Quelles limites ?

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EUROPEAN SOCIETY OF INTENSIVE CARE MEDICINE

The ESICM ECCRN Research Awards

Quelles limites ?

L'utilisation des ressources en fin de vie

Variations de l'utilisation des ressources en fin de vie

Variations de prise de décision de LATA en USI

Solutions potentielles

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L'utilisation des ressources en fin de vie

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Solutions potentielles

Change in End-of-Life Care for Medicare Beneficiaries

Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009

	2000	2005	2009
No. of decedents	270 202	291 819	286 282
Deaths in acute care hospitals, % (95% CI)	32.6 (32.4-32.8)	26.9 (26.7-27.1)	24.6 (24.5-24.8)
ICU use in last month of life, % (95% CI)	24.3 (24.1-24.5)	26.3 (26.1-26.5)	29.2 (29.0-29.3)
Hospice use at time of death, % (95% CI)	21.6 (21.4-21.7)	32.3 (32.1-32.5)	42.2 (42.0-42.4)
Health care transitions in last 90 d of life per decedent, mean (median) (IQR)	2.1 (1.0) (0-3.0)	2.8 (2.0) (1.0-4.0)	3.1 (2.0) (1.0-5.0)
Health care transitions in last 3 days of life, % (95% CI)	10.3 (10.1-10.4)	12.4 (12.3-12.5)	14.2 (14.0-14.3)

JAMA. 2013;309(5):470-477

Trends in the Aggressiveness of End-of-Life Cancer Care in the Universal Health Care System of Ontario, Canada

Thi H. Ho, Lisa Barbera, Refik Saskin, Hong Lu, Bridget A. Neville, and Craig C. Earle

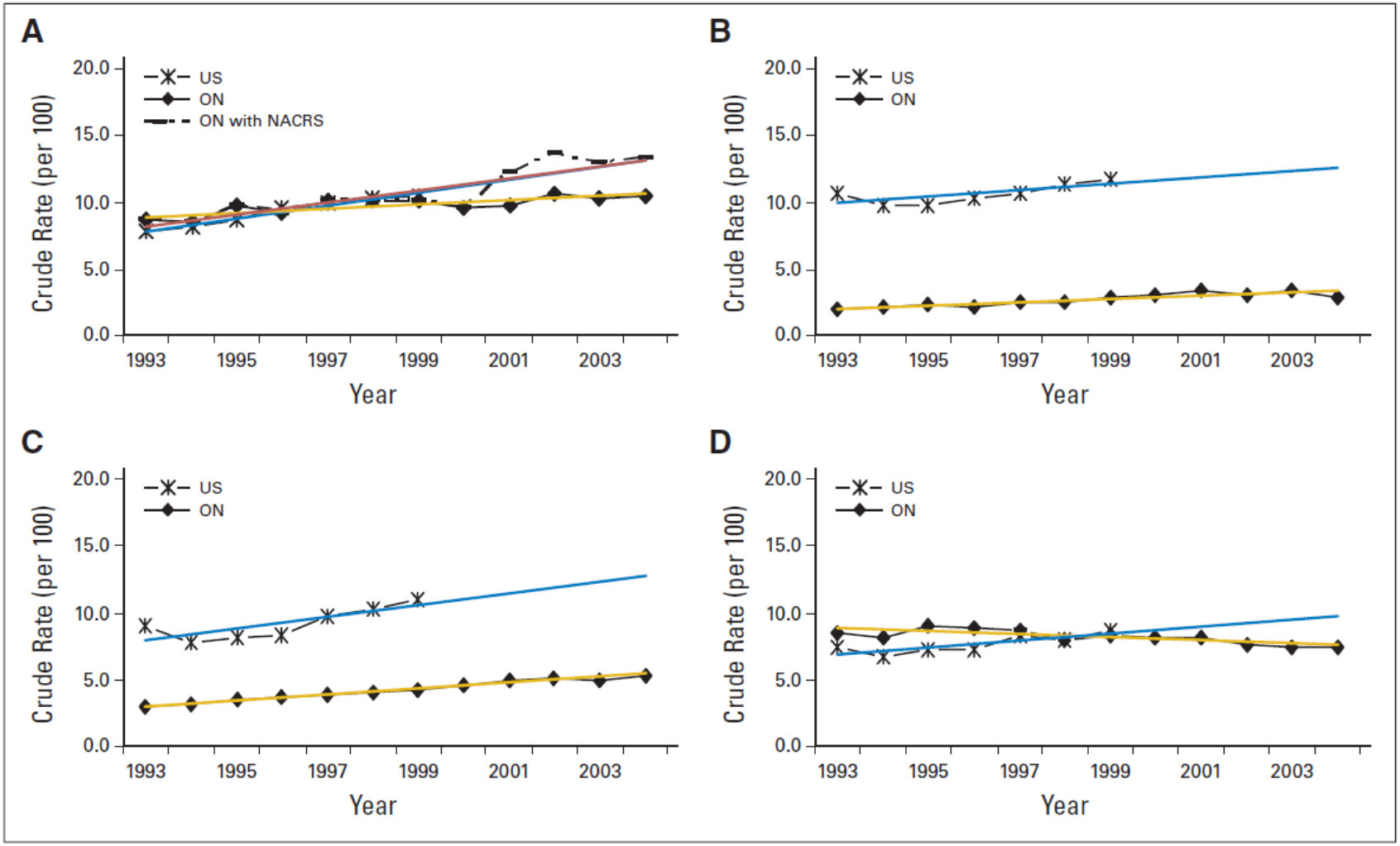
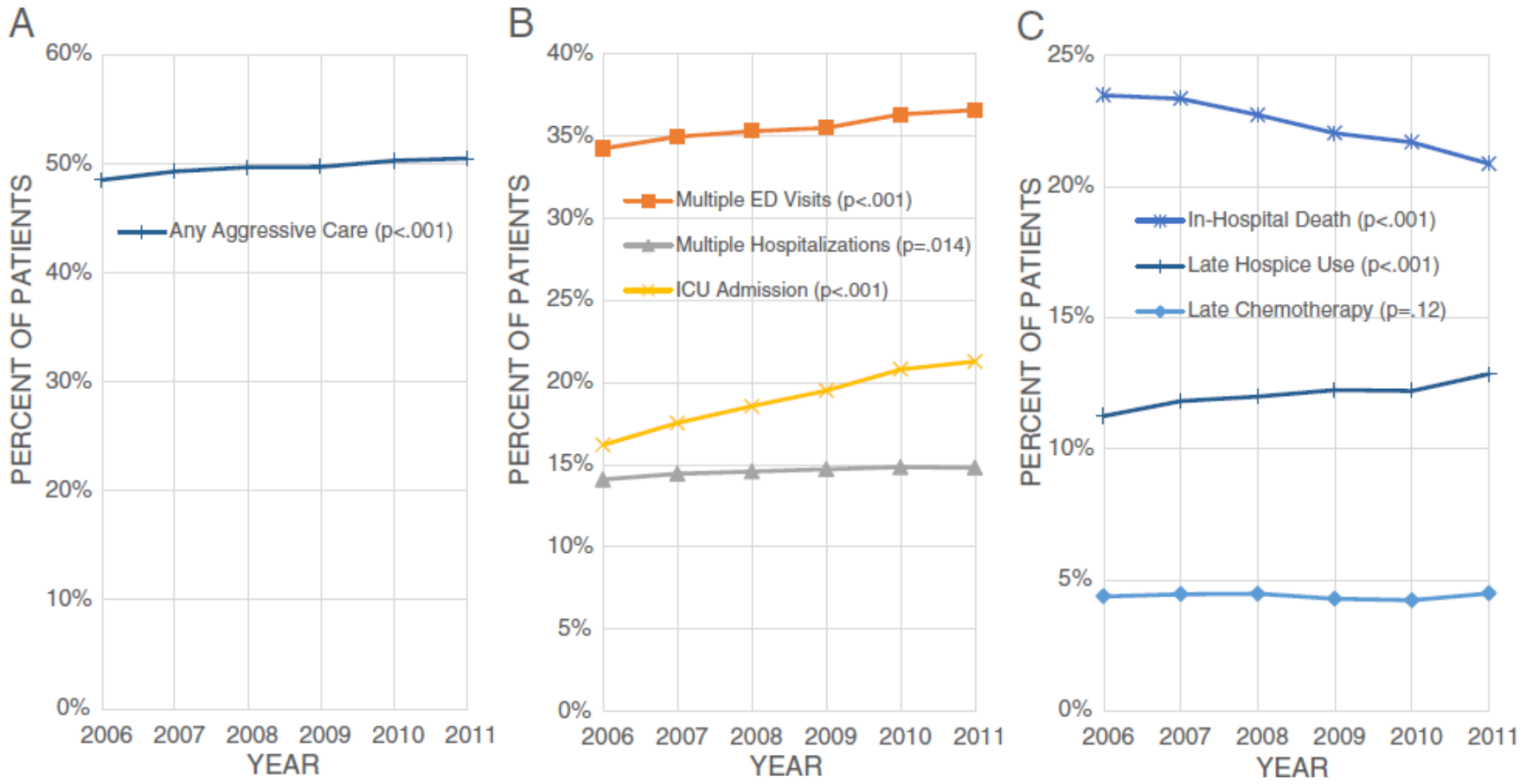


Fig 1. Trends in end-of-life care in Ontario (ON) compared with the United States (US). (A) Emergency department visits; (B) chemotherapy; (C) intensive care unit admissions; (D) hospitalizations. NACRS, National Ambulatory Care Reporting System.

J Clin Oncol 29:1587-1591.

Trends in end-of-life cancer care in the Medicare program

Shi-Yi Wang[a,b,*], Jane Hall[b], Craig E. Pollack[c], Kerin Adelson[b,d], Elizabeth H. Bradley[e], Jessica B. Long[b], Cary P. Gross[b,f]



ED: Emergency department; ICU: Intensive care unit

Original Investigation

Family Perspectives on Aggressive Cancer Care Near the End of Life

JAMA. 2016;315(3):284-292.

Alexi A. Wright, MD, MPH; Nancy L. Keating, MD, MPH; John Z. Ayanian, MD, MPP; Elizabeth A. Chrischilles, PhD; Katherine L. Kahn, MD; Christine S. Ritchie, MD, MSPH; Jane C. Weeks, MD, MSc†; Craig C. Earle, MD, MSc; Mary B. Landrum, PhD

Table 5. Associations Between Aggressive End-of-Life Care and Family Members' Overall Rating of the Quality of a Patient's End-of-Life Care

Type of Aggressive End-of-Life Care	Total No. (%) (N = 1146)	Family Member-Rated End-of-Life Care as Excellent Quality			
		Unadjusted No. (%)	Adjusted %	Risk Difference (95% CI)[a]	*P* Value[b]
During last mo of life					
Intensive care unit admission					
No	995 (86.8)	520 (52.3)	52.5	−9.4 (−18.2 to −0.6)	.04
Yes	151 (13.1)	68 (45.0)	43.1		
≥2 Hospitalizations					
No	1076 (93.9)	556 (51.7)	51.8	−8.5 (−20.8 to 3.8)	.17
Yes	70 (6.1)	32 (45.7)	43.3		
≥2 Emergency department visits					
No	1056 (92.1)	542 (51.3)	51.4	−1.5 (−12.8 to 9.7)	.79
Yes	90 (7.9)	46 (51.1)	49.9		
Chemotherapy ≤2 wk before death					
No	1071 (93.5)	551 (51.5)	51.5	−2.6 (−14.8 to 9.6)	.68
Yes	75 (6.5)	37 (49.3)	48.9		
No hospice or ≤3 d before death					
No	599 (52.3)	352 (58.8)	59.3	−16.5 (−22.4 to −10.7)	<.001
Yes	547 (47.7)	236 (43.1)	42.8		
Death occurred in hospital					
No	686 (59.9)	394 (57.4)	58.0	−17.0 (−22.9 to −11.1)	<.001
Yes	460 (40.1)	194 (42.2)	41.0		

Original Investigation

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Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment

Alexi A. Wright, MD
Baohui Zhang, MS
Alaka Ray, MD

JAMA. 2008;300(14):1665-1673

Table 4. Associations Between Caregivers' Outcomes and Patients' End-of-Life Care and Quality of Life (N = 202)

Caregiver Bereavement Outcomes	Aggressive Medical Care		Hospice Care		Patients' Quality of Life	
	Standardized β Coefficient[a]	*P* Value	Standardized β Coefficient[a]	*P* Value	Standardized β Coefficient[a]	*P* Value
Health-related quality of life[b]						
Overall	−0.15[c,d]	.004	0.06[c,d]	.31	0.20[c,e,f]	<.001
Self-reported health	−0.12[c]	.04	−0.06[c]	.30	0.17[c,e]	.004
Physical function	−0.10[c,g]	.05	0.010[c,g]	.85	0.14[c,e,h]	.02
Mental health	−0.11[c,i]	.06	0.01[c,j]	.81	0.13[c,e,j]	.04
Role limitation	0.17[c,k]	.008	−0.03[c]	.62	−0.10[c,e]	.15
Change in health adjusted OR, (95% CI)	0.57 (0.29 to 1.11)[c]	.10	1.55 (0.89 to 2.69)[c]	.12	1.17 (1.05 to 1.29)[c,e]	.003
Grief reaction						
Felt prepared for death	−0.30[c,l]	<.001	0.13[c,l]	.05	0.23[c,e,l]	.002
Regret	0.17	0.01	−0.08[f]	.25	−0.30[e]	<.001
Mental disorders[m]						
Any mental disorder adjusted OR (95% CI)	2.25 (0.81 to 6.23)[c,n]	.12	0.87 (0.38 to 1.97)[c,n]	.78	0.87 (0.73 to 1.03)[c,e]	.10
Major depressive disorder adjusted OR (95% CI)	3.37 (1.12 to 10.13)[c,n]	.03	0.46 (0.17 to 1.21)[c,n]	.12	0.86 (0.71 to 1.05)[e]	.09

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Conclusions

Augmentation de l'incidence d'admission en fin vie de patients cancéreux en USI les vingt dernières années

Une admission en USI en fin de vie réduit la perception de la qualité des soins chez les conjoints et augmente le risque d'un deuil compliqué.

Quelles limites ?

L'utilisation des ressources en fin de vie

Variations de l'utilisation des ressources en fin de vie

Variations de prise de décision de LATA en USI

Solutions potentielles

Original Investigation

Comparison of Site of Death, Health Care Utilization, and Hospital Expenditures for Patients Dying With Cancer in 7 Developed Countries

Justin E. Bekelman, MD; Scott D. Halpern, MD, PhD; Carl Rudolf Blankart, PhD; Julie P. Bynum, MD, MPH; Joachim Cohen, MSc, PhD; Robert Fowler, MDCM, MS(Epi); Stein Kaasa, MD, PhD; Lukas Kwietniewski, MSc; Hans Olav Melberg, PhD; Bregje Onwuteaka-Philipsen, PhD; Mariska Oosterveld-Vlug, PhD; Andrew Pring, MSc; Jonas Schreyögg, PhD; Connie M. Ulrich, PhD, RN; Julia Verne, MBBS, PhD; Hannah Wunsch, MD, MSc; Ezekiel J. Emanuel, MD, PhD; for the International Consortium for End-of-Life Research (ICELR)

JAMA. 2016;315(3):272-283.

Table 3. Health Care Utilization and Hospital Expenditures for Decedents Older Than 65 Years With Any Cancer in 7 Developed Nations

	Belgium	Canada	England	Germany	The Netherlands	Norway	United States
Decedents in cohort, 2010, No.	21 054	20 818	97 099	24 434	7216	6636	211 816
Deaths in acute care hospitals, No. (%)	10 780 (51.2)	10 846 (52.1)	40 514 (41.7)[a]	9369 (38.3)	2125 (29.4)	2966 (44.7)	47 087 (22.2)[b]
Last 180 Days of Life							
Inpatient health care utilization							
Hospitalization in acute care hospital, No. (%)	18 675 (88.7)	18 132 (87.1)	80 283 (82.7)	17 078 (69.9)	5524 (76.5)	5481 (82.6)	158 227 (74.7)
Per capita hospital admissions, mean (SD)	2.0 (1.5)	1.6 (1.2)	1.7 (1.5)	1.7 (1.8)	1.6 (1.9)	3.1 (1.8)	1.6 (1.5)
Per capita hospital days, mean (SD)	27.7 (27.4)	19.0 (21.5)	18.3 (20.7)	21.7 (25.0)	17.8 (24.9)	24.8 (12.8)	10.7 (14.0)
≥1 ICU admission, No. (%)	3684 (17.5)	3164 (15.2)		2014 (8.2)	737 (10.2)		85 362 (40.3)
Per capita ICU days, mean (SD)	1.3 (5.7)	1.2 (5.1)		0.6 (4.1)	0.7 (3.7)		3.6 (8.4)
ED visit, No. (%)	13 580 (64.5)	18 341 (88.1)	76 121 (78.4)	11 426 (46.8)			156 532 (73.9)
Per capita ED visits, mean (SD)	1.0 (1.0)	2.3 (2.1)	1.4 (1.2)	0.7 (1.0)			1.7 (1.7)

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79 ± 7 year

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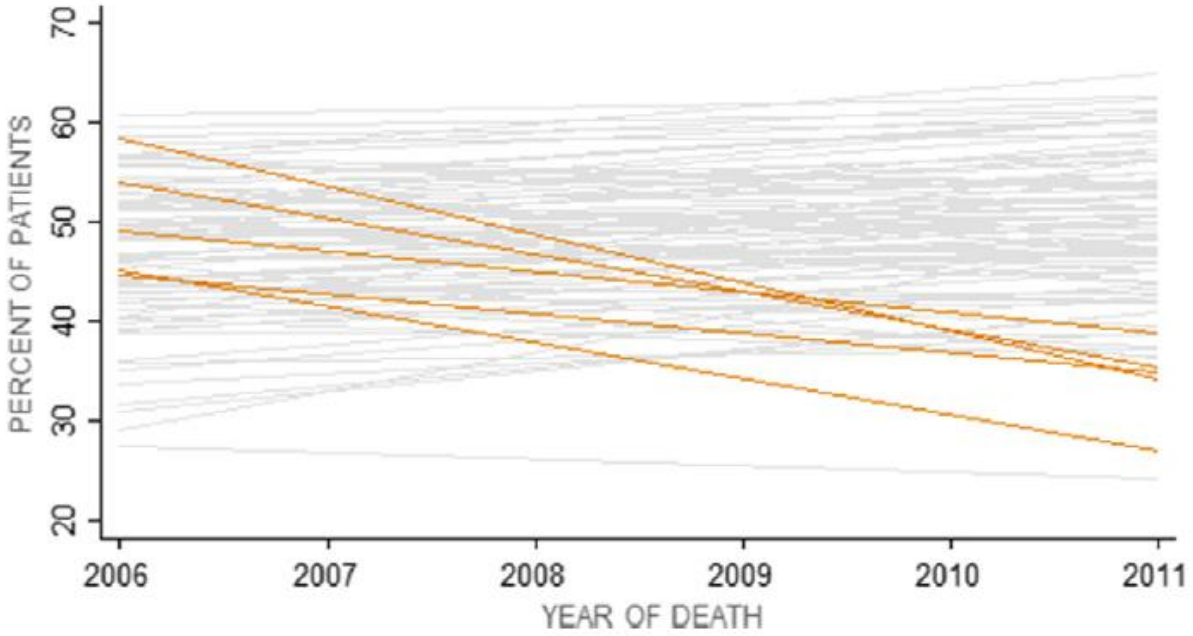

Fig. 2 – Trends of aggressive end-of-life care in 92 hospital referral regions among SEER-Medicare areas. Each line represents a hospital referral region (HRR), showing the regression for trend in aggressive end-of-life care. Five HRRs (highlighted in orange) had a trend of >2% decrease. SEER: Surveillance, Epidemiology, and End Results.

TABLE 3 ADJUSTED ASSOCIATIONS BETWEEN PATIENT CHARACTERISTICS AND DYING IN THE ICU OR IN THE HOSPITAL FOLLOWING ICU COMPARED WITH DYING IN THE HOSPITAL WITHOUT ICU UTILIZATION AMONG INPATIENT DECEDENTS AT THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER FROM 2003 TO 2007, N=3860

	Place of death					
	ICU[a]			*In hospital following ICU*[a]		
	OR	*95% CI*	p *value*	*OR*	*95% CI*	p *value*
Residence						
Harris County	1.00			1.00		
7 surrounding counties	1.13	0.88–1.44	0.339	1.29	0.95–1.74	0.104
Rest of Texas	1.28	1.05–1.55	0.014	0.97	0.75–1.26	0.835
Rest of United States	1.50	1.22–1.85	<0.001	1.16	0.88–1.53	0.305
International	1.85	1.18–2.91	0.007	0.87	0.43–1.76	0.698
Malignancy						
Hematologic	3.80	3.20–4.50	<0.001	1.97	1.57–2.46	<0.001
Nonmetastatic solid	2.81	2.17–3.63	<0.001	1.91	1.36–2.68	<0.001
Metastatic solid	1.00			1.00		
Months since diagnosis						
<2	1.42	1.13–1.78	0.003	1.02	0.75–1.39	0.895
2–<6	1.08	0.85–1.39	0.526	0.79	0.56–1.11	0.168
6–<12	0.86	0.67–1.12	0.262	1.02	0.74–1.41	0.898
12–<36	0.83	0.66–1.05	0.118	0.96	0.71–1.29	0.785
36+	1.00			1.00		
Admission Priority						
Elective	1.34	1.06–1.69	0.013	0.99	0.71–1.38	0.957
Urgent	1.74	0.92–3.30	0.090	1.13	0.45–2.82	0.794
Emergency	1.00			1.00		
Service						
Medical	1.00			1.00		
Pediatric	2.11	1.28–3.47	0.003	1.13	0.54–2.39	0.743
Surgical	2.34	1.81–3.04	<0.001	1.78	1.27–2.50	0.001
Palliative care consultation at hospital admission	1.00 0.05	0.03–0.10	<0.001	1.00 0.08	0.04–0.17	<0.001

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Nonmetastatic solid	2.81	2.17–3.63	<0.001	1.91	1.36–2.68	<0.001
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2–<6	1.08	0.85–1.39	0.526	0.79	0.56–1.11	0.168
6–<12	0.86	0.67–1.12	0.262	1.02	0.74–1.41	0.898
12–<36	0.83	0.66–1.05	0.118	0.96	0.71–1.29	0.785
36+	1.00			1.00		
Admission Priority						
Elective	1.34	1.06–1.69	0.013	0.99	0.71–1.38	0.957
Urgent	1.74	0.92–3.30	0.090	1.13	0.45–2.82	0.794
Emergency	1.00			1.00		
Service						
Medical	1.00			1.00		
Pediatric	2.11	1.28–3.47	0.003	1.13	0.54–2.39	0.743
Surgical	2.34	1.81–3.04	<0.001	1.78	1.27–2.50	0.001
Palliative care consultation at hospital admission	1.00 0.05	0.03–0.10	<0.001	1.00 0.08	0.04–0.17	<0.001

Conclusions

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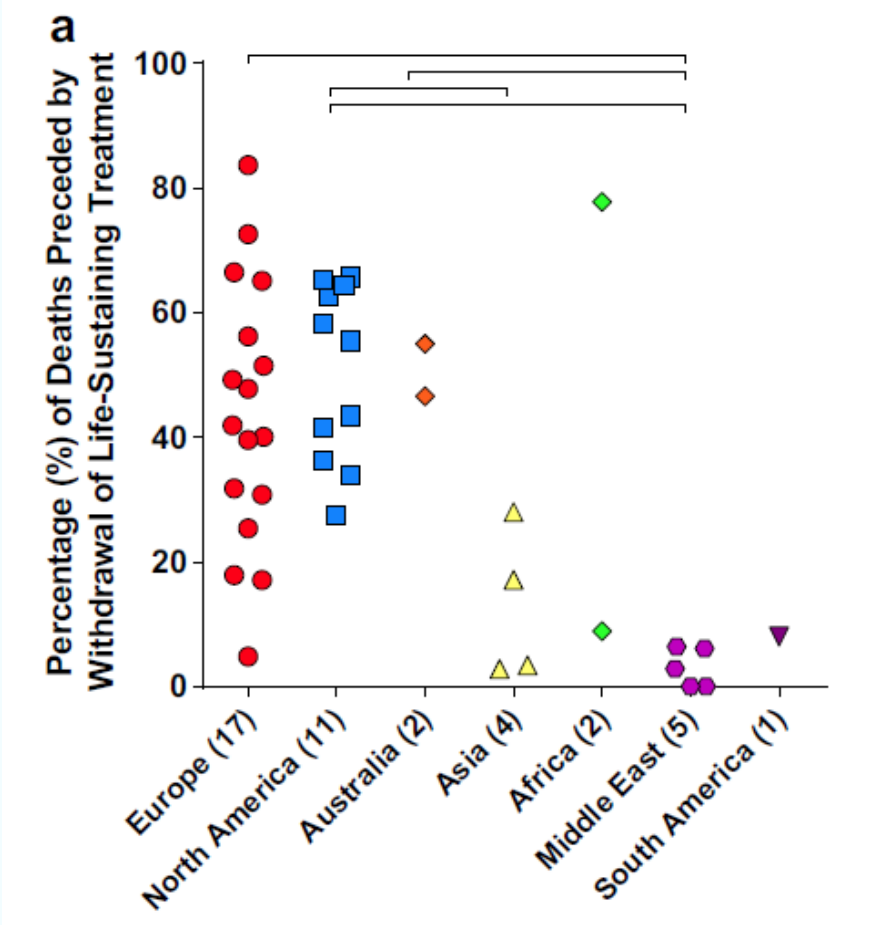
Intensive Care Med (2015) 41:1572–1585
DOI 10.1007/s00134-015-3810-5

SYSTEMATIC REVIEW

N. M. Mark
S. G. Rayner
N. J. Lee
J. R. Curtis

Global variability in withholding and withdrawal of life-sustaining treatment in the intensive care unit: a systematic review



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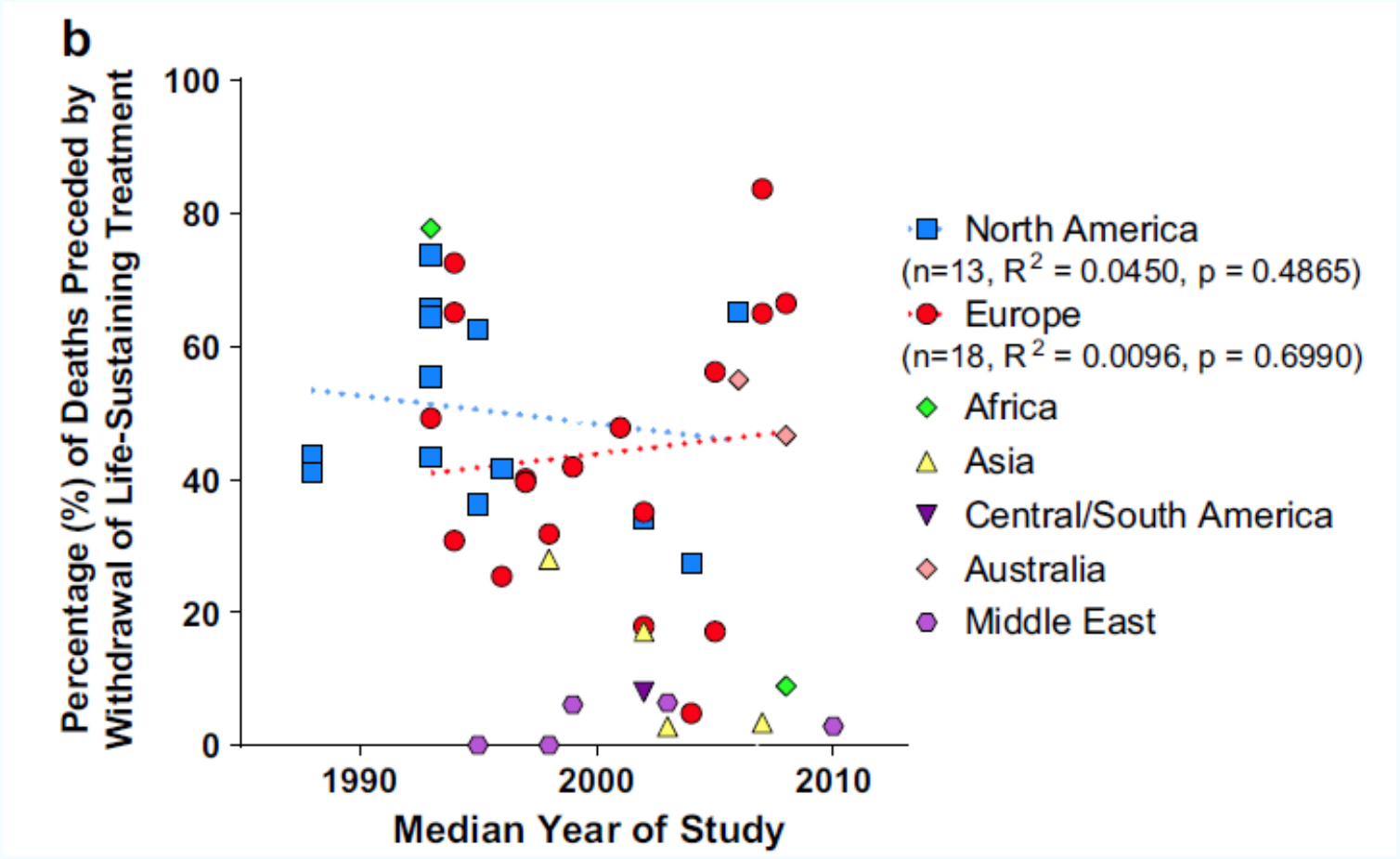


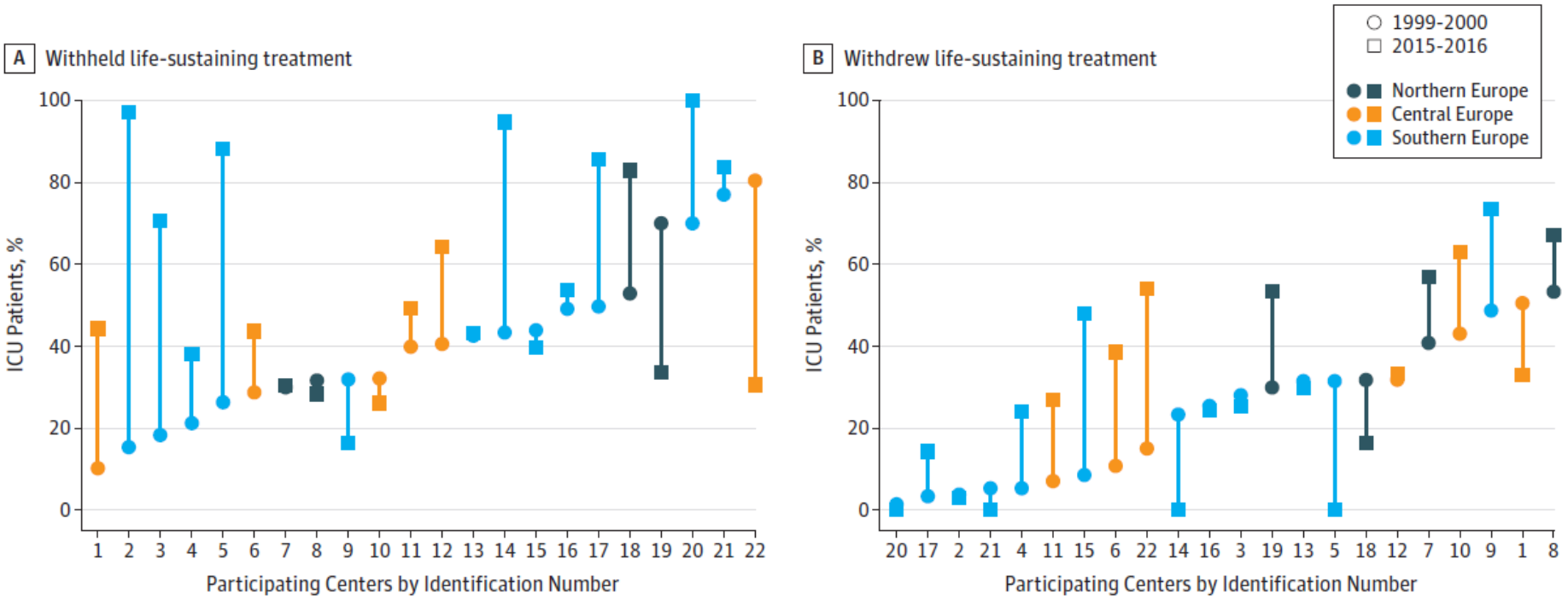
JAMA | Original Investigation | CARING FOR THE CRITICALLY ILL PATIENT

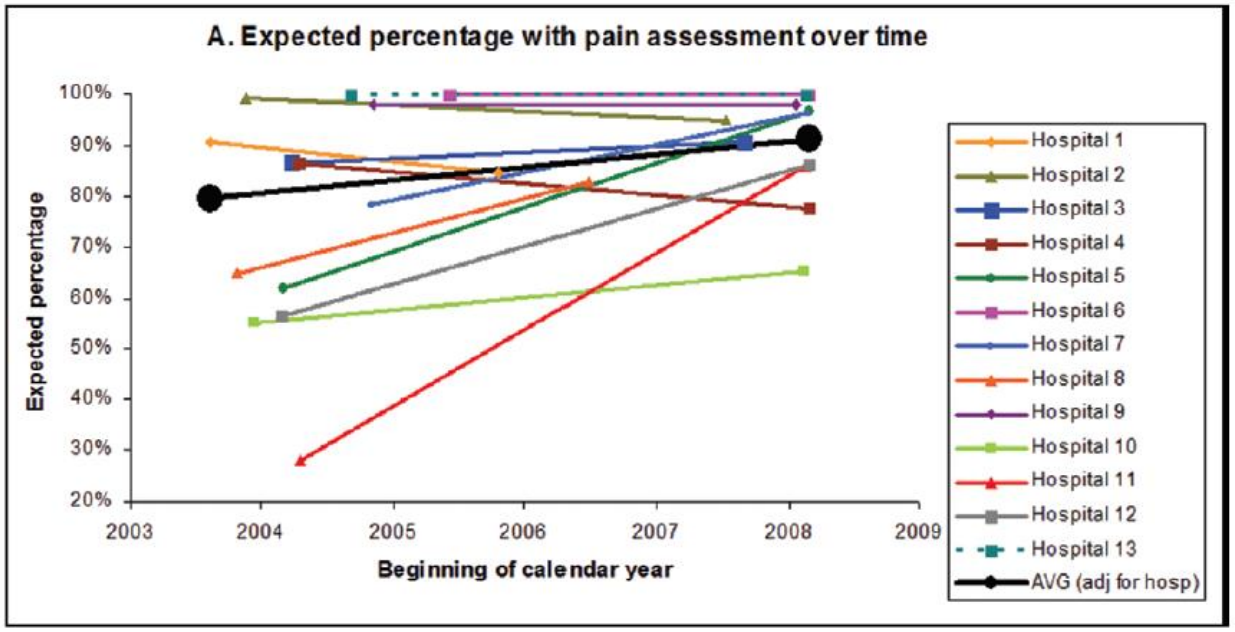
Changes in End-of-Life Practices in European Intensive Care Units From 1999 to 2016

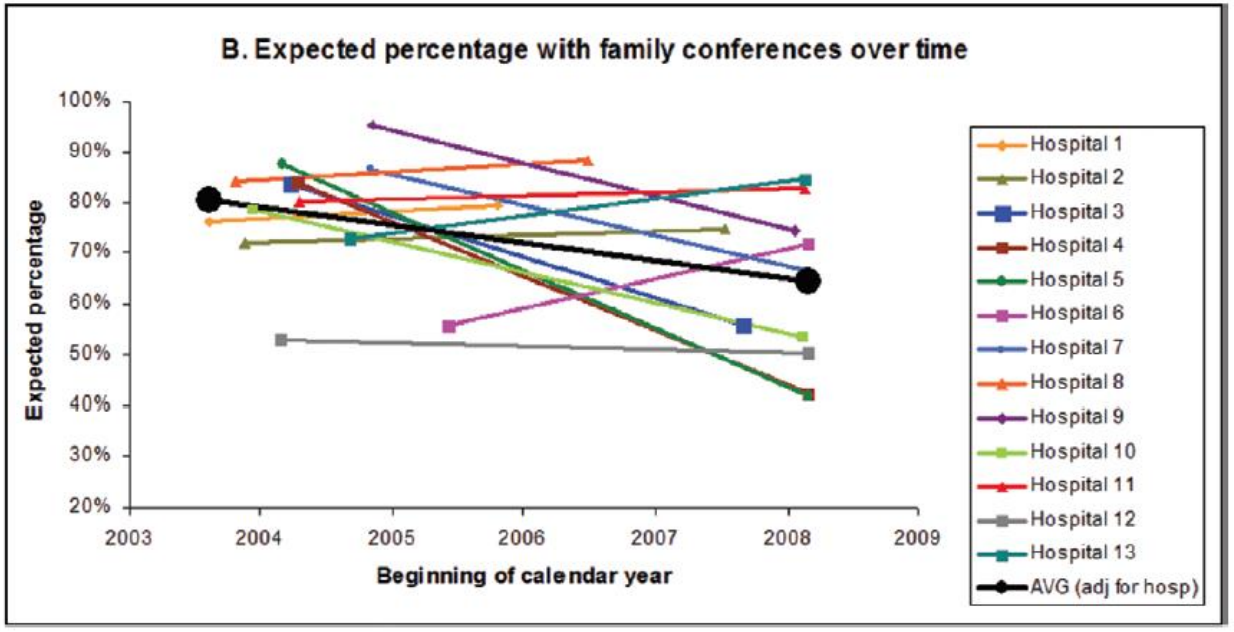
JAMA. doi:10.1001/jama.2019.14608
Published online October 2, 2019.

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

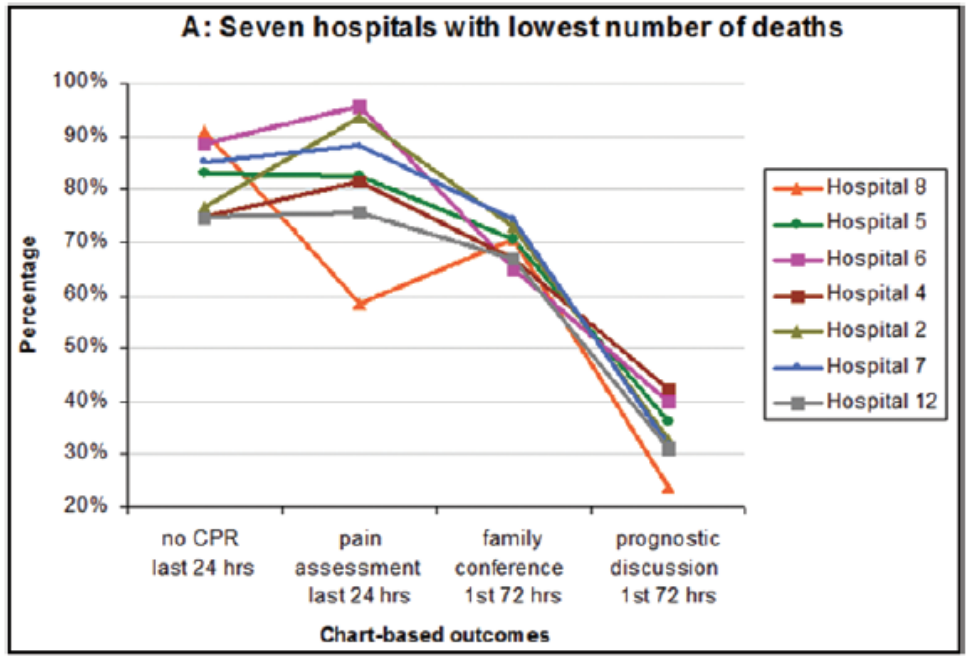
Figure. Changes in End-of-Life Practices From 1999-2000 to 2015-2016 in 22 ICUs by European Region

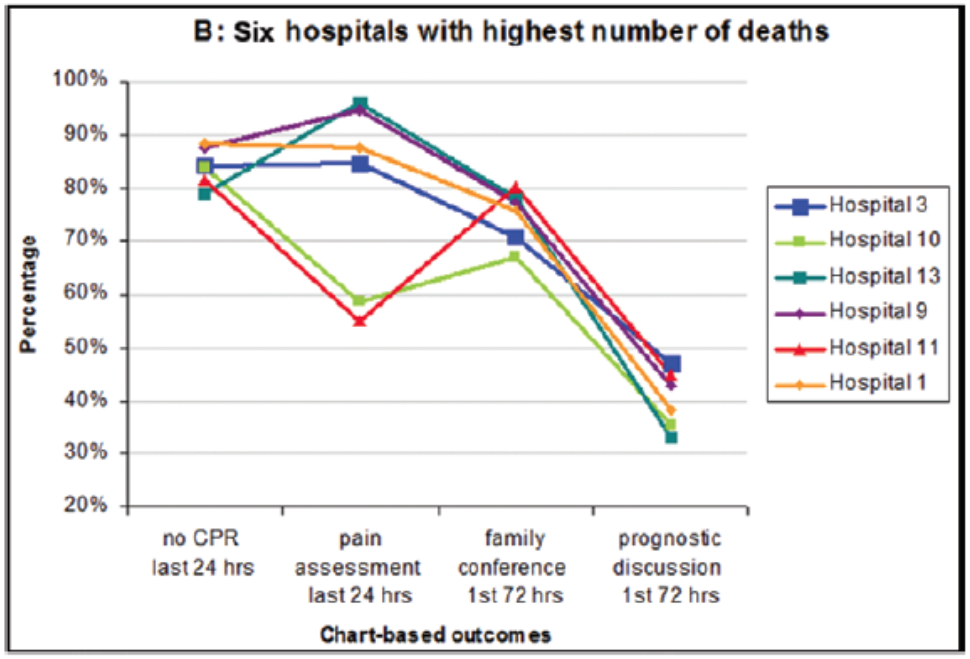






Thomas W. DeCato (*Crit Care Med* 2013; 41:1405–1411)





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Provider and Patient Gender Influence on Timing of Do-Not-Resuscitate Orders in Hospitalized Patients with Cancer

Melissa A. Crosby, MD,[1] Lee Cheng, MD, PhD,[2] Alma Y. DeJesus, MSN,[2] Elizabeth L. Travis, PhD,[3] and Maria A. Rodriguez, MD[4]

Table 3. Adjusted Odds Ratio for Early Do-Not-Resuscitate Order (<5 days) by Physician Gender

Patient characteristics	*OR*	*95% CI*	p
Physician gender			
Male	Reference		
Female	0.97	0.76–1.20	0.2449
Patient gender			
Male	Reference		
Female	1.27	1.07–1.50	0.006
Gender interaction			
Male physician*male patient	Reference		
Male physician*female patient	1.09	0.91–1.31	0.361
Female physician*male patient	Reference		
Female physician*female patient	1.48	1.13–1.94	0.006

JOURNAL OF PALLIATIVE MEDICINE
Volume 19, Number 7, 2016

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Subjectivité >>> "Objectivé"

Quelles limites ?

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Solutions potentielles

Solutions ???

Réduction du nombre de lits (et centralisation des soins) ?

Intensive Care Med (2012) 38:1647–1653
DOI 10.1007/s00134-012-2627-8

ORIGINAL

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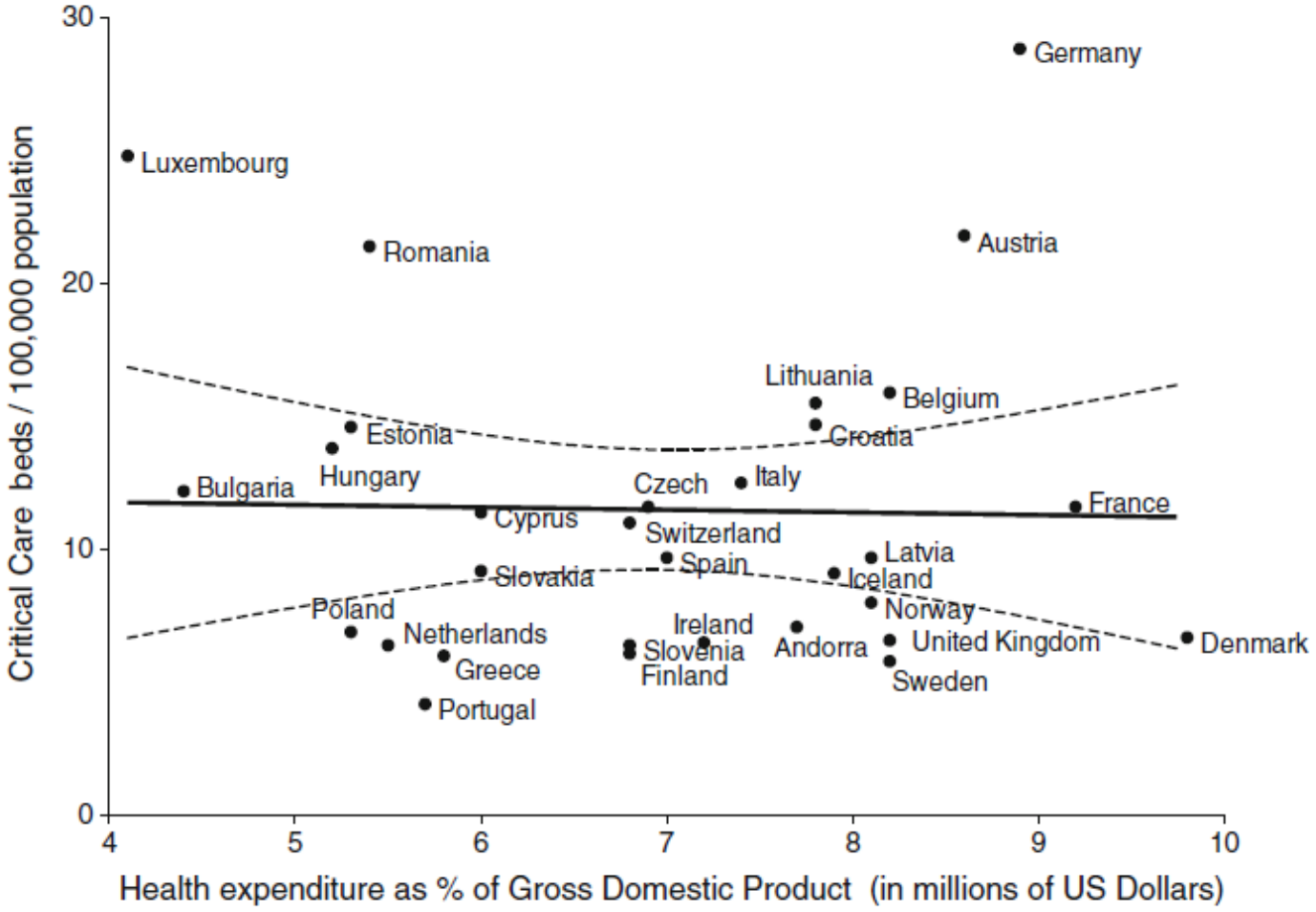
P. Ferdinande
H. Flaatten
B. Guidet
P. G. Metnitz
R. P. Moreno

The variability of critical care bed numbers in Europe



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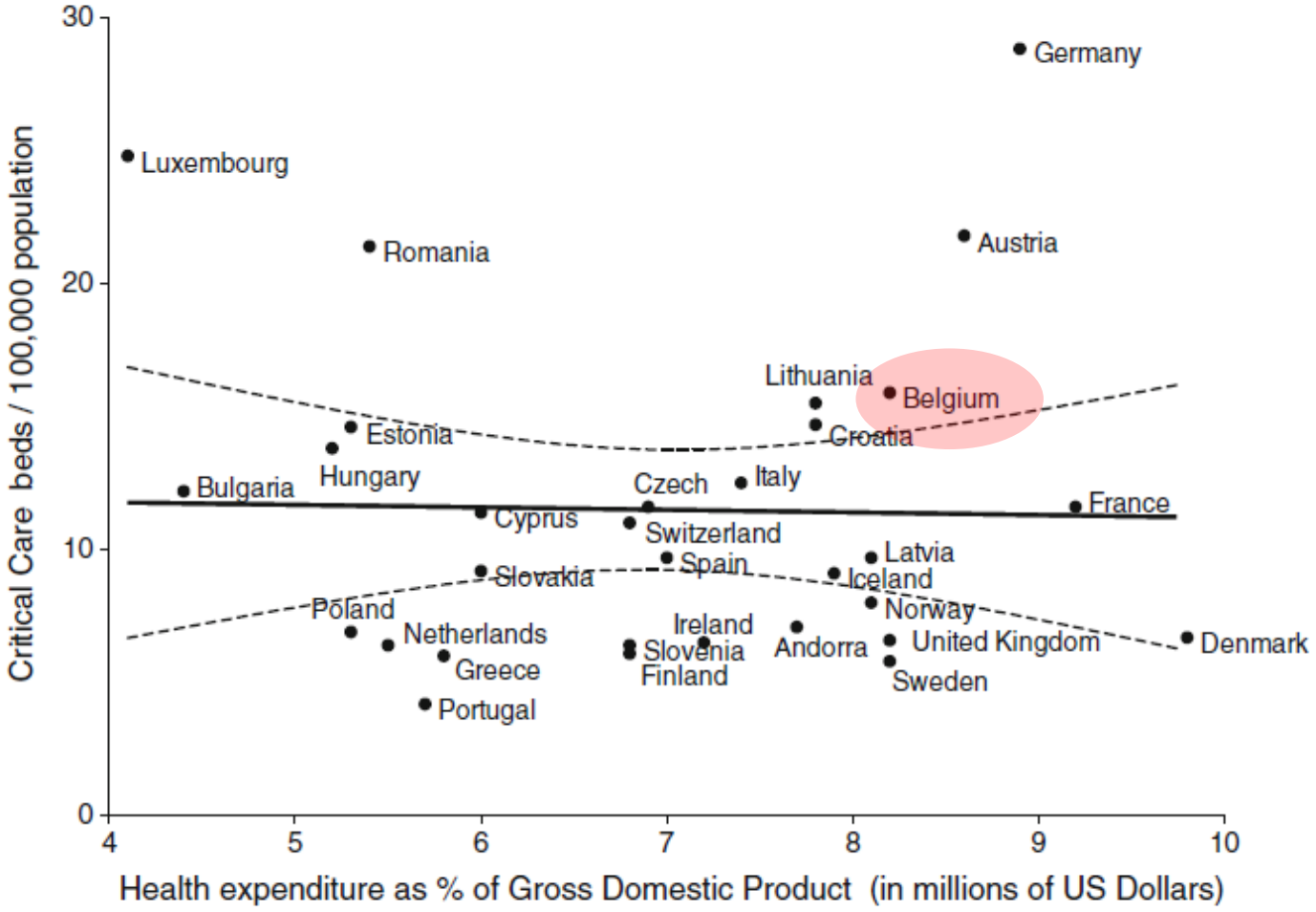

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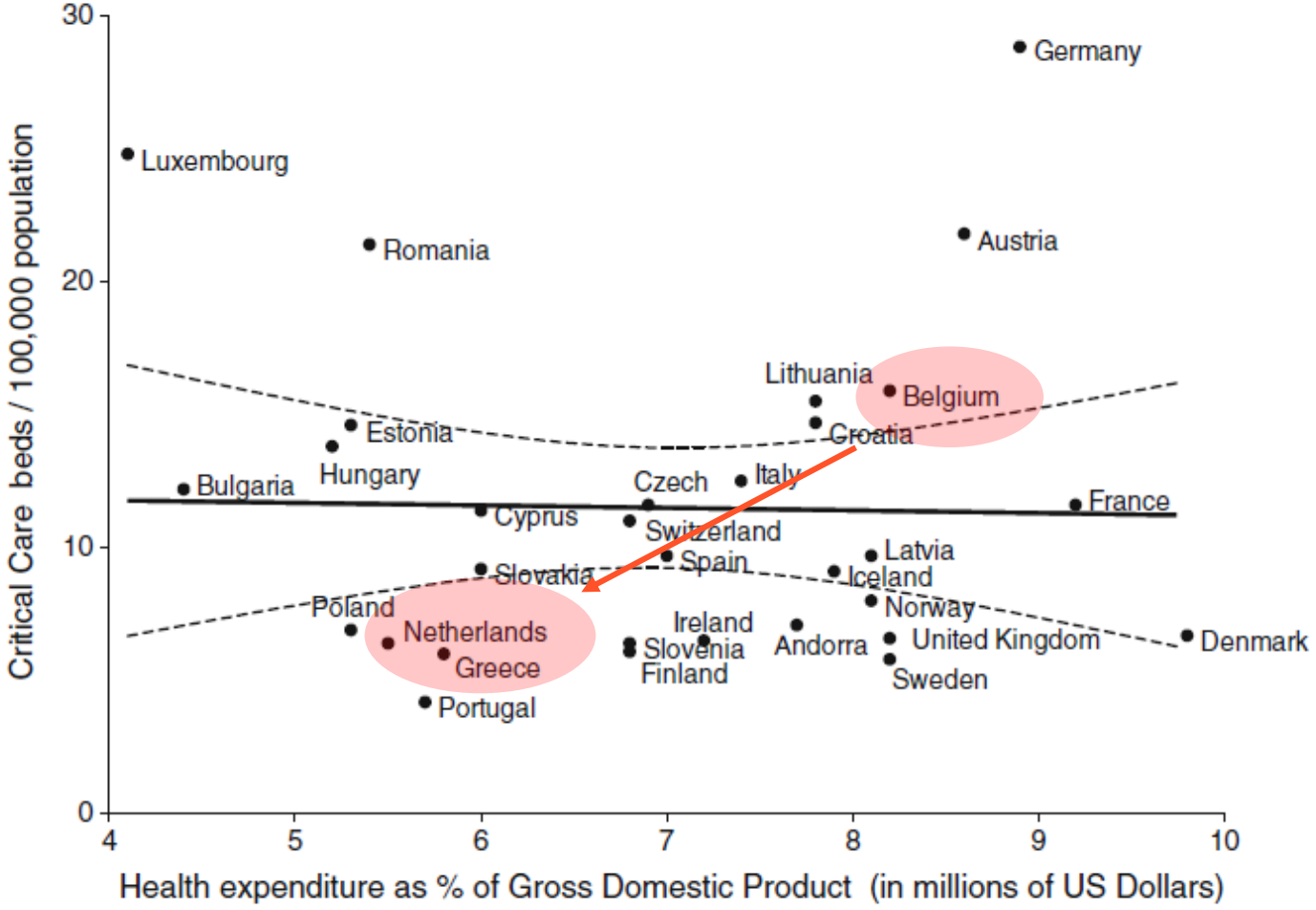

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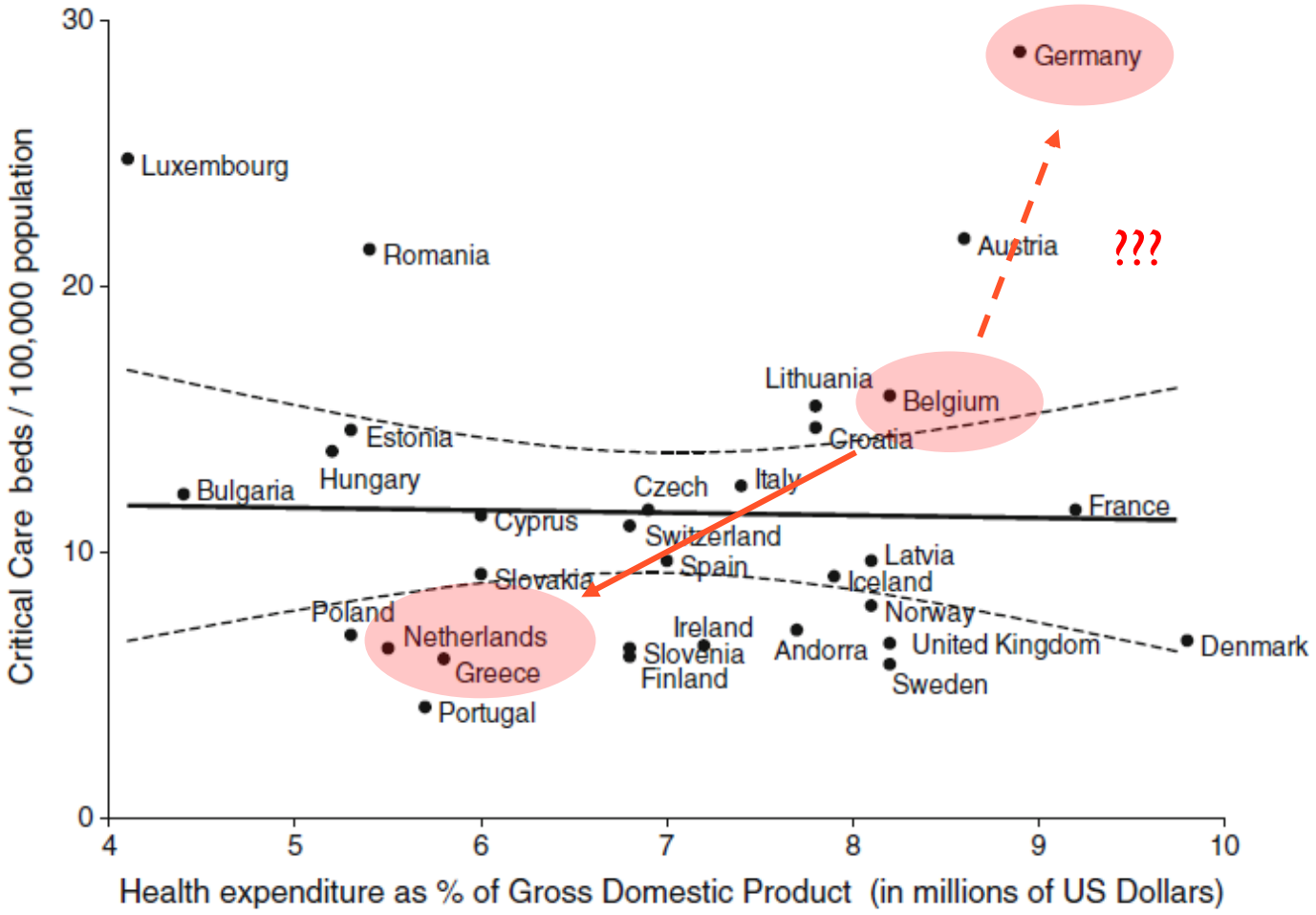

Solutions ???

Réduction du nombre de lits (et centralisation des soins) ?

Utilisation de critères de triage “objectifs” ????

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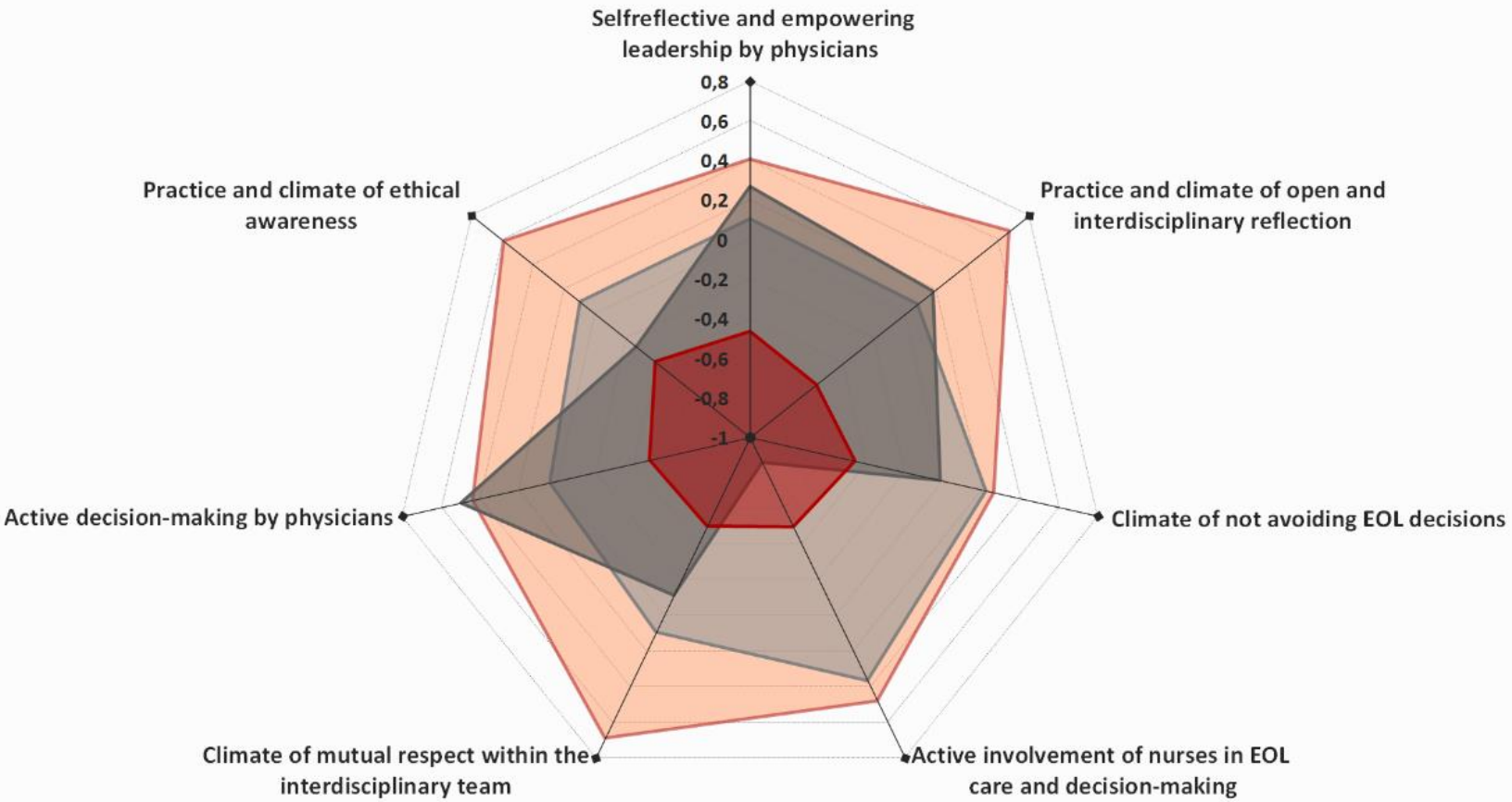
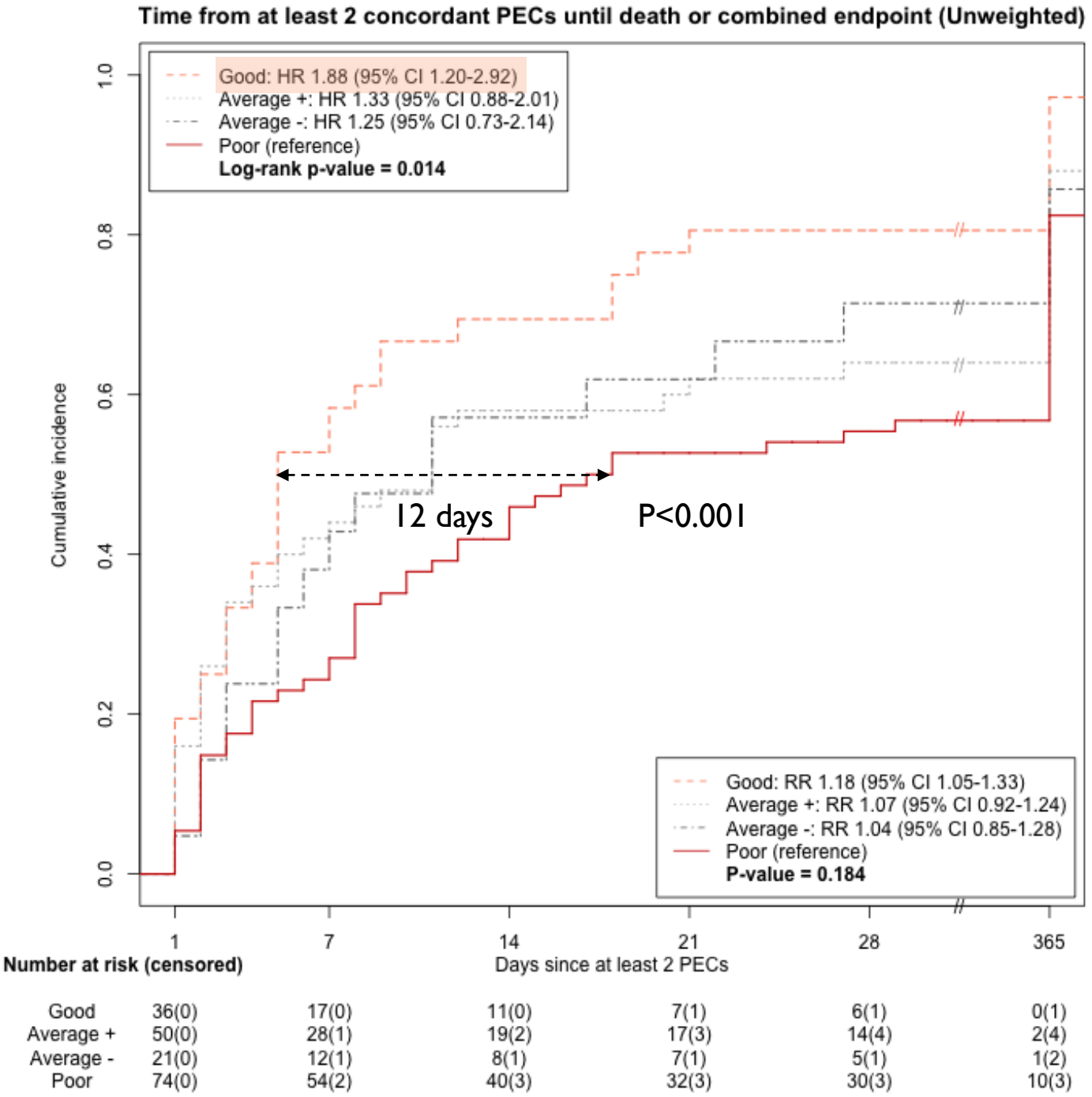
Décisions (“objectivité” + subjectivité) partagées en groupe

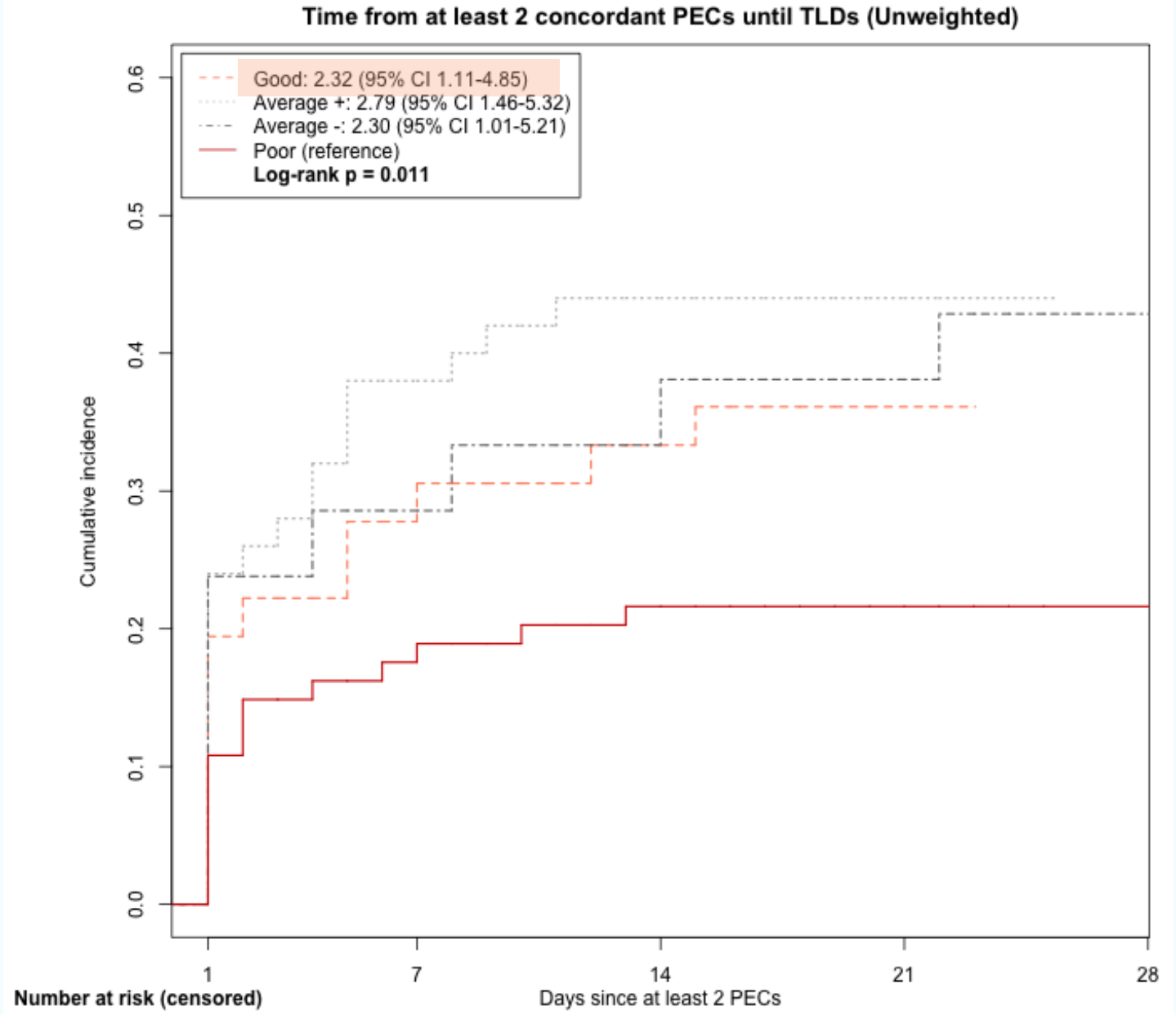
Radar chart 'ethical climates'



	Good	Average +	Average -	Poor
Number of ICUs:	12 (17,65%)	20 (29,41%)	12 (17,65%)	24 (35,29%)
Number of clinicians:	535 (17,88%)	1253 (41,88%)	302 (10,09%)	902 (30,15%)

DISPROPRICUS study group *Intensive Care Med (2018) 44:1039–1049*


Time from at least 2 concordant PECs until death or combined endpoint (Unweighted)
Good: HR 1.88 (95% CI 1.20-2.92)
Average +: HR 1.33 (95% CI 0.88-2.01)
Average -: HR 1.25 (95% CI 0.73-2.14)
Poor (reference)
Log-rank p-value = 0.014
Cumulative incidence
0.0
0.2
0.4
0.6
0.8
1.0
12 days
P<0.001
Good: RR 1.18 (95% CI 1.05-1.33)
Average +: RR 1.07 (95% CI 0.92-1.24)
Average -: RR 1.04 (95% CI 0.85-1.28)
Poor (reference)
P-value = 0.184
1
7
14
21
28
365
Days since at least 2 PECs
Number at risk (censored)
Good 36(0) 17(0) 11(0) 7(1) 6(1) 0(1)
Average + 50(0) 28(1) 19(2) 17(3) 14(4) 2(4)
Average - 21(0) 12(1) 8(1) 7(1) 5(1) 1(2)
Poor 74(0) 54(2) 40(3) 32(3) 30(3) 10(3)



Number at risk (censored)

Good	36(0)	10(15)	5(19)	0(23)	0(23)
Average +	50(0)	13(18)	6(22)	1(27)	0(28)
Average -	21(0)	11(4)	4(9)	2(11)	0(12)
Poor	74(0)	28(32)	9(49)	5(53)	0(58)

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Utilisation de critères de triage "objectifs" ????

Décisions ("objectivité" + subjectivité) partagées en groupe

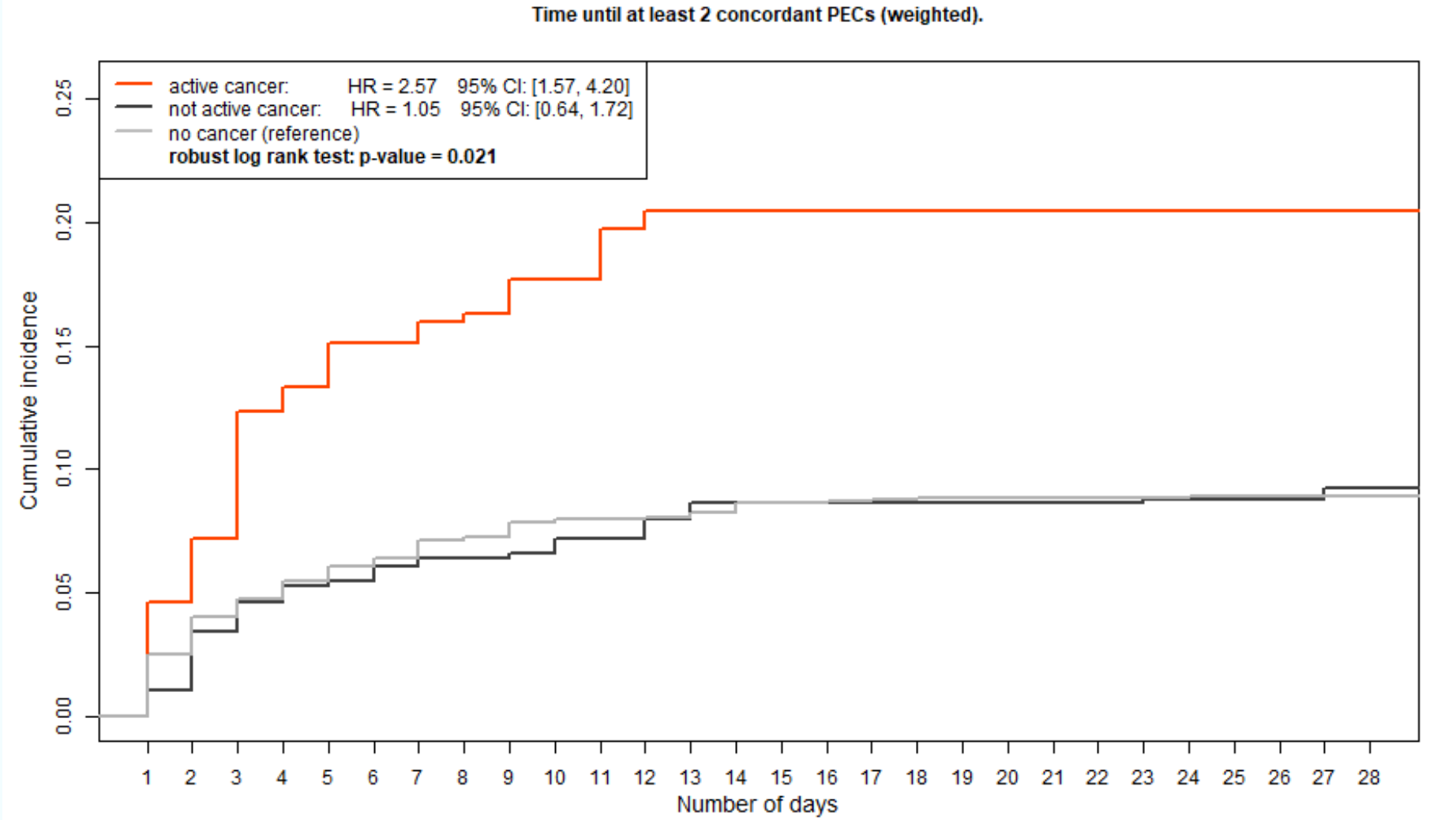
Risque de stigmatisation ou de discrimination ?

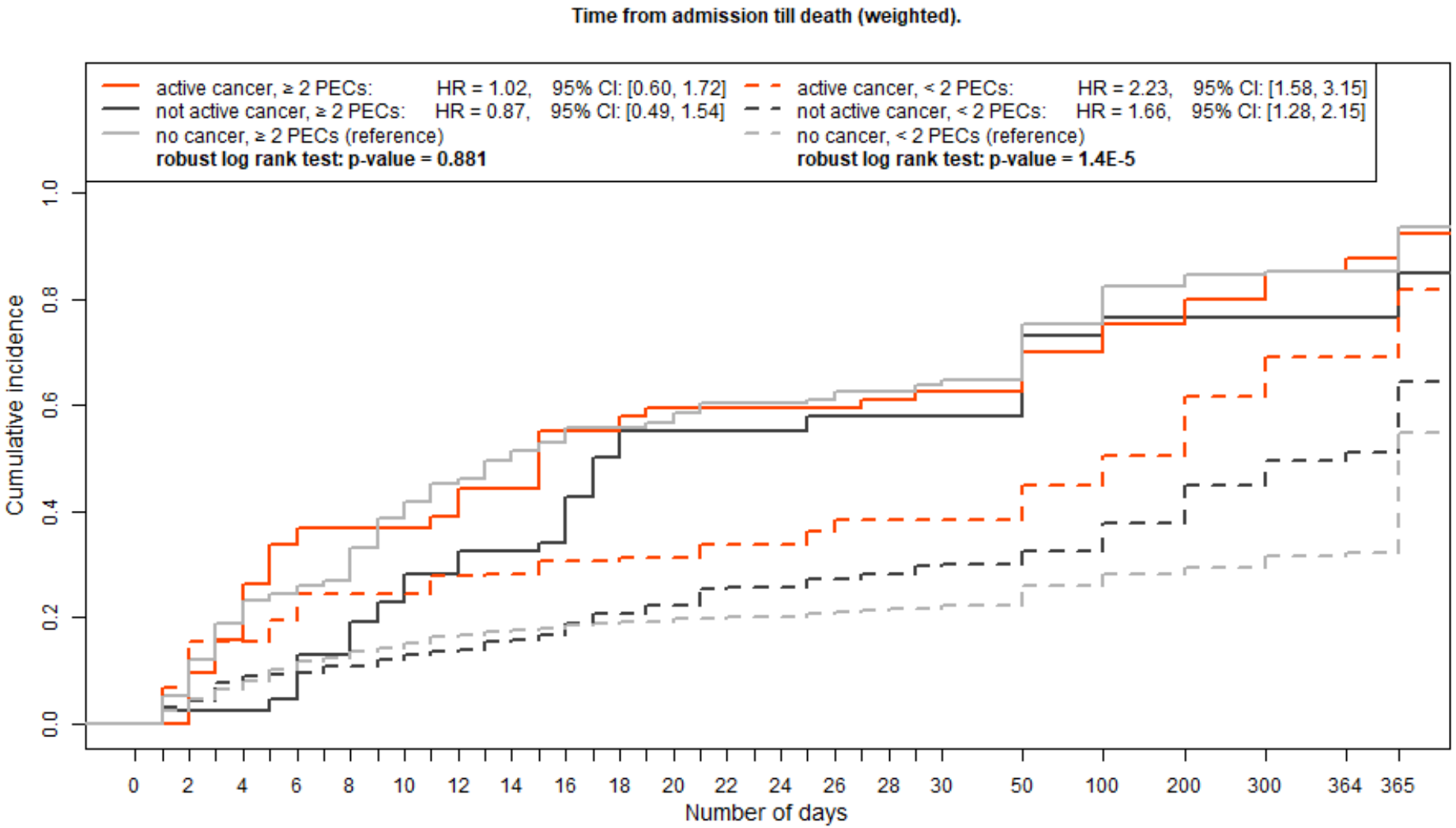
DISPROPRICUS : subanalysis

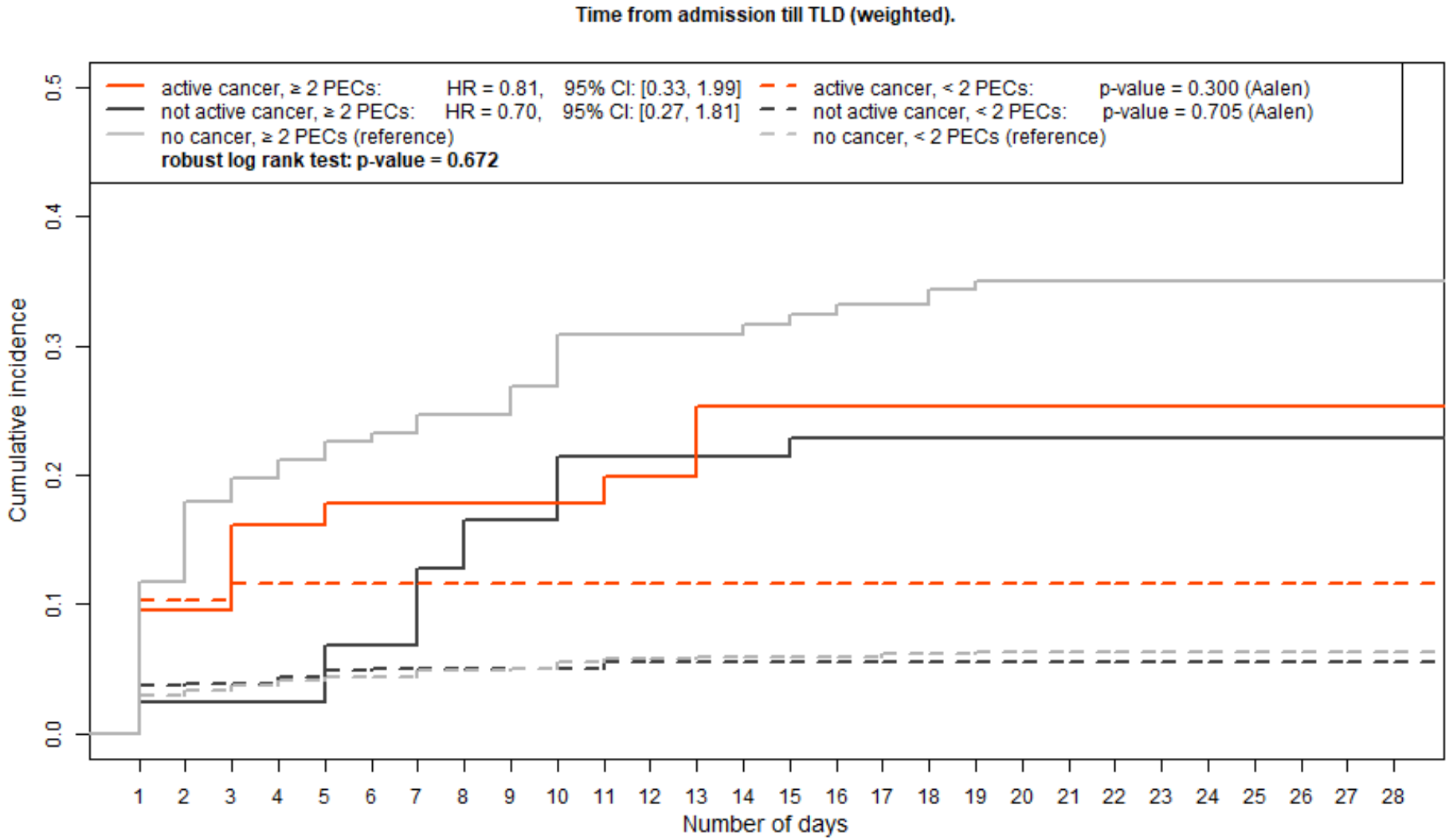
- Of the 1641 patients not admitted for monitoring only during the study period,
  - 117 (7.1%) had uncontrolled cancer
  - 270 (16.4%) had controlled cancer
  - 1254 (76.4%) had no cancer

- Of the 2690 participating clinicians,
  - 2293 (85.2%) provided 25025 perceptions of appropriateness of care
  - Of which 2279 (9.1%) Perceptions of Excessive Care
  - 728 (27.0%) clinicians perceived the care as excessive in 334 (20.3%) patients

- 160 (9.75%) patients had at least two PECs by different clinicians


Time until at least 2 concordant PECs (weighted).
active cancer: HR = 2.57 95% CI: [1.57, 4.20]
not active cancer: HR = 1.05 95% CI: [0.64, 1.72]
no cancer (reference)
robust log rank test: p-value = 0.021
Cumulative incidence
0.00
0.05
0.10
0.15
0.20
0.25
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
Number of days


Time from admission till death (weighted).
active cancer, ≥ 2 PECs: HR = 1.02, 95% CI: [0.60, 1.72]
not active cancer, ≥ 2 PECs: HR = 0.87, 95% CI: [0.49, 1.54]
no cancer, ≥ 2 PECs (reference)
robust log rank test: p-value = 0.881
active cancer, < 2 PECs: HR = 2.23, 95% CI: [1.58, 3.15]
not active cancer, < 2 PECs: HR = 1.66, 95% CI: [1.28, 2.15]
no cancer, < 2 PECs (reference)
robust log rank test: p-value = 1.4E-5
Cumulative incidence
0.0
0.2
0.4
0.6
0.8
1.0
0 2 4 6 8 10 12 14 16 18 20 22 24 26 28 30 50 100 200 300 364 365
Number of days


Time from admission till TLD (weighted).
active cancer, ≥ 2 PECs: HR = 0.81, 95% CI: [0.33, 1.99]
not active cancer, ≥ 2 PECs: HR = 0.70, 95% CI: [0.27, 1.81]
no cancer, ≥ 2 PECs (reference)
robust log rank test: p-value = 0.672
active cancer, < 2 PECs: p-value = 0.300 (Aalen)
not active cancer, < 2 PECs: p-value = 0.705 (Aalen)
no cancer, < 2 PECs (reference)
Cumulative incidence
0.0
0.1
0.2
0.3
0.4
0.5
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
Number of days

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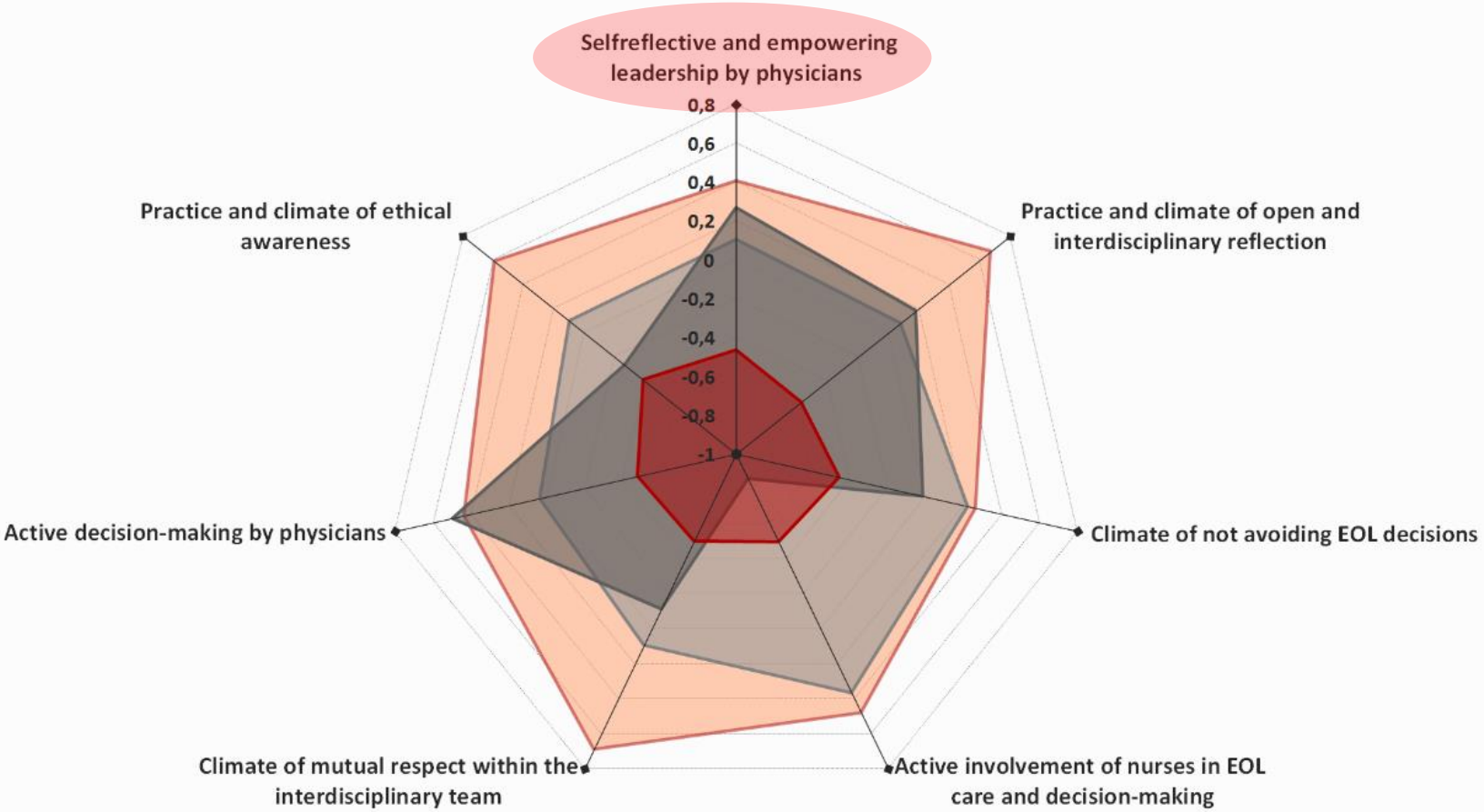

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Leadership éthique

Hierarchy of Intelligences

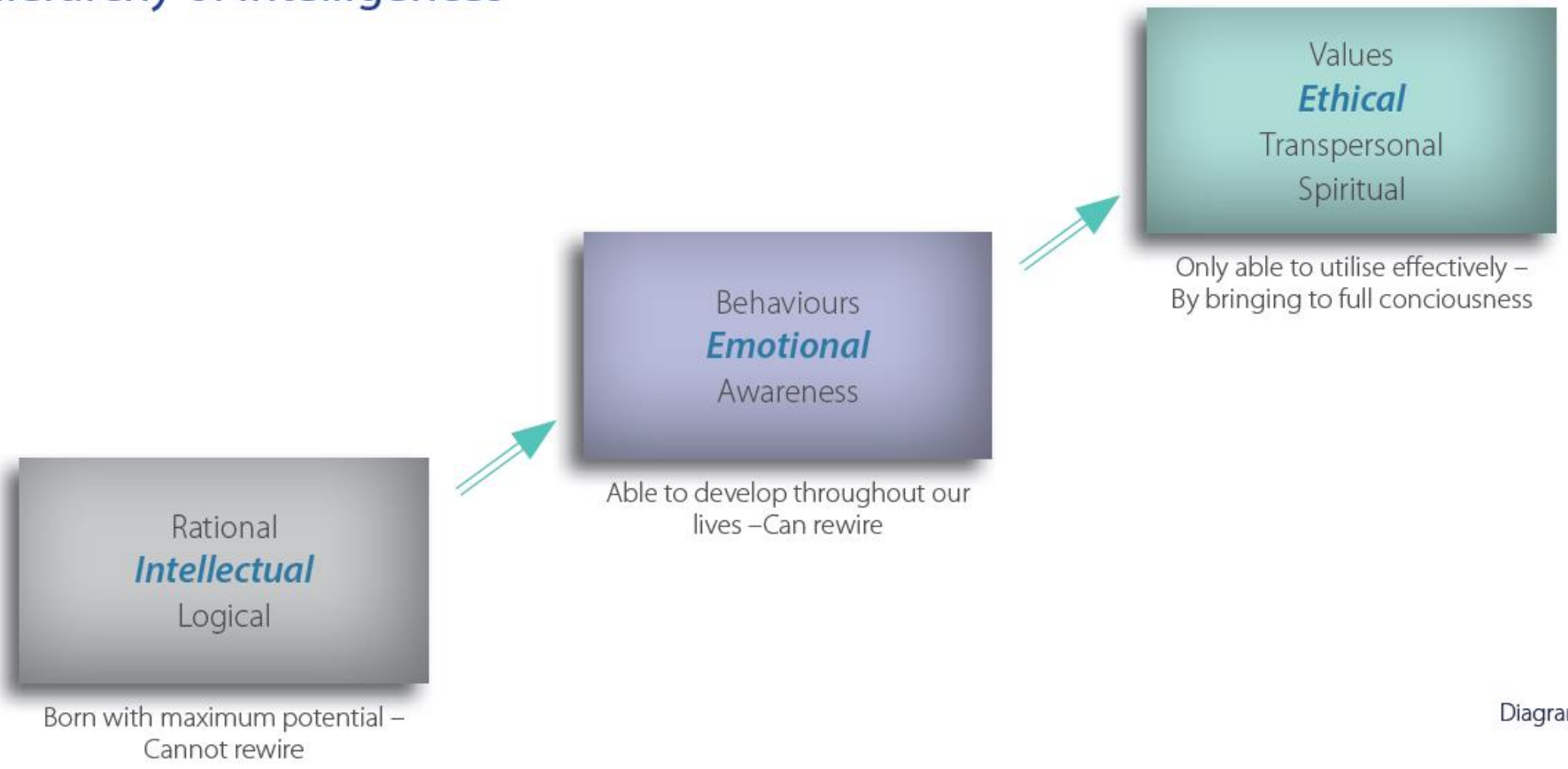

Diagram 1

Core Leadership Values

Personal Conscience Values

Fairness

Trustworthiness

Conscientiousness

Humility

Vulnerability

Patience

Truth & Honesty

Excellence

Integrity

Forgiveness

Altruistic Love

Self Determination Values

Purpose

Motivation

Drive (Intense Will)

Power

Energy

Courage

Resilience

Aspirations

Continuous Professional Development – CPD

Diagram 2

Core Leadership Values

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Self Determination Values

Purpose

Motivation

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Energy

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Leadership éthique (à Gand)

- Réflexion sur soi (étudiants en médecine 2012 & internistes 2011)
- Réflexion et simulation multidisciplinaires (2019)
- Coaching des médecins internistes (2020)

Trends in end-of-life cancer care in the Medicare program

Shi-Yi Wang[a,b,*], Jane Hall[b], Craig E. Pollack[c], Kerin Adelson[b,d], Elizabeth H. Bradley[e], Jessica B. Long[b], Cary P. Gross[b,f]

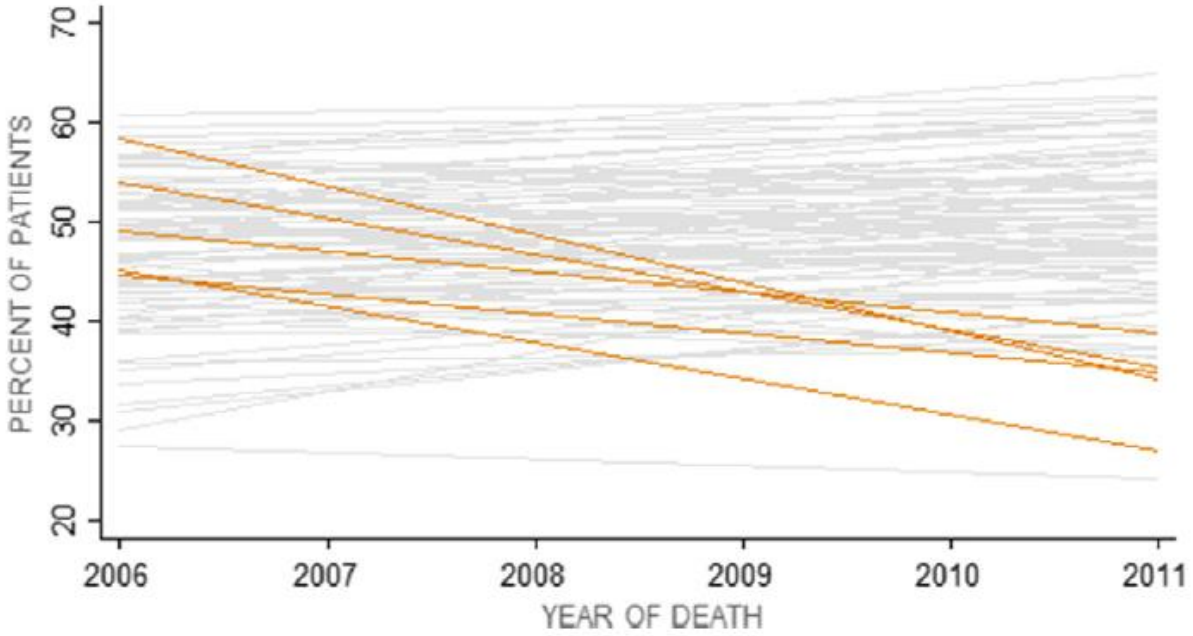

Fig. 2 – Trends of aggressive end-of-life care in 92 hospital referral regions among SEER-Medicare areas. Each line represents a hospital referral region (HRR), showing the regression for trend in aggressive end-of-life care. Five HRRs (highlighted in orange) had a trend of >2% decrease. SEER: Surveillance, Epidemiology, and End Results.

Conclusion

Intensive Care Med (2013) 39:1829–1831
DOI 10.1007/s00134-013-3013-x

Maité Garrouste-Orgeas
Andreas Valentin

What's new for patient safety in the ICU?

Fig. 1 Conceptualization of the evolution of safety in the ICU environment

Conclusion

"The success of intensive care is not, therefore, to be measured only by statistics of survival as if each death is a medical failure, it is to be measured by the quality of life preserved or restored, and by the quality of dying of those in whose interest is to die, and by the quality of human relationships involved".

Dunstan GR 1917-2004