

Section: 3

Guidelines for limiting life-prolonging interventions and providing palliative care towards the end of life in Indian Intensive care units

Executive summary

Committee for the Development of Guidelines for limiting life-prolonging interventions and providing palliative care towards the end of life: Indian Society of Critical Care Medicine

Abstract

Purpose:

To minimize inappropriate treatment and optimize comfort care for terminally ill patients in Indian intensive care units by standardizing the process of forgoing life support. It is also to define the ethical standards of physician-patient relationship in the context of critical care in India.

Evidence:

Review of recently published literature on the subject. Available empirical data from critical care practice in India were sparse. The terms for search were: end-of-life care; withdrawal and withholding; intensive care; terminal care; medical futility; ethical issues; palliative care.

Method:

Proposals from the Chair were debated and recommendations were formulated through a consensus process. The process took into account the guiding ethical principles and clinical practices elsewhere in the world, and incorporated the socio-cultural and legal perspectives unique to this country.

Guidelines:

1. The physician has a moral obligation to inform the capable patient/family, with honesty and clarity, the poor prognostic status of the patient when further aggressive support appears non-beneficial. The physician is expected to initiate discussions on the treatment options available including the option of no specific treatment.
2. When the fully informed capable patient/family desires to consider comfort care, the physician should explicitly communicate the available modalities of limiting life-prolonging interventions.
3. The physician must discuss the implications of forgoing aggressive interventions through formal counseling sessions with the capable patient/family, and work towards a shared decision-making process. Thus, he accepts patient's autonomy in making an informed choice of therapy, while he fulfills his obligation of providing beneficent care.
4. Pending consensus decisions or in the event of conflicts between the physician's approach and the family's wishes, all existingsupportive interventions should continue. The physician however, is not morally obliged to institute new therapies against his better clinical judgment.
5. The proceedings of the counseling sessions, the decision-making process, and the final decision should be clearly documented in the case records, to ensure transparency and to avoid future misunderstandings.

6. The overall responsibility for the decision rests with the attending physician /intensivist of the patient, who must ensure that all members of the caregiver team including the medical and nursing staff represent the same approach to the care of the patient.
7. If the capable patient/family consistently desires that life support be withdrawn, in situations in which the physician considers aggressive treatment non-beneficial, the treating team is ethically bound to consider withdrawal within the limits of existing laws.
8. In the event of withdrawal or withholding of support, it is the physician's obligation to provide compassionate and effective palliative care to the patient as well as attend to the emotional needs of the family.

INTRODUCTION

"Dying can be a peaceful event or a great agony when it is inappropriately sustained by life support"

Roger Bone (1)

In the context of critical care, the physician's approach to the patient has three dimensions: medical, ethical and legal. This is because critical care involves the application of life- supporting interventions.

Death is commonplace in the critical care unit. The dying frequently die in critical care units: it is estimated that one in five Americans die using intensive care (2). For many, life- support interventions have not helped to mitigate their suffering, but have rather added the agony and burden of a prolonged dying process. Death, which we all wish to be peaceful and to occur in the presence of loved ones, has become artificial, away from the family surrounded by the paraphernalia of modern critical care. Prolonged and futile life support has undoubtedly imposed enormous economic strains on patients and families. Potentially salvageable patients can be deprived of ICU care when scarce beds and resources are consumed in search of cure where death appears inevitable.

Where critical care is unlikely to restore patient to a meaningful existence, what is the responsibility of the physician? In today's world limitation of life-supporting interventions is being increasingly practiced, as physicians realize that the mission of intensive care includes the avoidance of inappropriate use of aggressive interventions (3). In the US and in Europe withholding or withdrawal preceded death in up to 90% of dying patients in critical care units (4,5,6) and 10% of admissions (6). The proportion of patients dying with a decision to limit life support increased from 51% to 90% over the 5-year period from 1988 (7) to 1992 (8). In Pediatric ICUs, retrospective studies in the last decade suggest that 40-60% of all deaths follow an end-of-life decision (9). In contrast, in a tertiary care center in India, withholding and withdrawal of life-supporting interventions (WOLS) preceded only 22% of deaths (10), although in some other centers limitation of life- support is showing a significantly higher trend (11). In the vast majority, however, the prevailing practice appears to be full, and often heroic, support until the very end.

The customary practices in India, however, may not accurately reflect the changing physician attitudes. In response to a questionnaire among 169 intensive care

physicians in a recent survey 80% felt there is a need for forgoing life-supporting interventions in critical care and 55% practice "Do not resuscitate" (DNR) directives discreetly and unilaterally (Mani R K, personal communication). The majority appeared to have fears of misuse of the life- support limiting approach or of being misunderstood by the families of patients.

There are several impediments to change in critical care practices in India: The approach to the patient is generally "paternalistic" as the concept of autonomy is weak in the prevailing cultural ethos. The physician's orientation by his training is only to a curative approach to disease rather than to one of palliation when the patient's prognosis is poor. The physician is generally fearful of being accused of providing sub optimal care or of possible criminal liability of limiting therapies. Adding to his dilemma there is a virtual absence of ethical or legal guidelines relating to deaths in intensive care units in India. Self -determination of patients relating to medical decisions is not well articulated in our Constitution (10). Indeed the position of the law with respect to death in dignity is unclear, as Indian courts have only addressed appeals for Euthanasia (12, 13,14). In the US and in Europe the Laws have evolved over the last 3 decades to accommodate the changing paradigm (15,16,17), while in India debate on the issue has only just begun (18,19,20).

The need for change, however, is of vital importance in India for several reasons. There is an unbearable financial burden to the average patient as healthcare expenses are borne mostly by the individual. Lack of appropriate policies for limiting life support make fair distribution of scarce facilities impossible in this populous country. Finally, a technologically prolonged dying process takes away the serenity and dignity accorded to it by the established cultural traditions and beliefs.

Ethical principles

Among the four cardinal ethical principles upon which the practice of critical care is grounded, respect for patient's autonomy has come to take precedence over the other three-namely, beneficence and non-maleficence and distributive justice (3,5,15,16,21,22). Autonomy means the Right to self-determination, where the informed patient has a right to choose the manner of his treatment. To be autonomous the patient should be competent to make decisions and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a Will, or the wishes of surrogates acting on his behalf ("substituted judgment")(3) are to be respected.

Beneficence is acting in what is (or judged to be) in patient's interest. In critical care, increasingly the physician is expected to care for patients with a high risk of death. As the physician is expected to act in the best interests of the patient and his family, his responsibility should extend beyond medical treatment to ensuring compassionate care during the dying process. In this context, the physician's expanded goals include facilitating (neither hastening nor delaying) the dying process, avoiding or reducing the sufferings of the patient and his family, providing emotional support and protecting the family from financial ruin. This is not to be confused with Euthanasia, which is a direct intervention by the physician to hasten the dying process by administering a lethal injection. When the physician, acting

unilaterally, makes decisions for the patient, he is said to be "paternalistic"(15,16). Respect for patient's autonomy requires that Beneficence also consist of educating the patient to enable him to make an informed choice

Non- malfeasance means to do no harm, to impose no unnecessary or unacceptable burden upon the patient. This is subject to varied interpretation, as the same act may be construed as harmful or beneficial depending on the circumstances (21). In practical terms, it requires the physician not to act contrary to the patient's values and perspectives.

Distributive justice means that patients in similar circumstances should receive similar care. Physicians need to have a socially responsible behavior, which makes it their duty to make good use of the material, financial and human resources under their control. The physician may thus provide treatment and resources to one with a potentially curable condition over another for whom treatment will be futile (21).

When to initiate end-of-life (EOL) discussions:

A workable instrument of mortality prediction is necessary to identify situations where EOL discussions can begin. Whether a patient is going through the dying process or not is not always clear. Often the clinician's judgment is colored by his own biases and attitudes towards death (24,25,26).

As with any diagnostic process identifying these situations needs expertise and experience. Each of the following criteria is not to be used in isolation, but in the context of the entire clinical history and status of the patient. When faced with prognostic uncertainty the physician should not take precipitous decisions but wait for the disease process to unfold. The following list is not to be regarded as definition of medical futility, but should help the physician to recognize when to start discussions on EOL issues.

Checklist for initiating EOL discussions:

1. Advanced age coupled with a poor premorbid state due to chronic debilitating diseases. E.g., advanced chronic obstructive pulmonary disease (COPD) requiring home oxygen and/or bilevel pressure support or with severe impairment of quality of life; advanced interstitial lung disease on oxygen therapy with failed medical treatment, chronic renal failure requiring long term dialysis, chronic liver disease, advanced congestive heart failure.
2. Catastrophic illnesses with organ dysfunctions unresponsive to a reasonable period of aggressive treatment.
3. Prolonged coma (in the absence of brain death) due to acute nonreversible causes or chronic vegetative state.
4. Incurable chronic severe neurological states rendering meaningful life unlikely-e.g. Progressive dementia, quadriplegia with ventilator dependency.
5. Progressive metastatic cancer where treatment has failed or patient refuses treatment.

6. Post -cardio respiratory arrest non-restoration of comprehension after a few days.
7. Comparable clinical situations coupled with a physician prediction of low probability of survival.
8. Patient/family preference to limit life support or refusal to accept life support.

Rationale:

Absolute certainty in the anticipation of death is impossible. However, mortality prediction is central to communication and decisions in the critical care setting. A variety of scoring systems have been developed based on physiological variables, however, none is reliable enough to be adequate for individual patients (23,27).

Despite these difficulties empirical data has accumulated that can guide the physician's predictive judgment. Indirect evidence for the validity of the "checklist" is found in the form of epidemiological data on ICU mortality and ICU use by decedents (2), prospective and retrospective observational studies on withdrawal and withholding of life support (WOLS) (5,6,27,28) and from predictive tools that have been used in prospective studies on DNR and WOLS in both Emergency Room and ICU setting (31,33). These data help to identify the patient characteristics that physicians generally use for limiting aggressive therapy.

In the US Angus et al (2) reported epidemiological data, which revealed that among infants most deaths occurred in hospitals, especially ICUs while above the age of 75yrs both ICU and hospital admissions at the time of death decreased, and beyond 85yrs, it was the least at 14%. ICU use was found to be limited for metastatic cancer as compared to acute myocardial infarction. These data clearly suggest that advanced age and certain disease conditions lead the physicians to limit ICU admission and aggressive treatments

According to a multicenter, prospective, observational study in Europe, decisions for limitation were related to age and diagnosis among others (6). Age, poor prognosis and poor quality of life were among the reasons cited in studies from France (5) and Canada (28). In the latter series, the mean age of patients undergoing withdrawal of support was 65+/- 14.6, most of who had severe or extreme dysfunction of at least one organ system. They also found that the timing of WOLS decisions from ICU admission depends on the type and severity of the disease. These data again give us an insight into what considerations lead physicians to shift to palliative care. Physician subjective estimates of intensive care survival < 10% are associated with a high probability of subsequent life support limitation and intensive care mortality (27,29), but it is difficult to standardize (30).

Evidence from DNR directives or ICU admission policies also help to define how physicians may anticipate death with a view to initiating EOL discussions. Sinuff et al (31) found that physician prediction of low probability of survival, physician perception of patient preference to limit life support, medical rather than surgical diagnosis and age are the strongest independent determinants of DNR directives. An earlier study (32) did not find age or severity of illness as independent predictors for WOLS decisions, for the latter as compared to setting DNR directives are more complex requiring physician-family consensus. Similarly, Le Conte et al (33) reported the determinants of DNR directives to be advanced age (mean age 75+/-13 yrs),

chronic cardiopulmonary disease, metastatic cancer or patients with acute non-treatable illness.

Recently, (34) it was found that having DNR and WOLS checklists improved the conduct of end-of-life care in the ICU as perceived by nurses. In acute processes, response to therapy may often be surprisingly good and observations over time or serial scoring coupled with physician prediction may improve prognostication (30). In the ETHICUS (6) study the greatest frequency of limitations occurred for acute neurological diseases. For quadriplegics, the option of home ventilation should be offered along with information and counseling, but the choice of the patient or family should guide the decision.

It should be noted that "cut off" values for age or duration of observation before considering EOL care are hard to determine as they vary with the overall health status of the patient and the nature of his disease.

Absolute objectivity in mortality prediction has so far been elusive. The American Thoracic Society definition of futility is therefore suggestive rather than definitive: "a life-sustaining intervention is futile if reasoning and experience indicate that the intervention would be highly unlikely to result in a meaningful survival for that patient"(35).

For Pediatric patients: Worldwide pediatricians are becoming more proactive in managing death and dying (36). The EACRCPCH guidelines (37) cite the following situations as justification for limitation and withdrawal of interventions: 1.The permanent vegetative state 2.The "no chance" situation where there is expectation of imminent death despite aggressive treatment 3.The "no purpose" situation where there is decrease in quality of life despite potentially extended survival. 4.The "unbearable" situation where in the face of progressive illness further treatment is more than can be borne.

GUIDELINES FOR LIMITING LIFE-SUPPORT INTERVENTIONS

Guideline 1:

The physician has a moral obligation to inform the capable patient/family, with honesty and clarity, the poor prognostic status of the patient when further aggressive support appears non-beneficial. The physician is expected to initiate discussions on the treatment options available including the option of no specific treatment.

Rationale:

Respect for patient's autonomy and the imperative to act in his best interest are the basis for providing accurate information, as worldwide we move away from the "paternalistic" model of care (6,15,22,23,35,38)). It is important for the physician to identify a suitable family member as a surrogate decision-maker for the patient, as according to one study less than 5% of patients are able to communicate with the physician regarding issues relating to life support (7,8,23). The "family" means spouse, children, parents, siblings, the next of kin who is available or even a trusted friend, though a hierarchy of surrogates does not exist in Indian Law for making medical decisions. Advance Directive stating the patient's preference is not a practice in India but public awareness in this regard should be encouraged.

Curative and palliative measures are coexistent but varying in degree at different phases of critical illness (17,38). Therefore, the physician must initiate discussions early with a clear expression of the patient's condition. Waiting, watching, and postponing discussions on prognosis may be more stressful to the family as well as the ICU staff (39).

Practice points:

- a.** It is important that the physician gives as accurate a prognosis as is possible, clarifying that uncertainty is inherent in the treatment of critical illness, in a language and in terms that the family can understand.
- b.** It is the responsibility of the physician to inform the capable patient or his family the diagnosis, prognosis, the range of therapeutic interventions available as well as the option of no therapy, including their risks, benefits, costs and consequences (35).

Guideline 2:

When the fully informed capable patient / family desires to consider comfort care, the physician should explicitly communicate the available modalities of limiting life-prolonging interventions.

If the patient or family do not desire the continuation of life supporting interventions the available options for limiting the supports should be identified as follows:

- 1. Do not resuscitate status (DNR)**
- 2. Withdrawal of life support**
- 3. Withholding of life support**

Definitions: modified from (4)

Full resuscitation (CPR):

Aggressive ICU management up to and including resuscitative attempts, in the event that cardio respiratory arrest occurs.

Withdrawal of life support:

the cessation and removal of an ongoing medical therapy with the explicit intent not to substitute an equivalent alternative treatment. It is fully anticipated that the patient will die following the change in therapy primarily because of the underlying disease conditions.

Withholding of life support:

the considered decision not to institute new treatment or escalate existing life support modalities (intubation, inotropes, vasopressors, mechanical ventilation, dialysis, antibiotics, intravenous fluids, enteral or parenteral nutrition) with the

understanding that the patient will probably die from the underlying condition.

Do not intubate/resuscitate (DNI/DNR):

aggressive ICU management up to, but not including endotracheal intubation (DNI) or attempts at CPR (DNR). As per the Indian Penal Code, this committee of the Indian Society of Critical Care Medicine forbids the use of Euthanasia and Physician Assisted Suicide.

Euthanasia is allowed in the Netherlands under certain strict regulations. Physician-assisted suicide (PAS) is legal only in the State of Oregon in the US. In India, the Supreme Court does not recognize that a terminally ill patient has the Right to choose the manner of his death (40). Requests for Euthanasia have been turned down (12,13,14). In fact, suicide and abetment to suicide are declared punishable by the Indian Penal Code (10), though this is not the case in most countries.

The other definitions are:

Physician assisted suicide:

A medical doctor provides patients with means to kill themselves

Euthanasia:

The intentional killing of a patient by the direct intervention of a doctor, ostensibly for the good of the patient or others.

Brain death:

Irreversible cessation of all functions of the brain including the brainstem. In the US, brain death is death. This category does not include patients who maintain brainstem function, such as patients with persistent vegetative state.

In India, brain death is defined only for the purpose of the Transplantation of Human Organ Act 1994. Indian law does not define the state of brain death in contexts other than organ transplantation. In the opinion of the Committee, brain death should be regarded, as equivalent of death in all circumstances and the law should be suitably amended.

Guideline 3:

The physician must discuss the implications of forgoing

aggressive interventions through formal counseling sessions with the capable patient/family, and work towards a shared decision-making process. Thus, he accepts patient's autonomy in making an informed choice of therapy, while he fulfils his obligation of providing beneficent care.

Rationale:

Communication with the family is the key to making appropriate decisions and ensuring quality end-of-life care in the ICU (17,23,38,41-47). If the best interests of the patient and family are to be served, they should be involved in an informed decision-making process at the outset. Surrogates need to be well informed and free from incapacitating anxiety and depression to be able to function effectively as substitute decision-makers for the patients.

Early and effective communication facilitates a more smooth transition from curative to palliative care, reduces the frequency of futile care and decreases the possibility of conflict and litigation between families and health care workers (38,41,47).

The correlates of effective communication and family satisfaction include the provision of adequate time, frequent and consistent information provided by a single contact physician, preferably an intensivist, adequacy of physician and nurse staffing and help from the family physician (41,42,43). Ensuring enough time for the family to ask questions and express themselves further enhances family satisfaction (38).

Practice points:

Empirical evidence from other cultures may not be applicable in India, where the impact of socio-cultural influences upon family needs have not been studied. We can however integrate the generalizable points into ICU practice in India:

- a. The discussions should be between the family and an intensivist. The presence of a nurse and a junior doctor will ensure consistency in subsequent discussions. It is desirable for the primary consultant and/ or the family physician to be present.
- b. There should be multiple counseling sessions of adequate duration. Family must be given adequate time and opportunity to ask questions and to express their views and emotions. This

should be done in a manner that ensures privacy, in a waiting room or similar area (44).

c. The possibility of death should be discussed along with the medical and palliative treatment options. The intensivist should enquire into any previously stated terminal care wishes or preferences directly or indirectly expressed by the patient. The discussions should include the relevant economic, ethical and legal issues.

d. The family members may express feelings of guilt or remorse that should be resolved with patience. It might be useful to remind the family that death is inevitable and medical science cannot offer cure in all situations; that during the dying process the patient needs a humanistic approach rather than a purely technical one. In case the family has difficulties in accepting the possibility of death counseling by a professional psychologist may be considered.

Guideline 4:

Pending consensus decisions or in the event of conflicts between the physician's approach and the patient's/ family's wishes, all existing supportive interventions should continue. The physician however, is not morally obliged to institute new therapies against his better clinical judgment.

Rationale:

The physician should not unduly influence the family in decision-making (7,23,35). Though the emphasis on patient autonomy versus medical paternalism varies in different countries and societies (3,5,16,23), the worldwide trend is towards a shared decision model (3,22,23). This would minimize the influence of physician preferences, social and religious biases on the issue of forgoing life support.

Several professional recommendations support the view that the physician may not be pressurized to apply treatments he does not find appropriate (23). Practice points:

a. The physician should guard against imposing his own values on end of life decisions or be in any way manipulative or coercive.

b. Decision may be taken in a stepwise manner towards deescalating the treatment through discussions until the

picture becomes clearer to the family.

c. Conflicts may be resolved through improved communications, deferring decisions, seeking second opinions, or a psychologist's consultation.

d. The physician may not subject a patient to a particular therapy, even if the family may demand it, if it is against his professional judgment.

Guideline 5:

The proceedings of the counseling sessions, the decision-making process, and the final decision should be clearly documented in the case records, to ensure transparency and to avoid future misunderstandings.

Rationale:

Documentation implies transparency, clarity, and evidence of an evolving decision-making process that indicates appropriate care on the part of the physician. This would be helpful to the physician to demonstrate his bonafide intentions in the event of litigation. It would provide security for the patient in case of malafide intentions on the part of caregivers or his own family. It would also ensure that the patient is informed of all the therapeutic choices available and that overall management plans are spelt out for him. Clear documentation is strongly recommended by European professional societies (23) and the American Thoracic Society (35).

Practice Point:

Details of the communications between the medical team and the family should be documented accurately and completely. The Committee does not regard the signature of a family representative to be a mandatory requirement. The specific modalities withheld or withdrawn should be documented.

Guideline 6:

The overall responsibility for the decision rests with the attending physician/intensivist of the patient, who must ensure that all members of the caregiver team including the medical and nursing staff represent the same approach to the care of the patient.

Rationale:

The physician in charge of the patient is ultimately responsible for the decision although it is the process requires full participation by the family/patient. The burden of the decision should not be put upon the family as several studies have found surrogates wanting in decision-making capabilities for the patient (48,49,50). The leadership role assumed by an intensivist with his experience and expertise generates trust and confidence in the family (23). Physicians/intensivists should minimize inconsistencies between members of the treating team (41).

Practice point:

Medical decisions and prescriptions should be made by the primary physician/intensivist. This should take into consideration and integrate the opinions of the various sub-specialists involved in the patient's care. The primary physician/intensivist should ensure communication and uniformity between the various members of the healthcare team.

Guideline 7:

If the family/capable patient consistently desires that life support be withdrawn, in situations in which the physician considers aggressive treatment non-beneficial, the treating team is ethically bound to consider withdrawal within the limits of existing laws.

Rationale:

Physician's obligation to respect patient's autonomy and to act in the patient's best interests does not permit him to continue a futile treatment even though the legal position is unclear. In the absence of case law, the physician may be apprehensive of the potential for litigation in the future. Obtaining signed consent for withdrawal of support may be viewed as protective to the physician but as coercive to the family. The process of withdrawal must find a suitable balance between the two concerns.

Practice points:

a. Since Indian Law has no clear stand on end-of-life issues except that suicide and abetment to suicide are punishable

offences (10), withdrawal even with the expressed consent of the patient or next of kin can be misinterpreted post hoc.

b. The physician must ensure clear documentation of the detailed discussions with members of the family who should be specified. The concerned physician, family member or both may then sign the records.

c. Terminal care may be offered in the ICU, or in another area of the hospital in keeping with the wishes of the family. If the patient is discharged from the hospital preterminally, an appropriate discharge process ("discharged on request", "left against medical advice" or "discharged against medical advice"), in keeping with the hospital policy, should be followed.

Guideline 8:

In the event of withdrawal or withholding of support, it is the physician's obligation to provide compassionate and effective palliative care to the patient as well as attend to the emotional needs of the family.

Rationale:

The US Supreme Court implicitly endorses the practice of using analgesics and sedatives to ensure that no patient dies in pain or distress (38). However, in high doses side effects may take place that may hasten the dying process. Physician-assisted suicide needs to be distinguished from these as hastening of death is unintended, the primary goal of therapy being only alleviation of pain dyspnoea, or distress. Quill and associates termed it "the double effect" to distinguish the intended and unforeseen effects (51). Since the Court cannot recognize intentions, we should take care to document the use of opiates and the indication for their use (15). This reduces the likelihood of misinterpretation or abuse (15,38).

Practice points:

When patient undergoes withdrawal/withholding of life-sustaining modalities, the physician is ethically obliged to continue to provide care that would alleviate the patient's distress:

a. All ethical issues relating to withdrawal should be discussed thoroughly with the family.

- b. If the patient is conscious and compos mentis, he should be clearly and with sensitivity explained what is expected to happen when a support is withdrawn. He should be reassured that possible pain or distress will be prevented by medication and prompt action should be taken for symptom relief.
- c. The optimal dose of opiates is determined by increasing the dose until the patient's comfort is ensured. There is no maximum dose recommended (17).
- d. The physician should continue to be available to the family for guidance and counseling.
- e. For patients discharged home for terminal care suitable arrangements for transport and home care should be made.
- f. The patient's family should be allowed free access to the patient during the last days of his life (42,43). In this situation, it would be permissible to allow children to visit the patient. The family should be encouraged to participate in the general care and nursing of the patient (38). Music, books, TV etc. that can help alter the environment should be made available. The patient should be allowed every opportunity to experience spiritual meaning and fulfillment. Performance of nonobtrusive bedside religious services or rites should be encouraged.

Medical futility and unilateral decisions by physicians

There are situations when the patient's family may insist on continuing life-support despite hopeless prognosis. The physician may have to act against his better judgment and thus face loss of self-esteem and professional integrity. Even in cases of documented brain death, there have been occasions when supports have had to be continued due to surrogates' unreasonable stand that everything possible should be done. We are obliged to define these situations and seek legal instruments to implement unilateral withdrawal of support.

What constitutes medical futility?

Here we are referring to clinical situations where in the absence of brain death the physician believes that continuing life support is futile and may justifiably take a unilateral decision to limit lifesupporting interventions for the patient. Clear and unequivocal situations of medical futility are rare (. Futility may be "quantitative"(how low are the odds of success) or "qualitative" (what are the desired ends) (52). There is no consensus among physicians about the exact definition of futility. More often than not, the issue is conflict resolution (35). There may be misunderstandings regarding

prognosis, the family may be pursuing unrealistic and unwanted plans, or the physician may be seeking to impose his ideas on the family. Examples of situations where the physician may consider unilateral action: patient has a prognosis of imminent death; patients with metastatic cancers in whom treatment has failed or has been declined; the very elderly with dementia; chronic vegetative state with organ dysfunction.

The proposed course of action may be:

1. A second opinion from another physician not hitherto involved in the care of the patient.
2. Multiple counseling sessions with the family explicitly informing the family the hopeless prognosis of the patient and the futility of continuing life support.
3. If the family is intransigent, then suggesting transfer to another treating team willing to continue supports.
4. With the help of the hospital administration, to set up a committee of doctors to counsel the family. The committee may also take the help of a social worker, psychologist or priest to help resolve barriers to understanding. Seeking a judicial review of medical cases for WOLS decisions has no precedence in India. Therefore, from the legal perspective unilateral action is not available to the Indian physician at present.

Conclusions:

Setting goals appropriate to clinical situations of poor prognosis are an integral part of critical care. Quality critical care requires that the practice be well grounded in ethical principles and that the ICU staff is trained in the skills of end of life care. A consensus regarding the practices relating to end-of life care in Indian ICUs should eventually lead to the evolution of appropriate legislation in keeping with the changing needs of critical care practice.

