

Occasional essay

“While we often manage dying patients, dying is not an indication for admission to an ICU”

He was 87 years old with a past history of tuberculosis, bronchiectasis and severe ischaemic heart disease. His ischaemic heart disease had left him with a dilated cardiomyopathy which required hospitalisation on numerous occasions, particularly over the last six months, due to episodes of acute pulmonary oedema. This admission was no different. He normally had a chronic cough but it had become worse during the night, finally leaving him distraught and gasping for breath. He had previously declared that he did not want cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest, so he was admitted to a general ward for comfort care. However, the ‘not for CPR’ message had not been relayed to the nursing staff so a cardiac arrest call was activated when he became unconscious and pulseless. Intubation, ventilation, 300 mg of amiodarone intravenously, two shocks and he was back in sinus rhythm. The cardiac arrest team burst through the doors of the intensive care unit, unannounced, and presented us with an obtunded and intubated patient. It was only when we read his notes that the background of this man’s problems and wishes emerged.

Thankfully, he was able to be extubated within the next few hours. We monitored him for a further 24 hours and discharged him to the ‘home’ team for further management. During the next few days he remained oxygen dependent with resistant pulmonary oedema and worsening renal failure, so he was admitted to the coronary care unit for further management.

During the period in coronary care, the idea that an aspiration pneumonia was the predominant problem gained momentum.

“If it’s just a pneumonia, we could anaesthetise him and put him on a breathing machine to enable us to remove the sputum which will then allow him to get better” the junior cardiological registrar enthusiastically informed the family “So we will ask the ICU team to admit him. They could also dialyse him.”

As the intensive care registrar was a little unsure of my view on this new turn in events, he asked me my opinion before admitting the patient to the intensive care unit.

“Do you remember Mr. Smith, the man with a dilated cardiomyopathy who was ‘not for CPR’ but was resuscitated and admitted to ICU for 24 hours after he had a cardiac arrest?” the ICU registrar began.

“Yes” I said.

“Well the cardiac registrar said that he needs to come to intensive care for a short period of mechanical ventilation and dialysis to tide him over his aspiration pneumonia and renal failure.”

“Really” I said. I imagined I probably had a wry smile “I better have a look at him.”

I first reviewed Mr. Smith’s case notes to see what had transpired over the last few days and if he had rescinded his decision to not undergo CPR or ‘life support therapy’ in the event of a cardiac or respiratory arrest. His recent investigations revealed that there had been no change in his temperature, pulse, chest x-ray or white cell count, and a repeated echocardiogram still demonstrated an ejection fraction of < 10% with biventricular dilation and left ventricular global hypokinesis.

I went to his bedside and reintroduced myself. “Good morning Mr. Smith, I am Dr. Worthley, you may remember me. I was the ICU specialist who managed you a few days ago.”

He was drowsy and breathless but nodded in acknowledgement. I added “I’m sorry to see that you still have trouble with your breathing. Do you mind if I have a look at you again?”

He nodded slightly and closed his eyes, so I began. I looked at his breathing pattern, asked him to take a deep breath, hold it and then cough, and then listened to his chest. He had coarse crepitations throughout both lung fields and gross peripheral oedema. The pulse oximeter revealed a saturation varying between 86% and 88% whilst breathing oxygen through a face mask.

After asking the registrar to hold my stethoscope, I held the patient’s hand and said slowly “Mr. Smith we have been asked to look at the possibility of giving you life support therapy” I stopped for a moment to allow him to concentrate on what I was saying. “However, I remember that you did not want this the last time we met. Have you changed your mind?”

He opened his eyes a little, looked at me and shook his head. I looked at the ICU registrar and said “I think I should talk to the relatives.”

After a long discussion with the patient’s son and two daughters, I stated that their father’s predominant problem remained his severe cardiac failure and that aspiration pneumonia was not an important component of his illness. Furthermore, as he confirmed that he did not want ‘life support’ therapy, his treatment should be concerned with ensuring that he remained comfortable.

I documented this in the patient’s notes, phoned the cardiac ‘team’ to state that this man did not have an

aspiration pneumonia, did not want ICU 'life support', required an improvement in his current conservative treatment and that perhaps morphine may be useful. I then turned to the intensive care trainee and said that any request that includes the statement "the patient needs to come to intensive care" is really an intensive care consult. I added "It's pretty simple: Intensivists are responsible for the admission and discharge policies for the ICU. If we believe that the ICU and its staff have the facilities and expertise that will benefit the patient, the patient should be admitted, otherwise admission is not required. While we often manage dying patients, dying is not an indication for admission to an ICU"

"From inability to let well alone; from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, science before art, and cleverness before common sense; from treating patients as cases and making the cure of the disease more grievous than the endurance of the same, good lord deliver us."

Sir Robert Hutchison (1871-1960)

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