

Open Letter to President Barack Obama and Congressional Leaders From the Critical Care Societies Collaborative

The Critical Care Societies Collaborative represents four US-based critical care professional societies whose members include 100,000 clinicians and scientists. Critical care is a specialty that provides care for the sickest of sick – working in intensive care units (ICUs) with patients that often require technological and expensive life-sustaining treatments.

Our Collaborative is extremely excited about the opportunities that exist for healthcare reform to dramatically improve the delivery of end-of-life care to patients with critical illness in the United States. We are distressed to hear discussion of removing improvements in end-of-life care from the agenda in response to misinformation that equates improvements in end-of-life care with rationing care or denying life-sustaining treatments to those who want it. Improving end-of-life care in acute and critical care represents a rare opportunity to improve quality of care and simultaneously reduce costs. Our nation cannot afford to let improving end-of-life care become a casualty of the healthcare reform debate.

Why should critical care societies care about end-of-life care? One in five deaths in the US occurs in the ICU. Studies suggest that when patients and families have earlier and more effective communication about end-of-life care, the result is higher quality end-of-life care that minimizes ineffective life-prolonging treatments and its associated costs and also improves quality of life and reduces symptoms. Consequently, improving the communication about end-of-life care offers us one of those rare opportunities to simultaneously improve quality of care and reduce costs.

We believe healthcare reform has the potential to dramatically improve the quality of end-of-life care in the US and simultaneously reduce costs of care with some simple and straightforward steps.

- Promote thorough and careful completion of advance directives with the guidance of knowledgeable and skilled clinicians in outpatient and community settings and with appropriate review when patients' condition or circumstances change.
- Provide support for training clinicians in effective communication techniques.
- Develop incentives for clinicians, in both inpatient and outpatient settings, to devote time talking with patients, families, and significant others about patients' values, treatment preferences, and goals of care at the end of life and document these discussions so they are available when needed.
- Develop incentives for hospitals and other components of the healthcare system to coordinate advance directives and improve communication about end-of-life care across institutions and settings.

Does this involve withholding life-sustaining treatments from those who request this care? Absolutely not. We support, for anyone who wants it, using all measures

that are indicated and can successfully sustain a person's life. However, much of the rhetoric opposing incorporation of end-of-life care into healthcare reform legislation makes the false assumption that such efforts will result in withholding life-sustaining treatments from those who want such treatment. On the contrary, we believe that healthcare reform can dramatically improve the quality of healthcare for patients with life-limiting illness or injury simply by ensuring that informed patients and families get the care that they would choose if they were fully informed. We also believe that facilitating communication around these difficult issues will likely be a source of great comfort for patients and their loved ones.

Unfortunately, our current system does not allow many patients and families to make informed choices in a timely way, doesn't train clinicians to facilitate these difficult conversations with patients and their families, and doesn't encourage clinicians to take the time to conduct these conversations. Furthermore, our fragmented system means that even if a clinician does take the time to have such a conversation, the information learned from the patient about their values, goals, and treatment preferences are often not disseminated to other clinicians that care for that patient. We firmly believe that improving the quality of care we provide and reducing costs can be accomplished without withholding the desired level of care from anyone. But we need to change the way our healthcare system is organized and the way that clinicians and hospitals prioritize end-of-life care.

We will be missing an enormous opportunity if we allow misinformation to remove improvements in end-of-life care from healthcare reform legislation. We sincerely hope that our government has the wisdom and fortitude to combat misinformation and to retain efforts to improve end-of-life care in the legislation.

J. Randall Curtis, MD, MPH, President, American Thoracic Society
Beth Hammer, RN, MSN, President, American Association of Critical-Care Nurses
Kalpalatha K. Guntupalli, MD, President, American College of Chest Physicians
Mitchell M. Levy, MD, President, Society of Critical Care Medicine