited knowledge of the patient, based on what other patients have wanted to do in similar circumstances.

The ACP process is developed with personnel that support health professionals, with the help of their families, to reflect their values and preferences for current and future treatments. These preferences will guide doctors and the family in providing appropriate medical treatment in the best interests of the patient [26]. It also allows registering the preference over certain treatments or documenting your point of view about an unacceptable evolution.

It is advisable that the ACP be discussed at the out-of-hospital level, with a GP or at the geriatric care center, without stress that implies an acute medical condition. This allows individuals, with the support of their families, to have time to discuss, reflect, and identify what is really important for them to "live well" and "die well." However, ACPs that are made in the hospital are also considered valid, even those made in extreme situations (for example, preoperative). GPs, in which the patient has placed their trust, are basic for the initiation of ACP discussions [27] and can be introduced in their routine evaluation, in case there is any change in the general situation of the patient. This confection is associated with greater family satisfaction in caring for him [28].

ACP is usually performed in hospitals with discussions with nurses for 20–45 minutes, which is accompanied by greater congruence between the patient and the substitute decision-maker, a feeling of being better informed, more confident in knowing benefits and loads of proposed treatments, and feeling that less pressure is transmitted in the decisions to be made [29] (although other works show the contrary, more discussions between patients and substitute decision-makers for end-of-life decisions) [30]. Intensivists should follow the expressed preferences of the patient, except if there is a good reason to believe that the preference of the patient changed recently.

9. Care of the patient who dies imminently; family and medical equipment

9.1. Patient care

The death of a patient after carrying out an LLTS plan is a very complex situation, and the way in which patients die and families coexist with it is variable. The palliative care plan should be individualized to the particular needs of each case and should include pharmacological and nonpharmacological measures. Practical and emotional support should also be offered explaining that dying could cause the presence of noisy and agonizing breathing. Attention should be paid to these signs (especially when they appear as a result of the withdrawal of respiratory support) to administer preventively sedation and analgesia; the withdrawal of renal or cardiovascular treatment does not require support measures for de-scaling. Palliative treatments will always be administered with the intention of relieving symptoms, not accelerating death. Properly document what therapies are removed such as mechanical ventilation, dialysis, inotropes, cardiopulmonary resuscitation, etc.

Some patients will die and some will leave the hospital [31]. Predicting the time of death is difficult. Several factors influence which palliative treatment measures are required:

- the patient's wishes in relation to their care and end-of-life needs;
- what treatments are removed and which are not initiated;
- the patient is conscious;
- how much dependence on UCI treatment the patient has;
- death is imminent;
- what are the patient's needs for analgesia and ansiolysis;
- what are the treatment needs of dyspnea and other symptoms;
- what are the family's treatment needs.

Once a decision has been made about not to initiate or suspend life support treatment, a palliative plan should be initiated. This will have to be properly documented. The ICU nurse has an essential role of caring for the patient and offering support to the family.

Nonpharmacological interventions aim to offer emotional and spiritual support through:

- offer an environment as private as possible;
- consider the visit of her/his favorite pet;
- nursing care: mouth, eyes, skin, intestinal, etc.
- removal of tubes and monitoring devices.
- nasal air to relieve dyspnea in a conscious patient, etc.

In some patients, noninvasive mechanical ventilation (NIMV) may be indicated. It can be used to reduce dyspnea in acute respiratory failure. Even in patients without indication of invasive mechanical ventilation (IMV), NIMV can be used to increase survival, although a clear consensus must be achieved before use [32]. No study has been made aimed at assessing the quality of death in patients with NIMV compared to patients with habitual treatment with sedoanalgesia. But it supposes greater discomfort, greater medicalization of the dying process, and ambiguity in terms of treatment, especially when removing it and initiating sedatives [33]. Therefore, its role should be evaluated patient to patient, and attention should be given above all in other aspects of palliative care.

When considering the interruption of ventilatory and circulatory support, the impact to the patient and his family must be anticipated. The patient can become dyspneic and that can be distressing for both. Prior medication should be administered to help prevent any resulting discomfort. Morphine can be administered at 5 mg/h and propofol al 50 mg/h. An important fact: the withdrawal of respiratory support followed by programmed extubation has been associated with higher rates of family satisfaction during the end-of-life process [34].

The pharmacological control of the symptoms is extensive and includes alleviating pain, agitation, dyspnea, and excessive respiratory secretions. A prepared medication checklist can be useful to ensure immediate access to the necessary medication. Muscular relaxants have no place in palliative management, only in association with sedatives and in certain circumstances such as adult respiratory distress syndrome. After extubation, the patient may die quickly, and the cause of death is the underlying disease; Sedation ensures that there is no awareness during the death process [35].

The dose of drugs can be increased, depending on age, the presence of multiple organ dysfunction, previous exposure to benzodiazepines or morphics, the current level of sedation, the underlying disease, and the wishes of the patient in relation to sedation in the end of life. There is no maximum dose in the relief of pain and suffering at the end of life, and the dose should be individualized for each patient and each situation. Although they have cardiodepressive effects, the proper use of opioids has been associated with longer life [36]. Morphine can be used for pain and dyspnea, midazolam for agitation and restlessness, haloperidol for delirium, and glycopyrrolate for respiratory secretions. The evaluation of the palliative treatment can vary according to the situation of the patient: in a conscious patient, we can ask him; in an unconscious patient, the signs of respiratory work and distress include restlessness, diaphoresis, high blood pressure, hyperventilation, tachycardia, grimacing or vocalizing after nursing care, etc. Always doctor must try to preserve the dignity of the patient.

If patients are awake before removing ventilatory support (e.g., motor neuron disease or high spinal cord injury). Sedatives or anesthetics may be administered to make them unconscious and spare them the suffering of dying [37, 38]. A consensus must be reached that allows the patient to have control over the dying process and fulfill his desire to "not die fighting, drowning." The slow withdrawal of sedation is accumulated by increasing the dose of sedation to achieve a respiratory frequency less than 20/minute.

If death is not imminent and the patient has a very minor distress, it should be made clear to the family that it is often difficult to predict the time of death. Nonpharmacological measures are important, and the opportunity for the family to spend time with the patient before he or she dies must be emphasized. The interruption of fluids and medical nutrition must be assessed individually. Oral food must be offered, although most patients reject it and reduce its intake [35].

All medical equipment should provide good end-of-life care. When death occurs in a short time, times are best handled in the ICU, the team being attentive to the needs of the patient and their family; if the process is longer, the patient should be transported to a palliative care area or even allowing the patient to die at home. Communication with the family must be clear, and the proper transfer of medical and nursing information is important to ensure a gradual transition of care.

The patient should be supported in their pain/suffering. The loss of autonomy, control of body functions, body image, and mobility should be remembered. This one is not with the people who they would like to be with. Although communication is limited, the patient should be insisted on our commitment to comfort and dignity. Your family should be asked to think with

the patient's perspective. Death is part of life and requires an individualized management of the situation.

9.2. Care of families

Families must have everything necessary to accompany the patient and carry out their grieving process. Sometimes the family asks to delay the withdrawal of treatment "to give time to arrive on time to members of the family"; this request must be overspent with what the sustained burden of treatment implies. We must collect data on the perception of family members to improve aspects of the care of the patient who dies. The reaction of bereavement changes over time, and its absence is abnormal: it can manifest with shock, distress, anger, fear, denial, confusion, guilt, numbness, etc.; even desolation and complete isolation. Religious stereotypes should not be followed but ask your family what they think is appropriate from the spiritual point of view, according to a holistic approach.

The behavior of the ICU is also important after the death, giving support to the family. The risk of postdeath bereavement is greater, and support may be needed in several situations: sudden death, traumatic death, preventable death, death of a child, social isolation, past history of mood disorders or other significant losses, and prolonged reactions mourning. The society ends soon the death, but the duel can be a long trip with a first year with experiences without the presence of the deceased. Contact with his GP can help restore physical and emotional well-being, although additional resources may be required, especially in frail and elderly people.

9.3. Care of the medical team

The death of the patient can imply a reduction in the personal and professional worth of the doctor and nurse. Regular multidisciplinary discussions should be integrated into the usual practice of the ICU. These discussions will help create an open, cohesive, and flexible teamwork culture, especially during a conflictive end-of-life process. It also facilitates a greater consistency of communication with the patient and his family. During the discussions, there are no successes or mistakes, but questions are opened for dialog. This shared experience can help team cohesion and prevent the team from being divided into complex end-of-life situations.

All ICU members are vulnerable to emotional stress, with complex clinical and ethical decisions. The presence of conflict increases the risk of adverse effects on health care workers. If the conflict is prolonged, and a legal action is taken, the risk is even greater. Also taking care of the patient and the people involved (families, friends, caregivers) is exhausting, and there is little time to recover; immediately, the door opens and another patient comes into.

There are other ways to support the staff. The intensivist must be separated from the family in a conflict. There must be flexibility in the support of the staff members; nobody is immune to the conflict. Sometimes the doctor can even be relieved of his work overload, if he is involved in a prolonged conflict; and this will allow you to focus on good communication and conflict resolution, with adequate rest periods.

10. Special situations

There are special end-of-life situations that involve different actions.

10.1. Suicide

Suicide is the leading cause of death among young people. For every completed suicide, there are about 30 suicide attempts, and many enter the ICU. Suicide damage affects the family and society broadly. Although suicide is not illegal, helping a suicide is punishable.

Many patients who make a suicide attempt have expressed their rejection of the treatment prior to admission. They may be mentally ill, but also nonill people who find in suicide the solution to a delicate situation or even in the bosom of a serious progressive disease. Life support measures may be withdrawn or not started in patients with serious organ damage after attempted suicide (i.e., severe hypoxic damage). That decision will be guided by the best interest of the patient. The severities of mental illness, and the absence of response to treatment, are relevant data when considering a life support treatment. Decisions can be made with the substitute decision-maker, and you can try to answer the question "would it be reasonable to withdraw active treatment given the clinical circumstances if there were not an attempted suicide?" It is accepted that patients with capacity have the right to refuse life support treatments. When the patients lose this capacity, these options are legally reinforced by the ACD, without the need to be agreed and even without clear reasons. Some patients may have freely decided suicide as an option. The consensus of the medical team must be achieved.

10.2. Chronic respiratory diseases

Patients with chronic respiratory diseases, such as Chronic Obstructive Pulmonary Disease (COPD), are at risk of suffering an acute exacerbation leading to admission to the ICU with mechanical ventilation or other supports. The decision-making in these patients is complicated, because of the unpredictability of their recovery, ignorance about the acceptable prognosis (unless the patient has ACD), their high levels of anxiety, depression, and fear of the sensation of drowning.

Several factors are associated with a poorer prognosis: poor lung function, exercise tolerance/functional stage, low body mass index, use of home oxygen, comorbidities, frequency of hospital admissions due to decompensation, etc. Recent studies show that 60% of patients with COPD intubate survive and can return to an acceptable situation; the average survival after admission to the ICU due to COPD is 2 years; and among COPD patients who required prolonged IMV with tracheostomy, 78% were weaned successfully and 43% were still alive 12 months later [39].

Patients with advanced respiratory diseases ideally have a good understanding of their life history, with gradual respiratory deterioration and exacerbations that follow recovery. Based on that, they will make their ACP; however, very few patients have done so for many reasons: uncertainty of the prognosis, slightly progressive disease, difficulties of the doctors to find

where and how to make these ACPs. Even when the ACP is done, many patients want a "treatment trial" without clear guidance on how to make limitation decisions. Also, the health professional is afraid that this discussion "will take away his hope." These conversations are useful for patients, and they allow them to maintain a certain degree of control; they can be stated in terms of "hoping for the best, planning the worst." Anxiety and fear disproportionate to lack of air influence the efforts of weaning and tolerance to the NIMV. The family and the patient can be battling to accept the information that the doctor gives during episodes of deterioration.

10.3. Chronic neurologic diseases

Patients with motor neuron diseases die due to progressive respiratory muscle weakness, aspiration pneumonia due to involvement of the bulbar muscles, and difficulty in coughing. Patients are aware of their poor prognosis, maintain their consciousness until advanced stages, and often have ACP (documented or not). The reasons for not using NIMV are the progressive nature of the disease that impairs their quality of life, the amount of resources required in daily care, the possibility of remaining not communicated, unable to express their treatment preferences, or having that you make a future decision to withdraw treatment. These situations are emotionally difficult, and most patients would prefer to avoid them. Weaning success of IMV is <50%, and most patients need NIMV. In these patients, IMV can only be considered in two scenarios: diagnosis of the pathology that has not given time to pose ACP, with infection or another reversible disease; and respiratory failure prior to the diagnosis of motor neuron disease.

A peculiar profile of neurological patients is the persistent vegetative states. This concept refers to patients persisting in a coma with eyes open at least 4 weeks after the initial damage. Each case must be treated individually, respecting the usual end-of-life criteria and the ACP of the patient and working with the substitute decision-maker to determine a reasonable care plan. Hydration and artificial nutrition are part of medical treatments and should be discontinued like other treatments. The belief in the sanctity of life is universal, but it can be confused with the most extreme version of vitalism. The National Health and Medical Research Council guidelines [40] make it clear: "the question is not whether the life of the patient is worthwhile, but whether it is worth the treatment".

10.4. Childhood

We usually do not have clear views of the child about their treatment. Intensivists and parents are obliged to act in the best interests of the child, although it may be difficult to know with certainty which option is valid. Sometimes there may be a difference of opinion between the medical team and the parents; parents believe they know what is best for the child, but as with adults, meeting family requests is not always appropriate. Parents sometimes ask the intensivists "what would you do if I were your son?"; if answered honestly, it can improve the relationship with parents, but they may not share their values and beliefs, and care should be taken to avoid influencing parents.

The child's ability to make decisions changes over the years. The views of the child are important and should be involved in decision-making, if they have considerable experience in medical treatment and according to their ability to interfere. Sometimes families do not want to make decisions and prefer doctors to make decisions for them; but on most occasions, parents want to be involved in decision-making. The best approach is shared, with joint deliberation over what course of illness would be best for the child.

Intensivists should be as safe as possible in any situation. A consensus among colleagues should be sought, a second opinion sought, information obtained from other experts, etc. Even if there is still uncertainty, the values and points of view of the parents play an important role in determining whether to administer a treatment, after being informed of all the possible benefits and associated risks. "Compassion fatigue" and caregiver frustration are not legitimate reasons to interrupt treatment, but deliberation about the end of life should be ethically rigorous and robust.

When the life of a child is endangered or there is risk of significant damage that will affect their health in a decisive way, it is not necessary to ask for consent. The decisions must ideally be agreed with the parents in situations of stability and must seek and follow the ethical principles of beneficence and not maleficence.

When discussing the prognosis with the parents, it is necessary to define the panorama that awaits the child in his daily life, that is, if he is going to be able to communicate properly, be able to procure self-care, sit-down and mobilize himself. All these will help parents to imagine this hypothetical situation and make a wise decision. A question that arises quickly is "under what circumstances is ethical to consider the limitation of life support therapy". Here some of them:

- the patient has a limiting disease and probably dies despite all efforts;
- it is very unlikely that the patient will benefit from any treatment if his life is prolonged. The "additional" time we offer does not give you other option to receive treatment.

As with adults, decisions at the end of life should be made with as much consensus as possible. All those involved in patient care should have one or more meeting prior to the one with the family, the intensivist and other specialist, nurses psychologists, social workers, etc., and have a "common idea" about how to approach the meeting with the family. The family should fell that all efforts from this point will be aimed at providing comfort and that does not mean leaving or abandoning him and that the team will continue to provide excellent care to the child.

It seems logical to think that early decisions do not take place when it comes to a child, and that the substitute decision-maker is usually the parent and must always be present when decisions of this type are made. Many children suffer from chronic and limiting illnesses. The doctors who regularly monitor these children must take part and be involved in the process, providing data, both technical and personal, as they know the patient and their family well.

Sometimes consensus may not be reached. When medical treatment suggests that life support benefits a child, it must be provided even if there is no agreement with your family. If there is a risk of relevant damage to a child for a treatment, without the corresponding benefit, it should

not be administered even if the parents request it forcefully. Clinicians must remain faithful to their integrity. Sometimes parents find offensive that doctors think about a subjective issue such as their child's quality of life. The task of the intensivist is to consciously determine the benefit of life, in terms of the child's pleasure to live and to face the burdens of the current treatment. This act of comparison must be carried out, and the terms "quality of life" and "futility" must be avoided.

The term "allow a natural death" seems more appropriate than "not resuscitate," since it avoids giving the impression that some potential benefits of the treatment are withdrawn [41]. The discussion with the parents must include which interventions are appropriate and which are not (nasogastric tube, orotracheal intubation, aspiration, intravenous access, etc.) the result should be clearly documented in the story. ACDs have less relevance in the pediatric patient because children have no ability to communicate their treatment options and because substitute decision-makers, parents, are almost always present when treatment decisions are made. When planning the LLTS, several issues can be proposed to the parents: petting the child while extubating (maintaining the role of parent caregivers), preventing them from seeing signs of agonizing breathing but that the child will be sedated, and having a single room and withdraw monitoring. Also when possible, they should have enough time and space to say goodbye.

A follow-up to the parents is accurate even weeks after the death, this follow-up must include the doctors involved, social worker, psychologist, etc. A subsequent meeting is the opportunity to clarify doubts and eliminate misunderstandings from parents.

10.5. Emergency situations

Emergency situations are outside end-of-life care. The definition of emergency is a situation in which the patient is unable to give consent for a treatment that is immediately needed to:

- save the patient's life, or
- prevent serious damage.

An authorization or a renunciation to consent is limited. The only treatments allowed are those that pursue those objectives. If the treatment carries a risk of permanent disability, it is best to obtain the informed consent if possible within a reasonable timeframe.

11. Organ donation

Donation is an integral part of end-of-life care and it is necessary to know how to recognize donation opportunities and to identify those situations in which death is a possibility. It is necessary to contact the local transplant organization, if such situations arise, to discuss the availability of the donation, the physiological support with active treatment of the potential donor, determine brain death, and assess the need to send information to the court and documentation of brain death. Most patients who die in the ICU are able to donate tissues.

12. Decision of not to reanimate (DNR)

Cardiac arrest is the immediate, unexpected and potentially reversible interruption of the circulation and spontaneous breathing. The objectives of cardiopulmonary resuscitation (CPR) are to preserve life, restore health, and limit the sequelae.

Bioethical principles apply in the general CPR situation in several aspects:

- CPR should be attempted in all patients suffering from cardiac arrest;
- patients can accept or reject any treatment, including a CPR; in most cases, it is assumed that the patient has not carried out a previous instruction and acts under the presumed consent for the benefit of the patient;
- all patients who can benefit from resuscitation efforts should have equal access to these efforts. In an emergency, we must prioritize the common good over the protection of individual autonomy, maximizing the number of survivors or years of life saved.

CPR makes sense if recovery expectations are reasonable. On the contrary, CPR should not be attempted in the following circumstances:

- obvious signs of biological death (rigor mortis, livicedes),
- reliable evidence that the patient doesn't want to be reanimed,
- chronic, debilitating and terminal illness,
- final stage of an acute process in which all available therapeutic options have been tried,
- permanent brain damage,
- danger for the resuscitating team,
- delay of more than 10 minutes between the start of the stop and the start of the resuscitation maneuvers.

Age is an element that doesn't influence the decision to reanimate or not to reanimate.

A "resuscitation plan" should be prepared and visible in the patients´ medical records when appropriate. It must be completed if there is a possibility of worsening and that it is not a candidate for invasive measures. The purpose is to provide clinical guidance to the nursing staff of the general ward to avoid inappropriate activation of the Emergency Medical Team. In previous articles, this document has been named as "not-for-resuscitation form" or "decision not-to reanímate" (DNR). Recently, a "positive" designation was chosen, and it must include other global treatment decisions, such as whether the patient agrees to a subsequent surgery or other intervention if his condition deteriorates.

This document must be completed by the intensivist if the treatment limitation follows the best interests of the patient or if it is in accordance with the preference of the patient or his substitute decision-maker. Also nonintensivist physicians must make a resuscitation plan if the limitation of treatment is appropriate. We could consider candidates for this option: older than 75 years, advanced cancer, COPD, heart failure, etc.

Filling that plan does not mean that the treatment is limited; in some cases, the patient can be a candidate for a full CPR.

13. Clinical practice guidelines for the terminal patient

- Palliative care plan
- Training in palliatives
- Institutional responsibility

Table 4 shows the 12 "good dying" points that must be contributed in the ICU [15].

These aspects should be included in the Clinical Practice Guide for the Comprehensive Management of Palliative Care. This guide should direct the palliative care plan, in patients in whom the goal of treatment has ceased to be healing, and has become comfort and symptomatic relief. It is highly recommended to implant in hospitals, first at the academic level, and then at the training level, training in palliative care. And there is no doubt that the hospital has an important responsibility in that its health professionals know how to apply palliative care to their patients.

- know that death is coming and understand what can be expected;
- have some control of what is happening;
- offer dignity and privacy;
- have control over the relief of pain and other symptoms;
- choose where to die;
- have sufficient information and technical skill;
- have access to spiritual and emotional support;
- have control over who will be with the patient;
- be able to ensure that the patient's wishes are respected;
- have time to say goodbye;
- be able to leave when it is time to leave and not prolong the situation indefinitely.

Table 4. Items associated with a good dying.

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