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Classic cases revisited: Mr David James, futile interventions and conflict in the ICU

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Abstract

The technology so prevalent in the modern healthcare setting often creates an illusion that the biological certainty of death can somehow be evaded. Increasing number of deaths worldwide occurs in hospitals, and doctors by necessity inherit the role traditionally owned by priests, in overseeing the dying process. Unrealistic expectations concerning cure or indeed different perceptions of patient's interests on a background of deficient communication can lead to conflict. The case of David James illustrates conflict arising in the context of critical illness where further life-sustaining interventions were deemed to be futile. Futility and conflict in context of critical illness are discussed along with the legal judgements pertaining to the case of David James.

Keywords

Ethical issues, end of life, communication, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

> Whenever the illness is too strong for the available remedies, the physician surely must not expect that it can be overcome by medicine. To attempt futile treatment is to display an ignorance that is allied to madness. – Hippocrates

Introduction

The technology so prevalent in the modern healthcare setting often creates an illusion that the biological certainty of death can be somehow evaded. More and more deaths worldwide occur in hospitals, and doctors by necessity inherit the role traditionally owned by priests, in overseeing the dying process. Yet the scientific approach to death has little to do with spirituality. This is particularly so when dealing with death in critical care rather than at a hospice or indeed at home. Unrealistic expectations concerning cure or indeed different perceptions of patient's interests and needs on a background of deficient communication can lead to conflict at a time that is particularly stressful and traumatic to all involved. Conflict sometimes escalates, becoming intractable. The case of David James illustrates conflict arising in the context of critical illness where further life-sustaining interventions were deemed to be clinically futile. An overview of the concept of futility and of the problem of conflict arising in critical care is provided as a backdrop to the court judgements that had arisen from this case.

Case history

Sixty-eight-year-old Mr David James was admitted to hospital in May 2012, suffering from constipation. Eleven years prior to the admission, he was diagnosed with bowel cancer. With the aid of surgery and oncological interventions he had overcome the disease, but was left with a colostomy. Right up to the day of the admission he remained active, enjoying life and playing music at a professional level. He was a devoted family man. After being admitted to hospital, he succumbed to a hospital-acquired infection, which complicated by presence of chronic obstructive lung disease led to severe hypotension and acute kidney injury. Almost three weeks after being admitted, Mr James was transferred to a critical care unit with respiratory, cardiovascular and renal failures. In the course of the next couple of months, his condition fluctuated, but he clearly suffered major setbacks in that he developed a myocardial infarction, a stroke that left him hemiplegic

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and a sacral pressure sore. Recurrent sepsis resulted in more and more need for organ support. There was an inexorable, gradual worsening of his condition as he accrued organ damage. On 13th of August 2012, he suffered an asystolic cardiac arrest, from which he was resuscitated after 6 min. In the subsequent months, the clinical picture was that of relapsing multi-organ failure. As agreement could not be obtained from the family, the hospital sought help of the Court of Protection to withhold cardiopulmonary resuscitation, invasive haemodynamic support and renal replacement therapy in the event of further clinical deterioration. On the sixth of December 2012, a Court Protection Judge refused the hospital's request to place a 'do not attempt resuscitation' instruction in Mr James' notes. Subsequent to that, as we read in the appeal judgement

> on the 18th December he suffered a further dramatic deterioration which included worsening of his respiratory failure to the point that it was extremely difficult even to achieve good mechanical ventilation. This was accompanied by hypotension which was unresponsive to fluids and required intravenous vasopressors to maintain his blood pressure. He was given further course of antibiotic therapy. His renal function also deteriorated. He was at that time comatose or semi-comatose, responding only to painful stimuli by flexing his left arm.[1]

Another urgent court hearing took place on the 21st of December and declarations sought by the hospital were granted. Mr David James sadly passed away on the 31st December 2012.

Futility in the intensive care unit

In medicine, the word futile came to mean situations in which non-beneficial life-sustaining treatments are employed. The issue of futility is well recognised in critical care. Over 70% of deaths are preceded by the withdrawal or withholding of treatment in an acknowledgement of futility of further life-sustaining efforts.[2] A significant number of patients are perceived to receive disproportionate and thus often futile interventions.[3] There is however a significant variability in terms of practice with regards to undertaking cardiopulmonary resuscitation or decisions to forgo life-sustaining therapies.[4,5] It has also been shown that ethics consultation can be used to reduce futile interventions without affecting mortality.[6] In spite of the acknowledgement of the real life problem of futility, the concept is difficult to handle. The definition of the concept, the utility of the concept and the very existence of the concept have been the subject of intense debate. It is useful to appreciate the different points of view in order to understand why this term remains problematic.

Some reject the concept of futility outright. Nair-Collins' eloquent argument against the concept of futility as a guide to treatment decisions is a good illustration why some may support arguably inappropriate interventions.[6] He argues that doctors lack moral authority to decide if someone should die or live. This decision should be based on autonomy and belong to the individual concerned or their surrogate. He argues that doctors lack moral authority to decide what is harm and what is benefit to an individual. Furthermore, he argues that doctors' epistemic authority is limited or to put in other words we do not know as physicians what we treat and how we should treat it and therefore do not have true foundations for prognostication (argument based on vegetative state having no definitive anatomical correlate, with no imaging or electrophysiological modality, or biomarker to prove diagnosis – doctors essentially make up the diagnosis to suit their view). He finally seems to view all decisions made in healthcare as unilateral. His stance is that all life-sustaining measures should always be attempted, and futility is a value-laden concept arising from medical paternalism. To quote from his essay:

> Deciding when to stop advanced life support, after it has earnestly been attempted, is a professional judgment. In one sense, this might be considered a retrospective evaluation of efficacy: the intervention was attempted, and it did not work to restore spontaneous circulation; therefore, we know now (but we did not know then) that it is ineffective in restoring spontaneous circulation in this particular patient. However, the more salient professional judgment here is that the patient is already dead.[6]

It is evident that he assumes we are treating circulation and not the person, not the individual, not the human being that feels and wants to experience the joy of life. His reductionist approach stands contrary to what the majority of doctors stand for. Or, do we think that human life should be merely defined as absence of death? He argues that clinicians have no moral qualifications to decide on whether to initiate life-sustaining treatment yet admits that it is a professional judgement to know when we should stop. Should we stop after 1 min or carry on for hours? That is a value judgement, which according to Nair-Collins should not belong in medicine. His assertion that medical knowledge is incomplete and therefore cannot be relied on questions the foundations of the medical profession and science in general. If something cannot be described in sufficient detail, it does not mean it does not exist. It means that the current state of knowledge is insufficient. Why are the principles of Newtonian physics still taught in schools if it has been superseded by Einstein's relativity and quantum physics? Knowledge evolves. The clinical reality of vegetative state, although without clear pathophysiological correlate, does not imply that the empirical knowledge about prognosis is incorrect. The extension of his view is that there should be no moral decision making at all in medicine and doctor's role could be reduced to that of a mere technician employed by the society to institute and supervise treatments including life-sustaining treatments, according to the wishes of patients or their surrogates, without any need for professional judgement. He denies doctor's right to judgement, arguing that the goals of publicly funded, contemporary healthcare, aka rationing, should be decided by the society and not at the bedside through a unilateral decision of an attending physician. This is a very narrow and unrealistic view of healthcare. Indeed, rationing is a domain of policy makers, but healthcare depends on value judgements. The uncertainty inherent in healthcare decisions demands not just a contractual relationship between a doctor and his or her patient. It demands trust, and how could any relationship be based on trust if doctors were mere technicians devoid of moral judgements? While historically correct, unilateral decisions in healthcare are increasingly rare and a shared decision model proposed over 30 years ago has been gradually adopted by the majority. Finally, the *burden* of decision making is exactly that – a burden. End-of-life decision making is difficult and does not come easy to majority of doctors.

Lawrence Shneiderman and Nancy Jecker, amongst others, support a different and a more pragmatic notion of futility.[7–9] Their view is perhaps closer to that held by many healthcare professionals and certainly many intensivists would identify with it. Their view considers harm, benefit and autonomy equally, and they draw a line at distributive justice linking it to rationing and thus policy rather than bedside decision making. Their qualitative definition states that medical futility is the unacceptable likelihood of achieving an effect that the patient has the capacity to appreciate as a benefit. This indirectly supports a patient's autonomy, in that it qualifies the futile intervention as directed not at the patient, as an autonomous sentient or at least aware being, but at a physiological parameter(s). Their quantitative definition of futility, as an intervention with less than one in a hundred chance of producing a meaningful outcome, addresses benefit and harm. As Shneiderman has stated:

> If you truly want to make a case for attempting aggressive, life-sustaining, rib-cracking CPR on a patient who has a 'one in a hundred chance' of working, you are claiming that it is appropriate to subject ninety-nine patients to an intervention that is painful, burdensome, and almost certainly useless in pursuit of one possible rare success. This violates medicine's duty to avoid unnecessary harm and the ethical duty of proportionality. Any physician who knowingly prescribed a drug with such a low therapeutic ratio and such severe side effects would be (deservedly) vulnerable to the charge of medical malpractice.[7]

They extend the argument further, suggesting that offering treatment which is not going to work is deceitful and thus violates patient's trust consequently denigrating the practice of medicine.[9]

In a somewhat more neutral analysis of the shape of modern clinical death and dying, with legal, cultural and ethical aspects considered, Michael A. Ashby takes middle ground noting critically that

> the concept of futility is a conflation of clinical judgment about outcomes of treatment and the quality or even value of life, and has really failed to contribute much to the advancement of decision making and hence care at the end of life. Much hope has been invested in a very fragile vessel that ultimately has little or no prospect of taking things to a better place. In fact there is no ethical or moral concept underpinning futility, except possibly the principle of not doing harm. It is really a clinical term, but one that blurs the clinical and the personal, in the sense of the subjective assessment of what gives life value and meaning.[10]

He goes on to provide an alternative approach

> It is surely better to locate these decisions about medical treatment abatement (or limitation) in a gentle, compassionate but clear understanding of the reality of death and the process of dying. It is our natural destiny to die, and obstruction of the dying process, when it is manifestly underway, is indeed both futile and unkind. This can be done by an honest and transparent evaluation of realistic goals of care: curative/restorative, palliative, or terminal.[10]

This avoids conflict and value judgements and does not require the veil of objective physiological barriers.

Given the above view points, one can understand the unease concerning uncertainties inherent in clinical judgements, the potential for differences in value judgements, the need for a pragmatic approach and the need to put the patient at the heart of it all. After all, it is not the treatment effect observed by the clinician, but the benefit perceived by the patient that should matter. In the face of the biological certainty of death, cure may not be possible, and the patient and, or their loved ones should not be deceived by interventions performed without the hope of success. Instead, the benefit may be derived from good palliative care, good communication and the understanding of patient values. And it is because of value judgements that the language of 'futility' is problematic. Recognising it, in a recent widely endorsed policy statement, the American Thoracic Society (ATS) recommended that the somewhat 'softer' term 'potentially inappropriate' should be used instead of 'futile' to describe treatments that have at least some chance to accomplish an effect sought by the patients.[11] The authors do however reserve the right to still use the word 'futile' where an intervention cannot accomplish the intended physiological goal. The guidelines do state that doctors should not provide futile interventions and should provide a careful explanation of the rationale. Inevitably, on rare occasions, an intractable conflict may arise where clinician's and patient's or family's judgements are at odds.

Conflict in intensive care unit

In an ideal world the patient would agree with the clinical team the goals of treatment. Options could be reviewed, and unbiased information about the chances of success could be provided. Ceilings of treatment could be agreed on. Even if paternalism is buried and autonomy is accepted as an absolute guiding principle, there still remains a problem of capacity to participate in the decision-making process. In the French LATAREA cohort of 7309 ICU patients, limitation occurred in 807 patients and only three patients participated in the end of life decision.[12] In the circumstances, where patient's wishes are unknown with no advance care plan or advance directive and with no legally appointed representative, the clinical team needs to establish the patient's best interests. As directed by law, those are wide ranging and significantly more than purely medical interests. The uncertainty relating to a patient's medical background, prognostication and actual wishes combined with the ethos of interventional medicine often leads to the commencement of a therapeutic process that may be doomed to fail. Sustaining someone alive can and should be assumed in the first instance as being in their best interest. The decision making in critical care involves the interpretation of complex data, a multi-disciplinary approach and value judgements. Error may occur. The patient is often unable to contribute to the decision-making process. Family on the other hand is and it is likely to be experiencing similar uncertainties. They may experience feelings of guilt, fear, anger or frustration. Consequently, the differences are bound to arise especially if communication between all stake holders is deficient. This has the potential to become particularly acute, when decisions concern the limitation of life-sustaining treatments. Value judgements differ significantly between healthcare professionals and patients. Physicians and nurses find quality of life more important and value of life less important in their decisions for themselves than patients and families. If diagnosed with a terminal illness, health professionals want fewer ICU admissions, uses of CPR and less mechanical ventilation compared with patients and families.[13] Sometimes, cultural or religious context may come into play.[2] Conflict may be expressed or remain hidden, and may lead to moral distress and potentially to job leave.[3] A study by Studdert and colleagues demonstrated that in long-stay ICU patients conflicts arouse frequently. In a sample of 656 patients whose stay exceeded the 85th centile length of stay for their unit conflict has been identified in 248 cases in 209 patients.[14] One hundred and forty two (57%) conflicts were between the team and patient's family, and 76 (31%) were conflicts within the team. Sixty-three conflicts (44%) concerned end-of-life decision making. In a similar fashion, the CONFLICUS study demonstrated a high prevalence of potentially preventable conflict in the ICU setting.[15] Surveying 7498 ICU staff members the authors reported conflict between physicians and nurses, amongst nurses and between healthcare workers and relatives. The overall prevalence of perceived conflict was 71.6% and specifically prevalence of conflict between healthcare staff and relatives 26.6%. Conflicts perceived as severe were reported by 53% respondents. Only half the conflicts have arisen from end-of-life care situations. The findings are particularly striking when one takes note of the fact that of the units participating in the survey, 45% had access to an ethics consultant and 56.6% to a psychologist. The authors felt that poor communication within the ICU team in general or concerning end-of-life care was the major source of conflict.[15]

Leading on from that, interventions aimed at communication have been trialled to improve the perceived quality of end-of-life care and improve outcomes for the bereaved families. Introducing trained facilitators to support communication with the families,[16] communication coordinators,[17] instituting enhanced communication strategy[18] or introducing proactive palliative care consultations[19] resulted in a reduction in ITU length of stay, greater family satisfaction with care and possibly a reduction in depressive symptoms following death of relative.

Occasionally, conflict becomes intractable. There is communication breakdown, lack of common ground and, not infrequently, frank hostility. Delivering care in those conditions becomes difficult and the individual that suffers in the end is often the patient. Conflict, even though it is often about goals of treatment and care, can dehumanise care and objectify the patient. Resolving entrenched conflicts is problematic and may require recourse to the courts. ATS statement mentioned above recommends that individual institutions have strategies to prevent intractable conflicts and arrangements for a fair dispute resolution. This may be through a legal route or possibly by means of using internal or external mediation.

Legal resolution of disputes may be considered as final solution. In the USA a fine example is provided by the Texas Advance Directives Act (TADA), which provides a framework for addressing conflict concerning treatments at the end of life. The judgement about appropriateness of ongoing treatment is subject to a review by an ethics or medical committee, which provides a decision which is then conveyed to patient's representative. The patient's representatives are notified 48 h in advance of the committee being convened and withdrawal of treatment may take place (if such was committees decision) 10 days after the decision is made. The experience with TADA demonstrated that committee would agree with the physicians in 70% of cases and majority of cases are resolved before the end of 10-day period with patients either dying, family agreeing to withdrawal of support or transfer to another institution being effected. Only in a minority of cases the treatment was discontinued against patient or patient representative wishes.[20] In the United Kingdom the case should be referred before the Court of Protection and this indeed happened in the case of David James.

The judgements

David James was on intensive care for several months. If only the summary of the facts provided by the judgement could also convey the emotions experienced by those involved we could better understand why some cases go to court and why some judgements are made. Also we can only guess as to the conflict that has driven the hospital to the pursuit of the legal route to resolve it. Hope, love and fear experienced by the family are difficult to quantify, date and tabulate. Likewise scrutiny of duty, conscience, care delivery and moral sense of what is right and what is wrong is difficult for clinicians. Having the judiciary wade into this emotional mire may sometimes aggravate conflict. The solution provided (whatever it is) is bound to leave one side of the conflict unhappy.[21]

The hospital treating David James applied to the Court of Protection to make the declaration for the treatments including cardiopulmonary resuscitation, invasive support for circulatory failure and renal replacement therapy to be withheld in the event of a clinical deterioration. Justice Peter Jackson the judge of the Court of Protection refused to make above declarations. He acknowledged legal foundation of futility. It is stated within Mental Capacity Act Code of Practice that

> there will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death.[22]

However, the judge did not feel that this point has been reached. He referred to the uncertainty surrounding treatments, took note of the non-medical best interests as promulgated by the family, referred to the Articles 2, 3 and 8 of the European Convention on Human Rights and finally rejected futility on several grounds. His reasons for rejecting futility included an opinion that cardiopulmonary resuscitation and invasive organ support worked so far, and therefore there would be no reason to believe that it should not work again. Acknowledging the burdens of interventions, he also questioned the medical approach to futility and the assumptions made by clinicians about the quality of life Mr James may experience. He felt that a possibility of existence with a 'worthwhile' quality of life still existed. He felt that declaration in favour of withholding treatment would '*undervalue the non-medical aspects of DJ's situation at the time*'.[1] There was within the judgement an implied question of the physician's epistemic authority. Reading the judgement, we are reminded of Nair-Collins' stance on futility. We can sense the judge's empathy for the family when he admitted a possibility of a miracle. As stated, hoping for miracles can lead to needless harm. Also, given modern technology with automatic resuscitation devices, we may find ourselves in a (hopefully theoretical) situation where CPR continues indefinitely – as it has worked so far and it is supporting a patient's life. Permission to appeal was refused by the judge but adjourned to the full court by Munby LJ on the 17th of December 2012 in face of a change in clinical condition. The urgent hearing was held on 21st of December and declarations sought by the hospital were made. David James passed away on the 31st of December 2012. The judgement that was handed down and the reasons were published after Mr James's death. The focus of the criticism of the initial judgement was on handling of the concept of futility.

> In my judgment to answer the question whether the proposed treatment would be futile one has to ask what result the treatment seeks to produce. Futility is an ethically controversial concept because what is worthwhile can only be assessed relative to its goal. noted Sir Alan Ward (1 para 35)

adding '*There is no duty to maintain the life of a patient at all costs. There is no duty needlessly to prolong dying*' (1 para 36). He felt that treatment must be 'worthwhile' in having '*a real prospect of curing or at least palliating the life threatening illness from which the patient is suffering*' (1 para 34). He concluded concerning futility

> it follows that in my judgment the judge erred in law in adopting to narrow view of futility. He was wrong to simply look at the past successful effect of the treatment without also having regard to the improvement, or lack of improvement, that such treatment will bring to the general health of the patient. He was wrong to concentrate on the usefulness of treatment in coping with the crisis and curing the disease or illness, e.g. cardiac arrest, and not also to be concerned instead with whether the treatment was

> worthwhile in the interests of the general well-being and overall health of the patient. (1 para 38)

One further important consideration highlighted is patient's personal wishes when considering best interests and futility. Sir Alan Ward notes that 'patient's wishes are not the deciding factor in working out his best interests and do not determine what treatment he should receive' (1 para 36).

Further grounds listed in favour of appeal include inconsistencies concerning views on the utility of cardiopulmonary resuscitation along with failure to address the hospitals anticipation of further crisis. The hospital also presented overwhelming evidence of the burden of treatment with associated potential for harm (Sir Alan Ward going as far as stating that cardiac arrest suffered by the patient may have been a consequence of circulatory support) yet the Judge Jackson felt the treatment was not overly burdensome.

Lord Justice Laws agreed with Sir Alan Ward and Lady Justice Arden, while agreeing with the conclusion of Sir Alan Wards judgement, stated that she arrived at her result by a different route. Using a reasonable individual principle, she stated

> acting with humanity, and with respect for DJ's autonomy, I consider in the light of DJ's medical condition, his wishes would be unlikely to be to have the treatment of the kind in issue here, and that a reasonable individual in the light of current scientific knowledge would reject it. (1 para 63)

She added

> I do not...consider that this case raises any legal issue in this case with respect to quality of life. Under the law, human life is sacrosanct, even that which is only partially enjoyed as in the case of DJ, with only diminished consciousness. (1 para 66)

This paragraph does underscore an assumption that was David James able to make the decision, he would have chosen to abandon further attempts at treatment, rather than that the treatment provided was futile.

The court of Appeal had handed down its judgement on the 1st of March 2013. The reader could be forgiven for thinking that this would be the end of the legal process. However, recognising the importance of the issues at stake the court gave the widow a permission to appeal. The hearing before the Supreme Court took place on 24th of July 2013. Lady Hale spoke for all Judges of the Supreme Court.[23] The facts of the case were heard again and the judgements were reviewed. The 19-page judgement is well worth reading. It is noted that with regards to medical interests doctors are the experts

> At the end of the day whether to administer treatment is a medical decision. We are reminded: This Act is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further. On an application under this Act, therefore, the court has no greater powers than the patient would have if he were of full capacity. The judge said: 'A patient cannot order a doctor to give a particular form of treatment, although he may refuse it. The court's position is no different'. (23 Para 18)

Normally for treatment to be lawful patient consents to it. If they cannot consent, the treatment needs to be in their best interest. And, as stated,

> in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be. (23 Para 39)

The Supreme Court thus challenged the view of futility put forth by the Court of Appeal. Lady Hale stated

> It follows that I respectfully disagree with the statements of principle in the Court of Appeal where they differ from those of the judge. Thus it is setting the goal too high to say that treatment is futile unless it has 'a real prospect of curing or at least palliating the life-threatening disease or illness from which the patient is suffering'. (23 Para 43)

She then adds that when

> a patient is suffering from an incurable illness, disease or disability, it is not very helpful to talk of recovering a state of 'good health'. The patient's life may still be very well worth living. Resuming a quality of life which the patient would regard as worthwhile is more readily applicable, particularly in the case of a patient with permanent disabilities. (23 Para 44)

The concept of futility in British Law and the Code of Practice is examined and traced back to the case of Anthony Bland where Lord Goff stated

> I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition.[24]

Viewing futility in this light and given the presumption that it is in a person's best interests to stay alive, however small benefit was offered by the treatment, it was worthwhile and thus initial judgement was correct. Consequently, the view of the Court was that Judge Peter Jackson was right in his interpretation of law at the time of judgement. There is an acknowledgement that the patient's condition deteriorated significantly by the time the Court of Appeal was making a decision

> on the basis of the fresh evidence which was before them, the Court of Appeal were correct to allow the appeal and make the declarations they did [. . .]. There had been such a significant deterioration in Mr James' condition that the prospect of his regaining even his previous quality of life appeared very slim. (23 para 46)

Lady Hale concluded

> I would dismiss this appeal on the ground that the Court of Appeal reached the right result but for the wrong reasons, while the trial judge had reached a result which was open to him having correctly directed himself as to the law. (23 Para 48)

Conclusions

Real, fascinating and contentious both in courts and in hospitals futility remains an issue that clouds medical interventions at the end of life. Prolongation of the dying process is not a goal of medicine. Focusing on the best interests of the patient may offer better chance of tailoring the treatment to the individual concerned. It is physician's decision, as to which treatments are medically appropriate, but one needs to be mindful of legal and moral presumption in favour of life. Interventions aimed at improved communication provide a hope for better decision making about which treatments are appropriate, and where the limits for interventions should be set. The judgements issued in the case of David James illustrate that in law, clarity is not always easily achieved, and that medical science, pushing at biological boundaries, is bound to create more and more ethical dilemmas. Appreciation of biological certainty of death along with the understanding of the limits of currently available critical care interventions should guide the early communication with the patients and their families to provide care focused on achieving patient-centred goals and to avoid conflict.

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