A73 - The Norwegian ETHICUS II data

A Robertsen 1; TA Aasmundstad 1; BÅ Sjøbø 2; T Legernæs 3; M Flückiger 4; E Søreide 5; K Dybwik 6; J Røe Ballestad 7; A Haavind 8; P Klepstad on behalf of the Norwegian ETHICUS II investigators 9

1 Oslo University Hospital, Department of Anesthesiology and Critical Care, Oslo, Norway, 2 Haukeland University Hospital, Department of Anesthesiology and Critical Care, Bergen, Norway, 3 Hamar Hospital, Department of Anesthesiology and Critical Care, Hamar, Norway, 4 Akershus University Hospital, Department of Anesthesiology and Critical Care, Oslo, Norway, 5 Stavanger University Hospital, Department of Anesthesiology and Critical Care, Stavanger, Norway, 6 Nordland University Hospital, Department of Anesthesiology and Critical Care, Bodø, Norway, 7 Drammen Hospital, Department of Anesthesiology and Critical Care, Drammen, Norway, 8 University Hospital of Northern Norway, Department of Anesthesiology and Critical Care, Tromsø, Norway, 9 St Olav University Hospital, Department of Anesthesiology and Critical Care, Trondheim, Norway

Introduction:
End-of-life (E-o-L) practices varies between countries and regions (1). Norway is an affluent, equality-based Northern European society with a public health care system. Legal frames and national guidelines on limitations of life-sustaining treatment exist. Four per cent of Norwegians dies within an ICU.

Methods:
An a priori post-hoc analysis of 11 Norwegian sites participating in ETHICUS II - a prospective, observational study including all consecutive ICU patients who died or had limitations of life-sustaining treatment from September 2015 to February 2016 (1).

Results:
Of 3298 admitted ICU patients 450 (14%) died or had limitations. Patients’ mean age was 69 years (16-96) and 90% had a chronic disease in addition to the acute condition that brought them to the ICU. Eleven per cent were assessed mentally competent. Eighty-eight per cent had limitations, 35% in the form of a sequence - decisions at multiple time points. Mutually exclusive E-o-L categories were; 33% withholding, 55% withdrawing, 0% shortening of the dying process, 4% brain deaths, 8% failed CPR. Primary reasons behind decisions are in table 1. E-o-L discussions were initiated in 1% by the patient, in 2% by family, in 3% by nurses and in 94% by physicians. In 57% nurses participated in discussions. In 35% physicians asked for or received information about patients’ preferences, only 2 patients had Advance Directives. Time from admittance to first limitation was 38h (25-75 percentile 6 – 133 h), from first limitation to death 21h (25-75 percentile 4-69 h). Major difficulties or disagreements occurred in 7%. Among patients with limitations the study survival (to ICU discharge or end of follow-up at 2 months from decision) was 20%.

Conclusion:
The Norwegian ETHICUS II cohort describe a proactive, but still somehow paternalistic E-o-L practice with room for improvement in nurse involvement and more active engagement of patients and families.

References:
(1) Sprung C el al JAMA 2019; epub ahead.

Table:

<table>
<thead>
<tr>
<th>Reason</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unresponsive to maximal therapy</td>
<td>153</td>
<td>39</td>
</tr>
<tr>
<td>Neurological prognosis</td>
<td>108</td>
<td>27</td>
</tr>
<tr>
<td>Reason</td>
<td>Count</td>
<td>Other</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Poor quality of life</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Age</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Patient request</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>53</td>
<td>13</td>
</tr>
</tbody>
</table>

*Primary reasons behind decisions to withhold or withdraw*