Limitation et arrêt de traitement en réanimation

Pr B Guidet, service de médecine Intensive et Réanimation
Hôpital Saint Antoine, Paris
Président du comité éthique de la FHF

Remerciements : F Lemaire

Contexte historique

LATAREA : Ferrand et al. The Lancet 2001; 357:9

Articles

Withholding and withdrawal of life support in intensive-care units in France: a prospective survey

*Edouard Ferrand, René Robert, Pierre Ingrand, François Lemaire, for the French LATAREA group**

Summary

Background In France, there are no guidelines available on withholding and withdrawal of life-sustaining treatments, and information on the frequency of such decisions is scarce.

Methods We undertook a prospective 2-month survey in 113, of a total of 220, intensive-care units (ICUs) in France to study the frequency of, and processes leading to, decisions to withhold and withdraw life-sustaining treatments.

Findings Life-supporting therapies were withheld or withdrawn in 807 (11·0%) of 7309 patients (withholding in 336 [4·6%] and withdrawal in 471 [6·4%], preceded in 358 by withholding). Of 1175 deaths in ICU, 628 (53%) were preceded by a decision to limit life-supporting therapies. Futility and poor expected quality of life were the most frequently cited reasons. Decisions were strongly correlated with the simplified acute physiological score, but an independent centre effect persisted after adjustment for this score. Decisions were mostly taken by all the ICU medical staff, with (54%) or without (34%) the nursing staff; however, a single physician made decisions in 12% of cases. The patient's family was involved in the decision-making process

Introduction

30 years after the advent of intensive care, the uncertain benefits of aggressive and costly life-support treatments for some critically ill patients have raised many ethical and practical questions for physicians working in intensive-care units (ICUs). Reports of clinical studies and guidelines have been published, in the USA especially, to govern and justify the withholding or withdrawal of life-saving treatments.[1-10] There are no such guidelines in France, where the relationship between patient and physician is limited to a traditional paternalism, based on the principle of beneficence.[11] However, societal changes have imposed new rights for the patient to be more informed. So far, only a few clinical studies on withholding or withdrawal of life support, involving a restricted number of patients or only a few participating centres, have been done in France.[12-14]

We undertook a large survey of practices in withholding and withdrawal of life-sustaining treatments in French ICUs to assess the frequency of such practices, the therapies withheld or withdrawn, and the processes leading to these decisions.

Methods

JEUDI 12 MARS 1998

Libération

En réanimation, un décès sur deux est lié à une interruption de traitement

Euthanasie passive, la fin d'un tabou

la Croix

JEUDI 17 MAI 2001 Quotidien - n° 35923 6,50F 0,99€

L'acharnement thérapeutique recule en France

Les médecins ne s'obstinent plus à soigner les malades à n'importe quel prix, et ils associent de plus en plus les autres soignants et les familles à la décision d'arrêter les soins

▶ Pages 4

Pourcentage de décès précédés d'une décision de LAT en Europe

Vincent	CCM, 1989	Brussels	1985	57%
Esteban	ICM, 2001	Spain	1996	35%
Giannini	ICM, 2003	Milan	2003	10%
Ferrand	Lancet, 2001	France	1998	50%
Sprung	JAMA, 2003	17 European countries	99-00	30-70%
Wunsch	ICM, 2005	UK	95-01	32%

Intensive Care Med (2004) 30:770–784
DOI 10.1007/s00134-004-2241-5

ESICM STATEMENT

Jean Carlet
Lambertus G. Thijs
Massimo Antonelli
Joan Cassell
Peter Cox
Nicholas Hill
Charles Hinds
Jorge Manuel Pimentel
Konrad Reinhart
Boyd Taylor Thompson

Challenges in end-of-life care in the ICU

Statement of the 5th International Consensus Conference in Critical Care: Brussels, Belgium, April 2003

International Consensus Conference in Intensive Care: Challenges in End of Life care in the ICU

- Recognize the necessity of limiting LST in ICUs
- Repeated information to the family
- Consensus between physicians and paramedics
- Discussions/decisions report in the medical files
- EOL decisions are physicians' responsibility
- Palliative care strategy implementation
- Make clear the distinction between withdrawal of LST and euthanasia

International CC on end of life

ICM 2004; 30: 2241

Table 2 Similarities between the views of European professional societies derived from a questionnaire sent to 19 intensive care societies of 16 European countries, of which 15 societies from 12 countries responded (presented at ICC Brussels April 2003 by Jean-Michel Boles)

Refer to the basic ethical principles of: autonomy, beneficence, non-maleficence, proportionate treatment, and distributive justice. Several state that the need for an ICU bed for another patient should not be a reason for withdrawing treatment.
Recognize the necessity for the limitation of life-prolonging treatments when the clinical situation is hopeless and a treatment appears either futile or inadvisable. Several societies state that there is no ethical difference between withholding and withdrawing life-prolonging treatments. Although many clinicians are reluctant to withdraw treatments once they have been introduced, it is suggested that a treatment may be withdrawn if it has proved to be ineffective.

Rôle de la famille dans les décisions de LAT en France

LATAREA (1997) : Lancet 2001

Famille présente et non informée :

Limitation: 29%

Arrêt des traitements: 27%

Pochard-Azoulay (2000) : CCM 2001

Décisions de LAT

Famille informée: 48 %

Famille impliquée: 17 %

Anxiété et dépression chez les proches de patients de réanimation

- Etude prospective dans 43 Réanimations
- 637 patients and 920 membres de la famille
- Evaluation de l'anxieté (A) et de la dépression (D)
  - A chez 69 % des familles et D dans 35 %
  - A ou D chez 84% des épouses

F Pochard, E Azoulay; CCM 2001; 29: 1893

Risque de syndrome de stress posttraumatique chez les proches de patients de réanimation

Table 3. Factors associated with the IES score in the overall population of family members

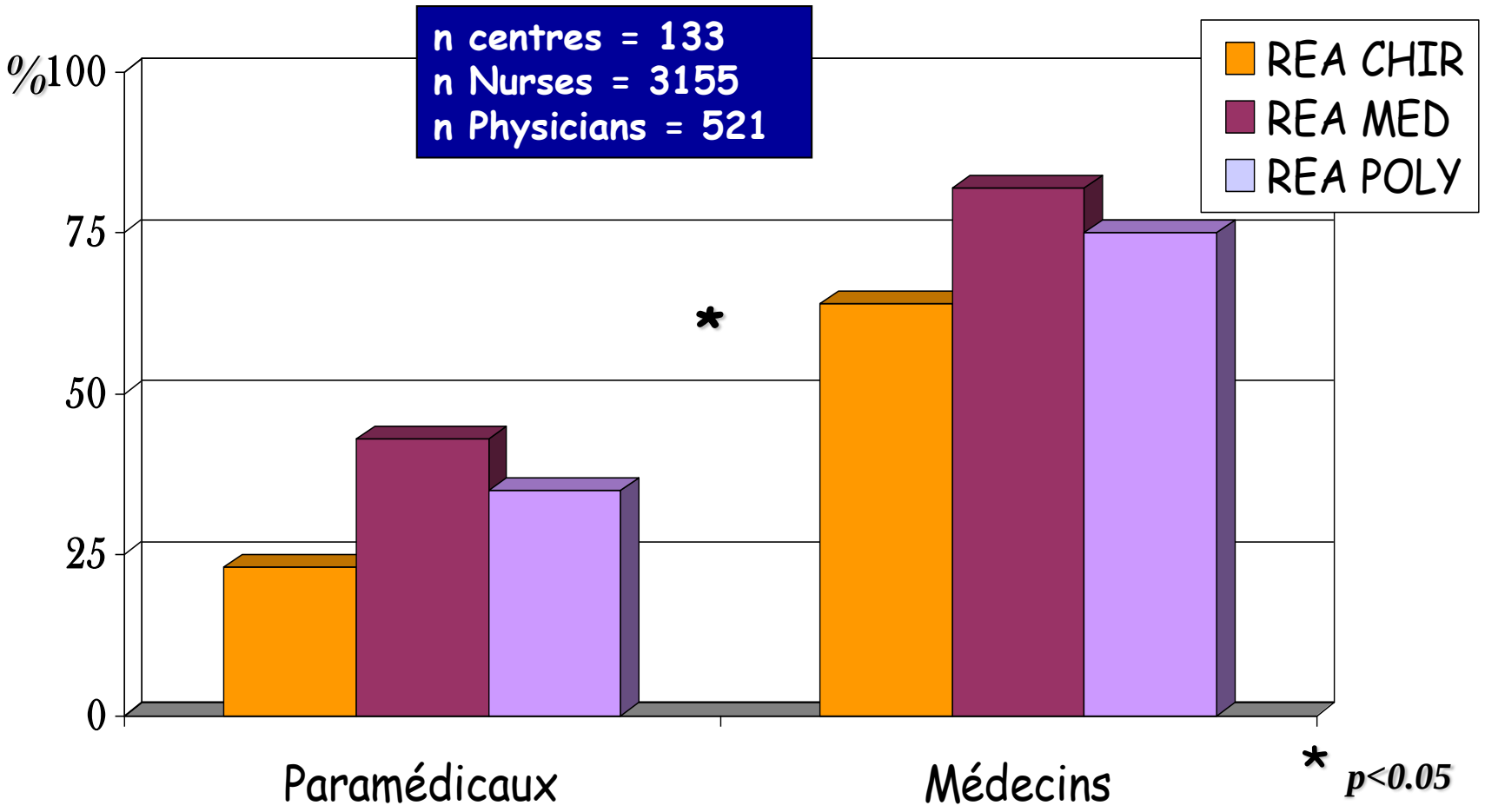
	Univariate Analysis		Multivariate Analysis	
	Coefficient (SD)	*P* value	Coefficient (SD)	*P* value
Patient characteristics				
Chronic heart failure	-9.08 (2.05)	0.0001	-7.29 (1.77)	**0.0001**
Cancer and haematological malignancies	+6.96 (2.2.36)	0.0034	+4.49 (1.98)	**0.0244**
Admission to the ICU for postoperative care	-6.98 (1.62)	0.0001	-3.80 (1.40)	**0.007**
SAPSII score at admission (per point)	+0.15 (0.04)	0.0003	+0.08 (0.037)	**0.028**
Death in the ICU	+8.41 (2.03)	0.0001	+6.19 (1.81)	**0.0007**
Family-member characteristics				
Children	+9.29 (2.41)	0.0001	+6.33 (2.12)	**0.0031**
Female gender	[illegible]	0.0001	+6.29 (1.46)	**0.0001**
Felt that information was incomplete	+5.27 (1.74)	0.0026	+5.33 (1.47)	**0.0002**
Involvement of family members in everyday decisions	+6.57 (1.90)	0.0006	+5.86 (1.64)	**0.0004**
Involvement of family members in end-of-life decisions	+9.54 (3.53)	0.0099	Not introduced in	this model

Elie Azoulay, Frédéric Pochard, et al.
***AJRCCM* January 21, 2005**

Implication des infirmières dans les décisions de LAT

Satisfaction des Médecins et Infirmières des conditions de decisions de LAT en réanimation.

(AJCCRM, 2003; 167: 1310)



Qui decide des LAT?

Le modèle de "decision partagée"

- Systematic (and early) family/caring team conference
- Early identification of a patient's surrogate
- Process of communication/bilateral information/negotiation
- Minimizing the physician's conflict of interest
- Common agreement on the final decision

Discussion (1)

La loi en France

Fin de vie.
Jugements avant la loi Leonetti

- Dieppe (1989); un "homicide involontaire"
- Berck (2002): un "cas d'empoisonnement"
- Besançon (2003): euthanasie/meurtre

XII[e] LÉGISLATURE

RAPPORT

N° 1708 tome 1

Respecter la vie
Accepter la mort

Juillet 2004

MISSION D'INFORMATION

ASSEMBLÉE NATIONALE

Jean Leonetti
Président

Documents d'information

www.assemblee-nationale.fr

Le Monde

www.lemonde.fr

60 ANS DU « MONDE »

1983, le Boeing sud-coréen abattu

page 24

GOÛTS

Les légumes de l'hiver

page 27

PORTRAIT

Christophe Salengro, l'emploi du physique

page 31

ANNÉE – Nº 18611 – 1,20 € – FRANCE MÉTROPOLITAINE – VENDREDI 26 NOVEMBRE 2004 FONDATEUR : HUBERT BEUVE-MÉRY – DIRECTEUR : JEAN-MARIE COLOMBANI

Fin de vie : consensus sur le droit de « laisser mourir »

UN AN ET DEUX MOIS après le décès, le 26 septembre 2003, du jeune tétraplégique Vincent Humbert, qui réclamait le *« droit de mourir »*, l'Assemblée nationale doit examiner, vendredi 26 novembre, une proposition de loi *« relative au droit des malades et à la fin de vie »*. Ce texte important, qui donne la possibilité de *« laisser mourir »* des malades qui en ont exprimé la volonté, devrait être voté par l'ensemble des députés.

Le Monde détaille le contenu de cette loi et montre ce qu'elle va changer tant du point de vue des malades et de leurs proches que du point de vue du personnel soignant. Nous racontons également le combat de deux députés, Nadine Morano (UMP) et Gaëtan Gorce (PS), qui, à force de persuasion, ont réussi à convaincre leurs collègues de la nécessité de ce texte, qui, en remaniant le code de santé publique, va modifier la prise en charge de la fin

- L'Assemblée unanime devrait voter une loi sur les droits des malades et la fin de vie
- Le texte entend faire respecter la volonté des malades
- Le combat de deux députés (UMP et PS)
- Enquête à l'hôpital Delafontaine : « La mort en face »

Lire page 8, l'enquête page 20

Le Sommet de la francophonie dominé par la crise ivoirienne

AU TERME de son voyage en Libye, Jacques Chirac était attendu, jeudi 25 novembre, à Ouagadougou (Burkina Faso) pour participer vendredi et samedi au 10e Sommet de la francophonie. Si le thème officiel de cette rencontre, à laquelle doivent assister les dirigeants d'une cinquantaine d'Etats, est le développement durable, la crise ivoirienne dominera les débats. *« Ce sommet affirmera qu'il est contraire à la francophonie de fonder une politique sur des critères raciaux ou sur l'exclusion »*, expliquait un porte-parole de l'Elysée à la veille de la rencontre.

Le Monde raconte aussi le bilan que font les entrepreneurs ivoiriens des pillages et présente les conclusions d'un rapport confidentiel d'experts, qui détaille l'utilisation de la filière cacao pour le financement d'achats d'armes.

Loi Leonetti (Avril 2005)

- Euthanasie est toujours un crime
- LAT si obstination déraisonnable
- Demandé par le patient lui-même
- Si incapable de consentir pour lui-même:
  - consultation de la famille (pas de consentement)
  - collégialité
  - transparence (traçabilité dans le dossier)
- Double effet (intentionnalité)
- Arrêt de la nutrition artificielle est possible

Loi Clayes Leonetti (2016)

- Tout le monde à droit à une fin de vie digne et apaisée.
- Les professionnels de santé s'assure que ce droit est respecté.
- Les volontés du patient sont respectées
- Les traitements actifs sont arrêtés ou non débutés si le seul objectif est de maintenir artificiellement la vie et s'ils apparaissent disproportionnés.
- La nutrition artificielle et l'hydratation sont des traitements.

Loi Clayes Leonetti (2016)

- A la demande du patient et afin d'éviter des souffrances et une prolongation inutile de sa vie, une sédation profonde et continue, pouvant induire une altération de la conscience, peut-être administrée jusqu'au décès, associée à des antalgiques et l'arrêt des traitements.
- Le patient a le droit de refuser des traitements. Le médecin a l'obligation de respecter les souhaits du patient après avoir expliqué les conséquences de son choix.

Loi Clayes Leonetti (2016)

- Directives anticipées
- Directives révisables ou révocables à tous moments
- Modèle standard mais optionnel.
- S'imposent au médecin pour
  - Les examens
  - Les interventions
  - Les traitements
- Sauf en cas d'urgence vitale en attendant de pouvoir recueillir tous les éléments d'évaluation.

Loi Clayes Leonetti (2016)

- Si les directives anticipées apparaissent manifestement inappropriées, le médecin doit organiser une réunion collégiale.
- La décision de refuser d'appliquer les directives anticipées doit être transmise à la personne de confiance désignée par le patient

Loi Clayes Leonetti (2016)

- Tout adulte peut designer une personne de confiance
  - Parent, proches, médecin.
- La personne de confiance doit être consultée dans la cas ou le patient ne peut plus exprimer ses souhaits et recevoir les informations pour éclairer son choix.
- La personne de confiance témoigne des souhaits du patient.
- Ce témoignage de la personne de confiance prévaut sur les autres témoignages.
- La personne de confiance peut avoir accès au dossier medical..

Loi Clayes Leonetti (2016)

- Développement des soins palliatifs
- Formation des professionnels de santé

Discussion (2)

Application en réanimation perspective européenne

Council Conclusions on Common values and principles in EU Health Systems
2733rd EMPLOYMENT, SOCIAL POLICY, HEALTH and CONSUMER AFFAIRS Council meeting Luxembourg, 1-2 June 2006

« All systems have to deal with the challenge of prioritising health care in a way that balances the needs of individual patients with the financial resources available to treat the whole population”

Etapes des décisions

Limitation ou optimisation des traitements		
Avant la réanimation	Directives anticipées	Réflexions anticipées en situation
Admission	Critères	Alternative à la réanimation
Réanimation d'attente	Conférence de famille	Durée avant la discussion?
Pendant le séjour	Limitation	Arrêt des traitements
Lieu et date de la sortie	Critères	Lieu
Réadmission	Oui/non	
Suivi à long terme	Prévention de nouvelles hospitalisations	programme de réhabilitation

JAMA | Original Investigation | CARING FOR THE CRITICALLY ILL PATIENT

Site of Death, Place of Care, and Health Care Transitions Among US Medicare Beneficiaries, 2000-2015

Joan M. Teno, MD, MS; Pedro Gozalo, PhD; Amal N. Trivedi, MD, MPH; Jennifer Bunker, MPH; Julie Lima, PhD; Jessica Ogarek, MS; Vincent Mor, PhD

	Decedents, % (95% CI)[a]				
	Medicare Fee-for-Service[b]				
	2000 (n = 270 202)	2005 (n = 291 819)	2009 (n = 286 282)	2011 (n = 262 338)	2015 (n = 251 229)
Place and Type of Care					
Hospice services at the time of death	21.6 (21.5-21.8)	32.3 (32.1-32.4)	42.2 (42.0-42.4)	46.4 (46.2-46.6)	50.4 (50.2-50.6)
Hospice services ≤3 d prior to death	4.6 (4.5-4.7)	7.6 (7.5-7.7)	9.8 (9.7-10.0)	7.5 (7.4-7.6)	7.7 (7.6-7.8)
General inpatient hospice care during last 30 d of life[d]	3.9 (3.8-4.0)	8.0 (7.9-8.1)	11.3 (11.1-11.4)	12.5 (12.3-12.6)	12.4 (12.3-12.5)
Continuous home hospice care during last 30 d of life[e]	0.9 (0.9-1.0)	2.3 (2.2-2.3)	3.1 (3.0-3.1)	3.4 (3.4-3.5)	2.7 (2.6-2.7)
Hospitalization during last 30 d of life	53.4 (53.2-53.6)	57.3 (57.2-57.5)	56.7 (56.5-56.8)	54.3 (54.1-54.4)	53.9 (53.7-54.1)
Hospitalization during last 90 d of life	62.9 (62.7-63.0)	70.1 (70.0-70.3)	69.3 (69.2-69.6)	65.6 (65.4-65.8)	65.2 (65.1-65.5)
ICU use during last 30 d of life	24.3 (24.1-24.4)	26.3 (26.1-26.5)	29.2 (29.0-29.3)	29.1 (28.9-29.3)	29.0 (28.8-29.2)
Mechanical ventilation ≥4 d during terminal hospitalization	3.1 (3.1-3.2)	3.3 (3.2-3.4)	3.2 (3.1-3.3)	3.2 (3.1-3.3)	2.5 (2.4-2.5)

JAMA. 2018;320(3):264-271.

JAMA | Original Investigation | CARING FOR THE CRITICALLY ILL PATIENT

Changes in End-of-Life Practices in European Intensive Care Units From 1999 to 2016

Charles L. Sprung, MD; Bara Ricou, MD; Christiane S. Hartog, MD; Paulo Maia, MD; Spyros D. Mentzelopoulos, MD, PhD; Manfred Weiss, MD; Phillip D. Levin, MB, BChir; Laura Galarza, MD; Veronica de la Guardia, MD; Joerg C. Schefold, MD; Mario Baras, PhD; Gavin M. Joynt, MBBCh; Hans-Henrik Bülow, MD; Georgios Nakos, MD, PhD; Vladimir Cerny, MD, PhD; Stephan Marsch, MD, DPhil; Armand R. Girbes, MD, PhD; Catherine Ingels, MD, PhD; Orsolya Miskolci, MD; Didier Ledoux, MD; Sudakshina Mullick, MD; Maria G. Bocci, MD; Jakob Gjedsted, MD, PhD; Belén Estébanez, MD; Joseph L. Nates, MD, MBA, CMQ; Olivier Lesieur, MD, PhD; Roshni Sreedharan, MD; Alberto M. Giannini, MD; Lucía Cachafeiro Fuciños, MD, PhD; Christopher M. Danbury, MB, BS, MPhil; Andrej Michalsen, MD, MPH; Ivo W. Soliman, MD; Angel Estella, MD; Alexander Avidan, MD

Limitation	2015-2016, No. (%)	1999-2000, No. (%)	Difference, % (95% CI)	*P* Value
Withholding of life-prolonging therapy	892 (50)	1143 (40.7)	9.3 (6.4 to 12.3)	<.001
Withdrawing of life-prolonging therapy	692 (38.8)	695 (24.8)	14.0 (11.2 to 16.8)	<.001
Failed CPR	110 (6.2)	628 (22.4)	−16.2 (−18.1 to −14.3)	<.001
Brain death	74 (4.1)	261 (9.3)	−5.2 (−6.6 to −3.8)	<.001
Active shortening of the dying process	17 (1.0)	80 (2.9)	−1.9 (−2.7 to −1.1)	<.001

JAMA. doi:10.1001/jama.2019.14608
Published online October 2, 2019.

Caractéristiques des patients

Patient Characteristics	1999-2000 (n = 2807)[a]	2015-2016 (n = 1785)[a]	Difference (95% CI)[b]
Age, median (IQR), y[c]	67 (54 to 75)	70 (59 to 79)	4.8 (3.8 to 5.8)
Age, decades[d]			
13-29	190 (6.8)	43 (2.4)	−4.4 (−5.5 to −3.2)
30-49	377 (13.4)	166 (9.3)	−4.1 (−6.0 to −2.3)
50-69	1020 (36.3)	656 (36.8)	0.4 (−2.4 to 3.3)
70-96	1220 (43.5)	920 (51.5)	8.1 (5.1 to 11.1)

JAMA. doi:10.1001/jama.2019.14608
Published online October 2, 2019.

Score éthique

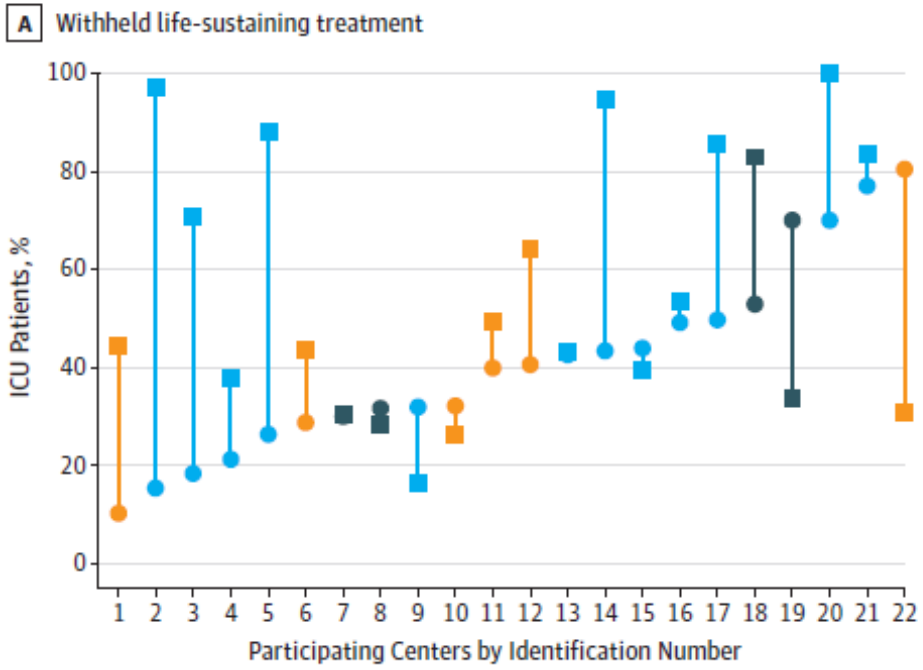
ICU Characteristics	Total ICUs	
	1999-2000 (N = 22)	2015-2016 (N = 22)
ICU ethical practice variables, No. yes (%)		
Routine family meetings	15 (68.2)	17 (77.3)
Daily deliberation for appropriate level of care for each patient	10 (45.5)	17 (77.3)
End-of-life discussions during weekly meetings	10 (45.5)	14 (63.6)
Written triggers for limitations	4 (18.2)	8 (36.4)
Written end-of-life guidelines	5 (22.7)	10 (45.5)
Written end-of-life protocols	1 (4.8)	5 (22.7)
Palliative care consultations	1 (4.8)	7 (31.8)
Ethics consultations	3 (13.6)	4 (18.2)
Staff taking communication courses	3 (13.6)	12 (54.5)
Staff taking bioethics courses	2 (9.6)	5 (22.7)
Country end-of-life guidelines	3 (13.6)	10 (45.5)
Country end-of-life legislation	6 (27.2)	12 (54.5)
Ethical practice score, mean (SD)[d]	2.9 (1.7)	5.6 (2.7)

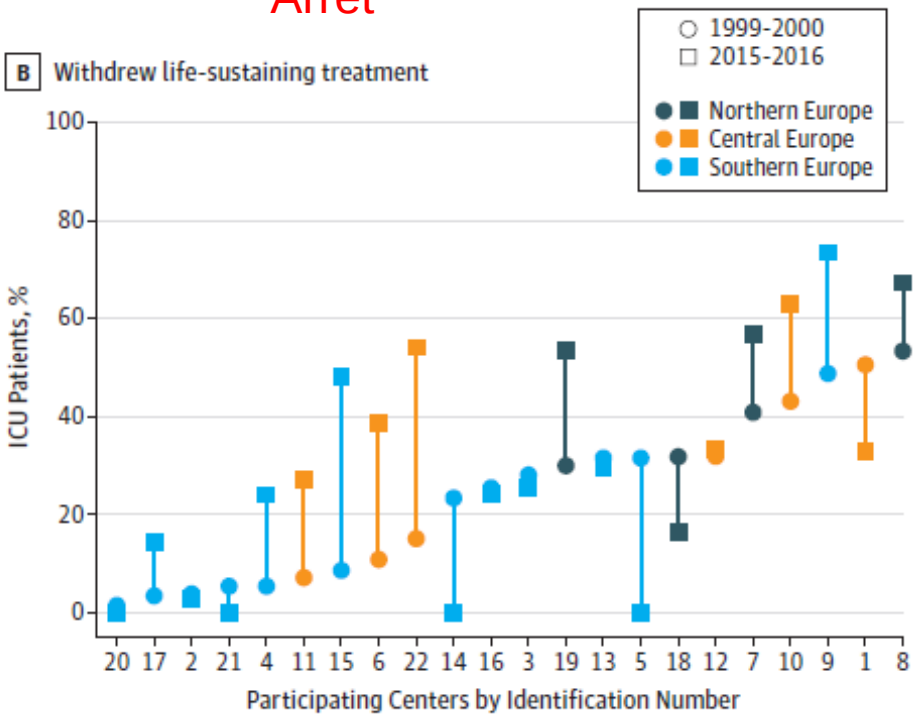
JAMA. doi:10.1001/jama.2019.14608
Published online October 2, 2019.

Evolution des LAT en fonction des pays

Limitation

Arrêt





JAMA. doi:10.1001/jama.2019.14608
Published online October 2, 2019.

Durée de séjour avant la décision de LAT
Délai LAT et décès

Years of Cohort	Median (IQR) 1999-2000	2015-2016	Difference (95% CI)[a]	*P* Value[b]
Overall				
Length of stay in the ICU, d	5.0 (1.0 to 13.0)	4.0 (1.0 to 11.0)	−1.8 (−2.8 to −0.9)	<.001
No. of patients	2799[c]	1785		
Time from ICU admission to first limitation, d	4.0 (1.0 to12.3)	2.1 (0.3 to 7.5)	−3.5 (−4.5 to −2.5)	<.001
No. of patients	1891	1538		
Time from first limitation of treatment until death, h	16.2 (3.6 to 57.0)	20.0 (3.0 to 87.9)	−32.4 (−50.2 to 14.7)	.08
No. of patients	1817	1274		
Time from withholding life-sustaining therapy until death, h	14.1 (2.8 to 63.5)	29.0 (4.5 to 134.8)	54.2 (24.3 to 84.2)	<.001
No. of patients	1034	581		
Time from withdrawing life-sustaining therapy until death, h	17.1 (4.5 to 49.8)	11.5 (2.3 to 54.6)	26.7 (7.5 to 45.9)	.02
No. of patients	686	676		

Résumé de l'évolution des pratiques

Period	2015-2016	1999-2000
Patients (n)	13625	2807
Age 70-96y (%)	51.5	43.5
WH decision (%)	50	40.7
WD decision (%)	38.8	24.8
Ethical practice score	5.6	2.9
Death with LLST	79.6	94.5
Time from ICU admission to first WH (days)	2.1	4
Time from WH decision until death (days)	29	14.1
Time from WD decision until death (days)	11.5	17.1

Survey on Withholding or withdrawing of treatment in elderly patients

Participating countries: 13

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Should the age of the patient ever make a difference in decisions regarding withholding (WH) or withdrawing (WD) life-sustaining treatments (LST) ?					
Age alone should be used as the sole criterion for WH or WD LST.	0	4	1	6	11
There should be a specific age for WH or WD LST.	0	0	1	4	17
Sometimes age should be an additional important consideration in conjunction with other factors when deciding on WH or WD LST.	6	14	1	0	1
The "life cycle principle" (prioritizing the young over the old since the old have already had the chance to live through life's stages) should be a consideration in WH or WD LST therapy					
in normal ICU operations when there is no limitation of resources ?	0	3	4	12	3
in an emergency triage situation when there are limitations of resources?	1	14	3	3	1

B Guidet et al. J Crit Care 2014; 29: 896-901

Treatment Intensity and Outcome of Patients Aged 80 and Older in Intensive Care Units: A Multicenter Matched-Cohort Study

Ariane Boumendil, MSc, Philippe Aegerter, PhD, MD,*† Bertrand Guidet, MD,*‡ and the CUB-Rea Network*

JAGS 53:88–93, 2005

- ✓Plus de ≥ 72 000 séjours enregistrés dans CUB-Réa entre 1997 et 2000
- ✓9,6% patients de plus de 80 ans
- ✓28,5 % patients âgés entre 65 et 79 ans

Suppléances d'organe

Table 3. Age-Related Differences in Hospital Care with and Without Adjustment for Matching Criteria

Support and Outcome	Risk Ratio (Miettinen 95% CI)	*P*-value*	Adjusted Odds Ratio (95% CI)	*P*-value†
Circulatory support	1.04 (0.98–1.1)	.19	1.08 (0.96–1.21)	.19
Mechanical ventilation	0.85 (0.81–0.90)	<.001	0.69 (0.61–0.78)	<.001
Renal support	0.57 (0.47–0.7)	<.001	0.52 (0.41–0.66)	<.001
Tracheostomy	0.41 (0.31–0.53)	<.001	0.37 (0.28–0.50)	<.001
ICU mortality	1.19 (1.08–1.31)	<.001	1.32 (1.13–1.54)	<.001
Hospital mortality	1.27 (1.17–1.38)	<.001	1.52 (1.31–1.76)	<.001

JAGS 53:88–93, 2005

Withholding or withdrawing of life-sustaining therapy in older adults (≥ 80 years) admitted to the intensive care unit

Bertrand Guidet[1,2*], Hans Flaatten[3,4], Ariane Boumendil[1*], Alessandro Morandi[5,6], Finn H. Andersen[7,8], Antonio Artigas[9], Guido Bertolini[10], Maurizio Cecconi[11], Steffen Christensen[12], Loredana Faraldi[13], Jesper Fjølner[12], Christian Jung[14], Brian Marsh[15], Rui Moreno[16], Sandra Oeyen[17], Christina Agwald Öhman[18], Bernardo Bollen Pinto[19], Ivo W. Soliman[20], Wojciech Szczeklik[21], Andreas Valentin[22], Ximena Watson[11], Tilemachos Zafeiridis[23] and Dylan W. De Lange[20] on behalf of The VIP1 study group.

Intensive Care Med (2018) 44:1027–1038

VIP1 study

- 21 countries
- 309 ICUs
- 5021 patients over 80y

B Guidet et al. Intensive Care Medicine; 2018; 44(7):1027-1038

Patients

LST Limitations: 27.2%
Withholding: 15.0%
Withdrawing: 12.2%

		All	No treatment limitation	Withholding alone	Withdrawing +/- withholding	p-value
	N	5021	3656	753	612	
	%	100	72,8	15,0	12,2	
Age	median	84	83	85	84	<0.0001
Frailty	median	4	4	5	5	<0.0001
SOFA score	median	7	6	7	10	<0.0001
ICU length of stay (days)	median	2.33	2.29	2.12	2.92	0.0406
Patient's sex	Female	2404 (47.9%)	1737 (47.5%)	395 (52.5%)	272 (44.4%)	0.009
	Male	2617 (52.1%)	1919 (52.5%)	358 (47.5%)	340 (55.6%)	
Type of ICU admission	Elective	906 (18%)	853 (23.3%)	38 (5%)	15 (2.5%)	<0.0001
	Acute	4115 (82%)	2803 (76.7%)	715 (95%)	597 (97.5%)	

B Guidet et al. Intensive Care Medicine; 2018; 44(7):1027-1038

Traitements, fragilité, mortalité

		All	No treatment limitation	Withholding alone	Withdrawing +/- withholding	p-value
		5021	3656	753	612	
Non invasive mechanical ventilation	Yes	1148 (22.9%)	745 (20.4%)	243 (32.4%)	158 (26%)	<0.0001
Invasive mechanical ventilation	Yes	2519 (50.2%)	1763 (48.2%)	292 (38.9%)	462 (75.7%)	<0.0001
Vasoactive drugs	Yes	2612 (52%)	1761 (48.2%)	392 (52.2%)	457 (74.8%)	<0.0001
Renal replacement therapy	Yes	461 (9.2%)	300 (8.2%)	70 (9.4%)	89 (14.7%)	<0.0001
Frailty level	Fit	1893 (37.7%)	1545 (42.3%)	161 (21.4%)	187 (30.6%)	<0.0001
	Vulnerable	972 (19.4%)	726 (19.9%)	140 (18.6%)	106 (17.3%)	
	Frail	2156 (42.9%)	1385 (37.9%)	452 (60%)	319 (52.1%)	
Death in ICU	Yes	1109 (22.1%)	387 (10.6%)	218 (29.1%)	502 (82.2%)	<0.0001
Death at day 30	Yes	1647 (32.8%)	677 (18.5%)	399 (53.1%)	569 (93.1%)	<0.0001

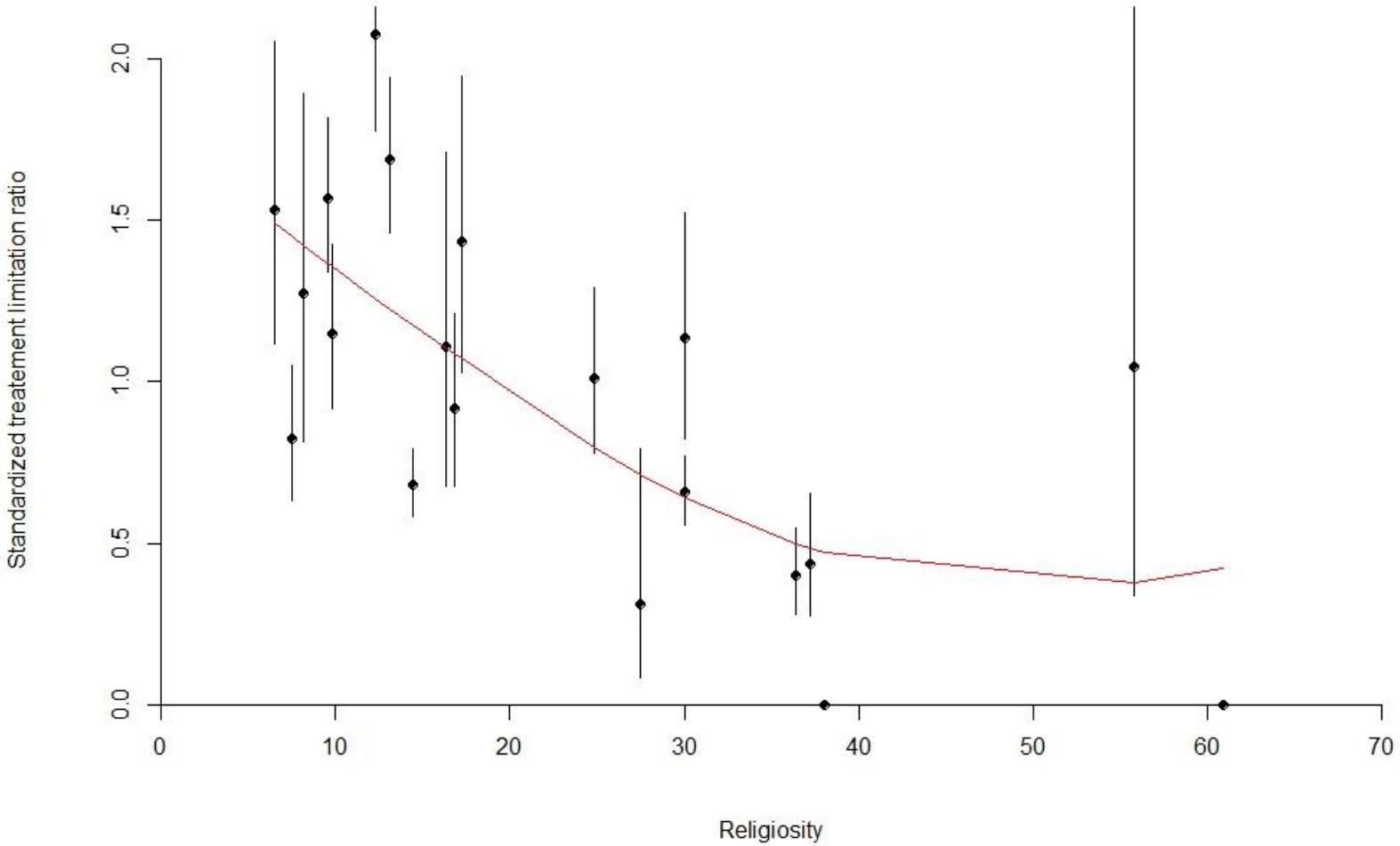
B Guidet et al. Intensive Care Medicine; 2018; 44(7):1027-1038

Analyse multivariée

	Empty model	Patients characteristics		Patients and countries characteristics	
		OR (95% CI)	p value	OR (95% CI)	p value
Frailty 4 vs 1–3		1.59 (1.3–1.95)	< 0.0001	1.59 (1.3–1.95)	< 0.0001
Frailty 5–9 vs 1–3		2.33 (1.98–2.75)	< 0.0001	2.33 (1.98–2.74)	< 0.0001
Age (5 years increase)		1.23 (1.11–1.35)	< 0.0001	1.22 (1.11–1.35)	< 0.0001
Male vs female patient		1.02 (0.89–1.18)	0.754	1.03 (0.89–1.18)	0.7305
Acute vs elective admission		5.61 (4.13–7.62)	< 0.0001	5.59 (4.12–7.59)	< 0.0001
Sofa score (one point increase)		1.12 (1.1–1.14)	< 0.0001	1.12 (1.1–1.14)	< 0.0001
GDP per capita (one point increase)				1 (1–1)	0.01976
Religiosity (one point increase)				0.96 (0.94–0.99)	0.00498

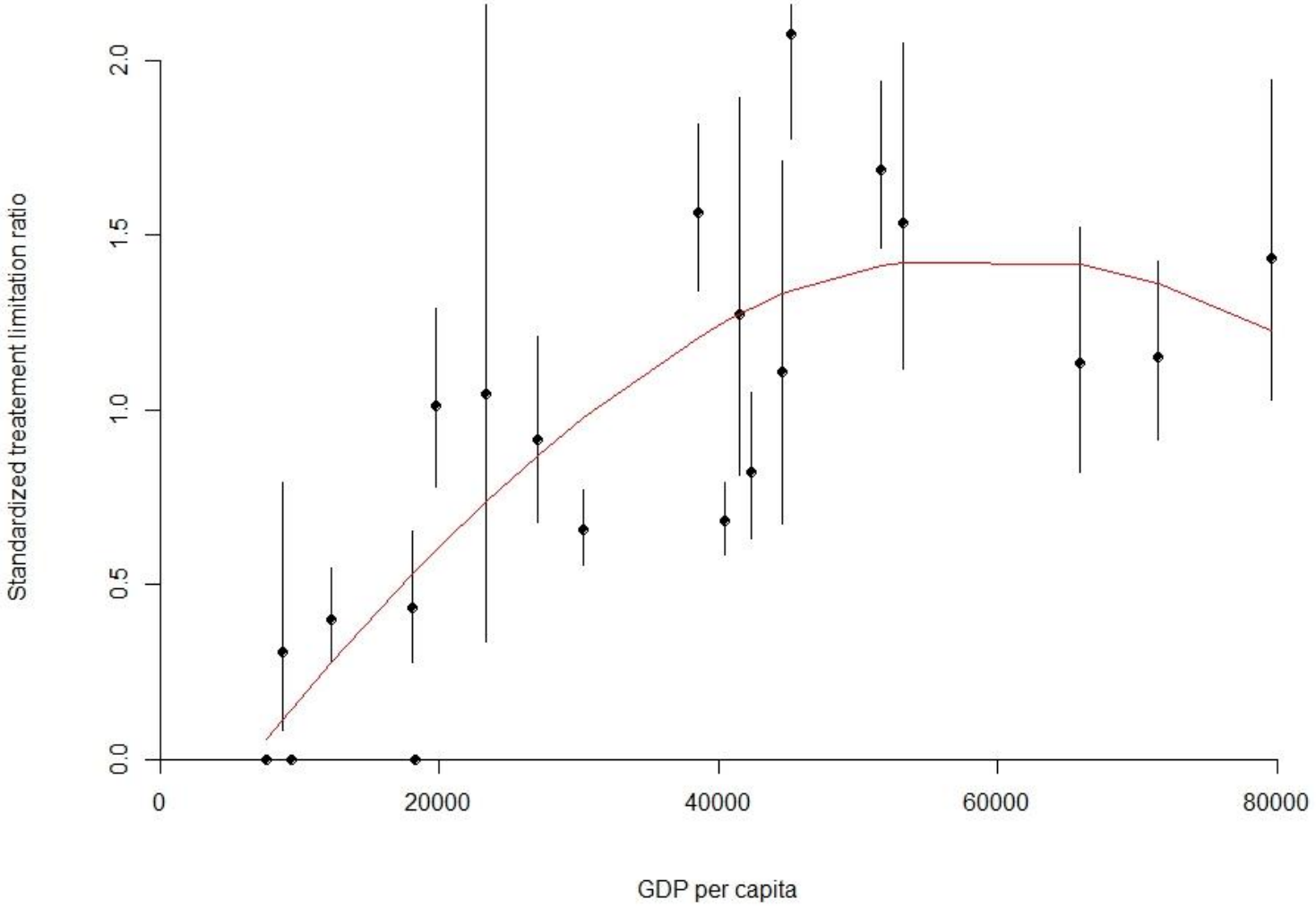
B Guidet et al. Intensive Care Medicine; 2018; 44(7):1027-1038

Importance de la religion



B Guidet et al. Intensive Care Medicine; 2018; 44(7):1027-1038

PNB par habitants



B Guidet et al. Intensive Care Medicine; 2018; 44(7):1027-1038

CLINICAL INVESTIGATION

Short-term mortality of patients ≥80 years old admitted to European intensive care units: an international observational study

BJA

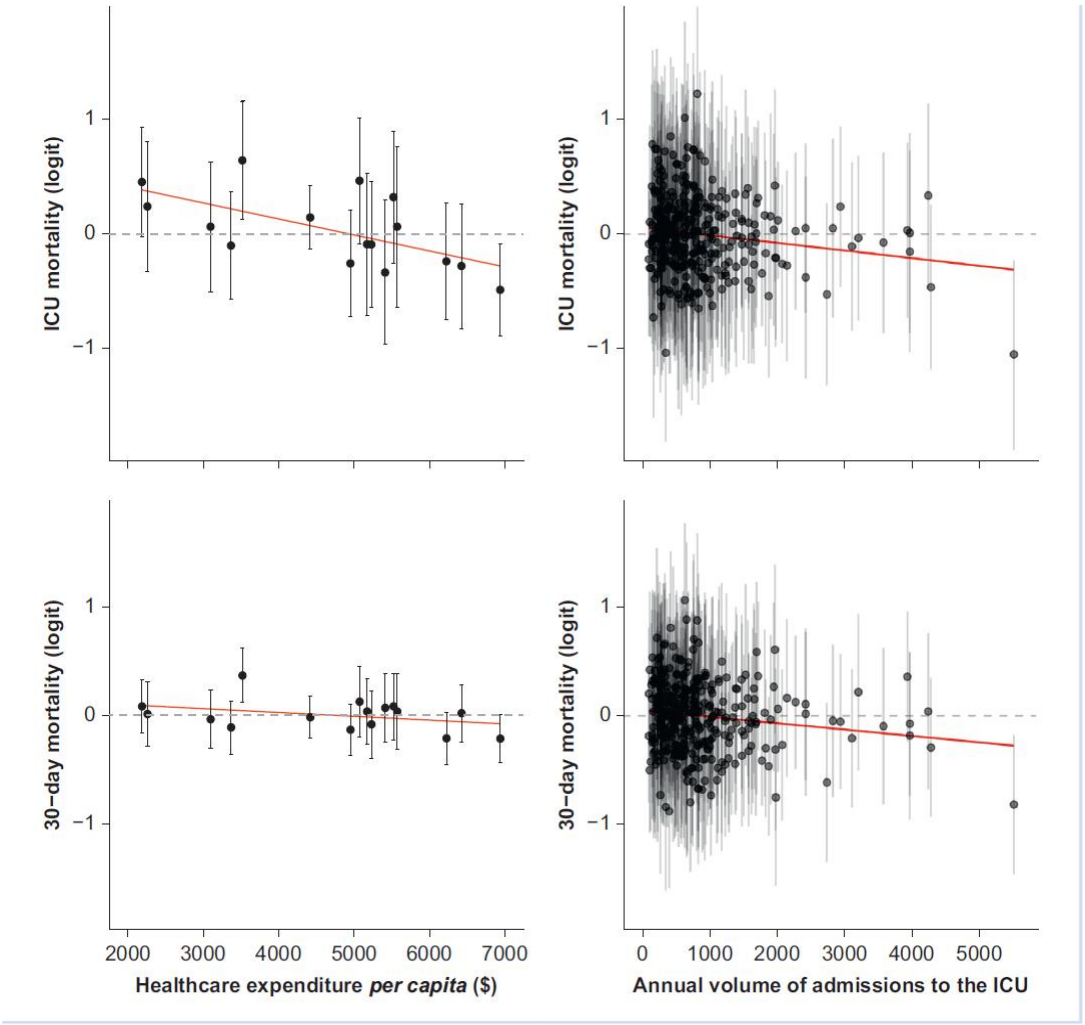
Jakub Fronczek[1], Hans Flaatten[2,3], Bertrand Guidet[4,5], Kamil Polok[1], Finn H. Andersen[6,7],

	Healthcare expenditure			P
	Lowest tercile (<$4428)	Medium tercile ($4428–5531)	Highest tercile (>$5531)	
Number of patients	3961	2029	1700	
Length of stay in the ICU, days (median [IQR])	3.70 [1.60, 8.00]	2.70 [1.10, 5.80]	2.00 [1.00, 5.00]	<0.001
Survivors	3.70 [1.80, 7.90]	2.90 [1.30, 5.80]	2.00 [1.00, 4.80]	<0.001
Non-survivors	3.60 [1.10, 8.72]	2.20 [0.83, 5.97]	2.50 [0.90, 6.93]	<0.001
Life-sustaining therapy limitation, *n* (%)				<0.001
No	3074 (77.6)	1129 (55.6)	989 (58.2)	
Withdrawal	471 (11.9)	339 (16.7)	269 (15.8)	
Withholding	416 (10.5)	561 (27.6)	442 (26.0)	
ICU mortality, *n* (%)	1080 (27.3)	498 (24.5)	304 (17.9)	<0.001
30-day mortality, *n* (%)	1479 (37.3)	785 (38.7)	559 (32.9)	0.001
Annual volume of ICU admissions (median [IQR])	673.50 [345.00, 1009.50]	845.00 [597.50, 1129.50]	1248.50 [625.00, 2005.50]	<0.001
Number of ICU beds/100 000 people (median [IQR])	6.60 [6.60, 9.70]	11.60 [5.80, 11.60]	8.00 [6.40, 29.20]	<0.001
Social health insurance system, *n* (%)	528 (13.3)	1072 (52.8)	1263 (74.3)	<0.001

Mortalité
Dépenses de santé
Nombre d'admission

Richesse du pays

Nombre d'admissions



Avis des patients
Directives anticipées

Avis de la personne de confiance

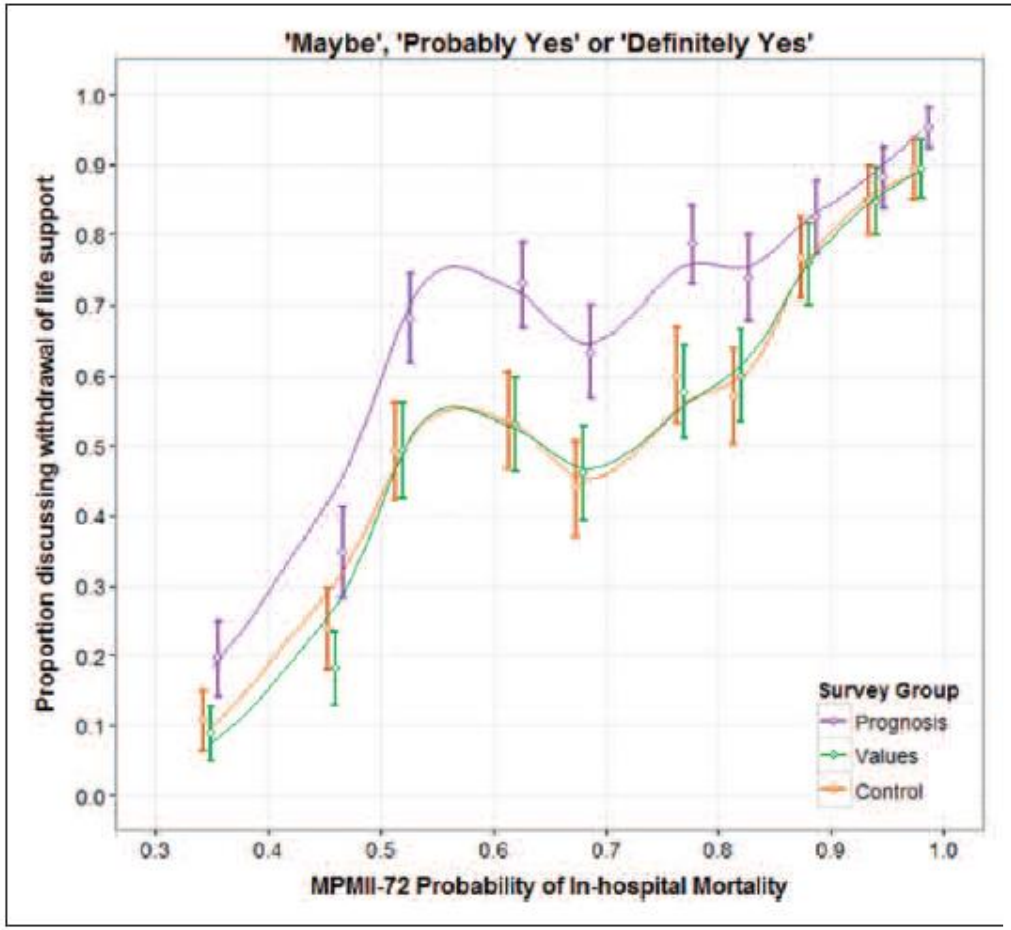
A Scenario-Based, Randomized Trial of Patient Values and Functional Prognosis on Intensivist Intent to Discuss Withdrawing Life Support*

Alison E. Turnbull, DVM, MPH, PhD[1,2,3]; Jenna R. Krall, BA[4]; A. Parker Ruhl, MD[2,3,5]; J. Randall Curtis, MD, MPH[6,7]; Scott D. Halpern, MD, PhD[8,9,10]; Bryan M. Lau, ScM, MHS, PhD

Study Attribute	205 Control Arm	215 First Experimental Arm	210 Second Experimental Arm
Group name	Control	Values	Prognosis
Scenarios reviewed	10	10	10
Severity of illness in the 10 scenarios	Vital signs and laboratory values consistent with a probability of in-hospital mortality ranging from 0.35 to 0.98 as calculated using the Mortality Probability Model II-72 hr (13, 14)	Same vital signs and laboratory values as control arm	Same vital signs and laboratory values as control arm
Family statements about patient values described in scenario background information	Mrs. X would not want to continue life-sustaining treatment if there was not a reasonable chance that she would eventually return to independent living in her own home	Mrs. X has always been a "fighter" and would want life-sustaining therapy even if her best possible outcome is transfer to a nursing home where she would receive help with her activities of daily living	Same as control
3-Mo functional prognosis required?	No	No	Yes
Outcome measures	Response to: "Would you bring up the possibility of withdrawing life support with Mrs. X's family?"	Same as control	Same as control

Care Med 2014; 42:1455–1462

Would you bring up the possibility of WD LST with Mrs X's family?



Care Med 2014; 42:1455–1462

Effect of Documenting Prognosis on the Information Provided to ICU Proxies: A Randomized Trial*

(*Crit Care Med* 2019; 47:757–764)

Alison E. Turnbull, DVM, MPH, PhD[1,2,3]; Margaret M. Hayes, MD[4,5]; Roy G. Brower, MD[2]; Elizabeth Colantuoni, PhD[1,6]; Pragyashree Sharma Basyal, BS[1,2]; Douglas B. White, MD, MAS[7]; J. Randall Curtis, MD, MPH[8,9]; Dale M. Needham, FCPA, MD, PhD[1,2,10]

Outcome	Intervention $n = 63$	Control $n = 53$	Difference in Proportions (95% CI)	p	Effect Size
Assessment of two blinded intensivists[a]					
"Did this intensivist…" (n [%] responding "yes")					
Communicate that the patient may die as a result of his current illness despite treatment?	43 (68)	23 (43)	25% (5–44%)	0.01	0.51
Clearly communicate that the patient may experience new functional impairments if he survives?	2 (3)	2 (4)	−1% (−8% to 7%)	1.0	0.03
Offer the alternative of care focused entirely on comfort either now or as a possibility in the future?	8 (13)	7 (13)	0% (−13% to 12%)	1.0	0.02
Intensivist self-report					
"During the simulation, did you…" (n [%] responding "Done")[b]					
Convey prognosis for risk of death?	58 (92)	36 (68)	24% (8–40%)	0.002	0.64
Convey prognosis for risk of postdischarge functional impairment?	43 (68)	26 (49)	19% (0–39%)	0.06	0.40
Offer the alternative of care focused entirely on comfort?	15 (24)	17 (32)	−8% (−26% to 10%)	0.43	0.18

Discussion (3)

Focus COVID

et

LAT

Comparaison de patients admis en réanimation pour détresse respiratoire avec ou sans COVID

ORIGINAL

Increased 30-day mortality in very old ICU patients with COVID-19 compared to patients with respiratory failure without COVID-19

Bertrand Guidet[1,2*], Christian Jung[3], Hans Flaatten[4,5], Jesper Fjølner[6], Antonio Artigas[7], Bernardo Bollen Pinto[8], Joerg C. Schefold[9], Michael Beil[10], Sviri Sigal[10], Peter Vernon van Heerden[11], Wojciech Szczeklik[12], Michael Joannidis[13], Sandra Oeyen[14], Eumorfia Kondili[15], Brian Marsh[16], Finn H. Andersen[17,18], Rui Moreno[19], Maurizio Cecconi[20], Susannah Leaver[21], Dylan W. De Lange[22] and Ariane Boumendil[1,2] on behalf of the VIP2 and COVIP study groups

- Deux cohortes européennes prospectives
- Patients de plus de 80 ans

Intensive Care Medicine 2022; 48(4):435-447

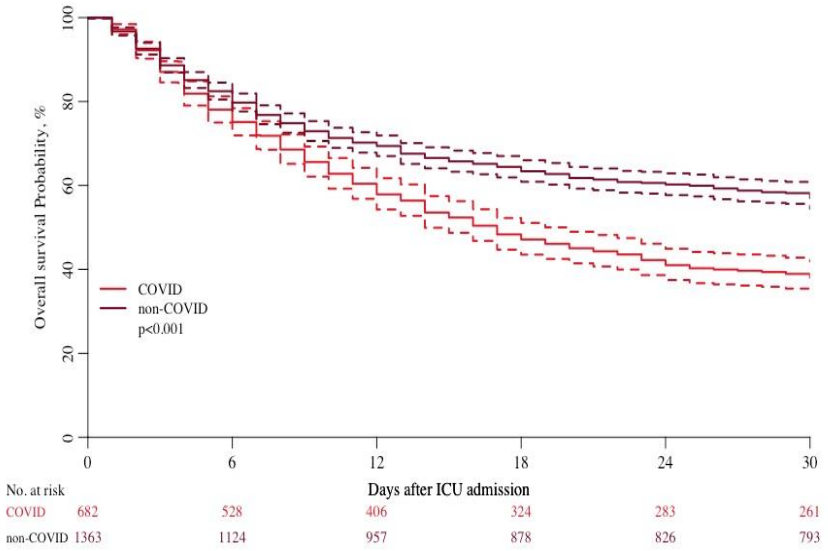
Caractéristiques des patients

		COVID	non-COVID	Test p-value
		693	1393	
Age	med (range) (IQR)	83 (range 80-96) (IQR 81-85)	84 (range 80-99) (IQR 81-87)	<0.0001
Gender	Male	456 (65.8%)	742 (53.3%)	<0.0001
	Female	237 (34.2%)	651 (46.7%)	
Frailty	fit (CFS 1-3)	285 (47.2%)	438 (31.6%)	<0.0001
	vulnerable (CFS 4)	104 (17.2%)	314 (22.6%)	
	frail (CFS 5-8)	215 (35.6%)	636 (45.8%)	
Sofa	med (range) (IQR)	5 (range 0-17) (IQR 3-8)	6 (range 0-18) (IQR 4-9)	<0.0001
Katz	med (range) (IQR)	6 (range 0-6) (IQR 4-6)	6 (range 0-6) (IQR 4-6)	0.062
MV	yes	404 (58.7%)	724 (52.1%)	0.0049
NIV	yes	215 (31.5%)	616 (44.4%)	<0.0001
Vasoactive drugs	yes	392 (57.6%)	751 (54%)	0.14
Renal replacement therapy	yes	70 (10.2%)	148 (10.7%)	0.81
ICU LOS in alive patients	med (range) (IQR)	7 (range 0.08-85) (IQR 3.79-14)	4.65 (range 0.04-120) (IQR 2.11-9.01)	<0.0001
ICU LOS in dead patients	med (range) (IQR)	7 (range 0.04-53) (IQR 3.04-13.75)	5 (range 0.04-85.5) (IQR 2-10.06)	<0.0002

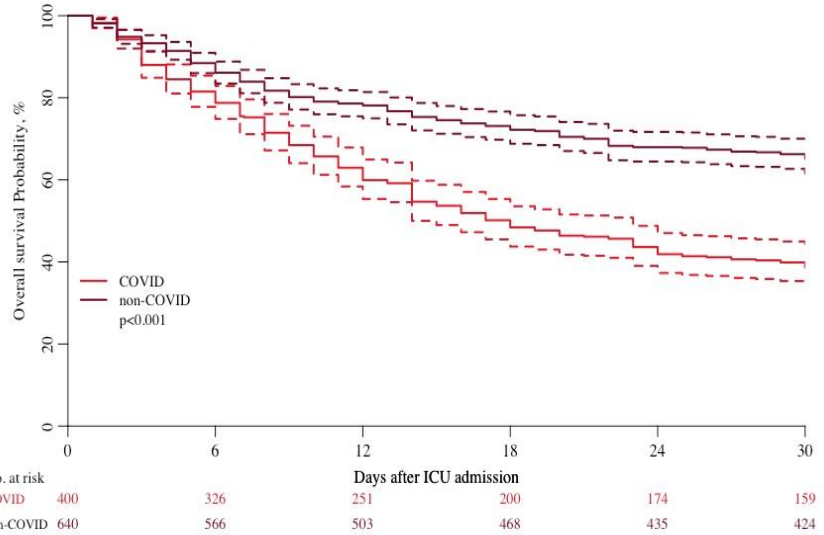
Guidet B; Intensive Care Medicine 2022; 48(4):435-447

Courbes de survie

Non ajustée



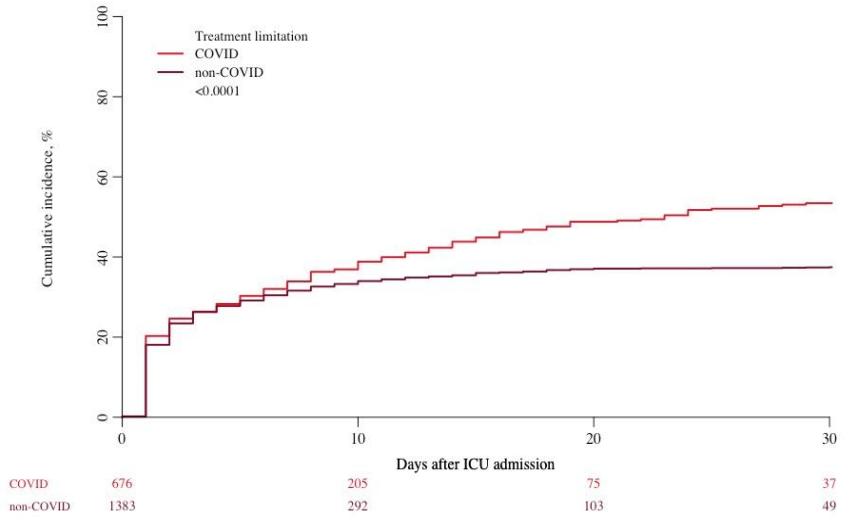
Ajustée
(âge, sexe, SOFA, Fragilité, Région)



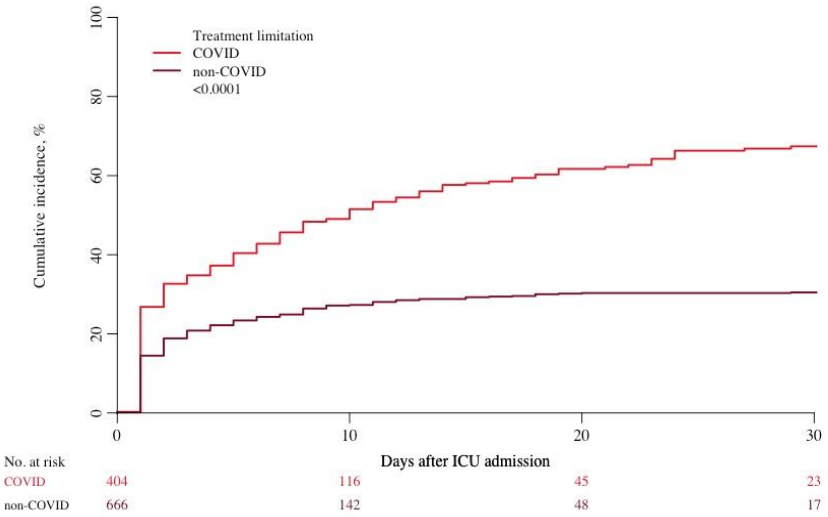
Guidet B; Intensive Care Medicine 2022; 48(4):435-447

Limitation des traitements

Non ajustée

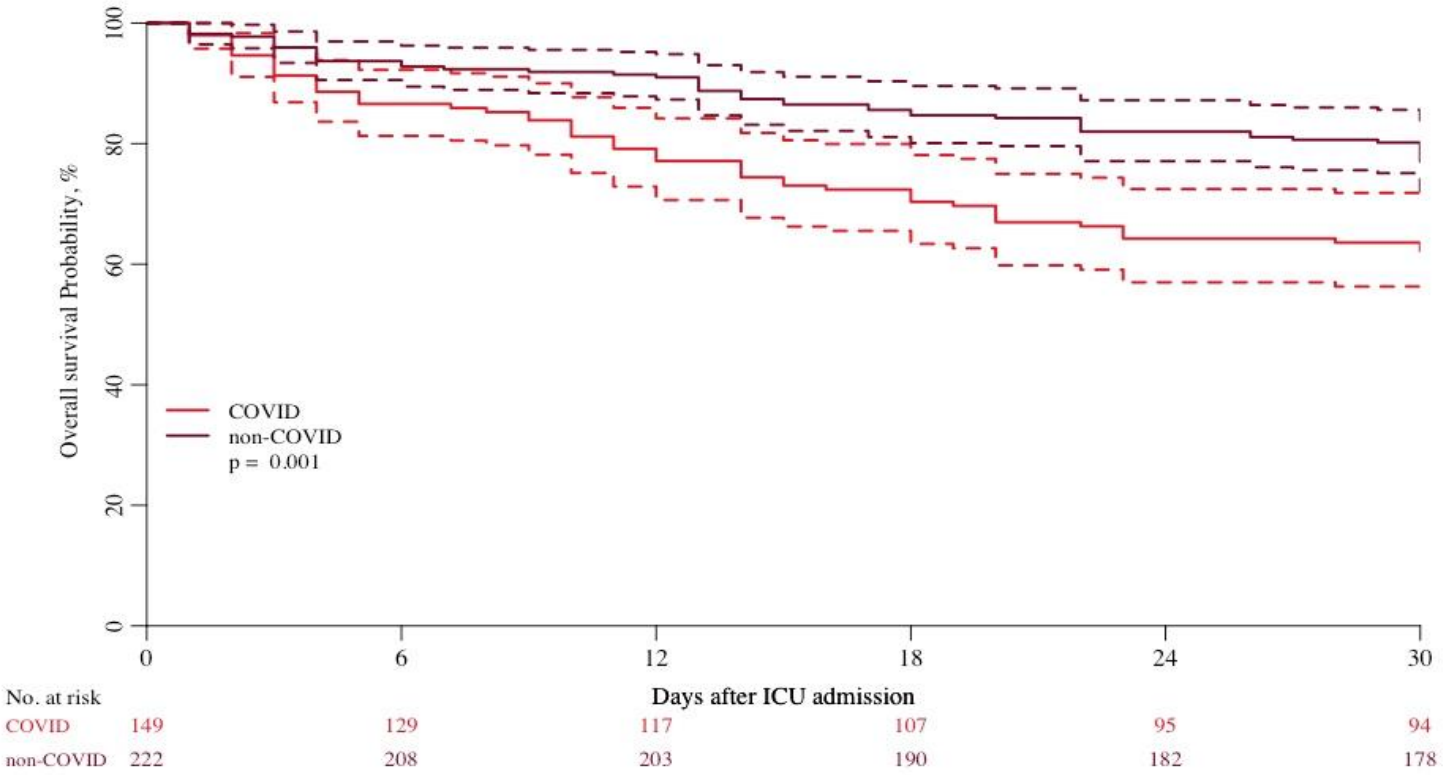


Ajustée



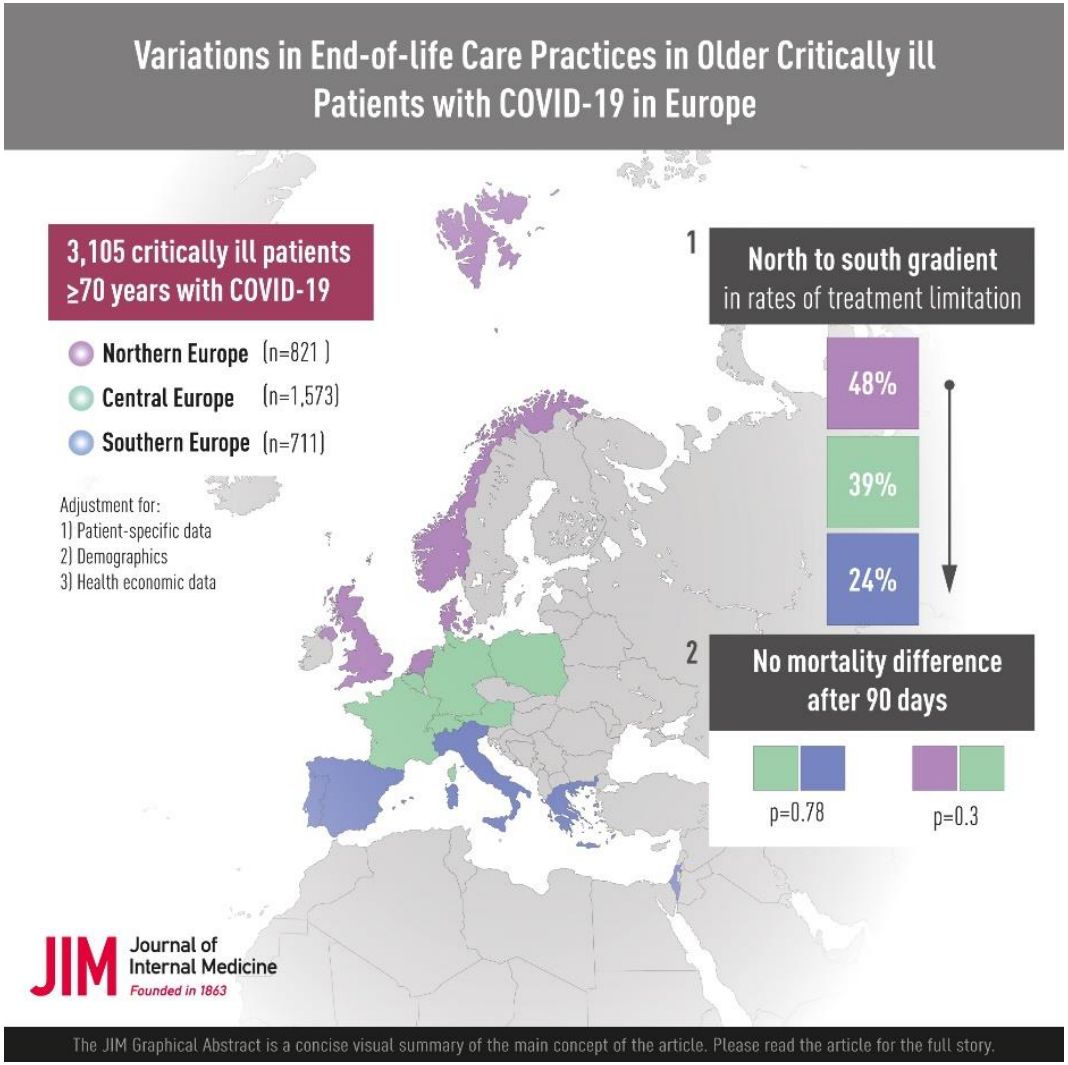
Guidet B; Intensive Care Medicine 2022; 48(4):435-447

Courbes de survie chez les patients sans limitation de traitement



Guidet B; Intensive Care Medicine 2022; 48(4):435-447

Limitation de traitement et COVID en Europe



J Intern Med. 2022
Apr 5. doi: 10.1111/joim.

Impact de la pression sur les lits sur les limitations de traitements

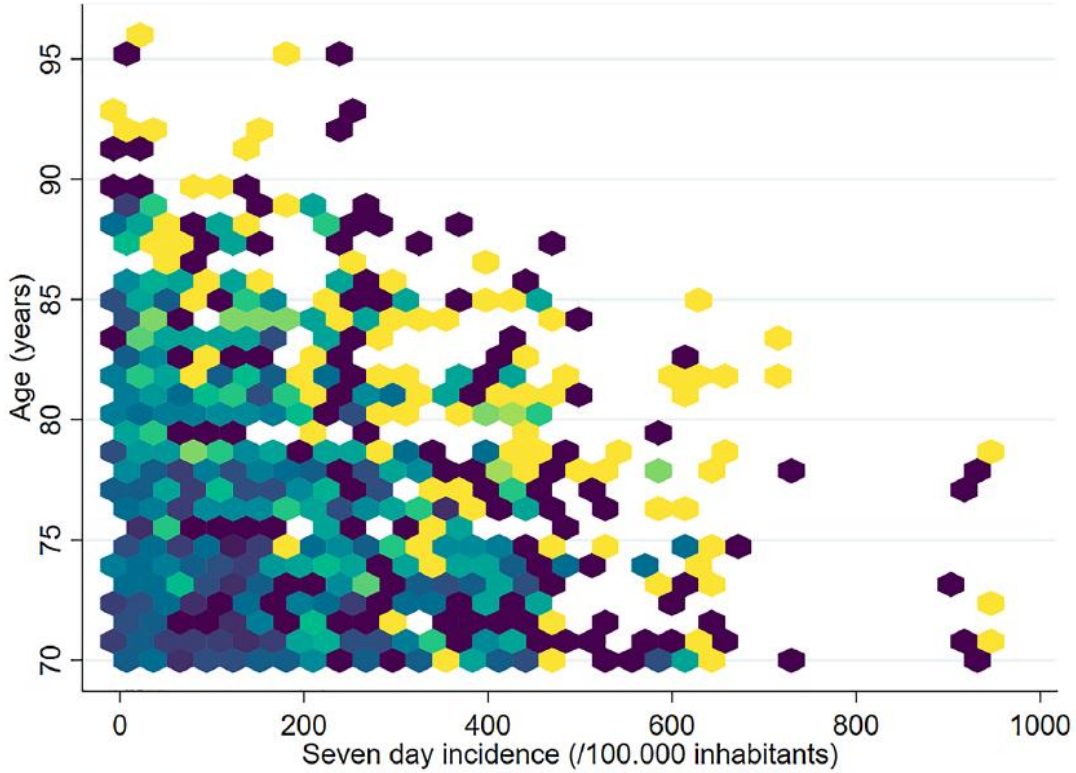


Fig. 1 A 20-step color gradient illustrates the density of the occurrence of the event (withholding or withdrawal of treatment) in relation to age and 7-day incidence. Yellow codes the highest event density; dark blue the lowest

Intensive Care Med 2022 Jan;48(1):124-125

Discussion (4)

Conclusions personnelles

- Donner du temps au temps
- Donner du temps à la mort (Réanimation compassionnelle)
- Favoriser la présence des proches
- Donner du sens
  - Médecin comme médiateur entre le patient, ses proches et la trajectoire de vie/mort
  - Travailler la communication: empathique, sensible, à l'écoute.
  - Considérer les aspects religieux et culturels
  - Eviter l'identification
  - Eviter un sentiment d'échec ou de culpabilité