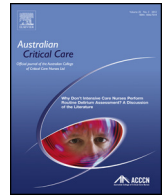




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Research paper

Exploring Australian intensive care physicians clinical judgement during Donation after Cardiac Death: An exploratory qualitative study



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ABSTRACT

Background: Donation after Cardiac Death (DCD) is one possible solution to the world wide organ shortage. Intensive care physicians are central to DCD becoming successful since they are responsible for making the clinical judgements and decisions associated with DCD. Yet international evidence shows health care professionals have not embraced DCD and are often reluctant to consider it as an option for patients.

Purpose: To explore intensive care physicians' clinical judgements when selecting a suitable DCD candidate.

Methods: Using interpretative exploratory methods six intensive care physicians were interviewed from three hospital sites in Australia. Following verbatim transcription, data was subjected to thematic analysis.

Findings: Three distinct themes emerged. Reducing harm and increasing benefit was a major focus of intensive care physicians during determination of DCD. There was an acceptance of DCD if there was clear evidence that donation was what the patient and family wanted. Characteristics of a defensible decision reflected the characteristics of sequencing, separation and isolation, timing, consensus and collaboration, trust and communication to ensure that judgements were robust and defensible. The final theme revealed the importance of minimising uncertainty and discomfort when predicting length of survival following withdrawal of life-sustaining treatment.

Conclusion: DCD decisions are made within an environment of uncertainty due to the imprecision associated with predicting time of death. Lack of certainty contributed to the cautious and collaborative strategies used by intensive care physicians when dealing with patients, family members and colleagues around end-of-life decisions, initiation of withdrawal of life-sustaining treatment and the discussion about DCD. This study recommends that nationally consistent policies are urgently needed to increase the degree of certainty for intensive care staff concerning the DCD processes.

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1. Introduction

In Australia organ transplantation is a well-established clinical practice and it is supported by the Australian Community. Organ transplantation is now considered a desirable treatment for many diseases, which affect organ function.¹ Donation after Cardiac Death (DCD) is a possible solution to the world wide organ

shortage.² However, it was largely abandoned in the 1980s once the neurological certification of death could be legally used to declare death.³ DCD has been re-introduced in many countries, including Australia, because of improved perfusion techniques which have led to better transplant outcomes.⁴ Recent studies have found that health care professionals have not embraced DCD and are reluctant to consider DCD as an option for patients.^{2,5–7}

There is evidence that health professionals are uncomfortable with the lack of standards for mortality prognostication and cardiopulmonary death. Moreover there is a perception that a perceived conflict of interest concerning priorities of goals of care exists between the junction of end-of-life care and the transition to implementing DCD procedures.⁶ Intensive care physicians are also apprehensive when performing clinical assessments that

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involve a prognosis of mortality and making a clinical judgement determining whether a patient could be a suitable DCD donor.⁸ Mortality prognostication and the associated requirement for an intensive care physician to predict survival times (to prevent prolonged warm ischaemia) following withdrawal of life sustaining treatments (WLST) have created uncertainty and trepidation for intensive care physicians.^{8–11} It has been shown that uncertainty about prognostication is due the wide variation in fertility assessments and practice surrounding WLST which precedes DCD.^{9–17}

Decision-making around end-of-life care in critical care has been studied extensively,¹⁴ although, the complexities of how intensive care physicians make their judgements prior to initiating end-of-life care is not well understood. Current research associated with DCD has focused primarily on ethical concerns and clinical objective variables in the international setting.^{4,6,18–21} This paper reports the findings of a small exploratory study which sought to identify the tensions and complexities experienced by intensive care physicians when assessing and identifying potential DCD candidates in Australia.

2. Methods

An interpretative exploratory approach was used to make sense of people's experiences within their own environment. This approach is useful to discover in-depth explanations from the perspective of participants when involved in prognostic decision making for the purpose of determining mortality and survival times necessary for DCD candidate selection.²²

Network sampling technique was used to recruit participants from three hospitals in New South Wales, Australia. This sampling method allows researchers to access populations that are not easily identifiable or are small in number. Furthermore, this sampling technique is used when eligible people are known to the researcher and participants can involve other participants known to them who are interested and eligible.²² All participants were members of the Faculty of Intensive Care Medicine and were recruited through an email invitation distributed by the Director of the Intensive Care Department or through the New South Wales (NSW) Organ Donation Intensive Care Physician Liaison committee. In exploratory qualitative research, the sample size is not pre-determined, rather data collection continues until saturation of themes is achieved.²³

Data was collected through semi-structured interviews with questions developed from the experiential knowledge of the authors and current literature (see Table 1). Participants were encouraged to expand on their responses by using additional probing questions such as “can you please tell me more about. . .” and

“what do you mean by. . .” Interviews lasted 60–90 min and were conducted in person at a location determined by the participant or over the telephone. Only minimal participant characteristics were obtained during data collection as: (1) it was not relevant for this type of study, (2) it contributes to protecting participant anonymity, and (3) all ethics committees agreed that other demographic details did not add value to the study. Interviews were transcribed verbatim.

Verbatim transcripts were then subjected to thematic analysis using inductive techniques.²¹ Thematic analysis involves searching through the data to identify recurrent patterns. A recurrent pattern then becomes a theme. The first analytical step involves coding each transcript line-by-line to develop first level codes. Subsequent steps involved grouping the initial codes into higher order common categories and then into final interpretive themes. These later steps were conducted by both authors independently. Discussion between the authors then occurred around the proposed theme. Through an exhaustive process of analysis and comparison back to the original transcripts, data were arranged in themes. These themes were then evaluated for the most appropriate fit with the original data (i.e. rigor). Saturation became evident as no new themes emerged. Finally one of the participants was invited to review the themes (i.e. confirmability).

Both hospital and university ethics approval was obtained at all sites from where participants were recruited. All participants were provided with an information statement prior to providing written consent. Each participant also had the option to withdraw consent at any time. All intensive care physicians approached agreed to participate (i.e. no-one refused) and neither did any participants subsequently withdraw. Interview transcripts were de-identified with numbers replacing participants' names.

3. Findings

Six intensive care physicians (5 males) were interviewed from three different hospital sites. All participants were qualified intensive care specialists who had, at the time of recruitment, performed between two and fifteen DCD candidate selections. Participants described having been involved in as little as 30 or “too many to count” end-of-life judgments.

Thematic analysis revealed three distinct themes: (i) reducing harm and increasing benefit; (ii) characteristics of a defensible decision; and (iii) minimising uncertainty and discomfort.

3.1. Reducing harm and increasing benefit

The first theme revealed how increasing benefit to the patient and their families was extremely important and a major focus for the participants in this study. If any treatment decisions led to harm for dying patients, participants felt it was ethically wrong to proceed with discussions concerning DCD. Accordingly, it was important for participants to create a benefit (e.g. initiate palliation and reduce suffering through undesired active treatment) for the patient and family. Participants felt it was essential to identify when active treatment was no longer curative and ongoing treatment became a burden to the patient. This was expressed by participant one as:

“... people go from being salvageable to being unsalvageable and that you begin to recognise when the person is no longer just very sick but is in fact actively dying and that once they move from that and into the face of being inevitably dying that I feel quite comfortable that I have reached the limit of my ability to make this person better,”

Table 1

Interview questions.

1. Could you tell me the number of patient assessments for potential Donation after Cardiac Death you have undertaken?
2. Could you describe how you make a prognosis of mortality in an intensive care patient?
3. Could you describe how you determine patient survival time following withdrawal of life sustaining treatment?
4. Please describe the NSW criteria for selecting of Donation after Cardiac Death candidate.
5. Could you please explain how you select a candidate for DCD?
6. Please tell me about your experiences of identifying a candidate for DCD.
7. Which elements of the criteria are
 - (i) easier to assess and why;
 - (ii) more problematic to assess and why?
8. Are there any aspects of identifying a DCD donor that you find confronting or inhibiting?
9. What have you learnt about or developed in your practice related to:
 - (i) candidate selection;
 - (ii) withdrawal of life-sustaining treatment; and
 - (iii) DCD process?

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