Traumatologia cranica
Aneurismi intracranici

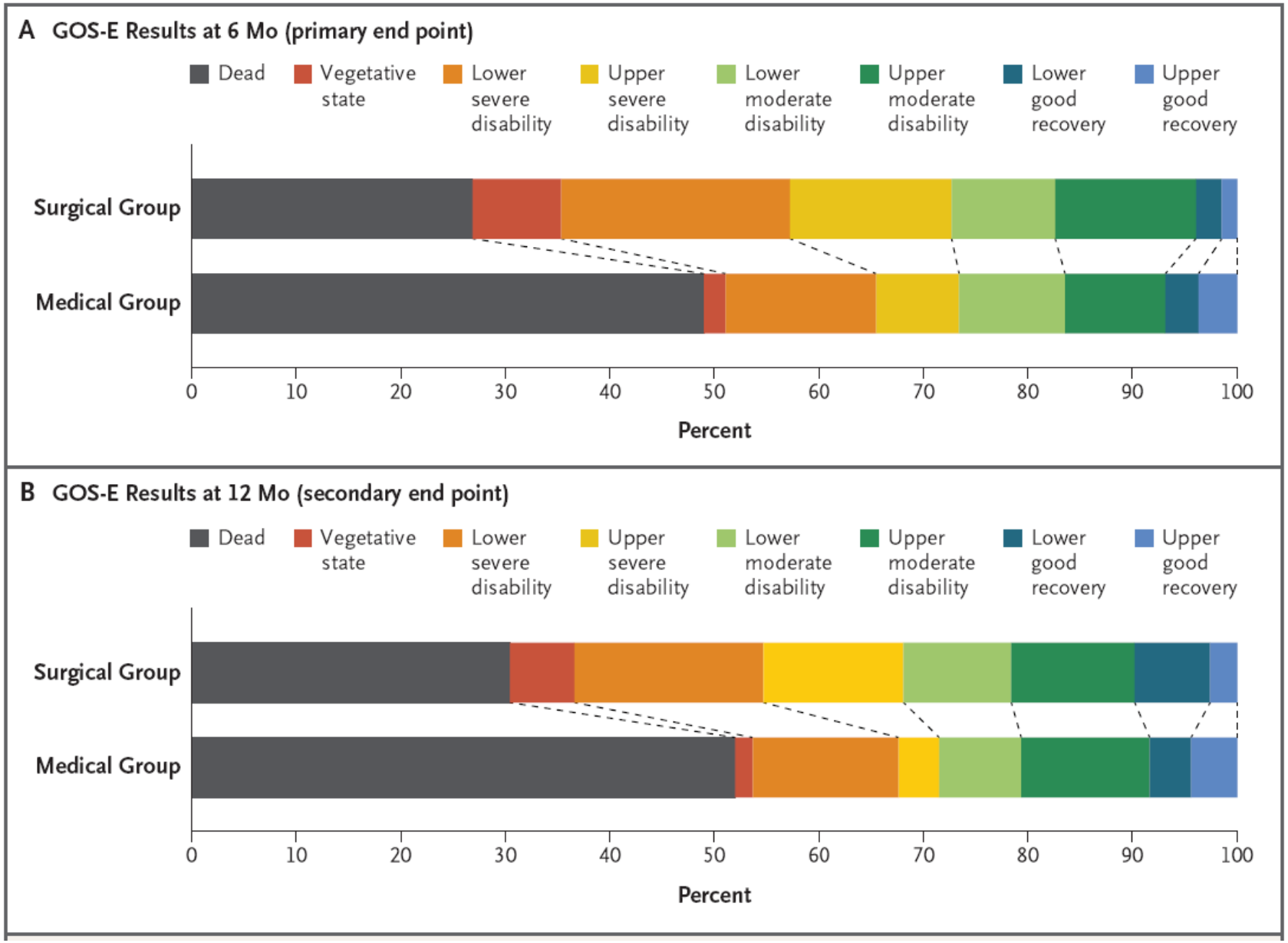
NEURO UPDATE TORINO

9-10 marzo 2017

fine vita nei traumi cranici gravi

Sergio Livigni

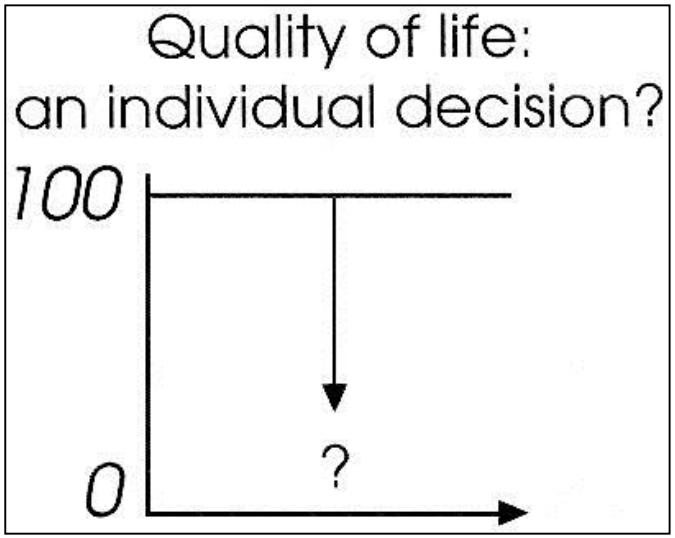
Ospedale San Giovanni Bosco Torino



N Engl J Med 2016;375:1119-30.

Futile care or caregiver frustration? A practical approach

Civetta, Joseph

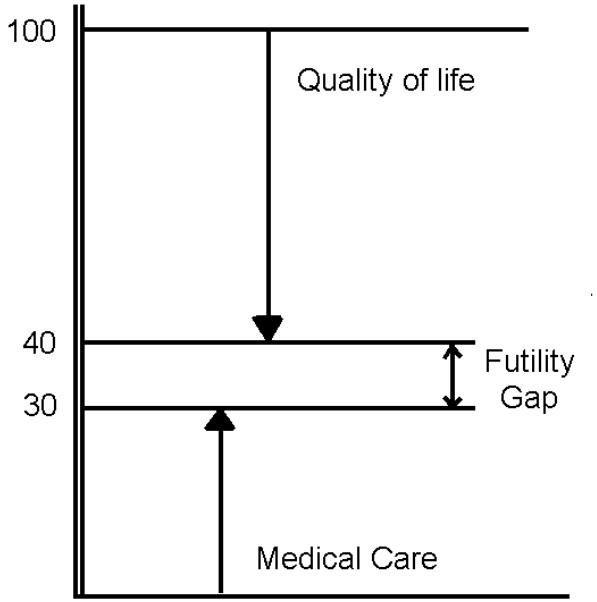


Quality of life can be considered on a 100 to 0 scale to define the lowest level that the patient would accept to justify continuing treatment

Critical Care Medicine. 24(2):346-351, February 1996.

Futile care or caregiver frustration? A practical approach

Civetta, Joseph



futility as a gap between the highest level of functioning achievable by medical care for the patient and the lowest quality of life acceptable to the patient

Critical Care Medicine. 24(2):346-351, February 1996.

Limitazione delle cure

Per LdC s'intende «l'interruzione o il non avvio di trattamenti diagnostici o terapeutici che risultino eticamente sproporzionati e/o clinicamente inappropriati»[10].

Sono "eticamente sproporzionati" i trattamenti che per il malato comportano oneri superiori ai benefici attesi. Gli oneri s'intendono come oggettivi, cioè previsti dalla scienza medica – gli effetti collaterali dei trattamenti – o soggettivi, quelli percepiti come tali dal malato. Sono invece "clinicamente inappropriati" i trattamenti che non corrispondono più ai criteri di efficacia non essendo più in grado di modificare positivamente la prognosi (guarigione o stabilizzazione della malattia).

Recenti Prog Med 2016; 107: 127-139

Limitazione trattamenti *(forgoing):*
non inizio - sospensione
(withholding - withdrawing)

Eticamente equivalenti

Non definibili come pratiche eutanasiche

Documenti SIAARTI 2003 e 2006
EAPC Ethics Task Force 2003

The Principles of Biomedical Ethics

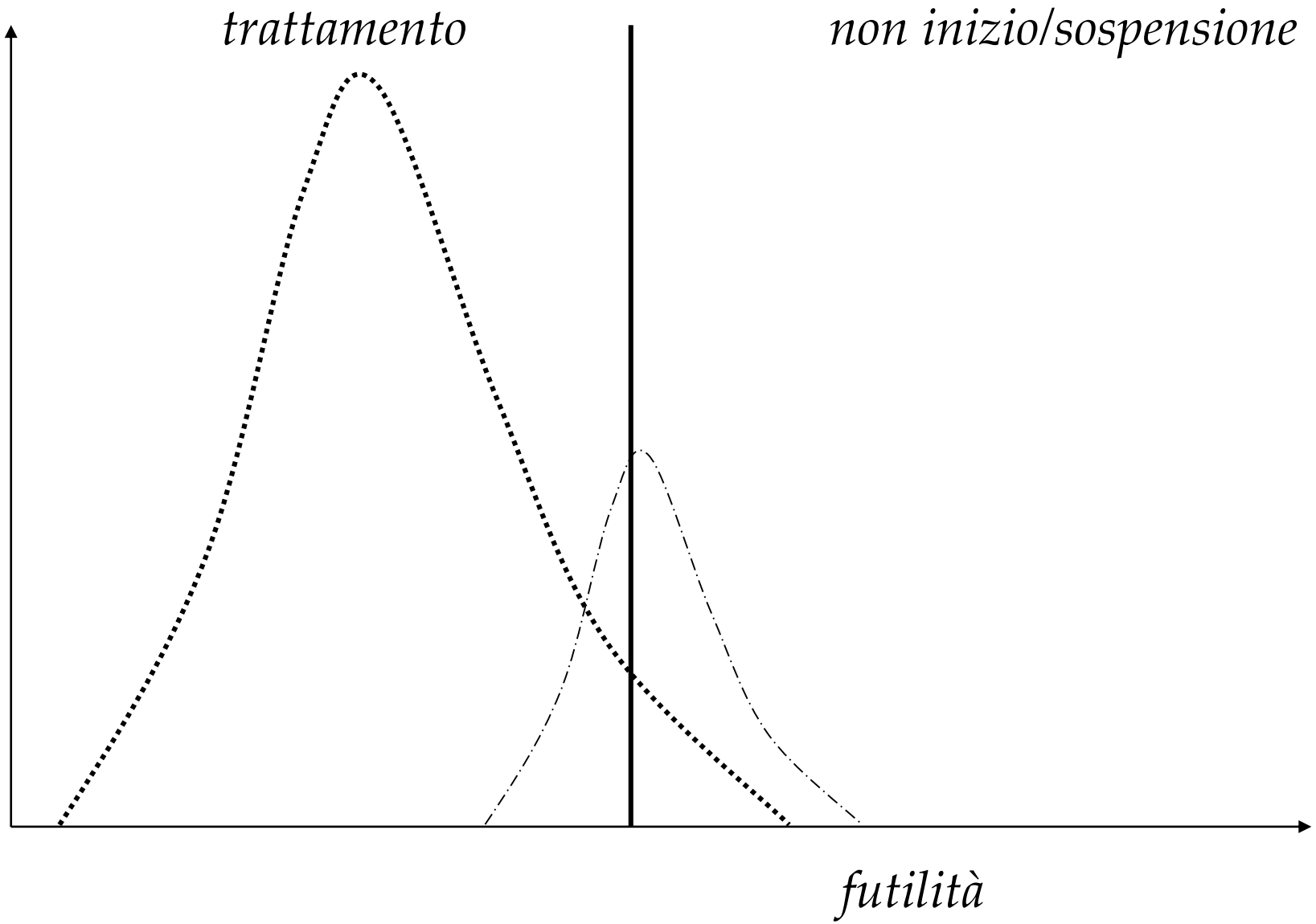
Respect for Autonomy

Nonmaleficence

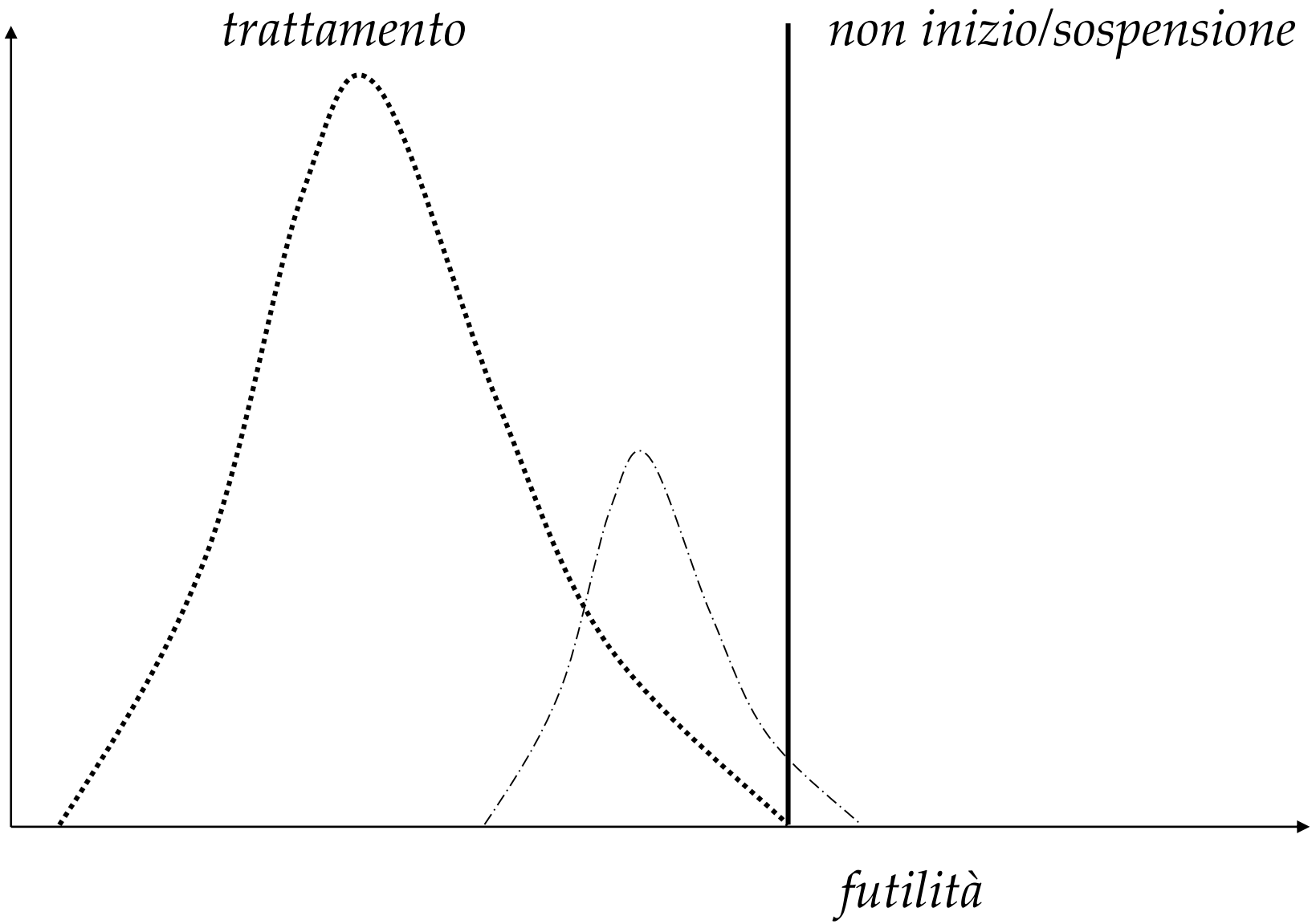
Beneficence

Justice

Beauchamp T. and Childress J., 2001 *"Principles of Biomedical Ethics."* Oxford University Press New York



Trattamento clinicamente ed eticamente inappropriato


trattamento
non inizio/sospensione
futilità
Trattamento clinicamente ed
eticamente inappropriato

Shared Decision Making in ICUs: An American College of Critical Care Medicine and American Thoracic Society Policy Statement

Alexander A. Kon, MD, FCCM[1,2]; Judy E. Davidson, DNP, RN, FCCM[3]; Wynne Morrison, MD, MBE, FCCM[4]; Marion Danis, MD, FCCM[5]; Douglas B. White, MD, MAS[6]

Conclusions: Patient and surrogate preferences for decision-making roles regarding value-laden choices range from preferring to exercise significant authority to ceding such authority to providers. Clinicians should adapt the decision-making model to the needs and preferences of the patient or surrogate. (*Crit Care Med* 2016; 44:188–201)

MAKING SHARED DECISION-MAKING A REALITY

No decision about me, without me

Angela Coulter, Alf Collins

The King's Fund

Foundation for Informed Medical Decision Making

Table 1 Sharing expertise

Clinician's expertise	Patient's expertise
Diagnosis	Experience of illness
Disease aetiology	Social circumstances
Prognosis	Attitude to risk
Treatment options	Values
Outcome probabilities	Preferences

Intensive Care Med (2010) 36:1495–1504
DOI 10.1007/s00134-010-1910-9

ORIGINAL

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End-of-life decision-making and quality of ICU performance: an observational study in 84 Italian units

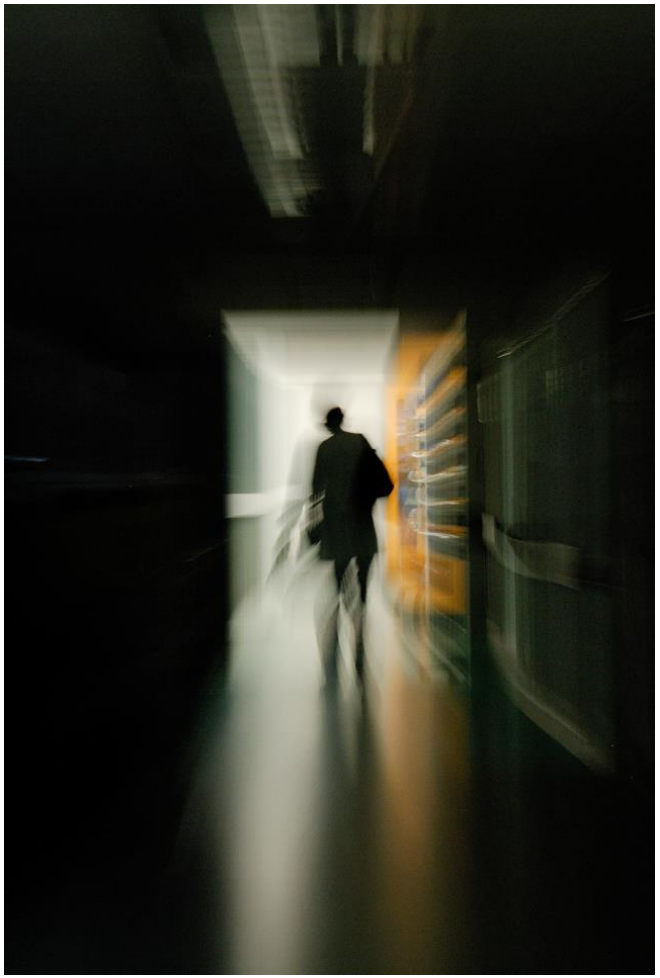

Table 2 (a) Treatment plan chosen for the patient at death or discharge and (b) details of treatment limitation

	All patients (no. = 3,168)		Variability among ICUs[a]
	N	%	Median (%)
(a)			
Therapeutic support, without withdrawal/withhold decisions	1,189	37.5	30.3
Therapeutic support, without cardiopulmonary resuscitation (CPR) in case of cardiac arrest	894	28.2	26.2
Treatment limitation	1,085	34.3	40.6
(b)			
Decision to withhold	494	15.6	12.9
Intubation	85	17.2	26.8
Tracheotomy	40	8.1	25.0
Mechanical ventilation	68	13.8	21.4
Vasoactive drugs IV	269	54.5	69.2
Hemodialysis/hemofiltration	230	46.6	51.7
Surgery	68	13.8	25.0
Transfusions	78	15.8	28.6
Nutrition	41	8.3	20.0
Hydration	7	1.4	15.0
Decision to withdraw	541	17.1	20.0
Mechanical ventilation (terminal weaning without extubation)	154	28.5	32.3
Mechanical ventilation (terminal weaning with extubation)	27	5.0	13.4
Vasoactive drugs IV	377	69.7	66.3
Hemodialysis/hemofiltration	71	13.1	20.0
Transfusions	80	14.8	23.1
Nutrition	98	18.1	34.8
Hydration	22	4.1	17.1

Table 3 Logistic regression model of limitation of therapy

Independent variable	Odds ratio (CI 95%)
Chronic or subacute conditions	
Comorbidities: dementia (yes versus no)	1.9 (1.3–2.8)
Comorbidities: hemiplegia or paraplegia (yes versus no)	1.6 (1.0–2.3)
Comorbidities: moderate/serious hepatopathy (yes versus no)	1.5 (1.1–2.2)
Comorbidities: myocardial infarction (yes versus no)	1.4 (1.1–1.8)
Comorbidities: renal failure (moderate/serious versus mild/no failure)	1.4 (1.1–1.9)
Comorbidities: malignant hematological disease (yes versus no)	1.5 (1.0–2.3)
Comorbidities: metastatic cancer (yes versus no)	2.3 (1.6–3.2)
Comorbidities: cerebral vasculopathy (yes versus no)	1.3 (1.0–1.6)
Diseases at admission: metabolic/postanoxic encephalopathy (yes versus no)	1.5 (1.1–2.1)
Diseases during the stay: metabolic disorder (yes versus no)	0.5 (0.3–0.8)
Acute conditions	
Failures on admission: postanoxic coma (yes versus no)	1.3 (1.0–1.7)
Failures on admission: cardiovascular, nonshock (yes versus no)	1.5 (1.0–2.3)
Diseases at admission: atelectasis (yes versus no)	1.9 (1.2–2.9)
Diseases at admission: peripheral vessel pathology (yes versus no)	1.8 (1.1–2.9)
Diseases at admission: head trauma (yes versus no)	0.7 (0.4–1.0)
Diseases during the stay: severe acute arrhythmia (yes versus no)	0.7 (0.5–0.9)
Diseases during the stay: cerebral edema (yes versus no)	2.9 (1.7–4.9)
Diseases during the stay: sepsis of unknown origin (yes versus no)	0.5 (0.3–0.9)
Diseases during the stay: acute ischemia (yes versus no)	0.3 (0.1–0.9)
Diseases during the stay: metabolic/postanoxic encephalopathy (yes versus no)	2.8 (1.6–4.9)
Patient infected during the stay (yes versus no)	1.5 (1.2–1.9)

Table 3 Logistic regression model of limitation of therapy

Independent variable	Odds ratio (CI 95%)
Hyperacute conditions	
Failures on admission: cardiogenic shock (yes versus no)	0.5 (0.4–0.7)
Failures on admission: hypovolemic/hemorrhagic shock (yes versus no)	0.7 (0.5–0.9)
Diseases at admission: gastrointestinal infarction (yes versus no)	1.7 (1.1–2.9)
Diseases at admission: intracranial bleeding (yes versus no)	1.9 (1.4–2.4)
Diseases at admission: heart failure (yes versus no)	1.4 (1.0–1.8)
Failure during the stay: cardiogenic shock (yes versus no)	0.7 (0.6–1.0)
Diseases during the stay: acute myocardial infarction (yes versus no)	0.2 (0.1–0.7)
Environmental	
ICU location: central versus northern Italy	0.4 (0.3–0.5)
ICU location: southern versus northern Italy	0.3 (0.2–0.4)
Urbanization level of ICU seat: city versus town (<15,000 inhabitants)	1.7 (1.3–2.0)
Urbanization level of ICU seat: metropolis (>500,000 inhabitants) versus town	1.4 (1.1–1.8)
Bed number of ICU: 6–10 versus 1–5	0.8 (0.7–1.0)
Bed number of ICU: >10 versus 1–5	0.3 (0.2–0.4)

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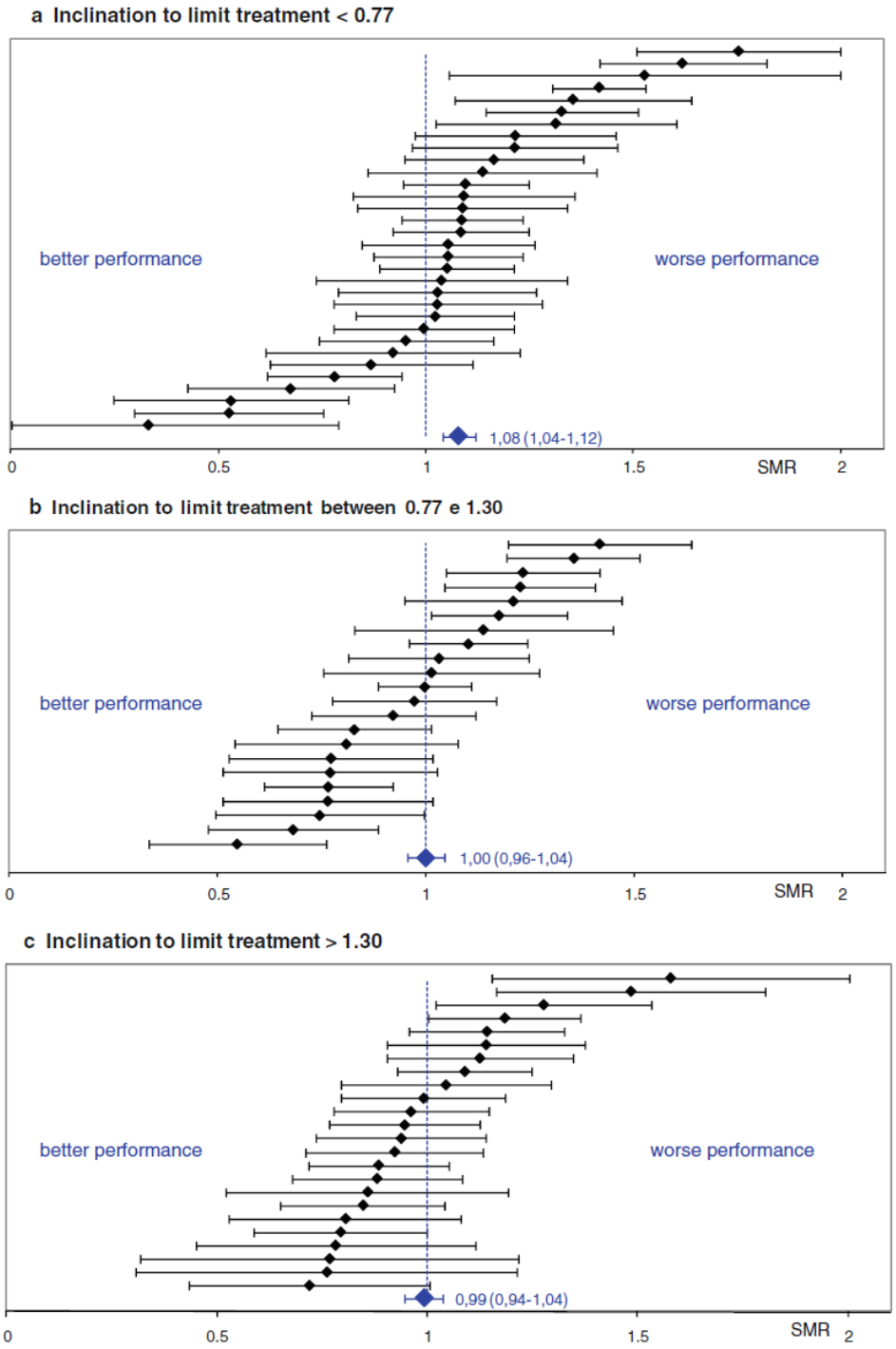
End-of-life decision-making and quality of ICU performance: an observational study in 84 Italian units

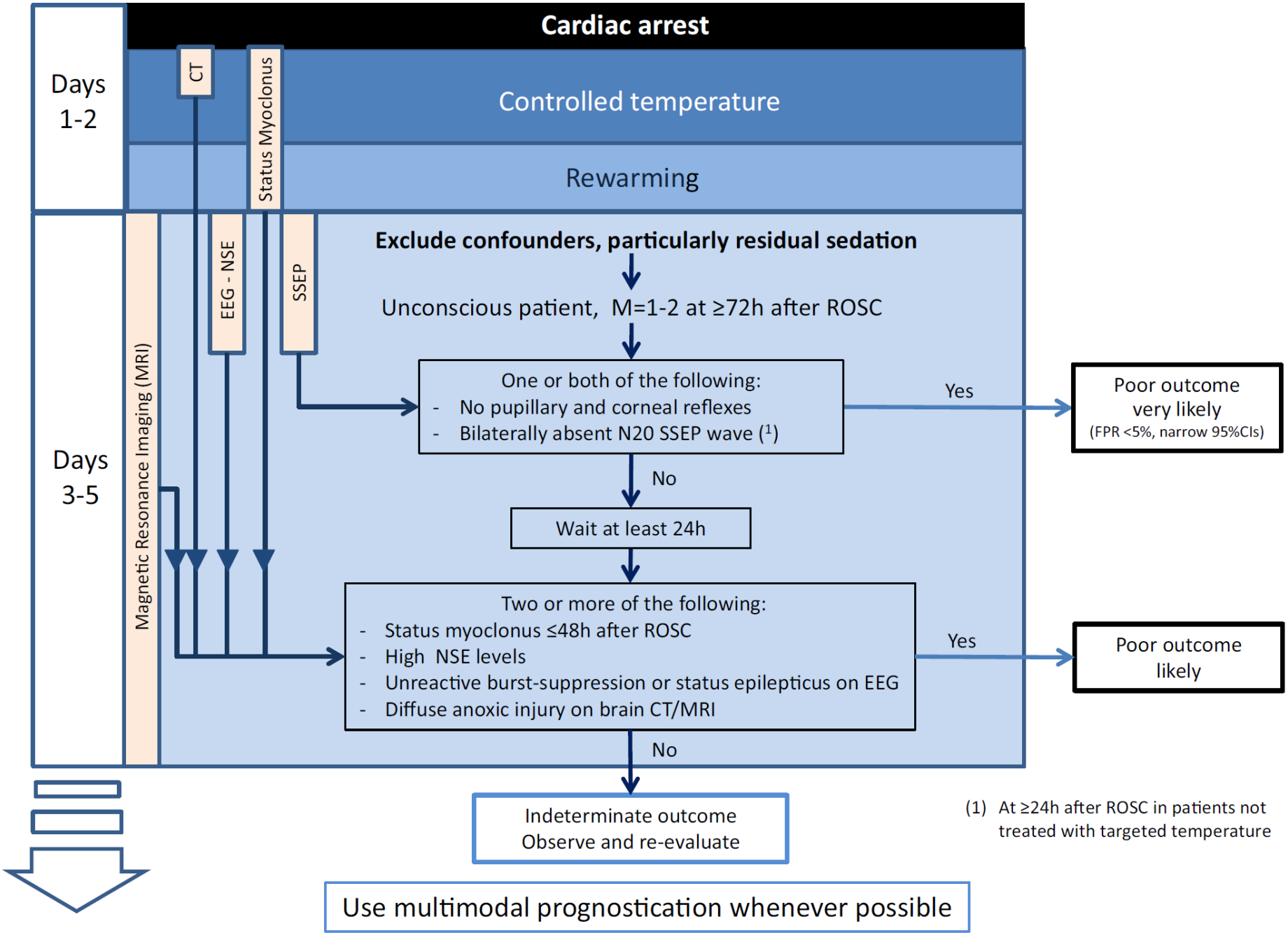
Conclusioni:
Una limitazione del trattamento è comune in Terapia Intensiva ed è principalmente responsabilità del medico. Le Terapie Intensive inclini a limitare meno i trattamenti presentano peggiori performance in termini di mortalità totale, dimostrando che la limitazione non è contro gli interessi del paziente.
Al contrario, la tendenza a limitare i trattamenti alla fine della vita può essere presa come un'indicazione di qualità nella unità.



End-of-life decisions in patients with severe acute brain injury

Marjolein Geurts, Malcolm R Macleod, Ghislaine J M W van Thiel, Jan van Gijn, L Jaap Kappelle, H Bart van der Worp

Most in-hospital deaths of patients with stroke, traumatic brain injury, or postanoxic encephalopathy after cardiac arrest occur after a decision to withhold or withdraw life-sustaining treatments. Decisions on treatment restrictions in these patients are generally complex and are based only in part on evidence from published work. Prognostic models to be used in this decision-making process should have a strong discriminative power. However, for most causes of acute brain injury, prognostic models are not sufficiently accurate to serve as the sole basis of decisions to limit treatment. These decisions are also complicated because patients often do not have the capacity to communicate their preferences. Additionally, surrogate decision makers might not accurately represent the patient's preferences. Finally, in the acute stage, prediction of how a patient would adapt to a life with major disability is difficult.


Cardiac arrest
Days 1-2
CT
Status Myoclonus
Controlled temperature
Rewarming
Days 3-5
Magnetic Resonance Imaging (MRI)
EEG - NSE
SSEP
Exclude confounders, particularly residual sedation
Unconscious patient, M=1-2 at ≥72h after ROSC
One or both of the following:
- No pupillary and corneal reflexes
- Bilaterally absent N20 SSEP wave (1)
Yes
Poor outcome very likely
(FPR <5%, narrow 95%CIs)
No
Wait at least 24h
Two or more of the following:
- Status myoclonus ≤48h after ROSC
- High NSE levels
- Unreactive burst-suppression or status epilepticus on EEG
- Diffuse anoxic injury on brain CT/MRI
Yes
Poor outcome likely
No
Indeterminate outcome
Observe and re-evaluate
(1) At ≥24h after ROSC in patients not treated with targeted temperature
Use multimodal prognostication whenever possible

	Factors included in model	Time of assessment	Predicted outcome	Predictive values
Ischaemic stroke[29]	Age, stroke severity (NIHSS), lacunar infarct, history of stroke, history of diabetes, and prestroke disability*	First 6 h	Poor outcome at three months (NIHSS ≥20 or death, BI <60 or death, and GOS 1–3)†	AUC 0·75–0·89[30]
Ischaemic stroke[31]	Age and stroke severity (NIHSS)	First 6 h	(A) Incomplete functional recovery (BI <95) or death and (B) case fatality after 100 days	AUC (A) 0·81[32] and (B) 0·71[32]
ICH[33]	ICH score: level of consciousness (GCS), ICH volume, intraventricular haemorrhage, location (supratentorial *vs* infratentorial), and age	Initial assessment	Case fatality at 30 days	AUC 0·88[34]
ICH[35]	FUNC score: ICH volume, age, ICH location (supratentorial *vs* infratentorial), level of consciousness (GCS), and pre-ICH cognitive impairment	Initial assessment	Poor outcome (GOS 1–3) at 90 days	AUC 0·82[35]
Subarachnoid haemorrhage[36,37]	WFNS scale:‡ level of consciousness (GCS) and presence of motor deficit	Admission	Unfavourable outcome (GOS 1–3) at 3 months	AUC 0·82[38]
Subarachnoid haemorrhage[39]	Hunt and Hess Scale: clinical symptoms, level of consciousness (GCS), and presence of motor deficit	Admission	In-hospital case fatality	AUC 0·77[40]
Traumatic brain injury[41]	CRASH CT model: age, level of consciousness (GCS), pupil reactivity, presence of major extracranial injury, and findings on cranial CT	First 8 h	(A) Death at 14 days and (B) unfavourable outcome at 6 months (GOS 1 – 3)	AUC (A) 0·71–0·87[42] and (B) 0·71[42]
Traumatic brain injury[43]	IMPACT extended model: age, motor score, pupillary reactivity, hypoxia, hypotension, CT characteristics, glucose, and haemoglobin	First few hours	(A) Unfavourable outcome (GOS 1–3) at 6 months and (B) mortality at 6 months	AUC (A) 0·71–0·86[42] and (B) 0·71[42]
Postanoxic encephalopathy[44]	Absence of pupillary and corneal reflexes	At 72 h	Death or persisting unconsciousness at 1 month	False-positive rate 0% (95% CI 0–9)
Postanoxic encephalopathy[44]	Bilateral absence of the N20 component of the SSEP	At 24 h	Death or persisting unconsciousness at 1 month	False-positive rate 0% (95% CI 0–4)
Postanoxic encephalopathy, treated with hypothermia[45]	Bilateral absence of the N20 component of the SSEP	After rewarming to normothermia (≤72 h)	Poor outcome (GOS 1–3) at 6 months	False-positive rate 0% (95% CI 0–18)

REVIEW

Intersection of prognosis and palliation in neurocritical care

Michael Rubin[a], Jordan Bonomo[b], and J. Claude Hemphill III[c]

KEY POINTS

- The use of early care limitations such as DNR orders or withdrawal of life support can lead to the self-fulfilling prophecy of poor outcome.
- A shared decision-making model of communication between families and medical providers may optimize challenging decisions regarding end-of-life care.
- Palliative care is an important skill for neurocritical care providers.
- Standardized definitions for determination of death by neurological criteria are important to reduce heterogeneity.
- New technologies such as ECMO are creating novel ethical questions regarding the definition and timing of death.

neurocritical care society Neurocrit Care
DOI 10.1007/s12028-015-0137-6

CrossMark

REVIEW ARTICLE

Recommendations for the Critical Care Management of Devastating Brain Injury: Prognostication, Psychosocial, and Ethical Management

A Position Statement for Healthcare Professionals from the Neurocritical Care Society

Michael J. Souter[1] · Patricia A. Blissitt[2,3] · Sandralee Blosser[4,5] · Jordan Bonomo · David Greer[8] · Draga Jichici[9] · Dea Mahanes[10] · Evie G. Marcolini[11] · Charles Miller[12] · Kiranpal Sangha[13] · Susan Yeager[14]

Recommendations

- We recommend determining prognosis from repeated examinations over time to establish greater confidence and accuracy (*strong recommendation, moderate quality of evidence*).
- We recommend applying these guidelines in the early stages of DBI treatment in order to maintain physiologic stability, even when early limitation of aggressive care is being considered. Such early implementation prevents unwarranted deterioration and allows sufficient opportunity for prognostic evaluation, care planning, and consideration of organ donation (*strong recommendation, moderate quality of evidence*).
- We recommend using a 72-h observation period to determine clinical response and delaying decisions regarding withdrawal of life-sustaining treatment in the interim (*strong recommendation, moderate quality of evidence*).

Recommendations

- We recommend the use of appropriate analgesic and sedative medication in DBI patients to relieve undue suffering regardless of secondary circumstances, such as futility, organ donation, and need for prognostication (*strong recommendation, expert opinion*).
- We recommend that palliative sedation should not exclude the possibility of organ donation (*strong recommendation, expert opinion*).

- In the absence of evidence to the contrary, we recommend that DBI patients should be resuscitated in an attempt to respect autonomy (*strong recommendation, expert opinion*).

- We recommend that clinicians respect legitimate directives to restrict resuscitative efforts in DBI patients (*strong recommendation, expert opinion*).

Recommendation

- The consent for initial resuscitation ought to be assumed unless there is a pre-existing known objection and should not be dependent on organ donor status (*strong recommendation, expert opinion*).

- We recommend that notification of DBI patient donor status during the resuscitative period, if done, should not alter resuscitative efforts (*strong recommendation, expert opinion*).

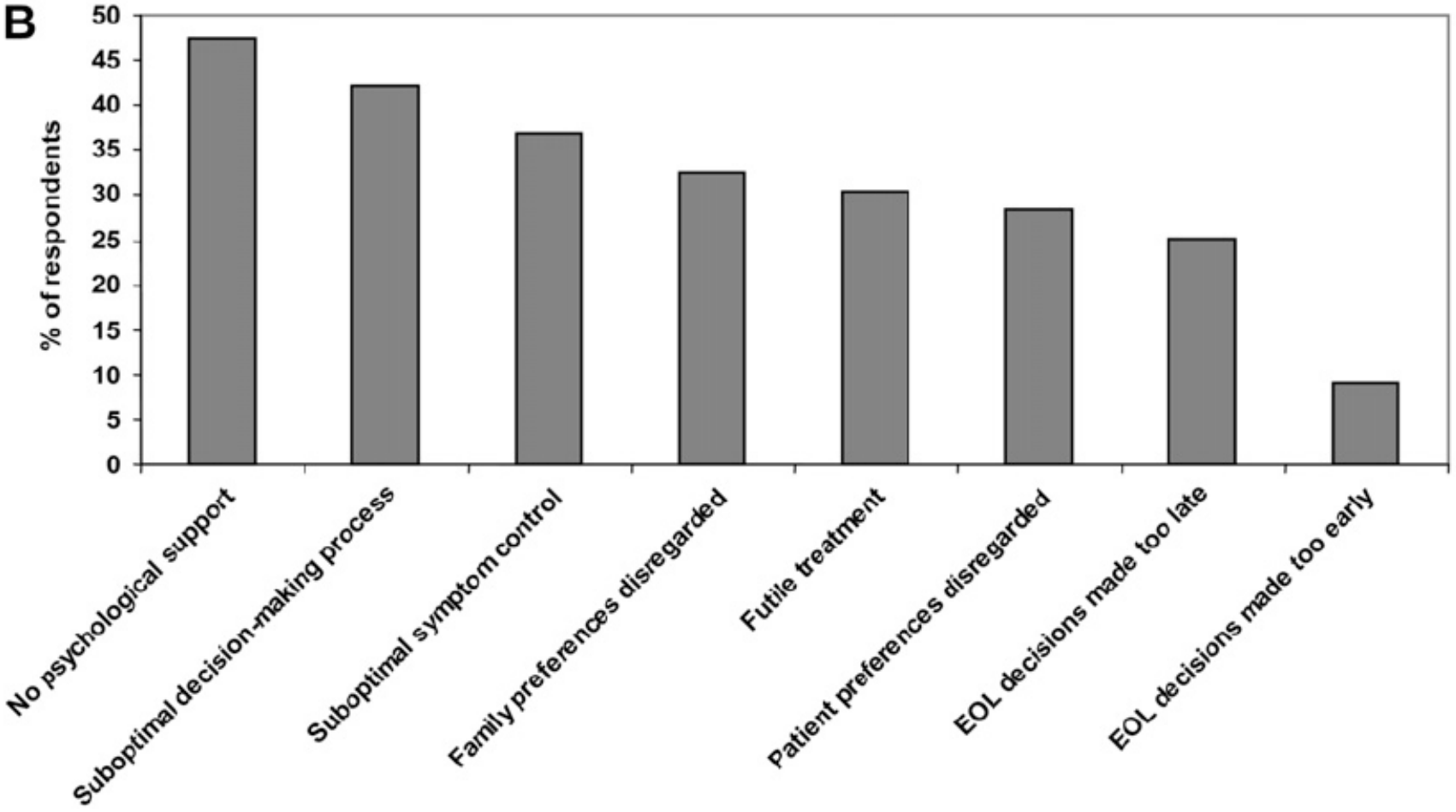
- We recommend that the resuscitation of the DBI patient should not be dependent on the possibility of organ donation (*strong recommendation, expert opinion*).

- We recommend that if resuscitative efforts are futile and no option for organ donation exists, there is no prima facie obligation to continue to resuscitate the DBI patient (*strong recommendation, expert opinion*).

Prevalence and Factors of Intensive Care Unit Conflicts

The Conflicus Study

Élie Azoulay[1], Jean-François Timsit[2], Charles L. Sprung[3], Marcio Soares[4], Kateřina Rusinová[5], Ariane Lafabrie[1], Ricardo Abizanda[6], Mia Svantesson[7], Francesca Rubulotta[8], Bara Ricou[9], Dominique Benoit[10], Daren Heyland[11], Gavin Joynt[12], Adrien Français[2], Paulo Azeivedo-Maia[13], Radoslaw Owczuk[14], Julie Benbenishty[3], Michael de Vita[15], Andreas Valentin[16], Akos Ksomos[17], Simon Cohen[18], Lidija Kompan[19], Kwok Ho[20], Fekri Abroug[21], Anne Kaarlola[22], Herwig Gerlach[23], Theodoros Kyprianou[24], Andrej Michalsen[25], Sylvie Chevret[26], and Benoît Schlemmer[1], for the Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine*



Am J Respir Crit Care Med Vol 180. pp 853–860, 2009

AF

- **62 anni**, **Femmina**
- 70 kg, 170 cm, BMI 24

APR

- **Nessuna** Patologia nota

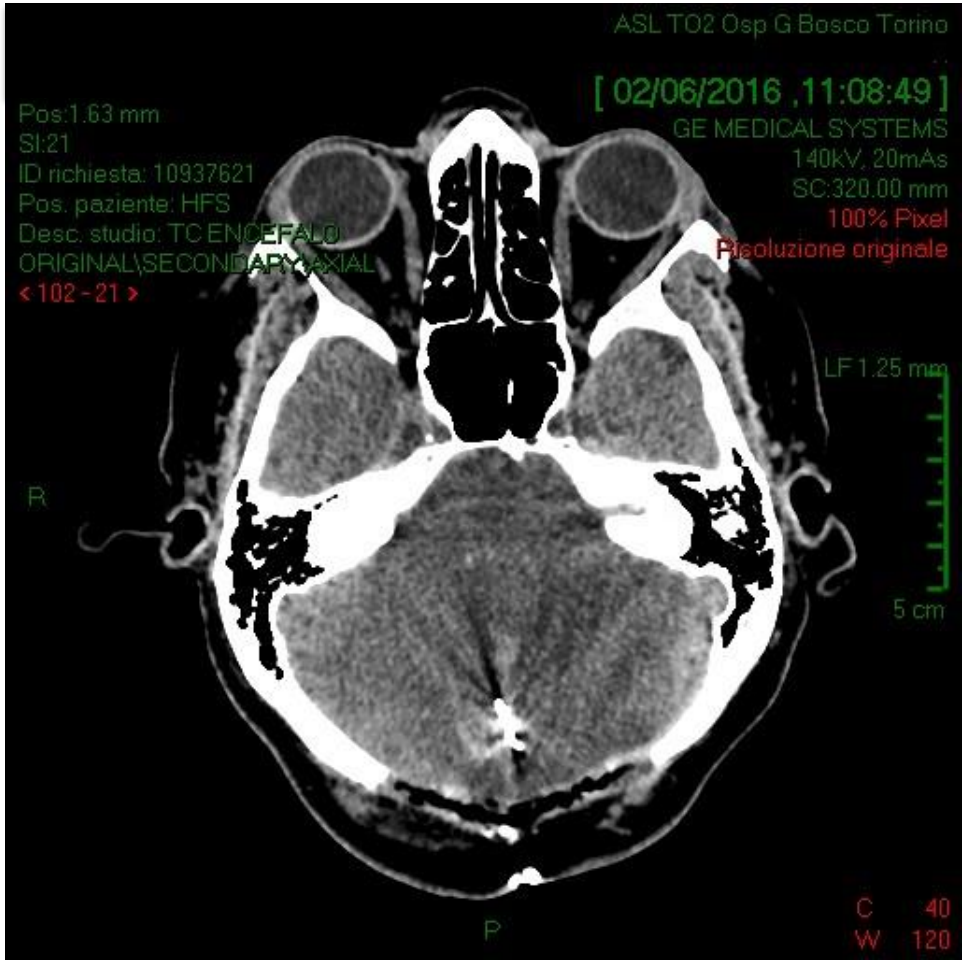
APP

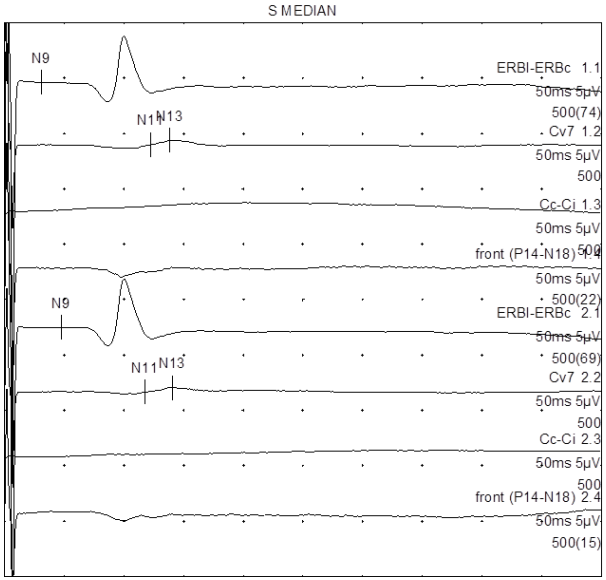
- **Danno cerebrale catastrofico** da emorragia intracranica massiva
- **Assenza di coscienza** e di **riflessi del tronco encefalico**
- **Minima attività elettrica residua all'EEG**

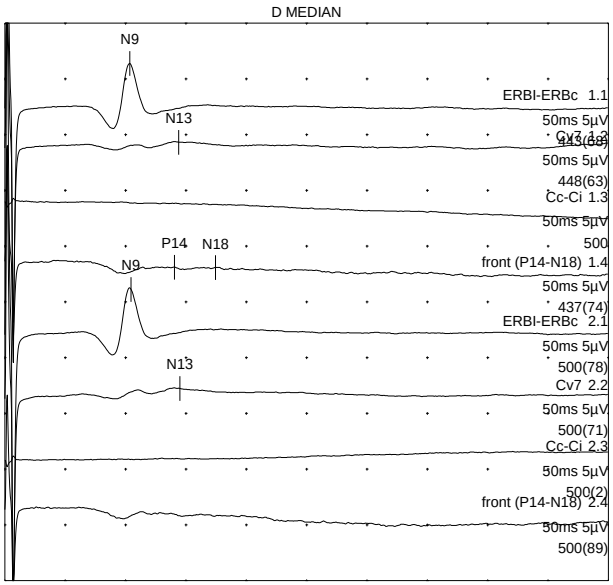
- Emorragia in fossa cranica posteriore da sanguinamento di MAV + aneurisma PICA sx

- Ritrovata in PEA da 118 → ACLS con ROSC all'arrivo in ospedale dopo 32 minuti di RCP

- Evacuazione ematoma intracranico + clipping di aneurisma e chiusura di MAV







POTENZIALI EVOCATI SOMATOSENSORIALI DEL N. MEDIANO

Stimolazione elettrica del n. mediano al polso bilat. con derivazione al punto di Erb con riferimento al controlaterale, a livello Cv7 con riferimento al punto di Erb, a livello parietale sia con riferimento cefalico che extracefalico ed a livello frontale con riferimento extracefalico.

Sono presenti bilat. le risposte plessulare e cervicale con valori di latenza nella norma.

Assenti le risposte corticali e sottocorticali bilat.

CONCLUSIONE: Segni elettrici di gravi anomalie della conduzione nervosa lungo la via somestesica bilat. a localizzazione centrale.

s HF: 30.0 Hz Notch: Y15.0 m

[Sens: 2.0 TC: 0.10 s HF: 30.0 Hz Notch: Y15.0 mm/s]
09.49.55 (00.01.29)

Registrazione EEG a montaggio semplificato -

Persistenza di attività bioelettrica > di 2 µV in sede occipitale > sin. - Dopo stimolo nocicettivo comparsa per breve periodo di attività lenta di ridottissimo voltaggio in sede temporale sinistra -

In conclusione: gravi anomalie EEG diffuse con persistenza di minima attività focale.

MKR

Pz-T4

T4-C4

C4-O2

Fp1-T3

T3-C3

C3-O1

REGIONE PIEMONTE ASL TO2
P.O. Torino Nord Emergenza
San Giovanni Bosco 010011
S.C. Neurologia - 3201
Dr. Roberto CAVALLO
869

A.S.L. TO2
Azienda Sanitaria Locale
Torino Nord

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Piazza del Donatore di sangue 3 - Torino,10154
S.C. ANESTESIA RIANIMAZIONE B DEA
Tel 011-240.22.65 Fax 011-240.24.02
ospedale.rianimazione@aslto2nord.it

nome e cognome del paziente.....

Vi preghiamo di lasciare qui di seguito il Vostro numero di telefono e il Vostro nome, in modo che, se fosse necessario, potremmo contattarVi facilmente.

prima persona da chiamare.....numero.....

altri numeri.....

Ci sono notizie sullo stato di salute e sulle abitudini del Vostro congiunto che possono esserci utili. Vi preghiamo di rispondere, se possibile, alle seguenti domande. *Sapete se il Vostro congiunto:*

assume farmaci?.....	si	no	se si, quali.....
è allergico a qualche farmaco?.....	si	no	se si, quale.....
ha avuto qualche malattia particolare?.....	si	no	se si, quale.....
a casa la sua salute era: *eccellente; molto buona; buona; passabile; scadente*			
fuma?.....	si	no	se si, quanto.....
beve alcolici?.....	si	no	se si, quanto.....
fa utilizzo di droghe?.....	sì	no	
lo ha fatto in passato?.....	sì	no	
è autosufficiente nelle sue attività quotidiane?.....	si	no	
ha problemi nel camminare?.....	si	no	
ha problemi di vista?	si	no	

potrebbe desiderare assistenza religiosa?... sì no di che religione?.....

ha fatto testamento biologico?..... si no

è favorevole alla donazione degli organi?.... si no

data e firma.....

assume farmaci?..... si ~~no~~ se si, quali.....

è allergico a qualche farmaco?..... si ~~no~~ se sì, quale.....

ha avuto qualche malattia particolare?..... si ~~no~~ se sì, quale.....

a casa la sua salute era: *eccellente; molto buona; buona; passabile; scadente*

fuma?..... ~~si~~ no se sì, quanto 1 PACCHETTO / GIORNO

beve alcolici?..... si ~~no~~ se sì, quanto.....

fa utilizzo di droghe?..... sì ~~no~~

lo ha fatto in passato?..... sì ~~no~~

è autosufficiente nelle sue attività quotidiane?..... ~~si~~ no

ha problemi nel camminare?..... si ~~no~~

ha problemi di vista?..... si ~~no~~

ha problemi di udito?..... si ~~no~~

è mancino? (per es: scrive con la mano sinistra)..... si ~~no~~

potrebbe desiderare assistenza religiosa?... ~~si~~ no di che religione? CATTOLICA

ha fatto testamento biologico?..... si ~~no~~

è favorevole alla donazione degli organi?.... ~~si~~ no

data e firma 01/06/16

cDCD

Category	Description	Type
I Uncontrolled Unwitnessed	Sudden unexpected irreversible CA; no attempt of resuscitation by a medical team,	Uncontrolled
II Uncontrolled Witnessed	Sudden unexpected irreversible CA; unsuccessful resuscitation by a medical team	Uncontrolled
III Controlled awaiting CA	**Planned, expected CA; withdrawal of life sustaining treatment (WLST)**	**Controlled**
IV Alternative death determination	IV-A Sudden or planned CA during or after brain death diagnosis, before retrieval IV-B Death diagnosis during ECMO-ECLS by circulatory (DCD) or neurological (DBD) criteria	IV-A Uncontrolled or controlled IV-B Partially controlled

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REVIEW

Ethical, legal, and societal issues and recommendations for controlled and uncontrolled DCD

Bernadette Haase,[1] Michael Bos,[2] Catherine Boffa,[3] Penney Lewis,[4] Chris Rudge,[5] Ricard Valero,[6] Tineke Wind[7] and Linda Wright[8]

Recommendation 2:

As the basis of any DCD program, there should be a clear medical, ethical and legal framework outlining when and how to decide on withdrawing or withholding life-sustaining treatment, or on the cessation of CPR. This should be based on the patient's best interests. In making these decisions each action involving that patient is justified by balancing the potential benefits and harms to that patient, also taking into account his or her wish to donate.

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Patients in a Persistent Vegetative State — A Dutch Perspective

Inez de Beaufort, Ph.D.

32

250

5000

n engl j med 352;23 www.nejm.org june 9, 2005

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AN ASSESSMENT OF THE COURT'S ROLE IN THE WITHDRAWAL OF CLINICALLY ASSISTED NUTRITION AND HYDRATION FROM PATIENTS IN THE PERMANENT VEGETATIVE STATE

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ABSTRACT

In this article, we reassess the court's role in the withdrawal of clinically assisted nutrition and hydration from patients in the permanent vegetative state (PVS), focussing on cases where health-care teams and families agree that such is in the patient's best interest. As well as including a doctrinal analysis, the reassessment draws on empirical data from the families of patients with prolonged disorders of consciousness, on economic data about the costs of the declaratory relief process to the National Health Service (NHS), and on comparative legal data about the comparable procedural requirements in other jurisdictions. We show that, following the decision in the *Bland* case, the role of the Court of Protection is now restricted to the direct supervision of the PVS diagnosis as a matter of proof. We argue that this is an inappropriate role for the court, and one that sits in some tension with the best interests of patients. The blanket requirement of declaratory relief for all cases is economically expensive for the NHS and thus deprives other NHS patients from health care. We demonstrate that many of the ancillary benefits currently offered by declaratory relief could be achieved by other means. Ultimately, we suggest that reform to the declaratory relief requirement is called for.

KEYWORDS: Disorders of consciousness, PVS, Life-sustaining treatment, Best interests, Court of Protection, Declaratory relief

ALLEGATO

Norme in materia di consenso informato e di dichiarazioni di volontà anticipate nei trattamenti sanitari. C. 1142 Mantero, C. 1298 Locatelli, C. 1432 Murer, C. 2229 Roccella, C. 2264 Nicchi, C. 2996 Binetti, C. 3391 Carloni, C. 3561 Miotto, C. 3584 Nizzi, C. 3586 Fucci, C. 3596 Calabrò, C. 3599 Brignone, C. 3630 Iori, C. 3723 Marzano, C. 3730 Marazziti e C. 3970 Silvia Giordano.

TESTO UNIFICATO ELABORATO DAL COMITATO RISTRETTO ADOTTATO COME TESTO BASE

While the diagnosis of pneumonia may or may not be correct, the risk that true pneumonia will develop is never increased by its diagnosis. In contrast, the risk of dying is increased by the primary diagnosis of dying.

Hilton *et al*. *Critical Care* 2013, **17**:224
http://ccforum.com/content/17/2/224

“The success of intensive care is not to be measured only by the statistics of survival, as though each death were a medical failure. It is to be measured by the quality of lives preserved or restored; and by the quality of the dying of those in whose interest it is to die.”

G. R. Dunstan, Professor of Moral and Social Theology, 1995