

Journal Watch

Dying in Hospital: Medical Failure or Natural Outcome?

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Journal of Pain & Symptom Manag. Vol 22 no 6 1035-1041.

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Received during: Case Rounds, RPCP

Abstract:

The purpose of this study was to describe patterns of medical and nursing practice in the care of patients dying of oncological and hematological malignancies in the acute care setting in Australia. A tool validated in a similar American study was used to study the medical records of 100 consecutive patients who died of malignancies before August 1000 at the Canberra Hospital in the Australian Capital Territory. The 3 major indicators of patterns of end of life care were documentation of Do Not Resuscitate (DNR) orders, evidence that the patient was considered dying, and the presence of a palliative care intention. Findings were that 88 patients had documented DNR, 63 patients' records suggested that the patient was dying, and 74 patients had evidence of a palliative care plan. 46 patients were documented DNR 2 days or less prior to death. Similar patterns emerged for days between considered dying and death, and between palliative care goals and death. 60 patients had active treatment in progress at the time of death. The late implementation of end of life management plans and the lack of consistency within these plans suggested that patients were subjected to medical interventions and investigations up to the time of death. Implications for palliative care team include the need to educate health care staff and to plan and implement policy regarding the management of dying patients in the acute care setting. Although the health care system in Australia has cultural differences when compared to the American context, this research suggests that the treatment imperative to prolong life is similar to that found in American based studies.

Comments:

Strengths:

- This retrospective chart review utilizes a validated tool used by Finn & colleagues to complete a chart review of 100 consecutive patients who died in hospital from an oncological or hematological malignancy over a one-year period.
- The tool allows for both quantitative and qualitative data to be reviewed utilizing data triangulation. (this term is not defined for the reader, but a reference is used)
- Rater reliability was addressed through a pilot of the first 10 charts being reviewed independently by at least one researcher. An experienced oncology nurse extracted the information.
- The authors acknowledge cultural differences and identify 3 ways the study could inform practice, as listed in the abstract. These are very useful.

- The authors identify the need for prospective work that would identify admissions other than when the patient dies and to gather information from other sources than the chart.

Weaknesses:

- Always an issue in palliative care is how one determines from a chart whether the patient is “palliative” and typical coding will not determine this. The authors considered a patient to be dying when certain key words such as “end stage, dying or prognosis grim” were used. They determined the presence of a palliative care plan by words such as “comfort care, supportive care”
- It is clear from the reason for admission that at least 8/100 were admitted for active treatment, with 17 receiving chemotherapy and 14 admitted to ICU suggesting active treatment was the focus of care. Not every patient admitted would be expected to have a palliative care plan if death was not expected. This is a common and acknowledged weakness for retrospective chart reviews.
- The authors suggest in their discussion that “subjecting dying patients to medical interventions no doubt adds to rather than reduces their suffering.” There are times when interventions such as blood work, radiographs are taken to determine the cause of a symptom to know best how to treat it, and should be considered appropriate. The authors do not discuss this issue.
- The term “active treatment in progress at the time of death” is problematic. Does not everyone deserve active care to provide comfort? The term active can be misunderstood.
- It is unclear from the description if the hospital has a palliative care or symptom management team and if so if the impact of that team was included.