Withdrawal of Treatment - Disparity Between Belief And Practice

Dr. Alex Psirides, Intensive Care Fellow

INTENSIVE CARE UNIT, WELLINGTON HOSPITAL, NEW ZEALAND

Background:

70-90% of all deaths in Intensive Care are preceded by withdrawal of treatment. Several Australasian units have developed withdrawal pathways to provide consistency in their approach to the palliation of dying patients. In our unit, it was observed that there was a large variability in the withdrawal process once the decision to cease active treatment had been made. This included documentation of final family meetings, not-for-resuscitation orders, which treatment and monitoring modalities should cease, and which drugs were to be used for palliation. As a precursor to proposing a more defined and consistent approach to our palliative patients, it was decided to poll staff perceptions of best practice and then compare this with what was observed to have happened.

Method:

Medical and nursing staff were asked to complete an anonymous questionnaire regarding their beliefs surrounding withdrawal of treatment and monitoring. It was stated that this was only in patients of whom the decision to cease active treatment had already been made, not for those on whom treatment had been limited. The question ‘What do you think should be stopped?’ was asked followed by a series of tick boxes listing various treatment and monitoring modalities. The staff member was also asked to indicate whether they were medical or nursing and their number of years of ICU experience.

To determine recent practice, the notes of the last 40 patients who died following withdrawal were audited retrospectively, beginning the day before distribution of the questionnaire. Documentation surrounding the decision to withdraw, treatment and monitoring in place at the time of death, and charted medications were recorded. This information was then compared with the results of the questionnaire.

Results:

Beliefs

56 staff replied (11 doctors, 45 nurses) representing 51% of those eligible to do so. The average ICU experience of respondents was 7.7 years (range 6 months to 20 years), 45% of doctors and 31% of nurses recommended stopping all of the treatments and monitoring listed. Recommending cessation of all monitoring and treatment was more likely with more ICU experience. Enoxaparin was the only treatment that all respondents agreed should be ceased. 43% believed pulse oximetry should continue along with 38% continuing ECG monitoring. 93% believed Total Parenteral Nutrition should be stopped but 80% wished to stop intravenous fluids. 22% believed discontinuing ventilation was inappropriate when withdrawing treatment. 84% and 94% wished to remove arterial and central lines respectively.

Practice

38 of 40 patients (95%) had ongoing fluid administration at the time of death. All patients had respiratory support withdrawn. One patient (2.5%) had all monitoring removed. Four patients (8%) had clear documentation regarding resuscitation status. The notes of 35 patients (87%) contained details of a family meeting and the rationale for withdrawal.

Discussion:

The results show differences in belief between medical and nursing staff and marked inconsistencies in belief and practice. The latter may reflect the wishes of medical staff not being communicated adequately (removal of all monitoring) to those who actually perform the end-of-life cares (the nursing staff). The biggest disparity was seen between stopping fluids, ECG and pulse oximetry monitoring. The reluctance to stop the latter two would seem to be in keeping with the highly monitored environment in which we work where even the dying process is recorded electronically. Internal inconsistencies were also seen with 12% more respondents wishing to stop TPN than intravenous fluids, despite both serving essentially the same purpose. 22% believed that stopping ventilation was inappropriate yet this had occurred in all of the patients at time of death, as extubation at time of withdrawal is an established practice in our unit as is cessation of all vasoactive infusions.

We intend to establish a care plan to standardise documentation and reduce the disparities that were measured in this study. This will improve communication between medical and nursing staff regarding the terminal care of ICU patients. A future audit will assess the effectiveness of this process, combined with feedback from the unit bereavement team to assess family perceptions.

Outcome:

80%

43%

93%

22%

84%

94%

Belief

Practice

Ventilation

Fluids

ECG

Pulse ox

Vasoactives


References:


