

Symposium, Saal 1
06.12.2018, 14:30 – 16:00
Die Diktatur des positiven Denkens - Oder Aufrichtigkeit und Hoffnung? Wie gehen wir damit um, wenn nicht alles gut wird.

Vorsitzende

Hilmar Burchardi, Göttingen

Gerald Neitzke, Hannover

Präsentation

Der Intensivmediziner Uwe Janssens , Eschweiler	14:30
Der Onkologe Norbert Frickhofen, Wiesbaden	15:00
Philosophische Aspekte Elke Muhl, Lübeck	15:30



Die Diktatur des positiven Denkens - Oder Aufrichtigkeit und Hoffnung? Wie gehen wir damit um, wenn nicht alles gut wird...

Der Intensivmediziner

Prof. Dr. med. Uwe Janssens, Eschweiler

Zwischen 2003 und 2018 Vorträge auf Honorarbasis für

Lilly, Abott, Astra
Zeneca, Sanofi-
Aventis, Mitsubishi,
Bristol-Myers
Squibb, Pfizer,
Novartis,
LifeBridge, Pulsion,
Servier, Bayer

Kein Honorar
Alle Honorare der
letzten Jahre auf
DM Konto
seit 2017 kein
Vortragshonorar

Reisekosten-
unterstützung durch
DIVI
(Hotelkosten,
Reise)

Keine Aktien
Keine
Beraterverträge
**Keine weiteren
Conflicts of
interest**

Das Experiment 1957 durch Curt Richter

Die wilden Ratten machten die Erfahrung, dass Rettung möglich ist

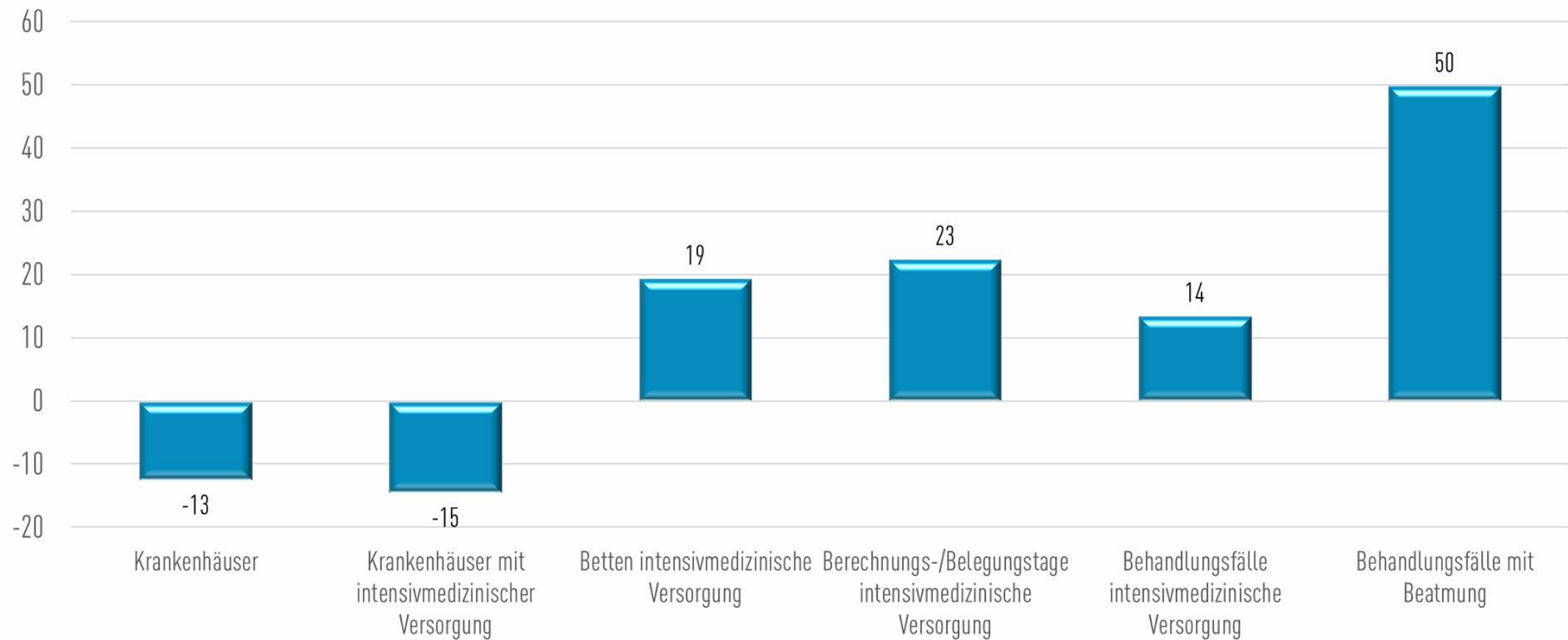
Man hatte ihnen etwas mächtiges gegeben, das sie tagelang durchhalten ließ: Die Hoffnung

AGENDA



- Intensivmedizin – unbegrenzte Möglichkeiten
- Ausufernde Therapie: Epidemiologie und Gründe
- Lösungsansätze

Gesundheitsberichterstattung des Bundes 2002 bis 2016



Bevölkerungsentwicklung und Altersstruktur

Bundeszentrale für politische Bildung (Zugriff 24.57.2018)

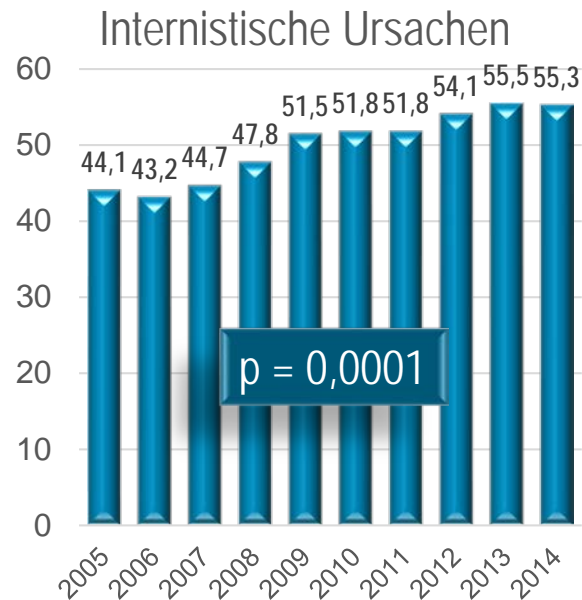
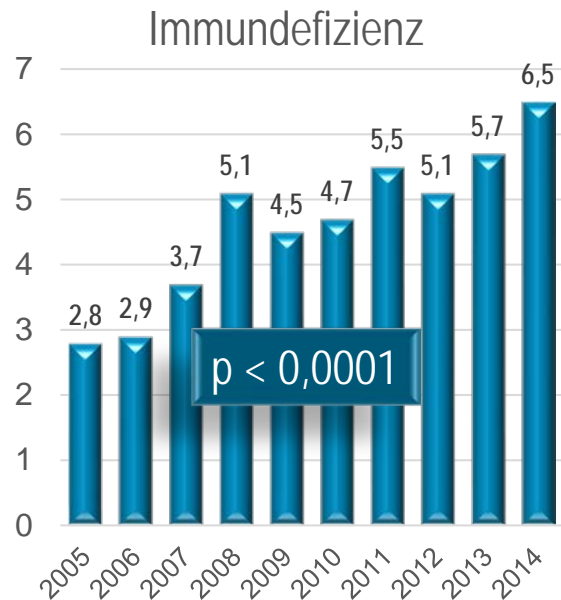
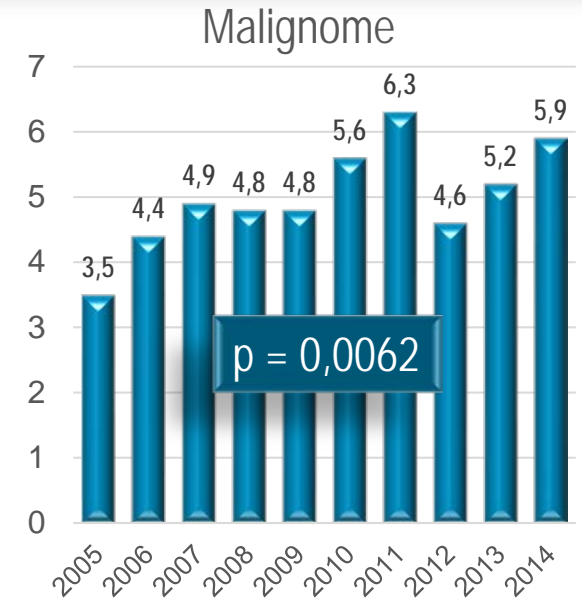
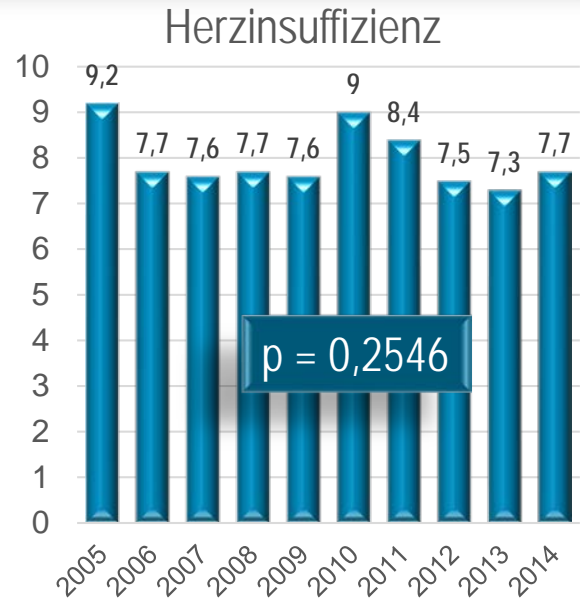
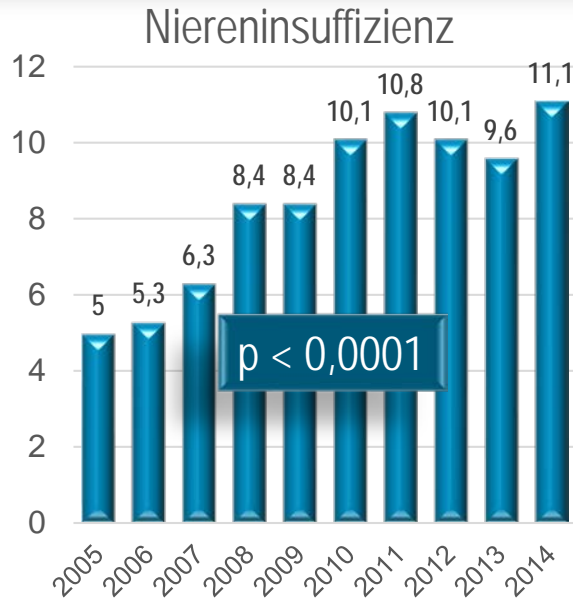
Hochbetagte
(> 80-
jährige)

- 2013: 4,4 Millionen
- 2050: 9,9 Millionen

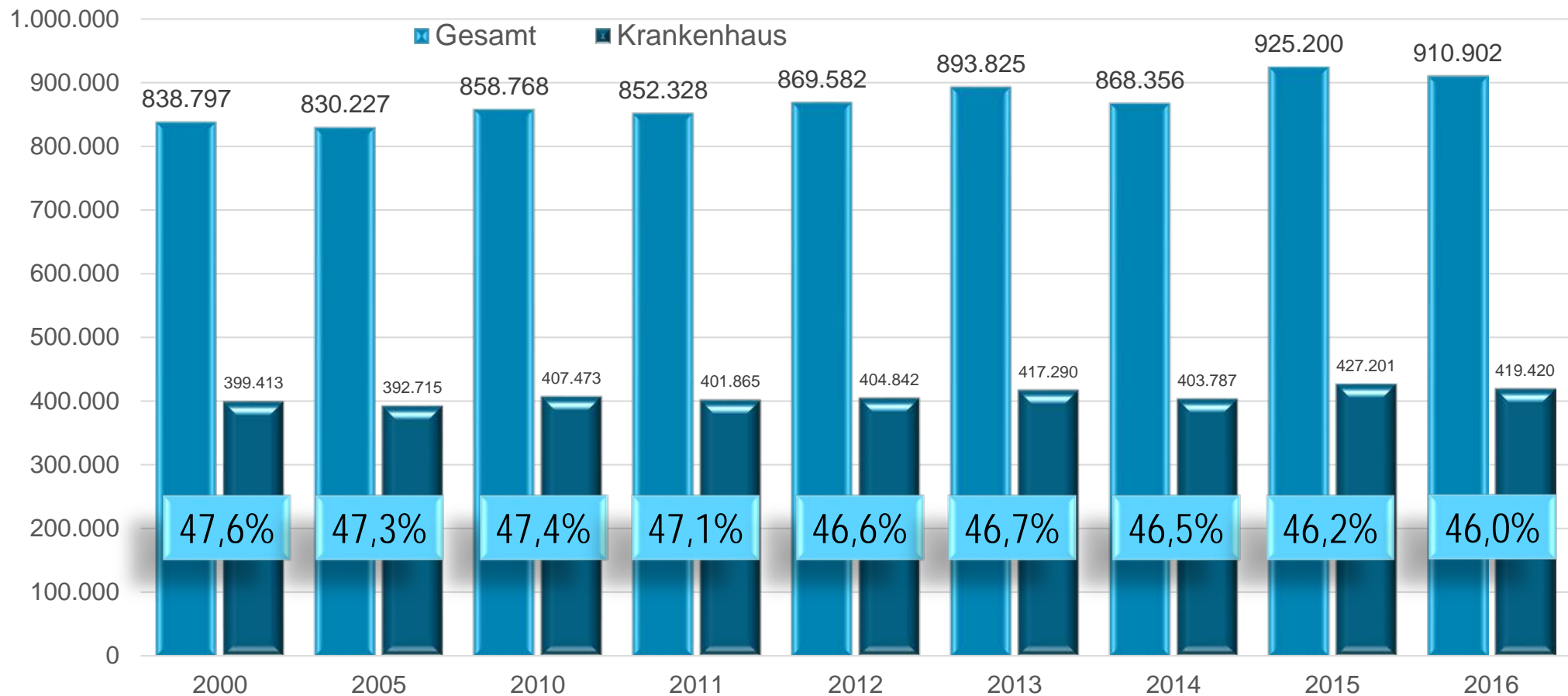
2060: Jede achte Person > 80 Jahre
(12,3%)

2060: Fast jede dritte Person > 60 Jahre

Anteil ICU Patienten ≥ 80 Jahre (NL) : Komorbiditäten



Sterben in Deutschland – wo?



Sterbeort Intensivstation

13% aller
Sterbefälle

25% aller
Sterbefälle im
Krankenhaus

Im Jahr 2016
2.162.221
Behandlungsfälle

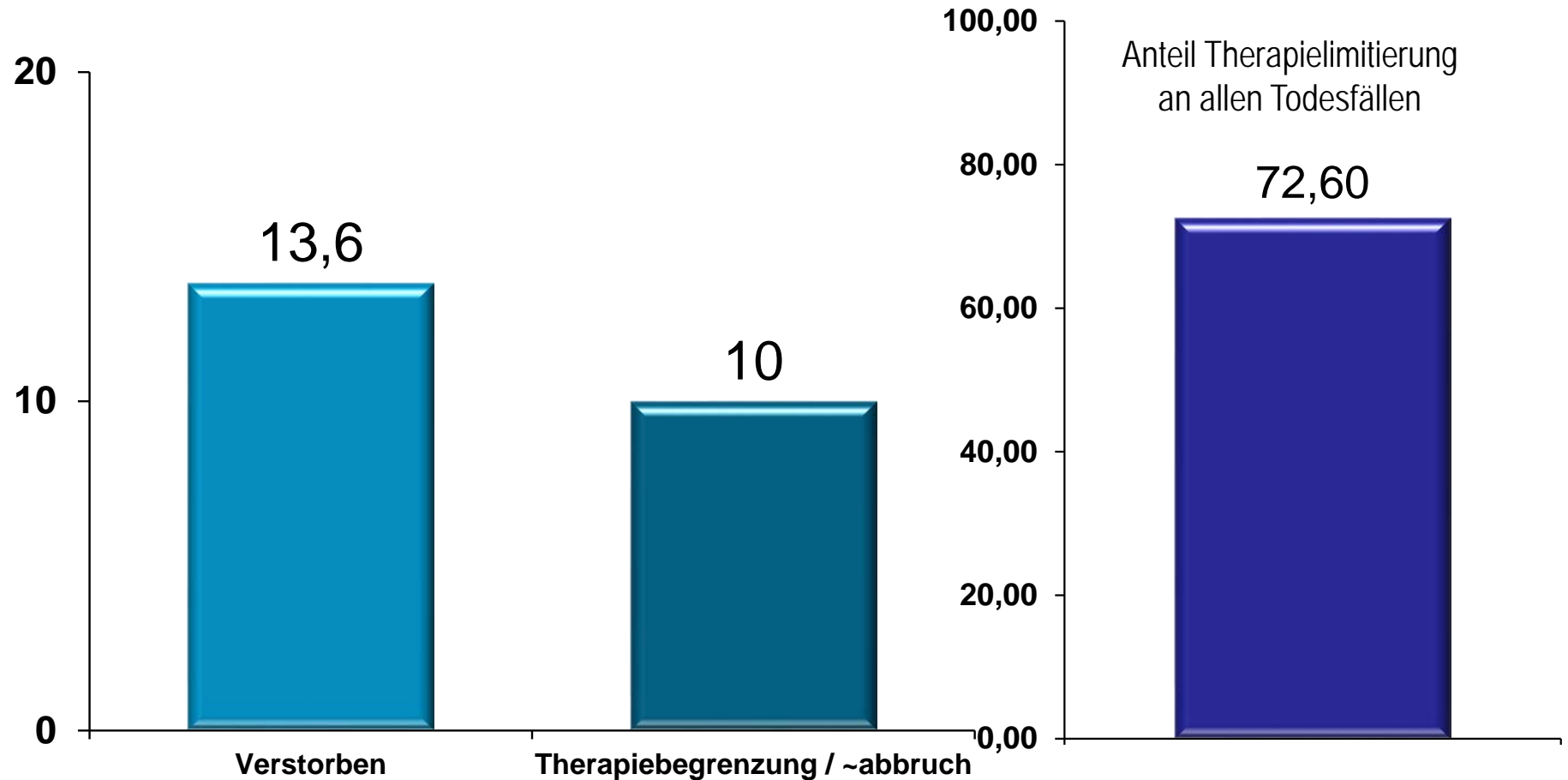
Ca. 104.850
Sterbefälle

Ca. 4,84% aller
Behandlungsfälle

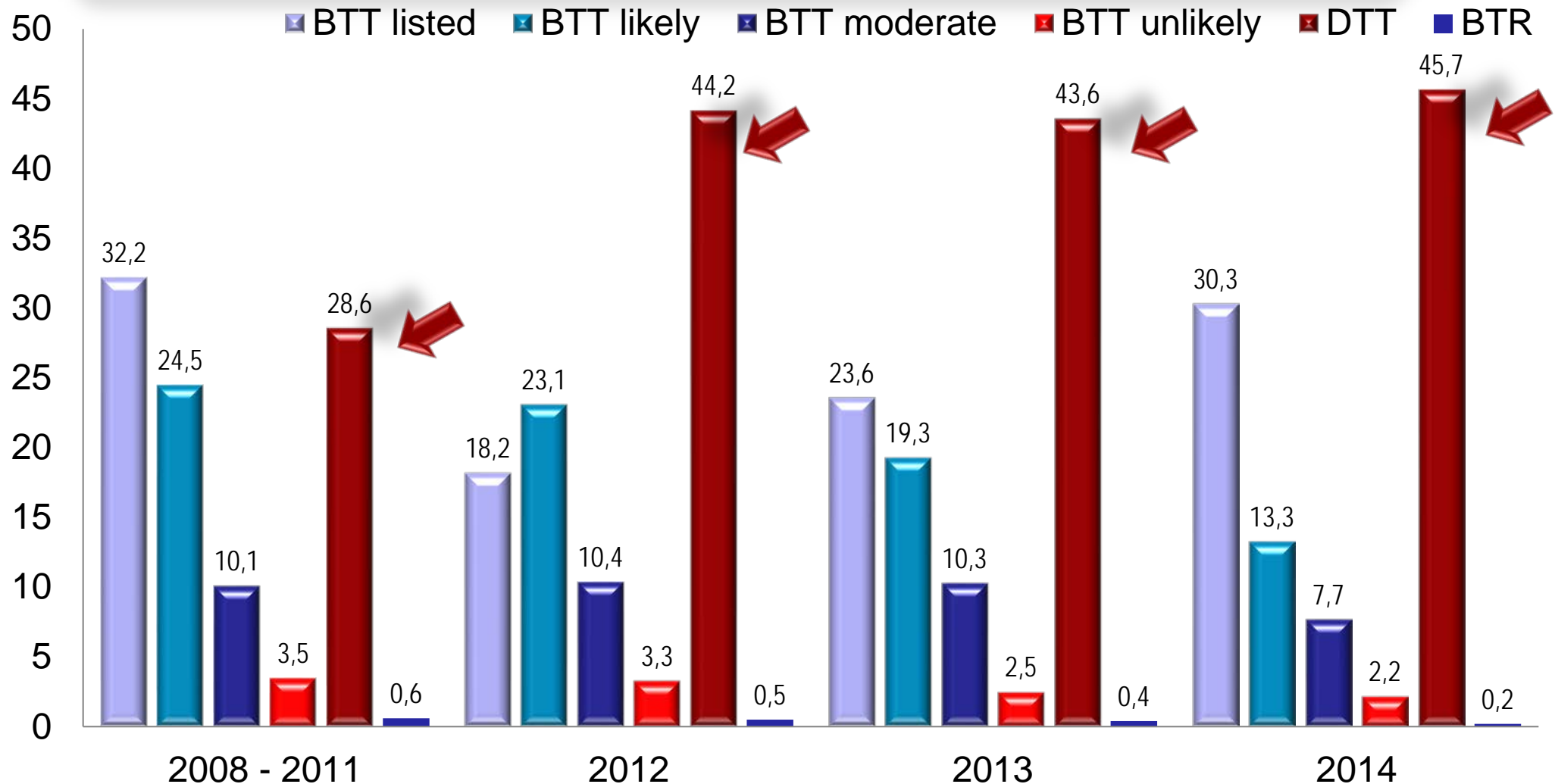
Anteil der
Sterbefälle
abhängig vom
Typ der ITS

End of life Praxis in Europa

31.417 Patienten, 17 Länder, 37 Zentren



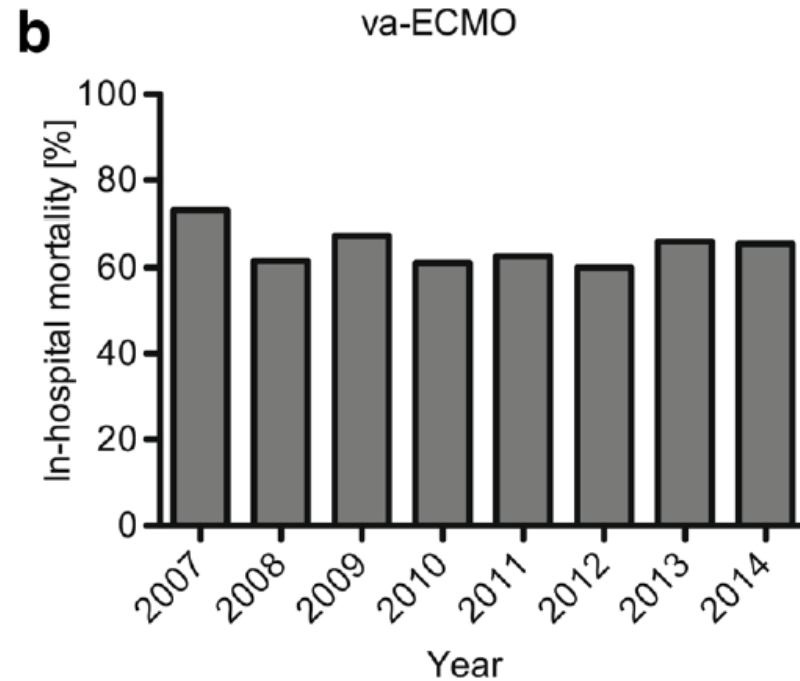
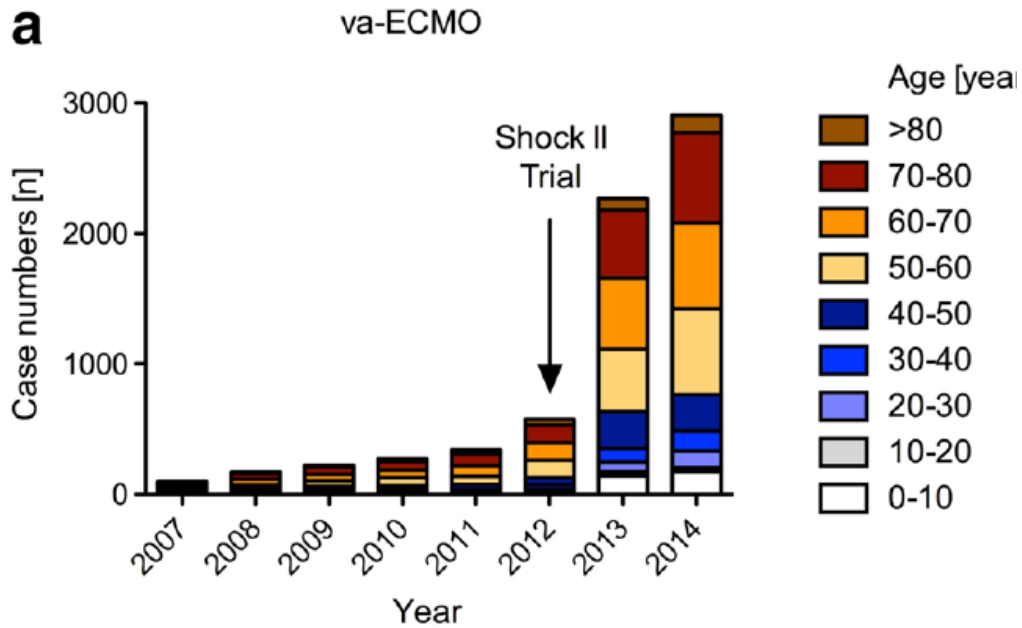
VAD zwischen 2008 und 2014



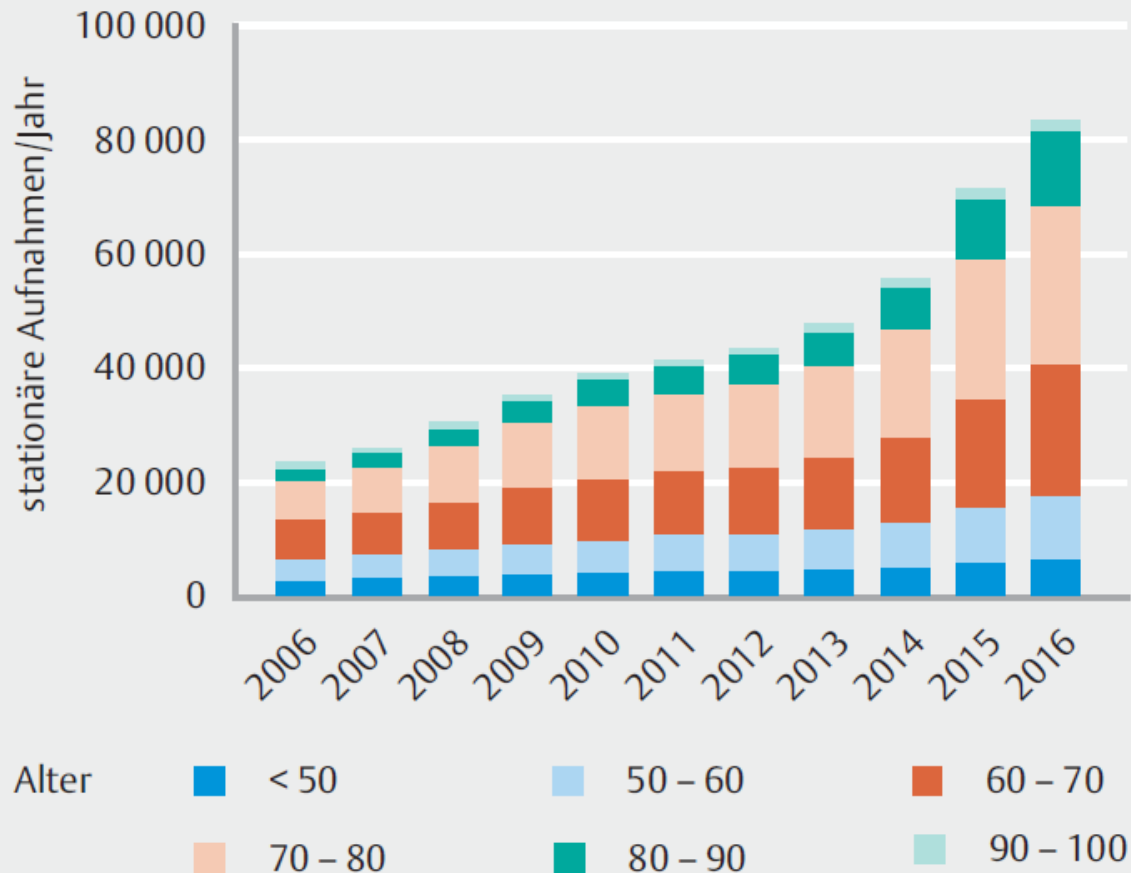
Va-ECMO bei schwerer Herzinsuffizienz

Einsatzzahlen ECMO

KH-Sterblichkeit ECMO



Epidemiologische Entwicklung der außerklinischen Beatmung



2006: 24.845
Patienten

2016: 86.117
Patienten

2016: 1.500
Patienten zwischen
90 und 100 Jahre alt

1. Kernaussage

Alter ↑
Komorbidität ↑
Prozeduren ↑

Intensivmedizin:
Scheinbar
unbegrenzte
Möglichkeiten

AGENDA



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- Ausufernde Therapie: Epidemiologie und Gründe
- Lösungsansätze

Right Care – The Lancet 2017

Evidence for overuse of medical services around the world

Right Care 1

Evidence for overuse of medical services around the world

Sharon Bravetta, Kijun Chahim, Jimmy Dixon, Adam G. Elshah, Paul Glavin, Brent Hanft, Jodi Nagler, William S. Oatis, Deyan Shindler, Sidney Stricker, Andrew Townsend

Overuse, which is defined as the provision of medical services that are more likely to cause harm than good, is a pervasive problem. Direct measurement of overuse through documentation of delivery of inappropriate services is challenging given the difficulty of designing appropriate care for patients with individual preferences and needs; overuse can also be measured indirectly through examination of unexamined geographical variations in provision of procedures and care intensity. Despite the challenges, the high prevalence of overuse is well documented in high income countries across a wide range of services and is increasingly recognised in low income countries. Overuse of essential services can harm patients physically and psychologically, and can harm health systems by wasting resources and diverting investments in both public health and social needs, which in turn is known to contribute to health. Although harm from overuse has not been well quantified and needs have not been well described, overuse is likely to be increasing worldwide.

Introduction Overuse, which Chassin and Gaba defined as "the provision of medical services for which the potential for harm exceeds the potential for benefit" is increasingly recognised around the world. Direct measurement overuse requires a definition of appropriate care, which is often challenging. In the USA, estimates of spending on overuse vary widely; conservative estimates based on the direct measurement of individual services range from 6% to 9% of total healthcare spending, whereas studies of geographical variation (an indirect measure) indicate that the proportion of Medicare spending on overuse is close to 20%. Worldwide, overuse of individual services can be as high as 80% in certain populations. Although overuse has mainly been documented in high-income countries (HICs), low- and middle-income countries (LMICs) are not immune. Evidence suggests widespread overuse is occurring in countries as diverse as Australia's "Bread" team, Brazil's "e-Spina" program, and even with common healthcare needs, particularly in LMICs.

We aimed to highlight the significance of the scope of overuse and explore what is known regarding the problem and consequences of such, around the world. We base claims on literature reviews, key papers, and a synthesis of evidence from the literature. We have supplemented with reference tracking and additional structured searches of scientific and grey literature. Subsequent papers in this series²⁻⁴ examine the underuse of medical services worldwide, the causes of overuse and underuse, and potential solutions for both.

What is overuse?

"Though the domain remains to be laid, and your firm meditations as done, be nevertheless resolved, in the way they will find peace."

Although Chassin and Gaba's definition of overuse is correct, and we have found broader support, it is

difficult to address. To directly measure overuse, a definition for the appropriateness of a service is required, based on evidence that considers the balance between benefits and harms for a population or individuals. However, quantifying benefits and harms is often problematic, because evidence regarding benefits is often incomplete, and for many services harms are poorly documented.⁵ Furthermore, the threshold between appropriate and inappropriate care can vary among patients or patient groups. Additionally, the role of cost in defining low-value services varies in different settings globally.

Ultimately, overuse can be considered to occur along a continuum. At one end of the continuum is tests and treatments that are universally beneficial when used in the appropriate patient, such as blood cultures in a young, otherwise healthy patient with sepsis, and insulin for patients with type 1 diabetes. At the other end of the continuum are services that are entirely ineffective, such as pain relief for a high-risk of harm to all patients that they should never be delivered, such as the drug combination fentanyl-buprenorphine for obesity.⁶ However, the majority of overuse and treatment

overuse occurs across a wide range of medical specialties.

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overuse occurs across a wide range of medical specialties.

Evidence for underuse of effective medical services around the world

Right care 2

Evidence for underuse of effective medical services around the world

Paul Glavin, Sharon Stricker, Sharon Bravetta, Jyoti Thakur, Lemuel Davis, Gordon Goyler, Adam G. Elshah, Robert Jones, Vikas Saxi

Underuse—the failure to deliver a health service that is well established, extending programs, have high likelihood to improve the quality or quantity of life, which is affordable, and that the patient would have wanted—is responsible for considerable avoidable morbidity and mortality. For example, WHO estimated that in 2005, 1.5 million children died of vaccine-preventable diseases. The Burn to Skin Proton Action Group estimates that an 80% reduction in the more than 1 million annual deaths in protein babies could be achieved through universal health coverage and use of additional interventions, such as universal cord care (level 1) and kangaroo mother care, which involves maintaining prolonged skin-to-skin contact between the baby and mother beyond the uptake of such interventions has been particularly slow.

Underuse varies substantially between and within countries. For example, high-income countries (HICs), which already have relatively low cervical cancer rates and well established screening programs, have documented a 68% reduction in high-risk human papilloma virus (HPV) infection rates as a result of HPV vaccination therapy.

1972 First randomised controlled trial (RCT) showing universal cord care reduces neonatal mortality, infection of respiratory distress syndrome, intraventricular haemorrhage, and neonatal death.

1984 Collaborative Group on Antineoplastic Testing: Effects of Oral Contraceptive Pills on Cervical Cancer Risk.

1989 Systematic review of RCTs shows significant benefits from cervical therapy.

1995 National Institute of Health and Consumer Affairs: Medicines Benefits Study on Cervical Cancer.

2010 Meta-analysis shows greater benefit in low-income and middle-income countries.

2011 WHO 3rd Country Survey of Maternal and Neonatal Health: Cervical cancer and HPV infection in women.

2013 WHO 3rd Country Survey of Maternal and Neonatal Health: Cervical cancer and HPV infection in women.

2014 WHO 3rd Country Survey of Maternal and Neonatal Health: Cervical cancer and HPV infection in women.

2015 WHO 3rd Country Survey of Maternal and Neonatal Health: Cervical cancer and HPV infection in women.

2016 WHO 3rd Country Survey of Maternal and Neonatal Health: Cervical cancer and HPV infection in women.

2017 WHO 3rd Country Survey of Maternal and Neonatal Health: Cervical cancer and HPV infection in women.

2018 WHO 3rd Country Survey of Maternal and Neonatal Health: Cervical cancer and HPV infection in women.

Drivers of poor medical care

Right care 3

Drivers of poor medical care

William S. Oatis, Lemuel Davis, Sharon Bravetta, Gordon Goyler, Adam G. Elshah, Sharon Bravetta, Jyoti Thakur, Lemuel Davis, Gordon Goyler, Adam G. Elshah, Robert Jones, Vikas Saxi

The global ubiquity of overuse and underuse of health-care resources and the growth of resulting health-care costs are an investigation of drivers to inform potential solutions. We describe the network of influences that contribute to poor care and suggest that it is driven by factors that fall into three domains: money and finance; knowledge, skills, and motivation; and power and human relationships. In each domain the drivers operate at the global, national, regional, and individual level and are mediated by the specific contexts within which they act. We discuss in detail drivers of poor care in each domain.

Introduction Papers 1 and 2 in this series outline the scope of poor care: from both overuse and underuse of medical services. Drivers of poor care reside in three major domains: money and finance; knowledge, skills, and motivation; and power and human relationships. Drivers operate in specific contexts and contribute to the overall quality and quantity of care delivered. These contexts are not considered a different level in an ecosystem of care, but rather a different level in an ecosystem of care, defined by global, national, legal, regulatory, and cultural, regional, institutional, and social, and the individual level of the doctor-patient relationship.

Key messages The historical model of the past century has been evaluated for some aspects of medicine to be a necessary, but not a sufficient, component for the proper care of patients. The biological, psychological, and social needs of patients and informed preferences must define desirable outcomes and expectations of care. Good, competing interests, and poor information are universal drivers of poor care that occur across all systems and settings.

The extent, knowledge, and information of all stakeholders regarding effective and ineffective care is a key driver of poor care. The extent to which health systems are organized and financed, and how resources are allocated towards effective health care, and how resources are allocated towards ineffective health care, are also key drivers of poor care. The way in which health systems are organized and financed, and how resources are allocated towards effective health care, and how resources are allocated towards ineffective health care, are also key drivers of poor care.

The institutional ecosystem, including the health-care industry and the alignment of incentives, structures within health systems are major drivers of potentially bad knowledge generation and health-care delivery outcomes. Failure to involve professional ethics and patient self-determination in decision-making, regulatory capture, development of communities and citizens, and a public response to priority setting of poor care. Understanding these drivers and the ways in which they act across systems provides opportunity to increase the social and individual value of care.

Non-mutually exclusive additional variables exist within this network, including the clinical capabilities of benefits and harms, patient preferences, physician preferences, patient training and competence, available infrastructure, financial incentives, trust, and understanding between patient and doctor, and the influence of ethics, both individually and through social norms. Clinical decision-making emerges from this complex interaction. In this

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Levers for addressing medical underuse and overuse: achieving high-value health care

Right care 4

Levers for addressing medical underuse and overuse: achieving high-value health care

Adam G. Elshah, Lemuel Davis, Jyoti Thakur, Sharon Bravetta, Gordon Goyler, Adam G. Elshah, Robert Jones, Vikas Saxi

The prevailing papers in this Series have outlined how underuse and overuse of health-care services occur within a complex system of health-care production, with a multiplicity of actors. Because poor care is ubiquitous and has considerable consequences for the health and wellbeing of billions of people around the world, resolving this problem is a morally and politically urgent task. Universal health coverage is a key step towards achieving the right care. Therefore, full consideration of potential levers of change must include an upstream perspective—i.e., an understanding of the system-level factors that drive overuse and underuse, as well as the various incentives or work design at clinical resources. One example of a system-level factor is the allocation of resources (eg, hospital beds and clinicians) to meet the needs of a local population to minimise underuse or overuse. Another example is priority setting using tools such as health technology assessment to guide the optimum distribution of safe, effective, and cost-effective health-care services. In this Series paper we investigate a range of levers for eliminating medical underuse and overuse. Some levers could operate collectively (and be politically viable) across many different health and public systems (eg, increase patient activation with decision support) whereas other levers must be tailored to local contexts (eg, having coverage decisions on a particular cardiovascular trial). Health policies must move beyond the purely incremental, that is, policies that merely tinker at the policy edges after underuse or overuse arises. In this report, efforts to increase public awareness, mobilisation, and empowerment hold promise as universal methods to treat all other contexts and thereby enhance all other efforts to promote the right care.

Introduction In this final paper in the Right Care Series on medical underuse and overuse,² we address a complementary approach to achieving the right care: so-called bottom-up approaches, whereby patients, clinical professionals, and system leaders take a proactive lead with limited information from managerial authorities and societal top-down policies, which have arisen as governments, medical societies, or private third-party payers face the challenge of improving the safety and quality of health care and addressing problems in control spending. Additionally, we suggest a more far-reaching perspective than is typical of micro-level reform initiatives.

Although we suggest a more far-reaching perspective than is typical of micro-level reform initiatives, we have been inspired by the work of the Institute of Medicine (IOM) and the National Academies of Sciences, Engineering, and Medicine (NASEM) in their landmark reports on the quality of health care, which are in line with the IOM's and NASEM's work on the quality of health care, which are in line with the IOM's and NASEM's work on the quality of health care.

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Terminologie

Overuse =
übermäßiger
Einsatz

- Gesundheitsversorgung oder Behandlung, welche
- nicht zu einer nennenswerten Verbesserung der Lebensqualität und ~quantität führt,
- mehr Schaden als Benefit verursacht oder
- von Patienten, die umfänglich über Nutzen und Schaden informiert wurden, nicht gewollt wurde

Terminologie

Low-value
care =
geringwertige
Behandlung

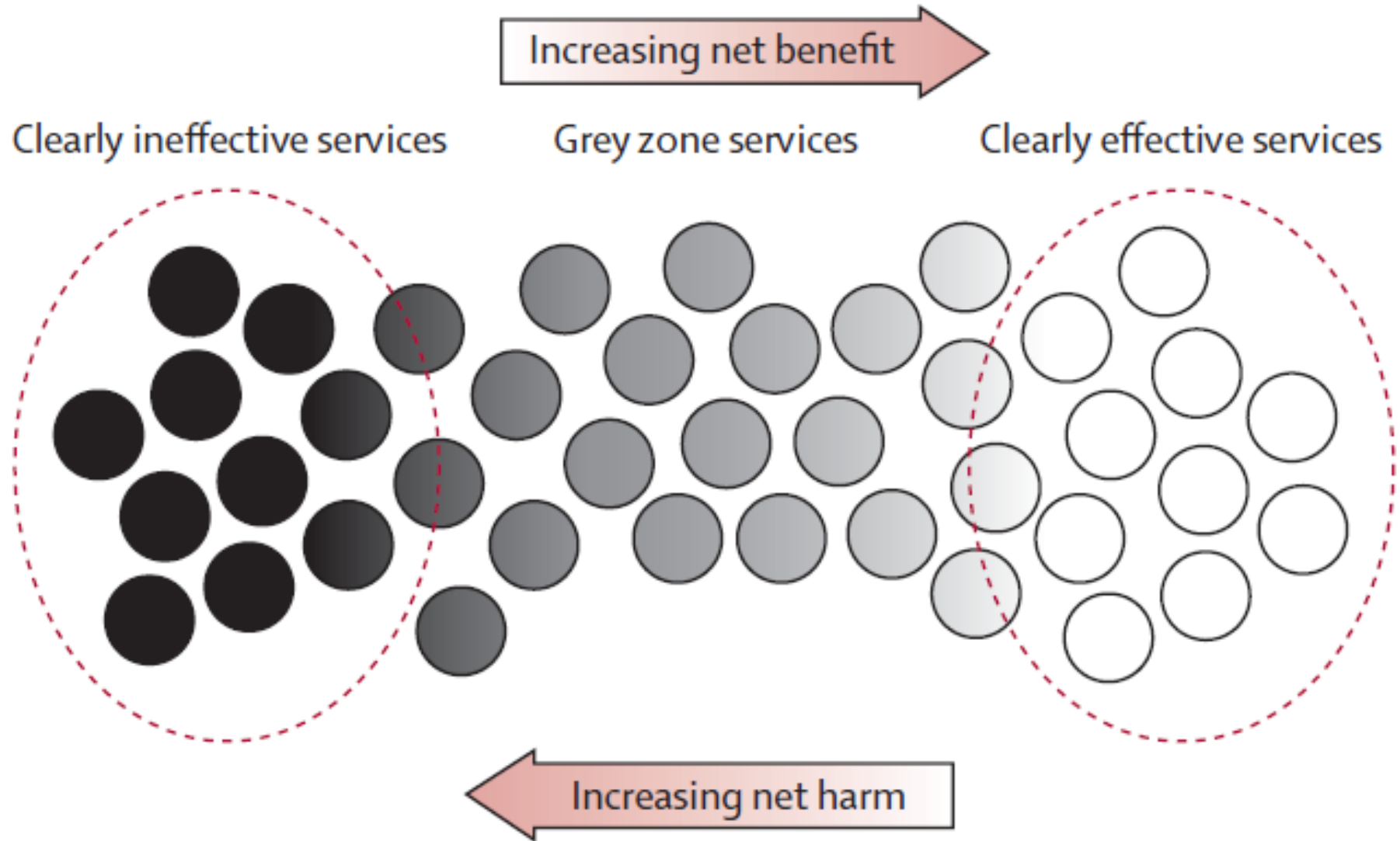
- Eine Intervention, bei der Evidenz darauf hinweist, dass
- Einsatz keine oder nur einen geringen Benefit für den Patienten besitzt
- Möglicher Schaden den Benefit überwiegt
- Zusätzliche Kosten nicht proportional zu einem potentiellen Benefit stehen

Terminologie

Right Care
= richtige
Behandlung

- Behandlung, die auf die Optimierung der Gesundheit und des Wohlbefindens zugeschnitten ist durch Bereitstellung von dem was benötigt, gewollt, effektiv, erschwinglich und ausgewogen sowie die Ressourcen verantwortlich einsetzt

Die Grenzen sind unscharf



Wo gibt es „overuse“?

Medikamente

Screening
Tests

Diagnostische
Testverfahren

Therapeutische
Prozeduren

Überversorgung Diagnostik/Therapie in der Medizin

Schwer zu messen und nicht gut definiert

Meiste Studien in Ländern mit hohem Einkommen

Überversorgung aber ein globales Problem

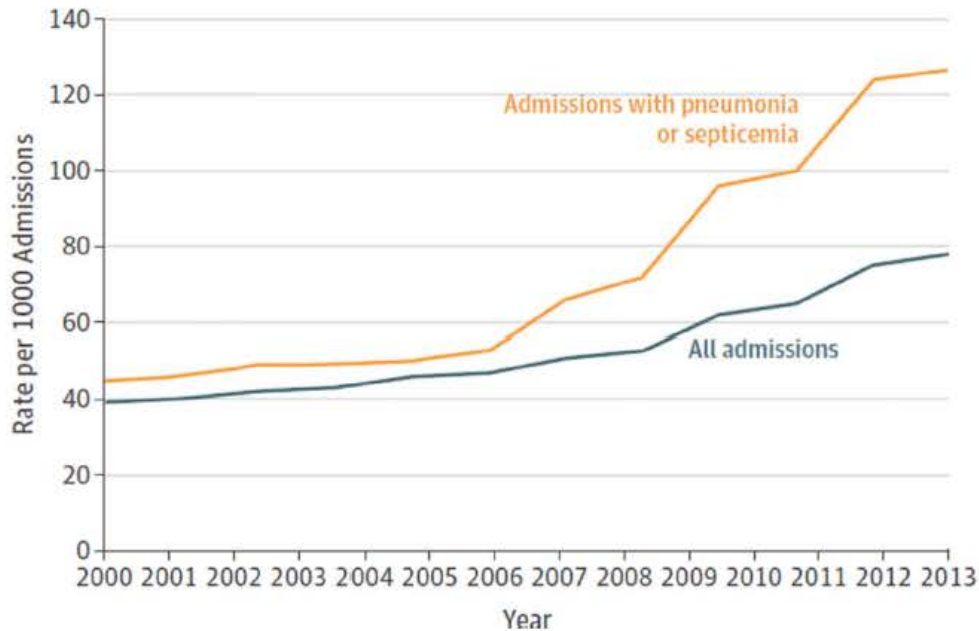
Führt zu körperlichen, psychischen und finanziellen Schäden bei Patienten

Lenkt die Ressourcen im Gesundheitssystem und Sozialausgaben um

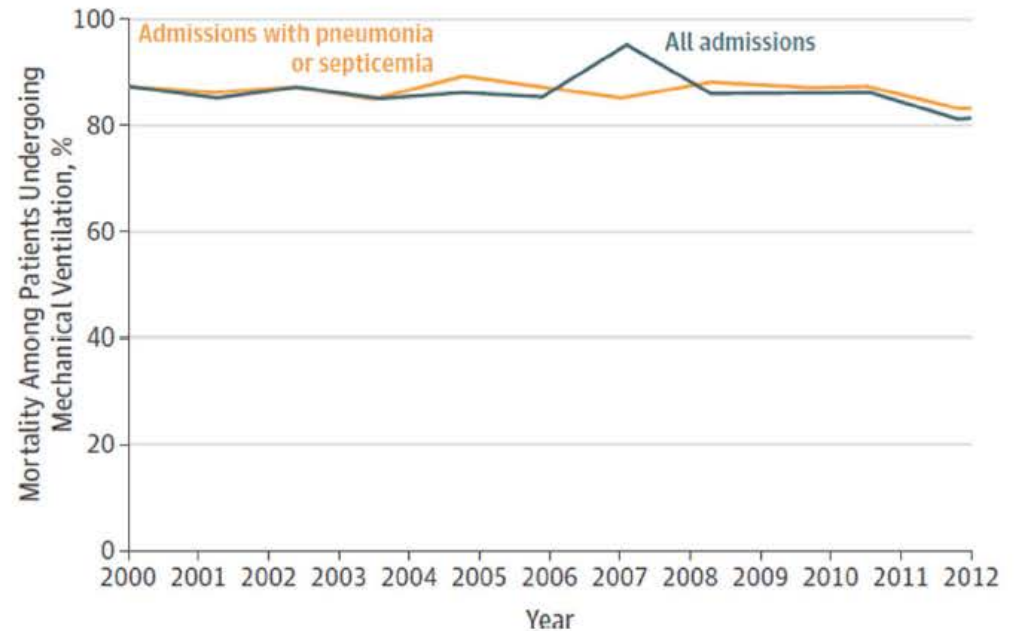
Tritt in fast allen medizinischen Bereichen auf

Zunehmender Einsatz der Beatmung bei Altenheimbewohnern mit fortgeschrittener Demenz und schwerer Gebrechlichkeit

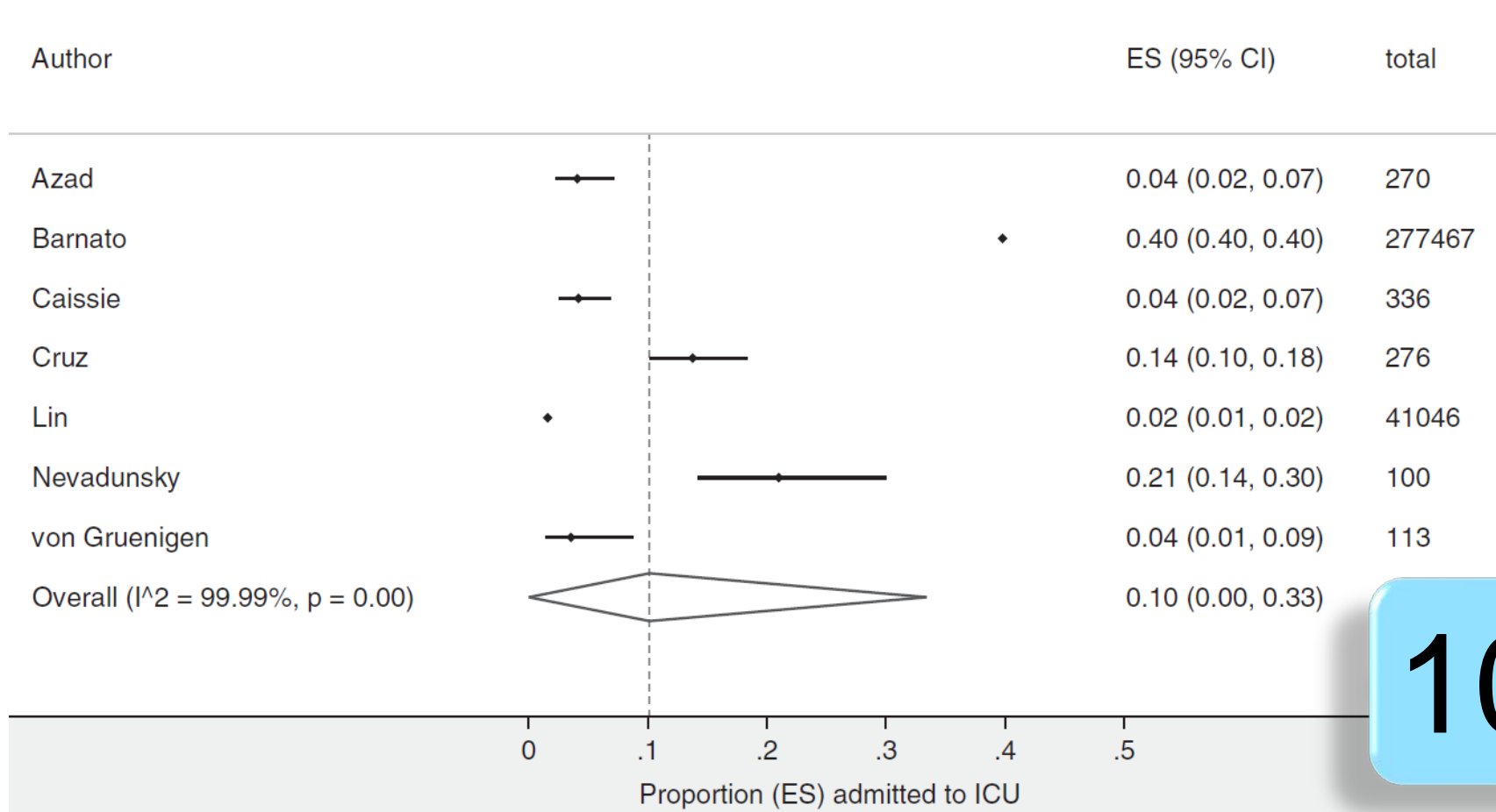
A Use of mechanical ventilation



B 1-year mortality

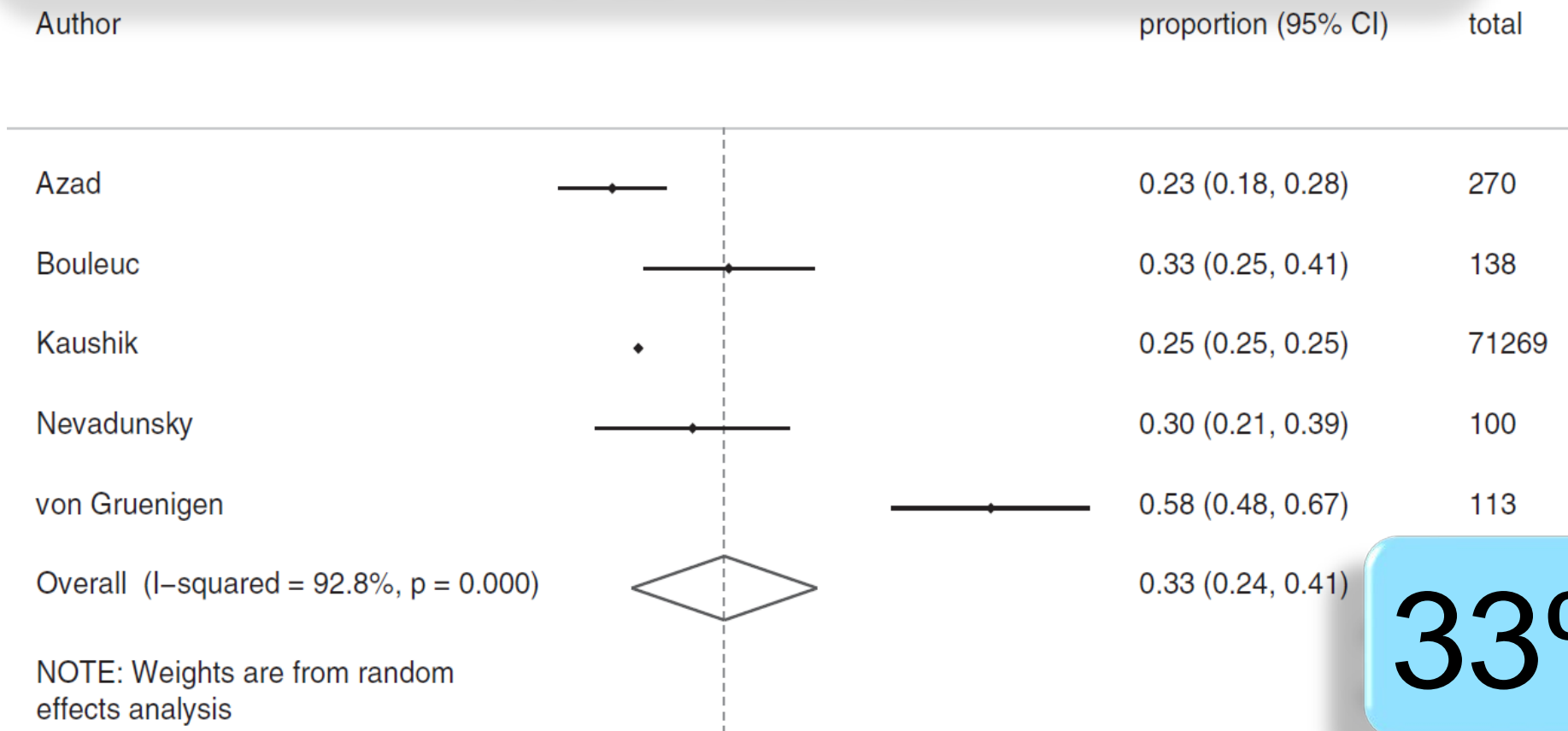


Nutzlose Behandlungen in Krankenhäusern am Lebensende: Ein systematisches Review Aufnahme schwerkranker Patienten auf ITS



10%

Nutzlose Behandlungen in Krankenhäusern am Lebensende: Ein systematisches Review Chemotherapie in den letzten 6 Wochen vor Tod der Patienten



33%

Sinnlose Therapie: Warum machen wir das?

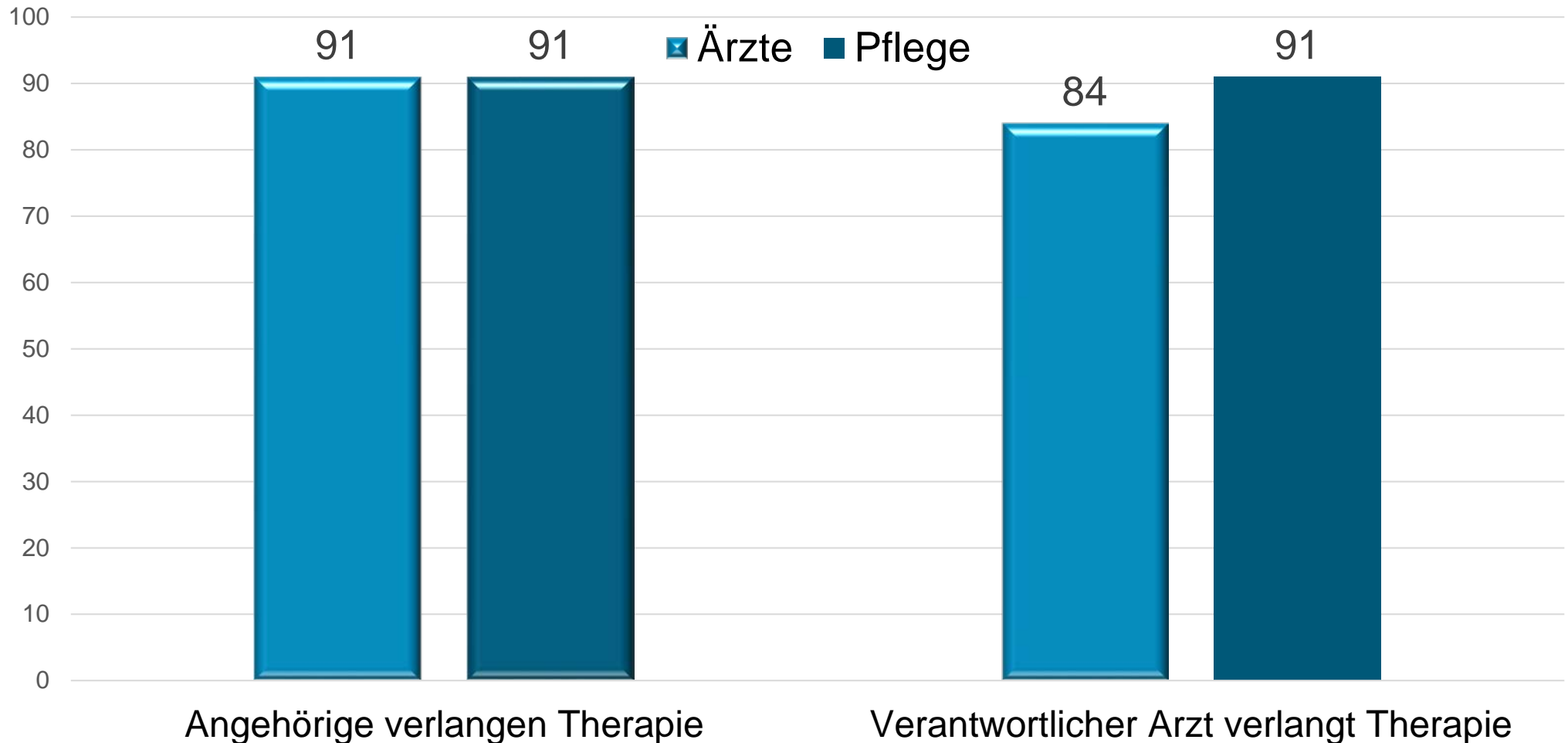
Kanadische Studie
238 Zentren, 157
Zentren geantwortet

41% komplette
Antworten
(verantwortlicher
Arzt und leitende
Pflegekraft)

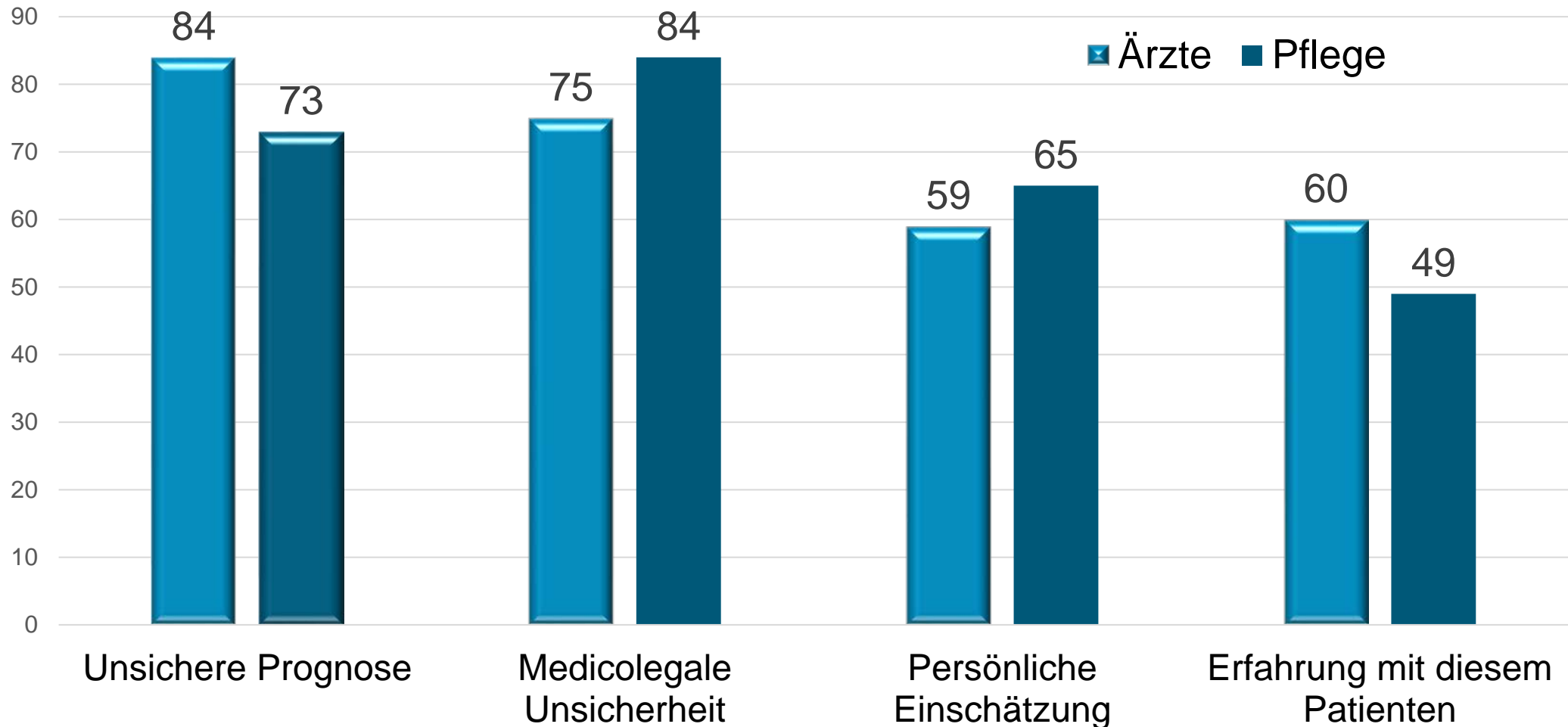
141 Pflegekräfte
und 114 Ärzte

Insgesamt
Antwortrate 72%

Sinnlose Therapie: Warum machen wir das? Begründung

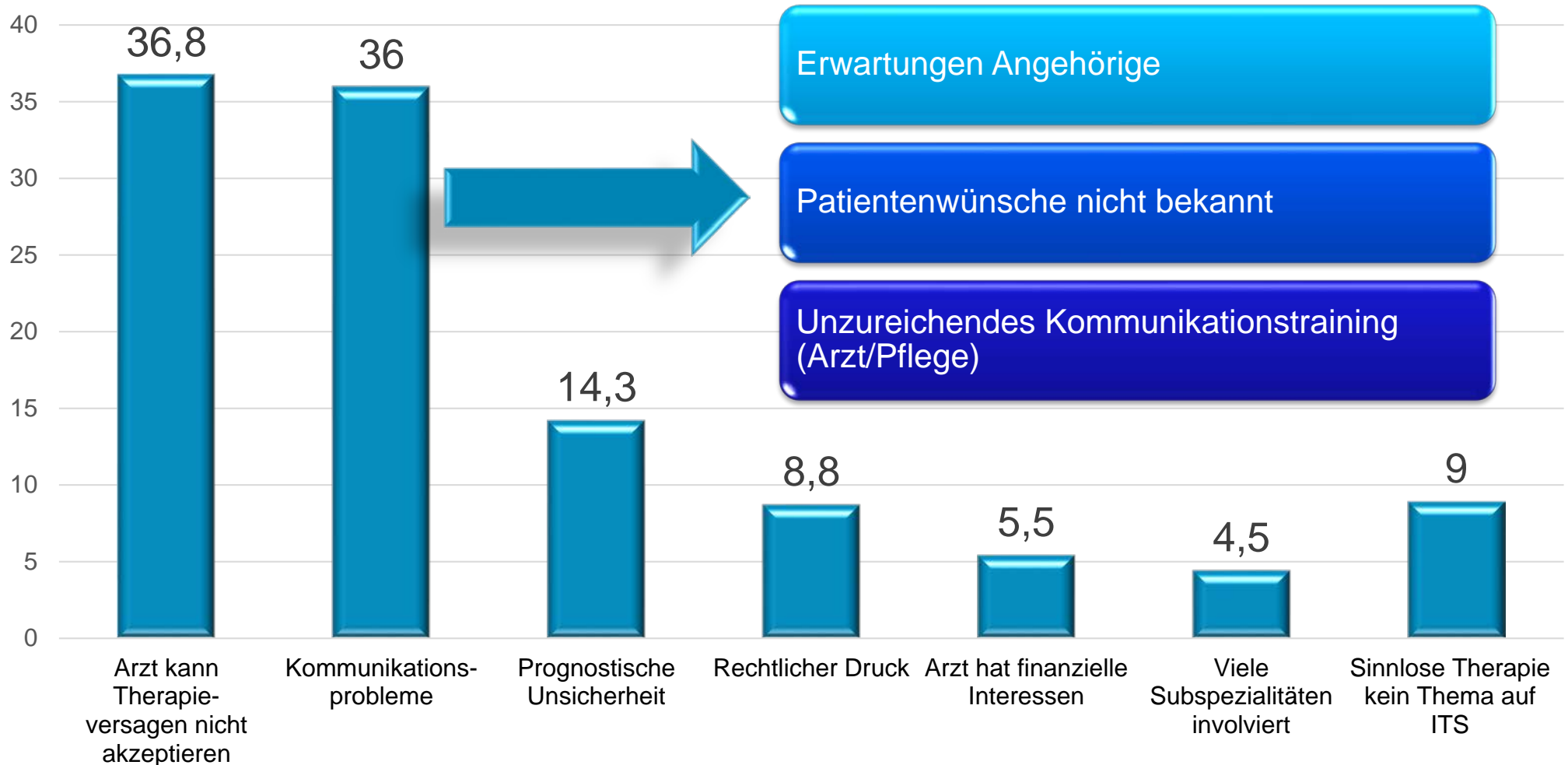


Warum ordnen verantwortliche Ärzte eine sinnlose Therapie an?

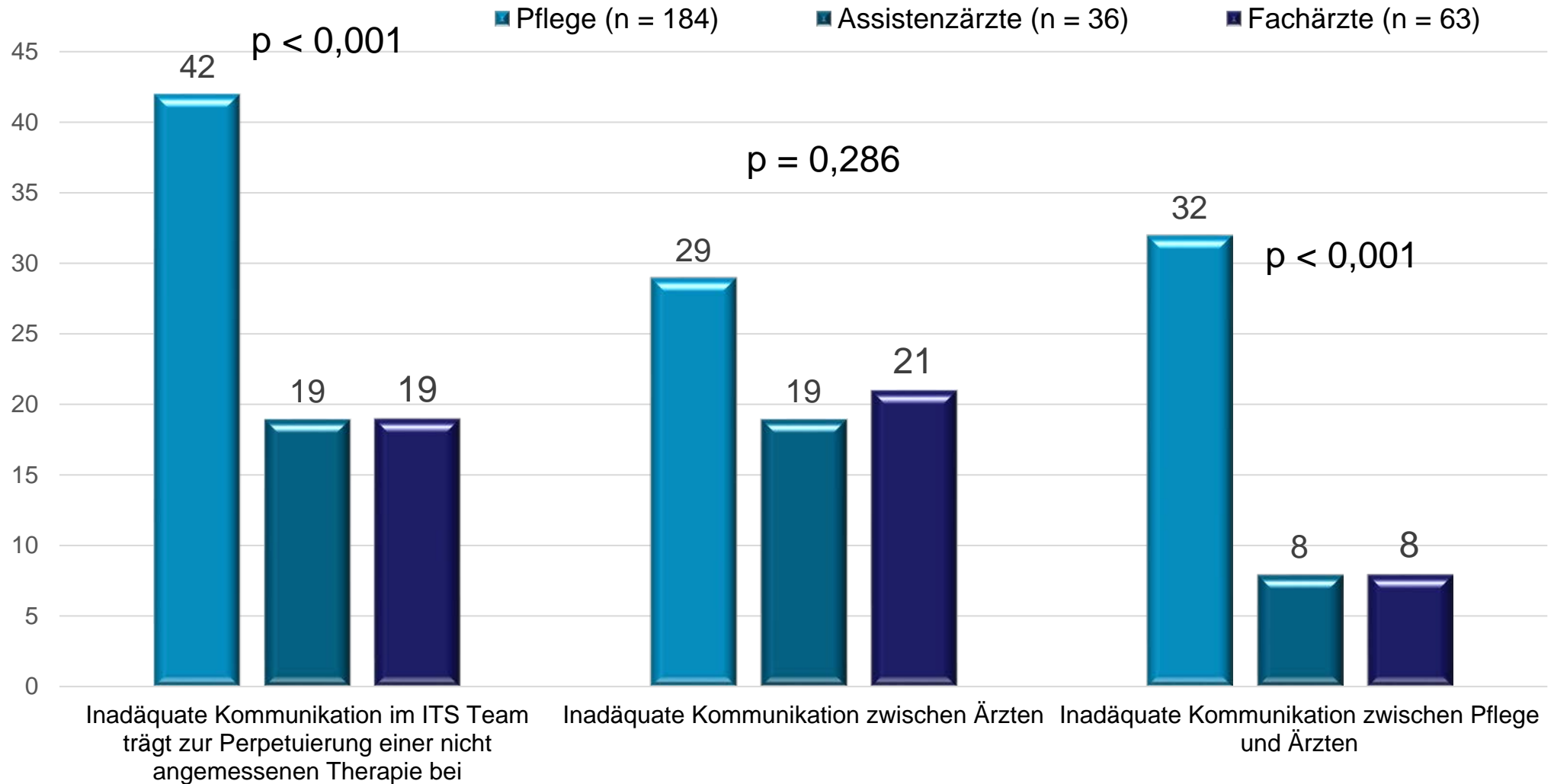


Gründe für eine sinnlose Therapie

Mittlere berichtete Häufigkeit (%)



Gründe für empfundene nicht angemessene Behandlung bei 289 Fällen (Inadäquate Kommunikation)



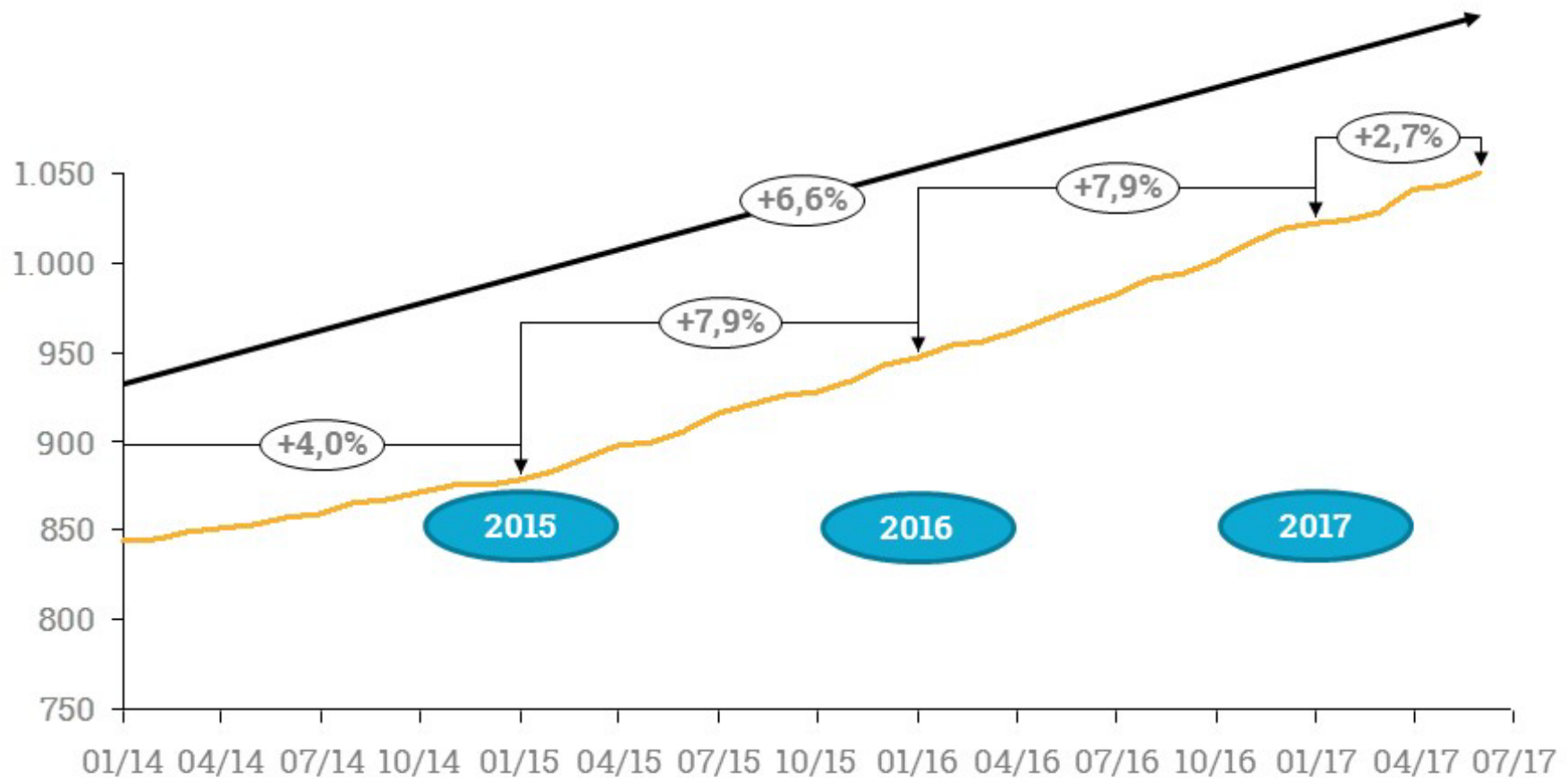
Heimbeatmung in Deutschland

Im Jahr 2003 ca. 500 Patienten in
ausserklinischer Beatmung

Im Jahr 2013 ca. 15.000 Patienten in
ausserklinischer Beatmung

Gesetzliche Krankversicherung: 4.33
Milliarden Euro

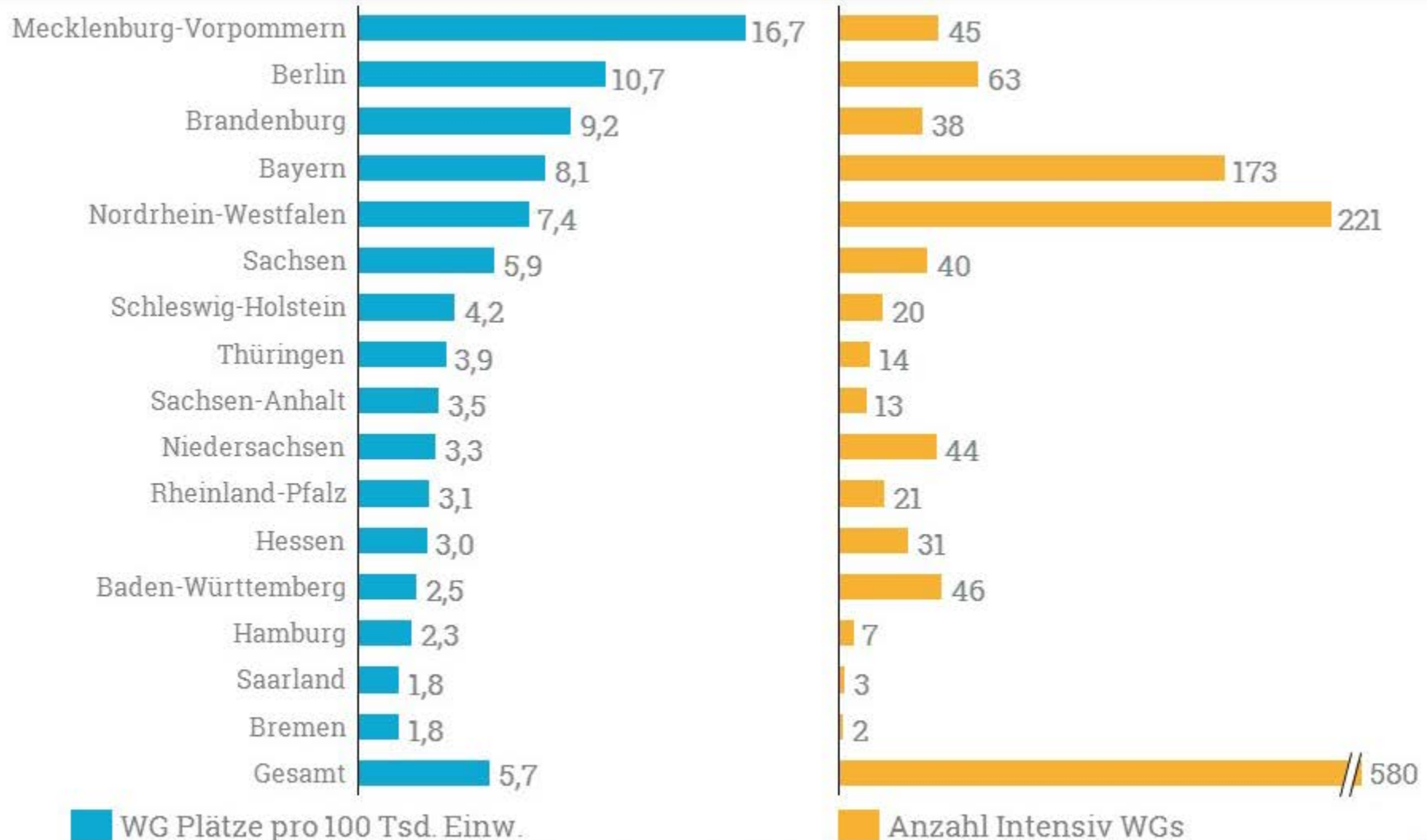
Entwicklung Intensivpflegedienste bundesweit 2014-2017



Quelle: Sebastian Meißner, pflegemarkt.com, abgerufen am 28.08.2017



Angebot Intensiv WGs im Bundesländervergleich 2017



Quelle: Sebastian Meißner, pflegemarkt.com, abgerufen am 28.08.2017

2. Key Message

Übersorgung
ein globales
Problem

Risiken und
Mechanismen
auf der ITS
kennen

Kommunikation
zentrales
präventives
Element

AGENDA



- Intensivmedizin – unbegrenzte Möglichkeiten
- Ausufernde Therapie: Epidemiologie und Gründe
- Lösungsansätze

Frage nach dem Sinn der Behandlung

Sinn

- Diagnostik
- Therapie
- Pflege
- Therapieziel

Frage nach Sinnhaftigkeit nicht objektiv zu klären
→ Rückgriff auf individuelle / subjektive Bewertungen

- Bedeutung von Leben, Sterben, Leid
- Einschätzung Lebensqualität
- Einschätzung Lebensziele / Lebensentwürfe

Überprüfung, ob eine Maßnahme sinnvoll ist

Bewertung der Zweckrationalität

- Ist die Maßnahme fachlich sinnvoll

Bewertung der Wert-rationalität

- Ist die Maßnahme menschlich angemessen

Zweckrationalität

Zweckrationalität: Eignung einer Maßnahme, ein bestimmtes Ziel erreichen zu können (Beispiel: „Es ist sinnvoll, diese Infektion mit Antibiotika zu behandeln.“).

Sinnvoll ist ärztliche oder pflegerische Maßnahme dann, wenn ausreichend Erfahrung oder Evidenz vorliegt, dass diese Maßnahme mit einer bestimmten Wahrscheinlichkeit einen Behandlungserfolg herbeiführen kann.

Wertrationalität

Wertrationalität: Maßnahme drückt in geeigneter Weise bestimmte moralische Grundwerte aus oder bringt sie zur Geltung (Beispiel: „Es ist sinnvoll, einem infektiös erkrankten Patienten zu helfen.“)

Fragen nach dem

- Wert der angestrebten Behandlungsziele,
- der Bedeutung von Leid und Krankheit,
- den subjektiven Faktoren der Lebensqualität sowie
- dem Stellenwert von professioneller und familiärer Unterstützung müssen hierbei geklärt werden.

Prüfung der Sinnlosigkeit von Behandlungskonzept oder Behandlungsmaßnahme

Kann das angestrebte Therapieziel nach professioneller Einschätzung erreicht werden?

Wird dieses Therapieziel vom Patienten gewünscht?

Sind die Belastungen während der Behandlung durch die erreichbare Lebensqualität / Lebensperspektive aus Patientensicht gerechtfertigt?

Behandlungskonzepte oder Behandlungsmaßnahmen sind sinnlos, wenn

Das angestrebte Therapieziel nicht erreicht werden kann

Dieses Therapieziel vom Patientenwillen nicht gedeckt ist

Die dadurch erreichbare Lebensqualität /
Lebensperspektive für den Patienten die Belastungen
während der Behandlung nicht rechtfertigt

Dokumentationsbogen Therapiebegrenzung

Teil 3: Autorisierung und Verbindlichkeit

Dokumentation Therapiebegrenzung



Datum: Patientenetikett
Gültig maximal bis:
(Gültigkeit erlischt mit der Entlassung aus dem Krankenhaus)

❶ Folgende Maßnahmen werden **nicht** durchgeführt*:

- Reanimation:
- Herzdruckmassage
 - Defibrillation / Kardioversion
 - Medikamente
 - Assist Devices
- Beatmung:
- Invasiv
 - Nicht-invasiv (Maskenbeatmung)
 - Intensivierung der Beatmung
 - Lungenersatzverfahren (z.B. ECMO)
- Verlegung Intensiv/IMC/andere Klinik
- Künstliche Ernährung:
- Enteral (Sonderkost)
 - Parenteral
- Andere:
- Medikamente (alle, außer zur Symptomkontrolle)
 - Medikamente (bestimmte, s. Besonderheiten)
 - Antinfektive Therapie (z.B. Antibiotika)
 - Blutprodukte
 - Nierenersatzverfahren (z.B. Dialyse)
 - Operative / diagnostische Maßnahmen
 - Passagerer Schrittmacher
 - Weitere:

Besonderheiten:

❷ Grund für die Begrenzung der Maßnahmen

- Medizinische Indikation nicht gegeben
(Therapie führt wegen schlechter Gesamtprognose nicht zum Erreichen des angestrebten Therapieziels oder Sterbephase hat begonnen)
- Therapiebegrenzung auf Grund des Patientenwillens
(Aussage kann von Patient/in jederzeit ohne Angabe von Gründen formlos widerrufen werden)
- Erläuterung zum Patientenwillen:
- Patient/in kann eigene Situation erfassen und die Folgen der Therapiebegrenzung verstehen
 - Patientenwille wurde durch Betreuer oder Bevollmächtigten zur Geltung gebracht
- Patientenwille gesichert auf Basis von:
- Patientenverfügung
 - Behandlungswünschen
 - Mutmaßlichem Patientenwillen

Besonderheiten:

Informationsgespräch erfolgte am:
am:
am:
am:

mit Patient/in
 mit Betreuer/ Vorsorge-Bevollmächtigtem
 mit Pflegekraft
 mit Angehörigen u. sonstigen Vertrauenspersonen, nämlich:

❸ Autorisierung

.....
[Unterschrift Ärztin/Arzt Name in Druckbuchstaben] [Zur Kenntnis genommen Unterschrift der/des Pflegenden Name in Druckbuchstaben]

Die Therapiebegrenzung gilt nur für die oben genannten Maßnahmen. Die Basisbetreuung, also z.B. Symptomkontrolle, Pflege und Zuwendung, wird nicht eingeschränkt.

Auf dem Dokumentationsbogen wird oben das Datum der Erstellung eingetragen.

Ebenfalls wird die maximale Gültigkeitsdauer der Entscheidungen festgelegt.

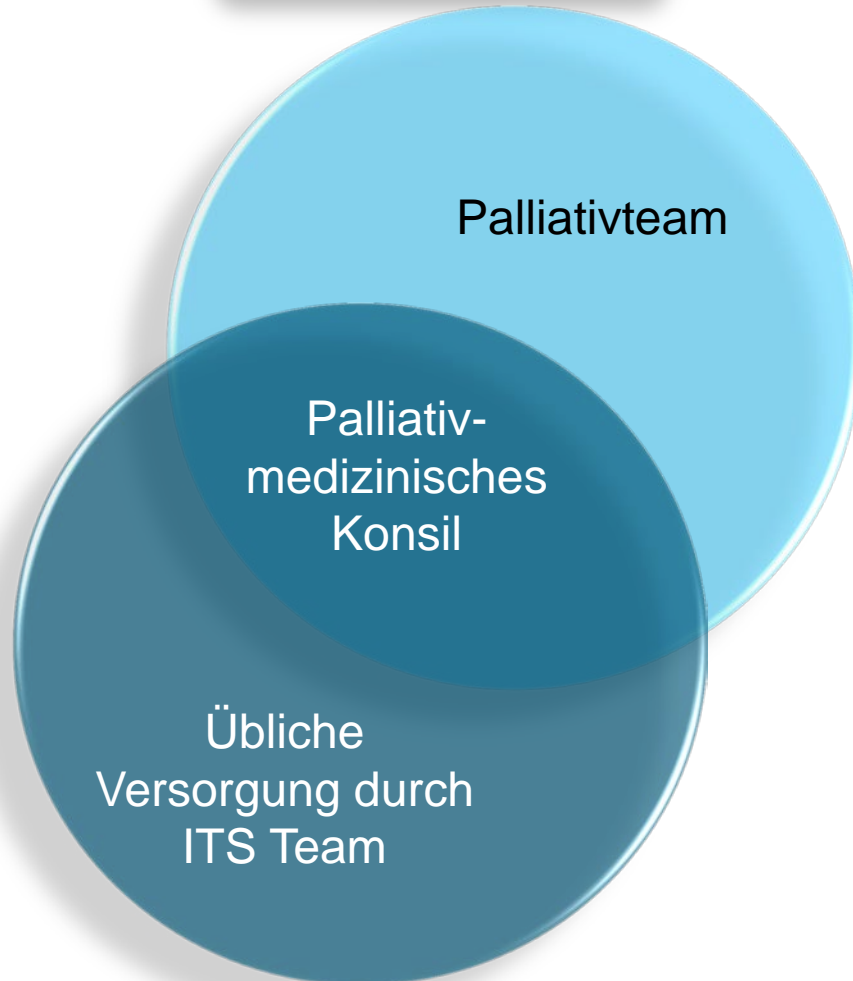
So wird sichergestellt, dass diese überprüft und ggfs. angepasst werden.

Des Weiteren wird im dritten Abschnitt festgehalten, wann und mit welchen Bezugspersonen ein Informationsgespräch durchgeführt wurde.

Dadurch ist nachvollziehbar, wer an der Entscheidungsfindung beteiligt war.

Modell für die Etablierung ITS Palliativmedizin

Konsultatives
Modell



Integratives
Modell



Vorteile der Integration Palliativmedizin in die ITS

ITS- und KH-
Liegedauer ↓

Übertherapie ↓

Dauer Beatmung ↓

Familien-
zufriedenheit ↑

Verstehen der
Familie ↑

Angst, Depression,
PTSD ↓

Konflikte über
Behandlungsziele ↓

Zeit bis Etablierung
symptomfokussierte
Behandlung ↓

Erfassung
Symptome /
Patientenkomfort ↑

ML Campbell et al. Chest 2003;123:266
SA Norton et al. CCM 2007;35:1530
O'Mahoney et al. Palliat Med 2010;24:154
ML Campbell et al. CCM 2004;32:1839

RL Pieruzzi et al. Pediatrics 2001;108:653
E Azoulay et al. AJRCCM 2002;165:438
A Lautrette et al. NEJM 2007;356:469
JF Payen et al. Anesthesiology 2009;111:1308

CM Lilly et al. Am J Med 2000;109:469
MA Erdek et al. Int J Qual Health Care 2004;16:59
G Chanques et al. CCM 2006;34:1691

**Neues Projekt der Sektion Ethik der DIVI
Übersorgung auf der Intensivstation:
erkennen, benennen vermeiden/verhindern**

Persönliche
Faktoren der
Behandler

Persönliche
Faktoren der
Patienten /
persönliches
Umfeld

Juristische
Faktoren

Organisationale
Faktoren

Ökonomische
Faktoren

Gesell-
schaftliche
Faktoren

Diktatur des positiven Denkens

Zahllose Ratgeber suggerieren, dass Krisen, Krankheiten, ja das ganze Leben allein durch positives Denken zu bewältigen seien

Wer eine böse Diagnose erhält, kriegt oft als Erstes zu hören: "Du musst jetzt positiv denken!,,

Das ist zwar gut gemeint, aber es setzt den Leidenden bei genauerem Hinsehen unter Druck: Es suggeriert, man sei allein verantwortlich für sein weiteres Schicksal.

Angst darf man nach den Regeln dieser Gedankenhygiene nicht haben – jeder negative Gedanke könnte ihn ja noch kränker machen.

Das Prinzip Hoffnung

Realistische Hoffnung ist wohltuend: Patienten, die ihre Krankheiten und Einschränkungen akzeptieren, sind weitaus zufriedener

„Wenn die Hoffnung auf Heilung unwahrscheinlich ist, muss das nicht bedeuten, dass jemand ohne Hoffnung ist“¹

Hoffnung ist nicht die Überzeugung, dass etwas gut ausgeht, sondern die Gewissheit, dass etwas Sinn hat – ohne Rücksicht darauf, wie es ausgeht“²

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Behandlung
muss geklärt
werden

Kommunikation
zentrales
präventives
Element

Palliativmedizin
in
Intensivmedizin
integrieren

Realistische
Hoffnung
unverzichtbar

Take Home Message

1. Kernaussage

Alter ↑
Komorbidität ↑
Prozeduren ↑

Intensivmedizin:
Scheinbar
unbegrenzte
Möglichkeiten

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THANK YOU