

End-of life thoughts in the ICU: results of a survey

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using telemedicine to provide acute burn and critical care consultation on pediatric and adult burn patients in Lviv, Ukraine, as well as in triage and transport of critically ill patients from Lviv to a tertiary-care facility in the USA for further management.

Methods Using a new telemedicine learning center established at City Hospital #8 in Lviv, Ukraine, consultations regarding acutely injured burn victims occurred between physicians in Ukraine and physicians at Shriners Hospital and Massachusetts General Hospital in Boston. After the initial presentation, each patient was reviewed on a daily basis by physicians in Boston. Skype, an Internet-based communication tool, was used in communication with the Burn Center in Lviv. Radiographic images were scanned and digitalized using an electronic scanner, and JPEG image compression was used to facilitate the transmission of radiographic images and patient charts. Informed consent and HIPPA guidelines were followed in transmitting any patient-related information.

Results Since 2011 we have provided consultation on 14 patients in Lviv, Ukraine, ranging in age from 15 months to 63 years. Each patient had an average of six consultations. We present two of these cases as examples of the capabilities of our telemedicine program. The first case involved a 15-month-old female with 40% TBSA from scald injury, where telemedicine was instrumental in the primary assessment as well as to arrange a direct assessment from a nearby burn surgeon. The second case resulted from a house fire with multiple casualties, where physicians in Boston were able to utilize telemedicine to guide the initial resuscitation and airway management of three critically burned children, as well as to arrange for transport of one of the victims, an 11-year-old male with 87% TBSA, from Ukraine to the USA for acute management. Multiple difficulties were overcome in implementing the system between the two countries including: time zone differences, language barrier, and different approaches to patient care.

Conclusion We have established a telemedicine program linking physicians in Boston, MA, USA with City Hospital #8 in Lviv, Ukraine to improve care in pediatric and adult burn patients. Our program has provided consultation on 14 patients since 2011, and it highlights the capabilities of telemedicine for acute consultation as well as triage and transport of critically ill patients to tertiary-care facilities.

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Different aspects of therapy limitation: a comparative study of the nurse's view

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Introduction During the last few years the frequency of end-of-life decisions (EOLD) significantly increased in ICUs. The method of nurse involvement in making EOLD is different worldwide [1,2]. The purpose of this study was to analyze opinions of nurses about therapy restriction. We have examined with a multicenter study the opinions of the medical staff about end-of-life care in Hungarian ICUs.

Methods We performed a questionnaire evaluation among physicians and nurses of ICUs about influencing factors of therapy restriction, the method of the decision-making process, and the frequency of different EOLD. The questionnaire, containing 21 questions, was delivered electronically to Hungarian ICUs, and then we analyzed the responses anonymously. The retrieved 302 answers (191 physicians, 102 nurses) were analysed using a nonparametric Student's test.

Results A total 71% of the nurse responders work in university clinics, 2% in regional centrum, 24% in municipal hospital, 3% in other ICUs. The nurses found both human (2.72/5 vs. 1.98/5) and material (2.81/5 vs. 2.12/5) resources more restrictive factors during patient admission than physicians ($P = 0.025$, $P = 0.0024$). Nurses working in municipal hospital were more strongly influenced by lack of material and human resources (3.34/5, 3.3/5) than nurses working in university clinics (2.2/5, 2.43/5), $P = 0.01$, $P = 0.025$. Younger nurses (working between 6 and 10 years) were more interested in the patient's or surrogate's wishes than older nurses (working more than 10 years). Religion did not influence patient admission and forego therapy; however, religious nurses compared with atheists and nonpracticing believers preferred to prolong therapy against the patient's will ($P = 0.04$). Nurses felt that

physicians slightly involved them in the end-of-life decision-making process (2.1/5 vs. 2.4/5 $P = 0.0001$).

Conclusion We found that the workplace, level of medical attendance, godliness, work experience, and position in medical staff strongly influenced making EOLD. While limitation of the therapy should be team work, nurses felt their opinions were hardly taken into consideration, although nurses seemed to be more realistic in the decision-making process.

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Alternative to improve palliative care for all patients and families in critical care units: development and preliminary evaluation following MRC guidance of the King's Psychosocial, Assessment and Care tool

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Introduction More than one in five people admitted to an ICU will die there. Research has highlighted concerns about support for patients and families and decision-making in this context [1,2]. Here, we describe the development and evaluation of a tool to improve palliative care in a 32-bed general ICU in a central London teaching hospital.

Methods Medical Research Council guidance for complex interventions Phase 0 to I comprised literature review, theoretical modelling, observation and qualitative interviews and focus groups with staff and families exploring concerns and views of interventions identified in the literature review. Phase II comprised intervention development, implementation and evaluation of tool feasibility and effects using staff survey, observation, audit of records and relative survey.

Results Phase I: 47 staff and 24 family members were interviewed. The short time between decisions for treatment withdrawal and death, plus concerns for support management, communication and decision-making, highlighted a need to ensure excellent psychosocial assessment for all. Phase II: as part of integrated care guidelines, we developed the King's Psychosocial Assessment and Care tool (K-PACE). K-PACE is used for all patients entering the ICU, completed within 24 hours of admission. It contains psychosocial assessment of the family and patient needs, and identifies key individuals for contact. Educational training was supported by K-PACE and was implemented in two waves. Post-implementation survey of 95 ICU staff found that most (80%) were aware of K-PACE. Eighty-two per cent of nurses but only 17% of doctors had completed the tool. In total, 158/213 (74%) family members responded to the survey (additionally three patients responded). There were high levels of satisfaction for symptom control and psychosocial care but concerns continued regarding explanation of treatment and care.

Conclusion K-PACE is a feasible tool to improve the palliative care of patients and their families in the ICU. Further refinement is needed and planned, with consideration of roll-out into the wider medical centre.

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End-of life thoughts in the ICU: results of a survey

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Introduction The decision of terminal care in the ICU is a very tough issue because the law, ethics, traditions and futility should

be concerned involving the family's will. Especially, stopping or withdrawing therapy is a quite difficult operation in Japan because of legal issues. Our hypothesis is that some difference exists in thoughts between physicians and nurses for terminal patients in the ICU. The aim of this study is to know their real thoughts.

Methods A questionnaire survey was performed on physicians and nurses in our medico-surgical ICU. The questionnaire consists of 11 questions with five optional answers related to the thoughts of participants about treatment of hopeless or brain death patients. Concretely, the questions were; whether to withhold therapy or not, whether to accept to withdraw therapy or not and with family's will, whether to accept to immediately stop therapy and with family's will, whether to positively or not donate organs from a brain death patient, necessity of ICU care for brain death patients, and feeling guilty and stress for stopping or withdrawing therapy. The optional answer has five gradations from 'Yes' to 'No' for all questions. The participants were asked to answer the questionnaire by expressing themselves without regarding legal issues or the consensus. It was guaranteed to be anonymous for them in the data analysis. The answers were compared between physicians and nurses. The Mann-Whitney *U* test was used for statistical analysis. $P < 0.05$ was considered statistically significant.

Results There were in total 52 participants (response rate 98.1%) with 20 physicians and 32 nurses. Withdrawing therapy was significantly accepted in nurses than in physicians (83% vs. 55%, $P = 0.039$), when the family well understood. Withholding therapy should not be operated for brain death patients for physicians (65%), while it seemed a difficult judgement for nurses (23%, $P = 0.021$). ICU care for brain death patients is less necessary for physicians than nurses (80% vs. 53%, $P = 0.016$). There were no significant differences in other questions between physician and nurses such as feeling guilty or stress for stopping or withdrawing therapy.

Conclusion Some of end-of-life thoughts in the ICU showed differences between physicians and nurses.

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End-of-life decisions in Slovenian ICUs: a cross-sectional survey

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Introduction The purpose of our study was to assess the attitudes of Slovenian intensivists towards end-of-life (EOL) decision-making and to analyze the decision-making process in their clinical practice.

Methods A cross-sectional survey among Slovenian intensivists and intensive care medicine residents from 35 different ICUs was performed using a questionnaire containing 43 questions about views on EOL decision-making. Fisher's exact test and the Fisher-Freeman-Halton test were applied to cross-tabulated data; significance level was set at $P \leq 0.001$ due to the large number of tested hypotheses.

Results The response rate was 72.1% (267 questionnaires were returned out of 370 distributed), which represented roughly the same percentage of all Slovenian intensivists. Termination of futile treatment was assessed as ethically acceptable ($P < 0.001$). The statement that there is no ethical distinction between withholding and withdrawing of treatment could not be confirmed (the answers 'there is a difference' and 'undecided' were less frequent, but not statistically significant; $P = 0.216$). A do-not-resuscitate order (DNR) was used more often than other withholding treatment limitations ($P < 0.001$). A DNR was used most frequently in internal medicine ICUs ($P < 0.001$; compared with paediatric and surgical ICUs). Withdrawal of inotropes or antibiotics was used more often than withdrawal of mechanical ventilation or extubation (66.7% vs. 12.0%; $P < 0.001$). Withdrawal of mechanical ventilation or extubation was more often used in the paediatric ICUs (21.7%) as compared with the internal medicine ICUs (19.6%) and the surgical ICUs (3%) ($P < 0.001$). Over two-thirds (70.6%) of intensivists were against termination of hydration, which would be more often used in the internal medicine ICUs ($P < 0.001$). Thirty-one percent of intensivists used written DNR orders.

Conclusion Termination of futile treatment was found to be ethically acceptable for Slovenian intensivists, although they were not convinced

that withholding and withdrawing of treatment were ethically equal. A DNR would be used most often. Withdrawal of inotropes or antibiotics would be used more often than withdrawal of mechanical ventilation or extubation. Termination of artificial hydration would be rarely used in practice.

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Attitudes of intensivists in the UK to withdrawal of futile therapy

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Introduction We aimed to determine the current practice and attitudes of consultants in intensive care medicine when withdrawing futile life-sustaining therapy. Published guidelines suggest variation in withdrawal of futile life-sustaining therapy and are therefore not prescriptive [1]. Although there is an awareness of differing practices, the extent of these variations is not established.

Methods We surveyed a convenience sample of delegates at the Intensive Care Society (UK) State of the Art Meeting (2012) on attitudes and practice regarding withdrawal practice. Anonymised data were collected using surveymonkey.com.

Results Of 457 consultant attendees from the UK, 149 completed the survey (33%). For 58% of consultants there was no formal institutional protocol for withdrawal of futile therapy. When deciding to withdraw therapy, 57% of consultants routinely seek and document a second opinion. Regarding donation after cardiac death (DCD), 93% of consultants were happy to delay withdrawal to facilitate successful donation, 85% have already done so in their practice and 14% routinely withdraw therapy in theatres rather than on the ICU. Even if it would impact on the care of other patients, 48% would delay withdrawal of therapy to facilitate DCD. For patients accepted for DCD, 36% think that some intensivists withdraw more aggressively (in essence, hasten death) in the hope of improving the likelihood of a successful organ donation and 29% have felt pressurised to withdraw therapy more quickly than their usual practice. Furthermore, 45% experienced pressure to refer a patient for DCD when they felt it was not appropriate.

Conclusion This survey confirms variation in the practice and attitudes to withdrawal of futile therapy amongst UK consultant intensivists. Formal protocols were frequently unavailable to guide withdrawal and second opinions were often not sought. Nearly one-half of the intensivists delay withdrawal to facilitate donation, even if this may impact on the care of other patients. Many intensivists have felt pressure to refer for donation when they feel this is inappropriate and there is a perception that some intensivists may withdraw care more aggressively in those who are accepted for DCD to improve the likelihood of a successful donation. This survey may help inform debate in this ethically challenging area.

Reference

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[http://www.ics.ac.uk/professional/standards_and_guidelines/dcd]

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Parent's perception on end-of-life care in Brazil

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Introduction The aim of the study is evaluate the perceptions of parents of children who died in two Brazilian pediatric ICUs.

Methods An exploratory-descriptive study with a qualitative approach in the PICU of Hospital São Lucas and Hospital de Clinicas de Porto Alegre involving 15 parents of children who died. Data collection was performed through three steps: (a) the researchers contacted the parents through a telephone call to invite them to attend the hospitals; (b) at the hospital, the doctors who assisted the children clarified doubts about the therapy offered; and (c) an interview was carried out by two researchers not involved in the care. Data analysis was performed using the technique of thematic content analysis.