Withdrawal of ventilatory therapy in South Africa

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Declarations

- No financial conflict of interests
- I am a paediatrician
- Food for thought
PICU in South Africa

- Intensive care facilities are not recommended in countries with an under 5 mortality rate greater than 30 per 1000 live births

- South Africa (2010) : 56.6

- Thus, the presence of PICU in South Africa represents a remarkable privilege
In developed countries 8–12% of hospital beds are dedicated ICU beds

No. of paediatric beds at CHBAH : 400
Expected no. of ICU beds : 32–48
Actual no. of ICU beds : 8
Percentage of total beds : 2%
The Role of the Intensivist

- A manager of resources

- A ‘referee’ or ‘judge’ caught in the conflict between the principles and the models of medical ethics
The Ethical Dilemma

- Autonomy
- Beneficence
- Non-maleficence
- Justice
- Honesty
- Dignity
# Medical vs Epidemiological Ethics

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<td>Person-orientated</td>
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Health care ethics

3 categories

- **Distributive** – fair distribution of scarce resources
- **Rights based** – respect for people’s rights
- **Legal** – respect for morally acceptable laws

In practice, the principles of medical ethics are applied according to the public health model rather than the patient–care model.
Balance
The South African ‘Balance’

- Autonomy
- Beneficence
- Non-maleficence
- Dignity
- Honesty
- Justice
Justice

- The moral obligation to act on the basis of fair adjudication between competing claims
- Linked to fairness, entitlement & equality
- Equitable distribution of resources
- Egalitarianism vs Utilitarianism
Withdrawing ventilatory support

- The decision to withdraw ventilatory support represents one of, if not the most, difficult tasks facing an intensivist

- This difficulty is immeasurably increased when ICU resources are in scarce supply, as is the case in South Africa (and the rest of the developing world)

- Nevertheless, our professional responsibilities do not allow us to walk away from such difficulties

- Thus a framework to guide clinicians is an invaluable tool
Withdrawning ventilatory support

Physicians are vocationally committed to the promotion of health, to the treating of their patient’s illnesses and to saving of their lives.

Any discussion on the subject of withholding or withdrawal of life sustaining treatment tends to be contentious, difficult and at times emotive.

The achievement of total consensus in such a subject is probably impossible, particularly when so many are consulted.
Curative–Palliative care continuum

- Curative care

- Palliative care
Five scenarios where the withdrawal or withholding of life sustaining medical treatments may be considered: (The Royal College of Paediatrics and Child Health)

1. The “Brain Dead” Child
2. The “Permanent Vegetative State”
3. The “No Chance” Situation
4. The “No purpose” Situation
5. The “Unbearable” Situation
What about......

- Situations that do not fit with these five categories?
- Uncertainty about the degree of future impairment?
Medical futility

- Subjective concept

- Defined as: a clinical action serving no useful purpose in attaining a specified goal for a given patient

- Qualitative goals:
  - Physiologic futility
  - Benefit centered futility
  - Operational futility (utility)

- Necessitates clearly defined goals of treatment from the onset of care
Medical futility

- 3 core principles:
  - Physicians are not obliged to provide treatments they believe are ineffective or harmful to patients.
  - Physicians must not merely refuse requests for treatments they deem ineffective but must engage all involved parties in dialogue in an attempt to reach a common understanding.
  - Physicians must distinguish between life prolonging treatments and treatments aimed at providing comfort and dignity for the dying patient.
Practical approach

- Establish the presence of medical futility
  - A shared, multidisciplinary approach is recommended
  - Dynamic process aimed at reaching consensus, initially among the medical staff and secondly with the family
  - Communication is the cornerstone of this process
  - May require several care conferences
  - Take, and document the decision to withhold/withdraw care
Practical approach

- Draw up a detailed, step-wise plan of how you are going to proceed
Withholding vs Withdrawing

- Ethically and legally equivalent
- Emotionally, can be worlds apart
- Neither equals the cessation of treatments designed to make the patient comfortable
- Entails a redirection of the treatment plan with the emphasis shifting to palliative care
Practical approach

- Draw up a detailed, step-wise plan of how you are going to proceed
- If possible, move the patient to a private setting
- Ensure patient comfort – analgo-sedation
- IV fluids and feeds?
- Once the patient is adequately sedated, wean FiO₂ to 21%
- Reduce respiratory rate to physiological norms and pressure support to enough to provide a tidal volume of 5mls/kg
Practical approach

- Adjust analgo-sedation as required
- Disconnect the patient from the ventilator
- Inform staff and family that transient patient agitation can occur
- If prolonged survival is a possibility, extubate the patient
- Ensure patient comfort and provide support to family members
- Following death, complete all necessary paperwork
Practical considerations

- Decisions must never be rushed
- Paramount to obtain all available evidence
- Rigid rules should be avoided
- Decisions should never be the sole responsibility of junior staff
- The decision to withhold or withdraw life sustaining therapy should always be taken with consideration of the child’s overall palliative or terminal care needs – including symptom alleviation thus ensuring the maintenance of human dignity and comfort.
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Questions & Comments