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EVALUATING END OF LIFE PRACTICES IN 10 BRAZILIAN PEDIATRIC AND ADULT INTENSIVE CARE UNITS

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Objective: Evaluate modes of death and the treatment offered in the last 48 hours of life to patients dying in 10 Brazilian intensive care units (ICU) in a period of 2 years.

Design and setting: Cross-sectional multicenter study based on medical chart review. The medical records of all patients that died in 7 Pediatric and 3 adult ICU belonging to university and tertiary hospitals in a period of two years were included. Deaths in the first 24 hours of admission to the PICU/ICU and brain death were excluded.

Intervention: 2 fellows of each ICU were trained for filling a standard protocol (Kappa=0.9) to record demographic data and all medical management provided in the last 48 hours of life. The Student *t* test, Mann Whitney, chi-square and relative risk were used for data comparison.

Measurements and main results: 1,053 medical charts were included (59.4% adult patients). Life Support Limitation (LSL) was more frequent in the adult group (86% versus 43.5%; $p < 0.001$). Do not resuscitate order was the most common mode LSL in both groups (75% and 66%), whereas withholding / withdrawing were more frequent in the pediatric group (33.9% versus 24.9%; $p = 0.02$). The LSL was rarely reported in the medical chart (52.6% and 33.7%) with a scarce family involvement in the decision making process (23.0% versus 8.7%; $p < 0.001$).

Conclusion: LSL decision is frequent in Brazil but the most common practice is the DNR orders. The decision making process is predominantly centered on the medical perspective, with scarce participation of the family.

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“ALLOW ME TO DECIDE “! THE DYING CHILD RIGHTS

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In Israel about 450 children are annually diagnosed with hemato-oncological diseases.

About 150 children die every year from cancer. Palliative care for children is provided in different settings, home, hospitals and in “Bet Wiesel”, the supportive care inpatient unit for children which offers various services at different stages of the disease.

We believe that the children have basic rights like: right to privacy, autonomy, open communication, confidence and the right to be treated with dignity; in order to prevent anxiety and isolation in the final stages of life, and facilitate successful treatment.

Difficult ethical dilemmas are encountered in our daily work such as the right to accept or refuse a certain procedure/treatment that in the past rested entirely with the parents or guardian and not with the minor. Rejection of a minor to a medical procedure creates a conflict of values between the child, parents and health care providers. The law in Israel enables a minor to express his intentions, via the parents and thus to accept or refuse the proposed care plan. The ethical question that arises: Would it be correct if the measure of such rights be defined by the minor’s age only? Or by the parents and health care providers who are obligated to protect and preserve the sanctity of the child’s life?

A “tailor made” care plan is designed based on the child’s health condition, wishes and level of understanding considering the parents’ expectations and support needs during every decision making process to obtain optimal care.

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SPIRITUAL APPROACH FOR SICK CHILDREN

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When a child got ill the patient and his family will be affected in different aspects. The psychological aspect of the family and the spiritual status should