In Collaboration with

22 to 24 March 2019 DOHA

Middle East Forum on Quality and Safety in Healthcare

Palliative and End-of-Life Care, & Do-Not-Attempt-Resuscitation: Qatar Critical Care Perspective

Dr Alhady Alfian Yusof MB ChB, EDIC, FRCEM, FFICM (UK)

22nd March 2019

Patient Safety First

Brought to you by Hamad Healthcare Quality Institute

Conflict of Interest

I have no financial conflict of interest or disclosure in relation to this presentation.

I work as a Consultant in Medical ICU and Emergency Department at Hamad General Hospital (HGH)

I am a member of HGH clinical Ethics Committee and Corporate DNAR Committee

Learning Objectives

At the end of this session, participants should have an:

1. Increased awareness of issues surrounding 'Palliative Care' in Medical ICU in Qatar
2. Insight on how Critical Care Physicians in Qatar have been dealing with the issue: Resuscitation vs DNAR
3. Ideas on potential areas of quality improvement and research project in this subject

Examples of typical cases of critically ill patient referred to MICU for continuation of resuscitation (consideration of End-of-life care and Do-Not-Attempt-Resuscitation)

Patient admitted with any serious acute illness with any combinations of characteristic listed below:

- ‘Elderly’ and fully dependent on care
- Severe dementia, non communicating
- Bedbound, limb contractures, previous strokes
- NG/PEG fed and double incontinent
- Cachexic, malnourished, pressure sores
- Metastatic cancers
- End-stage lung or heart condition despite maximum therapy

(after detailed assessment some of these cases might be appropriate for resuscitation)

Main Strategy for palliation of acutely ill patient with terminal disease

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Patient under MICU care will often have repeated DNAR discussion
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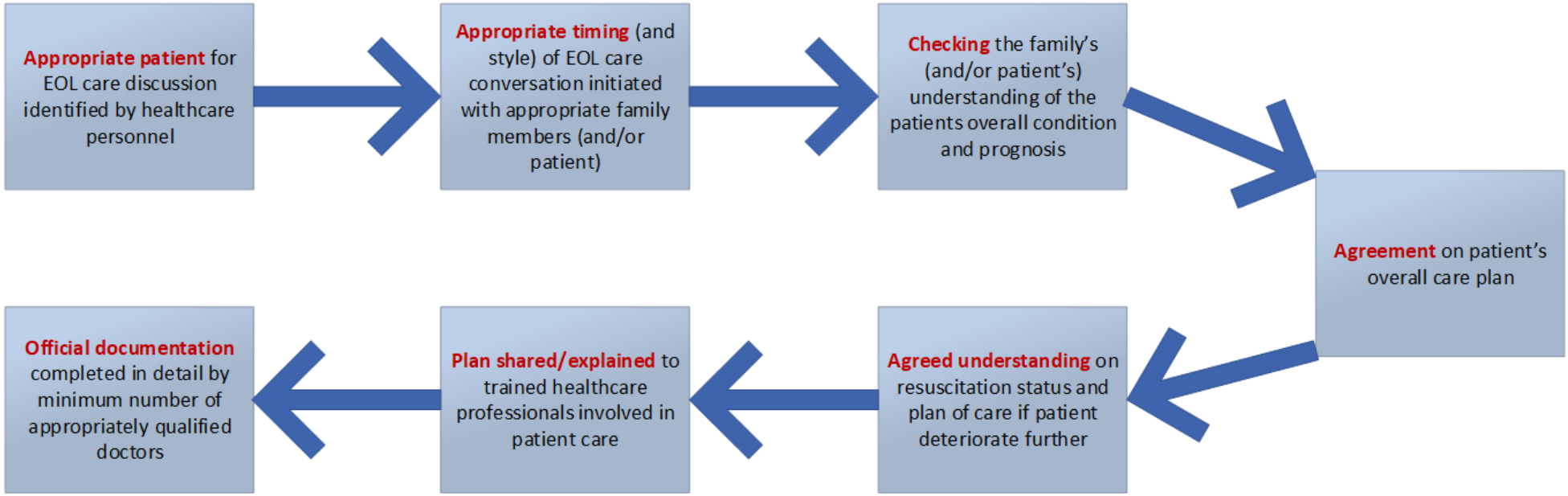
‘Emergency’ DNAR discussion for acutely ill patients with underlying terminal disease

Often undertaken in the Emergency Department or medical ward

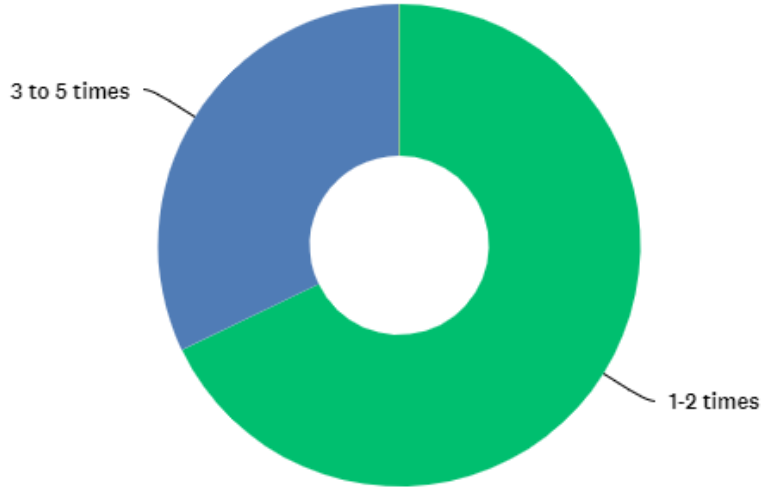
Often done by MICU doctor after patient been referred

Increasingly being done by Emergency Physicians and Medical team

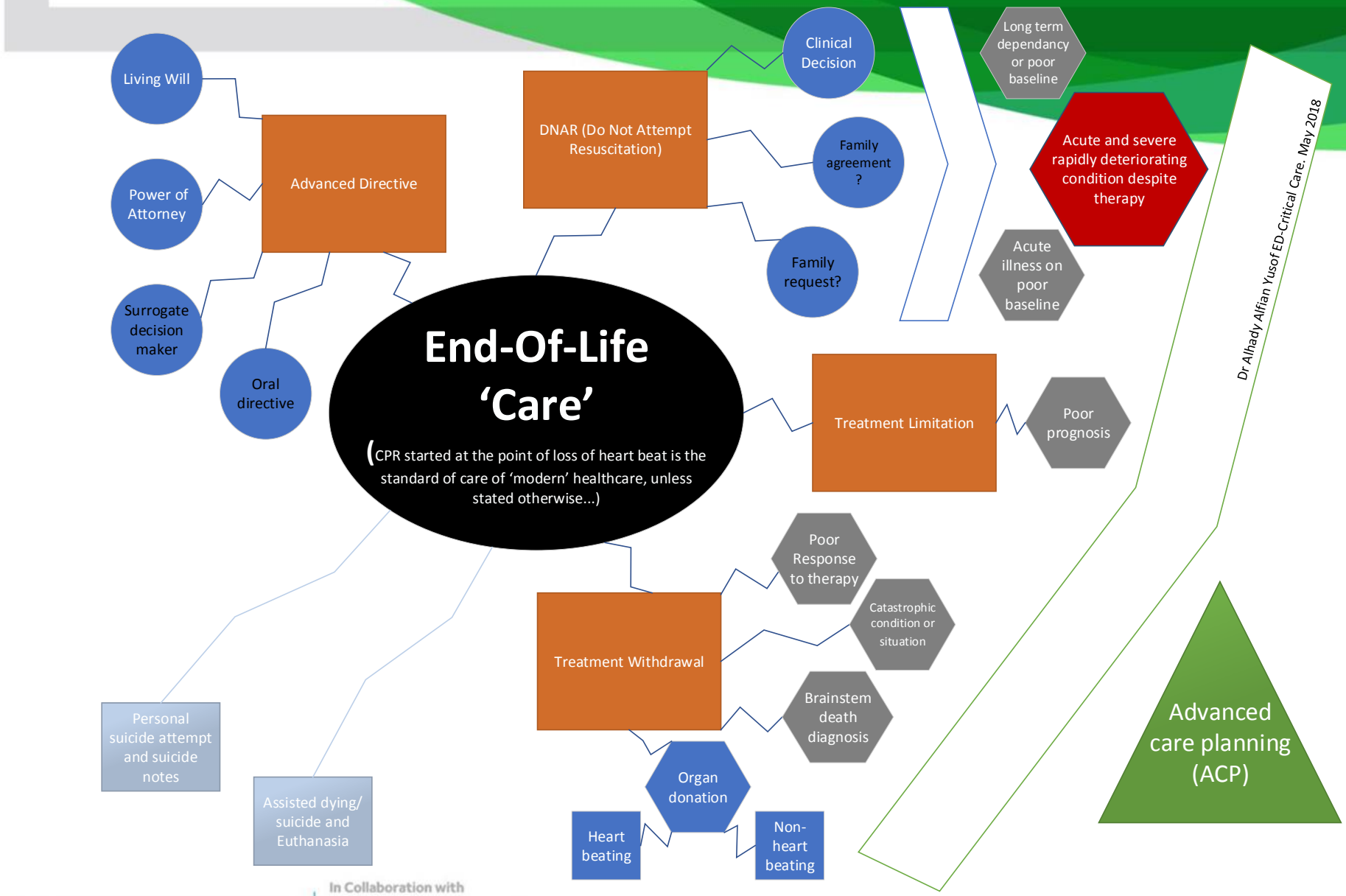

Appropriate patient for EOL care discussion identified by healthcare personnel
Appropriate timing (and style) of EOL care conversation initiated with appropriate family members (and/or patient)
Checking the family's (and/or patient's) understanding of the patients overall condition and prognosis
Agreement on patient's overall care plan
Agreed understanding on resuscitation status and plan of care if patient deteriorate further
Plan shared/explained to trained healthcare professionals involved in patient care
Official documentation completed in detail by minimum number of appropriately qualified doctors

On average, how many times do you conduct DNAR discussion with patient family in 1 week of clinical duty in ICU?

Answered: 28 Skipped: 0



ANSWER CHOICES	RESPONSES	
1-2 times	67.86%	19
3 to 5 times	32.14%	9
6 to 10 times	0.00%	0
more than 10 times	0.00%	0
TOTAL		28



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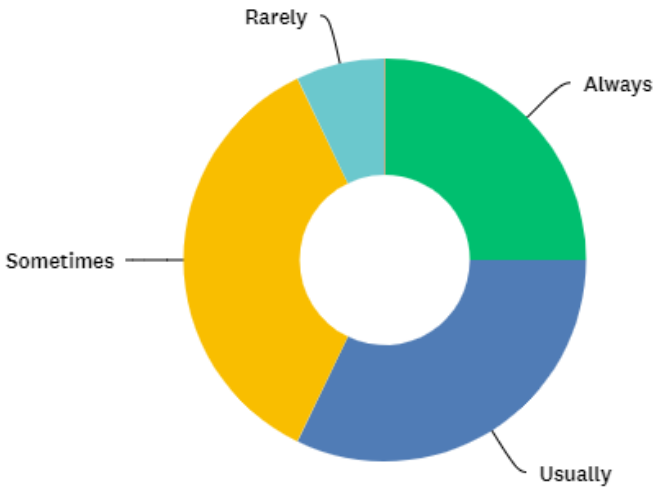
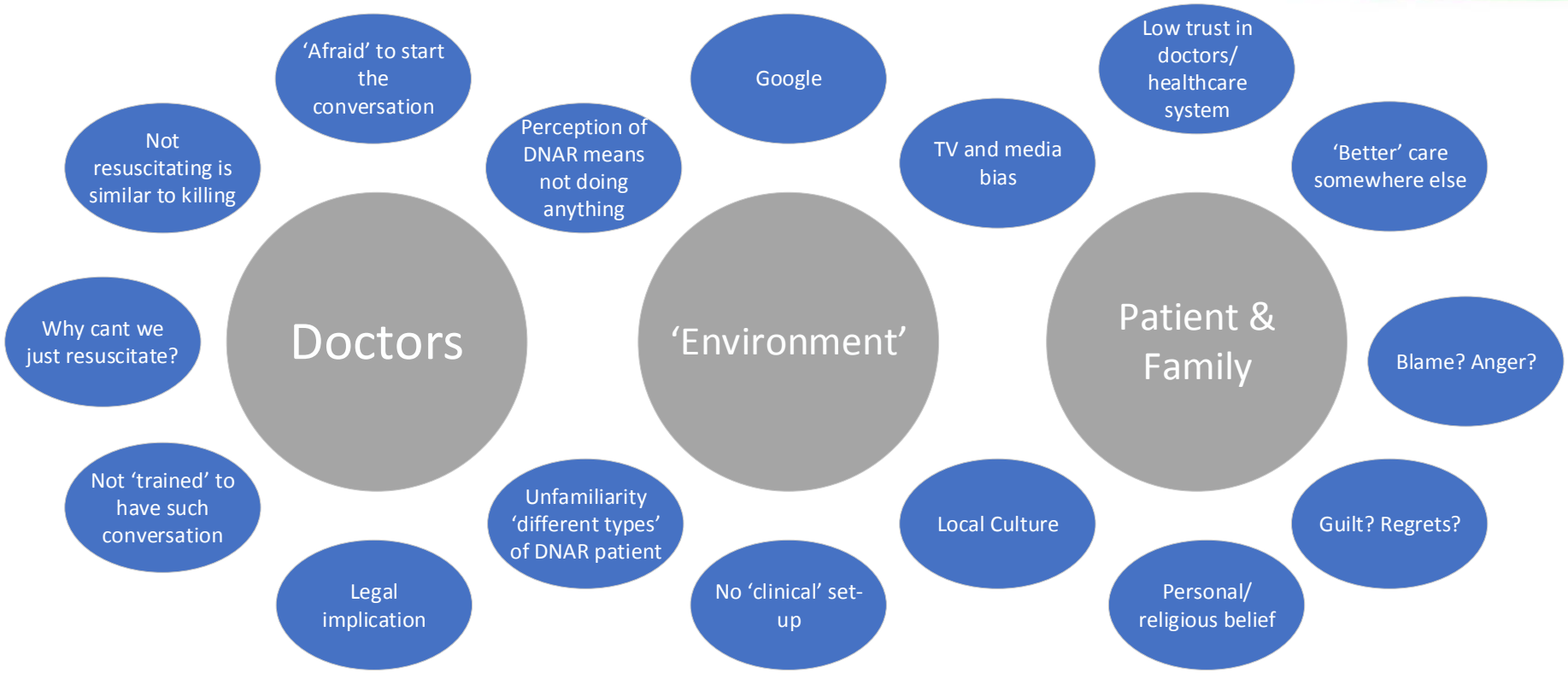
If the patient's medical background and current condition is highly appropriate for DNAR, how often do you open the discussion during the first family encounter?

Answered: 28 Skipped: 0



ANSWER CHOICES	RESPONSES	
Always	25.00%	7
Usually	32.14%	9
Sometimes	35.71%	10
Rarely	7.14%	2
Never	0.00%	0
TOTAL		28



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How often do you manage to get 'acceptance' for DNAR order after the discussion?

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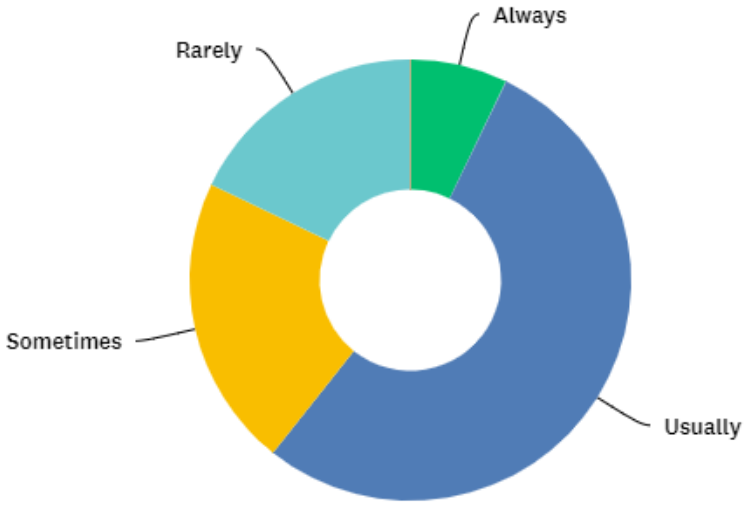

ANSWER CHOICES	RESPONSES	
Always	7.14%	2
Usually	53.57%	15
Sometimes	21.43%	6
Rarely	17.86%	5
Never	0.00%	0
TOTAL		28

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‘Aggressive’ Conservative intervention

Fluid resuscitation based on clinical gestalt and/or non-invasive hemodynamic assessment

Electrolytes correction

Nasogastric Tube

Patient managed in resuscitation area (or Rapid Response Team activation)

Appropriate and early empirical therapy

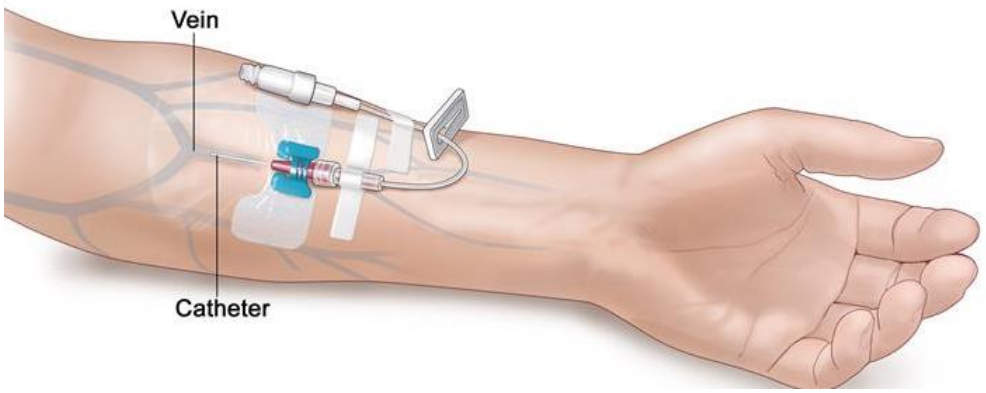
In order to ‘avoid’:

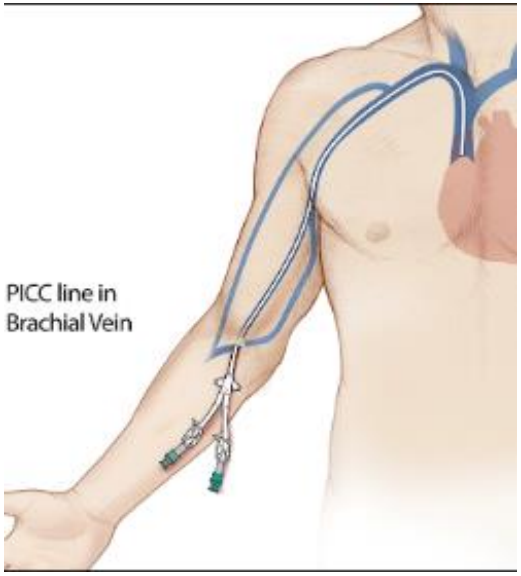
Intubation

Central line insertion

Arterial line insertion

Use of ‘minimally’ invasive organ support manageable on the medical ward





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Prioritisation of Critical Care beds

If patient is already intubated (either by prehospital, ED doctors, or RRT doctors) patient will need to remain under MICU care regardless of DNAR status

If family completely refused DNAR and patient deteriorated, intubation will often follow

Due to patient's poor prognosis status and/or 'ICU palliative care' status, often these patients will continue to be managed in the ED and or on the medical ward if they are already there, under the care of MICU outreach team and often MICU nurses.

ICU admission is reserved for 'non-palliative' cases unless there is a lot of bed available (often there's more than 100% occupancy)

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After taking over the patient's care (or referral) from another specialty, and it was endorsed to you that family has 'refused DNAR', how often do you still open the subject again with the family?

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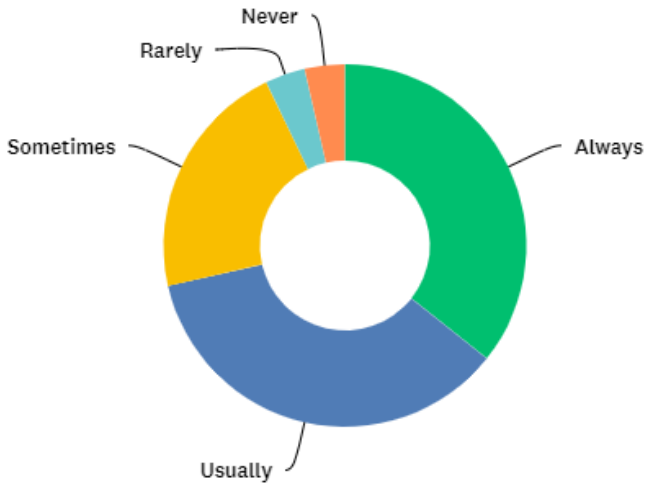
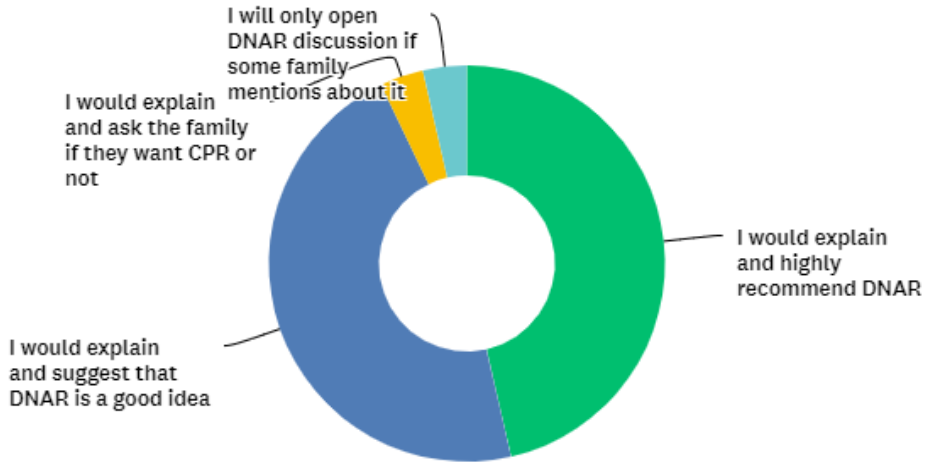


ANSWER CHOICES	RESPONSES	
Always	35.71%	10
Usually	35.71%	10
Sometimes	21.43%	6
Rarely	3.57%	1
Never	3.57%	1
TOTAL		28

If you feel patient medical background and current condition is highly appropriate for DNAR, how is your general approach towards the discussion with family?

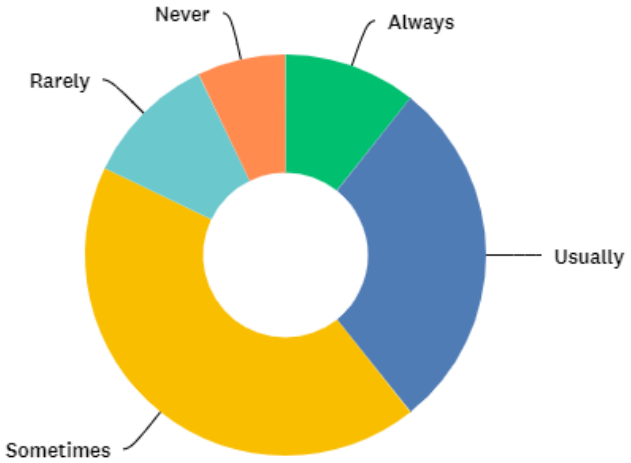
Answered: 28 Skipped: 0



ANSWER CHOICES	RESPONSES	
I would explain and highly recommend DNAR	46.43%	13
I would explain and suggest that DNAR is a good idea	46.43%	13
I would explain and ask the family if they want CPR or not	3.57%	1
I will only open DNAR discussion if some family mentions about it	3.57%	1
TOTAL		28

If the patient's medical background and current condition is highly appropriate for DNAR, and their initial reaction to you is refusal to accept the situation, how often would you still continue to try to make them understand and accept?

Answered: 28 Skipped: 0



ANSWER CHOICES	RESPONSES	
Always	10.71%	3
Usually	28.57%	8
Sometimes	42.86%	12
Rarely	10.71%	3
Never	7.14%	2
TOTAL		28

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Treatment Limitation and Withdrawal

HMC Hospital policies are available for both circumstances

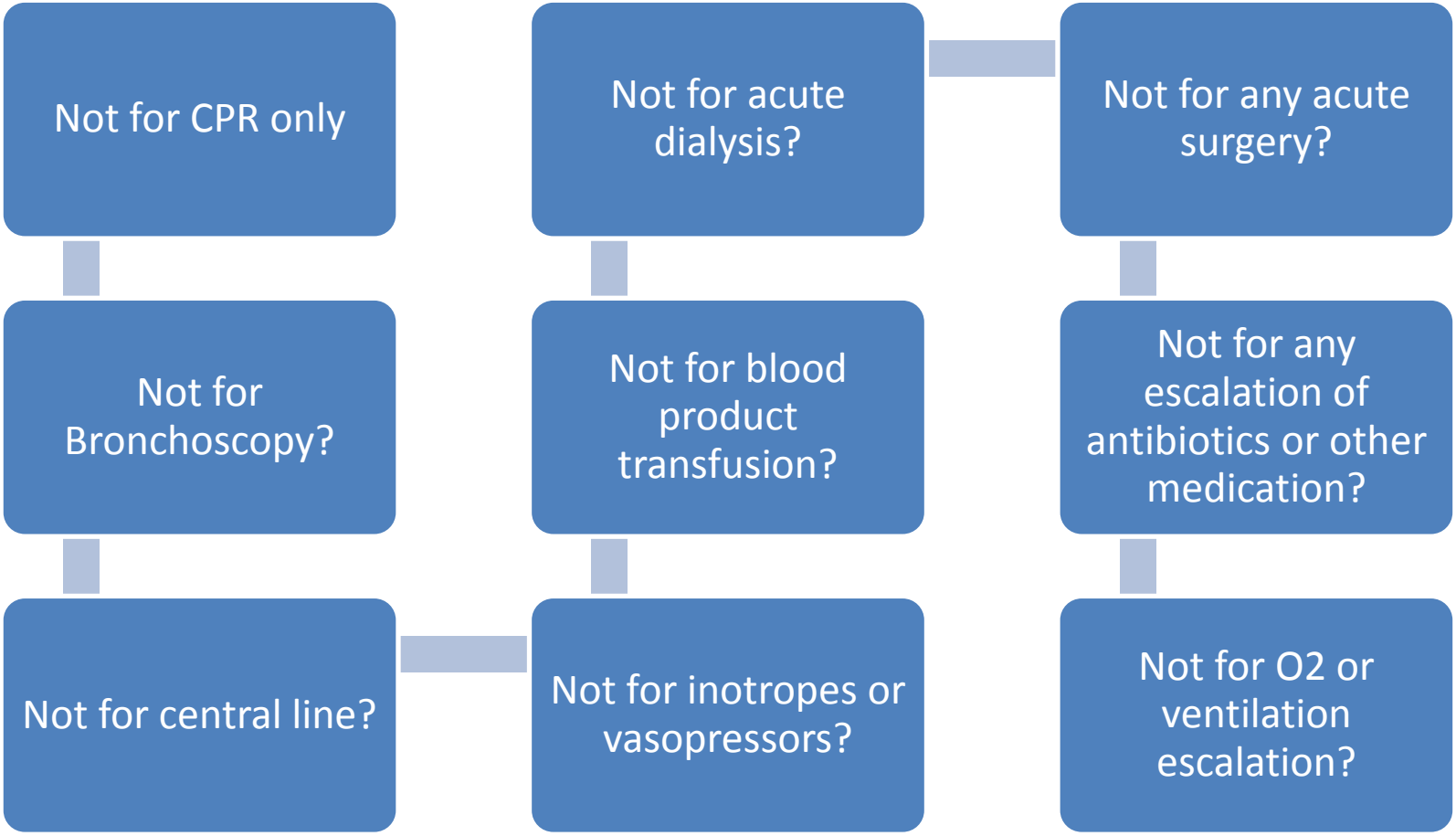
Treatment withdrawal

- e.g. One way extubation (often only trial of extubation is accepted)
- Mainly not seen as acceptable (we have some experience withdrawing from patients with brainstem death diagnosis)

Treatment Limitation

- mainly physician clinical decision, often these can be very ‘grey’…

Possible Treatment limitation for Intubated Palliative care patients



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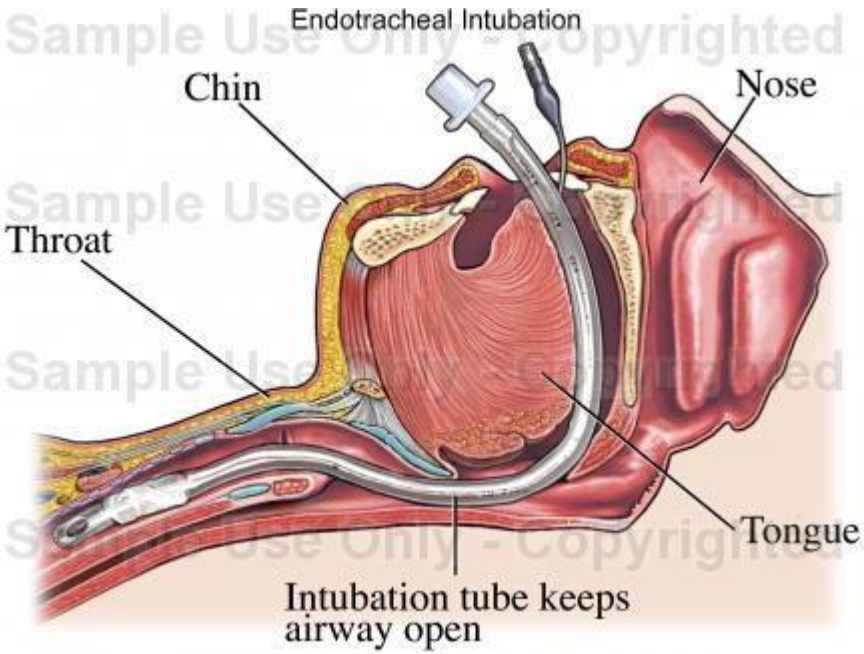

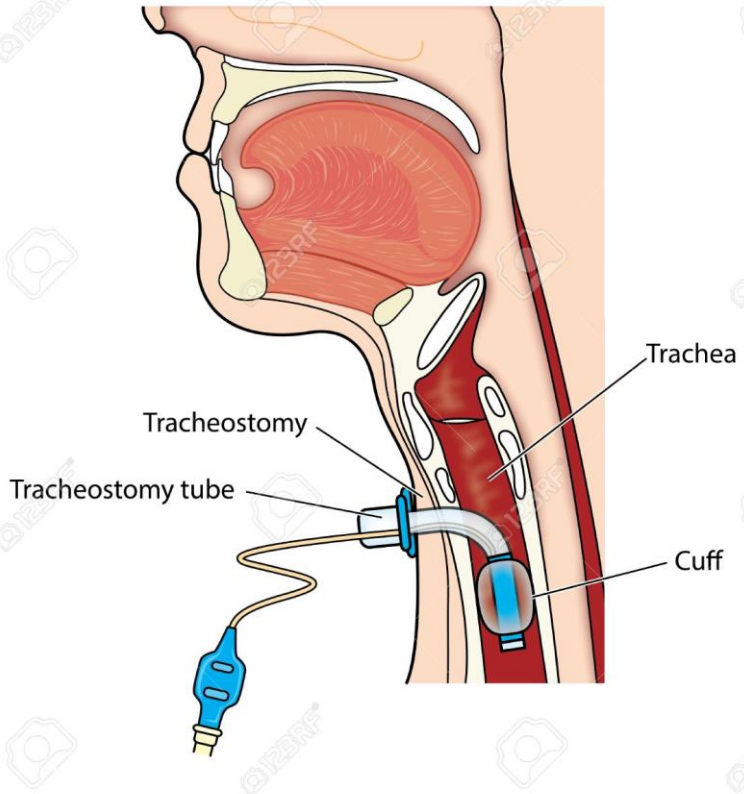

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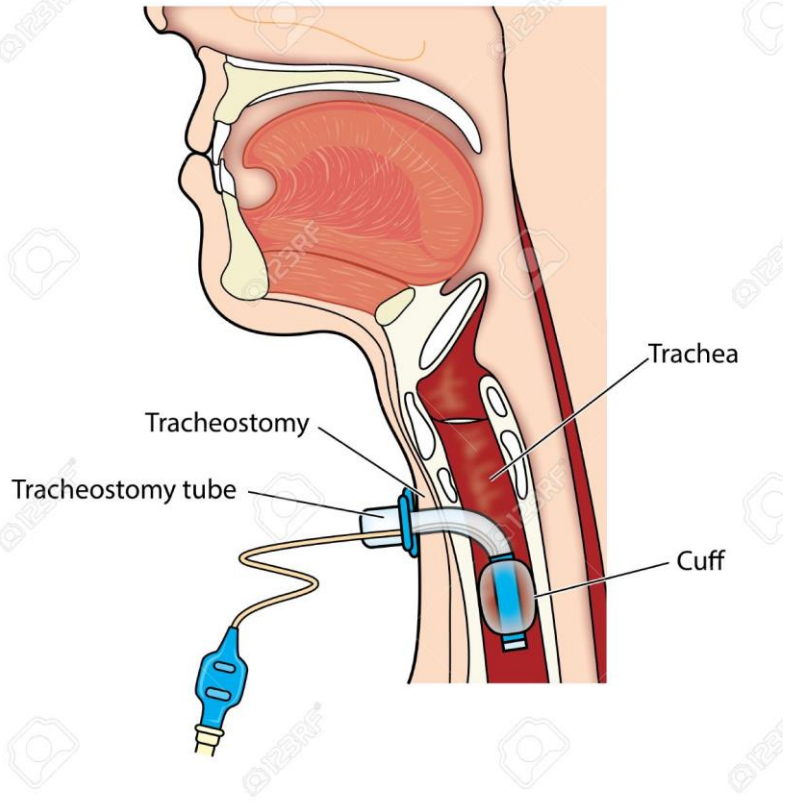
Potential issues

Family refusal

Family wanted to give longer time for patient to ‘wake’ up

Anatomical and physiological limitation to undertake percutaneous procedure

Elective status of surgical tracheostomy procedure



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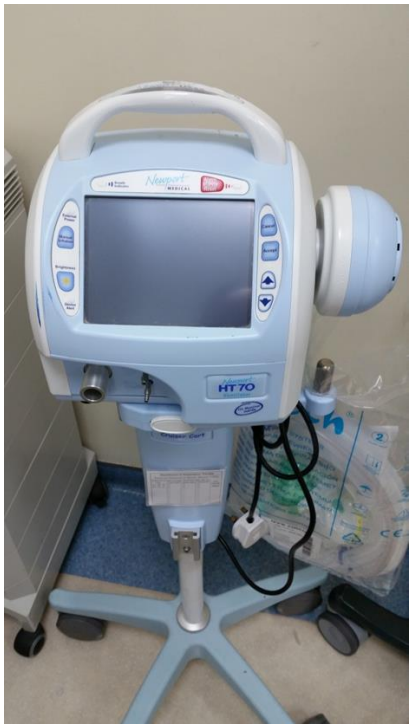
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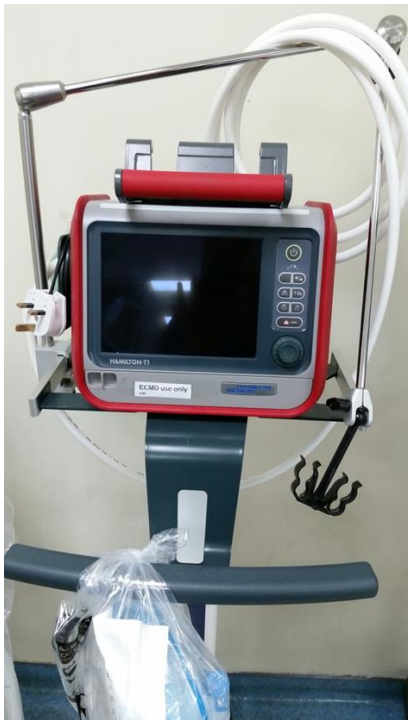
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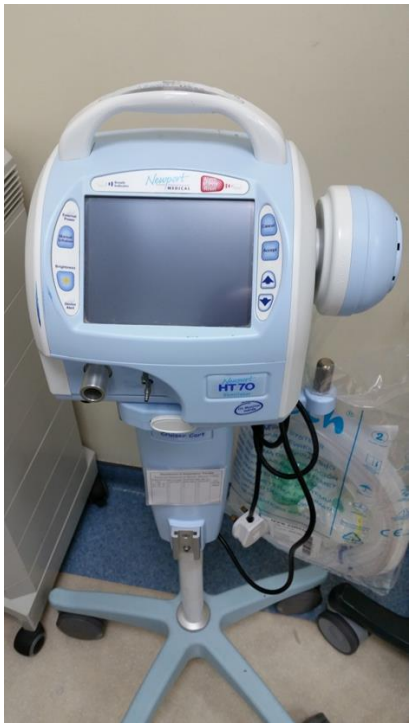
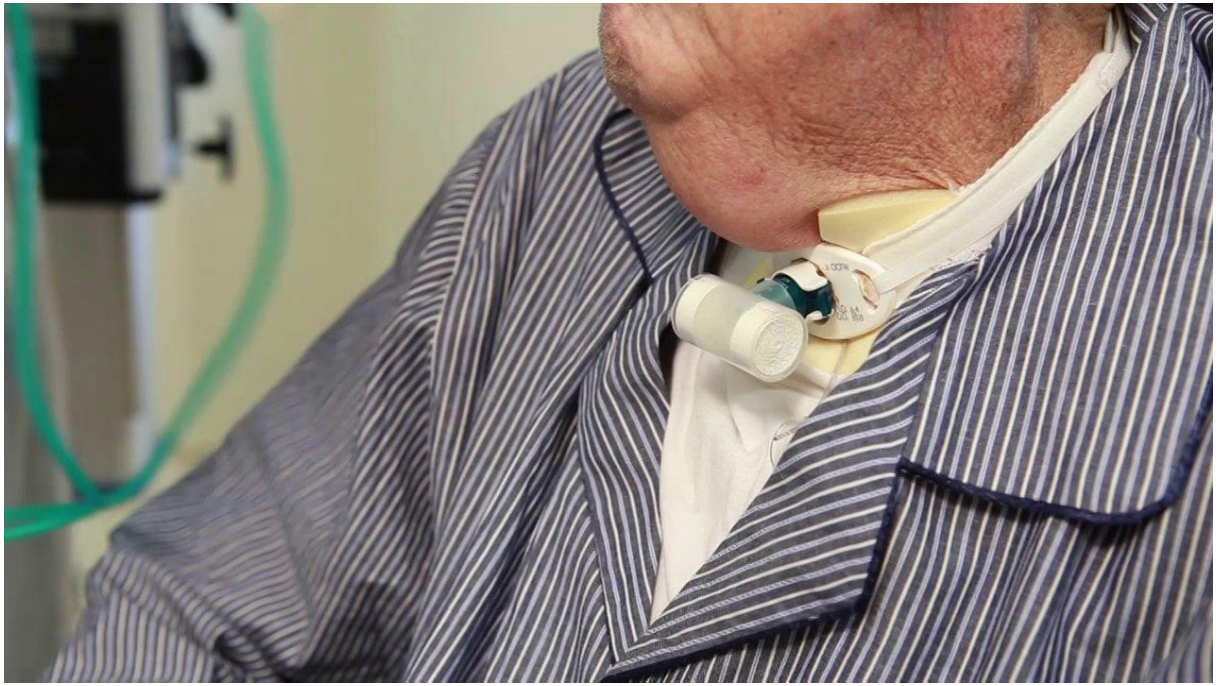
- The procedure of transferring patient from a ‘large’ or advanced ventilator to a ‘small’ portable ventilator often is straight forward but it may be unpredictable – dysynchrony, desaturations, tachypnoea etc.
- This step is highly dependent on our Respiratory Therapist team skills and perseverance.





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Transfer out from MICU

Can be a very difficult step to achieve

Possible outcome:

- Medical ward
- Long term care unit
- Rehabilitation unit
- Home with trained nursing care
- Transfer abroad
- MICU long-term patients

Respiratory therapy team will continue to follow patient care and progress

Promoting Autonomy vs Paternalistic approach?

Holistic approach vs resuscitative approach
Quality of life vs ‘alive’ at any cost
Family opinion/request is the same as patient’s autonomy?
‘Good care’ vs good doctoring/diagnosis and treatment
Patient-centred care vs Family-centred care
Curative/organ support therapy vs symptom control therapy
‘Aggressive’ vs ‘comfort’ therapy

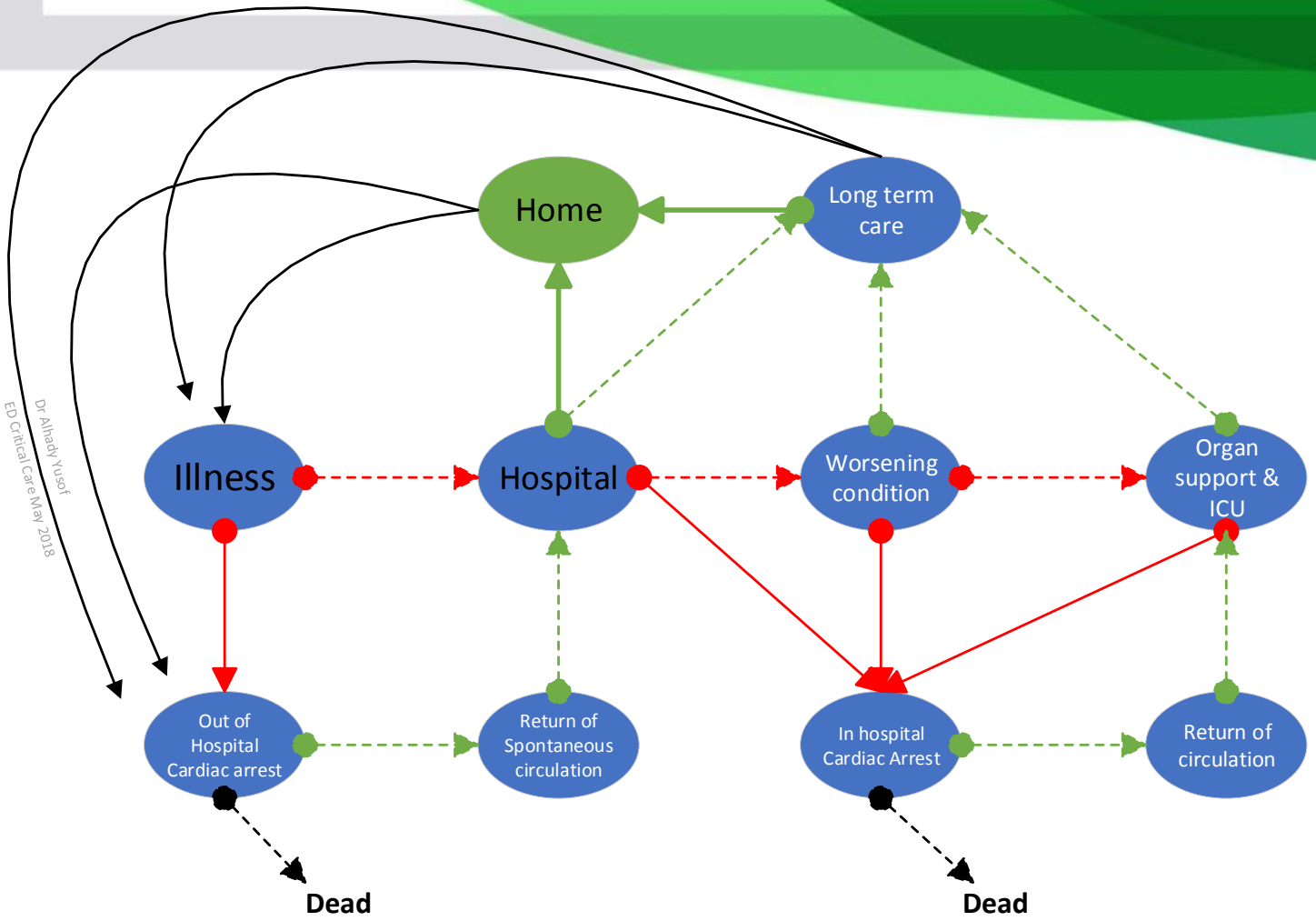
Conclusion

ICU ‘Palliative Care’ in Qatar is quite different from Traditional Palliative care concept as there is a lot ‘Intervention and Resuscitation’ involved in patient care

This is how Qatar’s Medical Intensivist driving Critical Care ‘Palliative Care’ Service

Concept:

Sensible resuscitation while trying to convince family of treatment futility, followed by rapid de-resuscitation, and de-escalation (if possible) to accommodate comfort and conservative care.



Thank you for listening

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