



Do End-of-Life Communication Tools Improve Decision-Making?



Patients admitted to the ICU commonly have not have discussed their end-of-life (EOL) goals with family or surrogate decision-makers. Even if patients have discussed their preferences, they may not be documented in the medical record. ICU staff therefore may need to discuss goals with families and patients. A variety of decision aids, communication tools and interventions have been developed to guide conversations. A [systematic review and meta-analysis](#) of 19 studies in the ICU setting, published in [Critical Care](#) (Oczkowski et al. 2016) found that use of communication tools increased documentation of goals-of-care discussions, but did not affect code status documentation. Overall the quality of evidence was low.

The study, by [Dr. Simon Oczkowski](#), [Division of Critical Care, McMaster University](#), Hamilton, Canada and colleagues from McMaster University and the [Canadian Hospice Palliative Care Association](#), found very low-quality evidence that the use of structured communication tools increases the number of documented goals-of-care discussions and low-quality evidence that they do not affect the number of patients with documented code status / Do Not Resuscitate (DNR) forms or decisions to withdraw/withhold life-sustaining treatments. They also found very low-quality evidence that the use of structured communication tools results in reduced health care resource utilization compared to usual care.

They conclude: “Given the centrality of end-of-life decision-making to the care provided in the ICU, it is surprising that our review found so few studies evaluating the use of structured communication tools to assist surrogate decision-makers and clinicians with this process. Only very low-quality evidence (from one randomised controlled trial with a high risk of bias and four observational studies) was found that evaluated whether such tools increase the number of documented goals-of-care discussions, indicating that future studies are very likely to alter our estimates of effect.”

See Also: [Canadian Researchers at the End of Life Network \(CARENET\): Interview with Professor Daren Heyland](#)

The authors note that it is surprising to find that the use of communication tools, in comparison to usual care, had minimal to no effect in the studies that reported on these outcomes. Reasons may include underpowered studies, ineffective tools or tools with variable efficacy or because there is little room for measurable improvements beyond standard care once the patient is in the ICU. They suggest that if the latter is true, “it may be more effective to direct structured interventions earlier in the course of a patient’s care, before they are in the ICU, when there is a greater opportunity for such interventions to help patients and families create documented care plans, and improve the concordance between the care they receive, and the care they wish to receive.”

The authors recommend further research into simple communication interventions to compare structured to ad-hoc approaches to end-of-life decision-making in relation to patient, family and systems outcomes. Such research should include including concordance between patient wishes for care and the care received at the end of life.

Withdrawal of Life Support in ICUs

Also from Canada, [Jesse W. Delaney, MD, from Rouge Valley Health System, Toronto](#) with [James Downar, MDCM, MHS, from the Department of Palliative Care Medicine and the Department of Critical Care Medicine, University of Toronto](#), have written a narrative review of the withdrawal of life support (WDLS) in intensive care units (ICUs). The article is published in press in the [Journal of Critical Care](#). Their review is intended to inform the development of guidelines for the withdrawal of life support, and covers the literature on 6 themes: preparation for WDLS, monitoring parameters, pharmacologic symptom management, withdrawing life-sustaining therapies, withdrawal of mechanical ventilation, and bereavement. There were few relevant publications, but the authors note that these agreed on important elements of WDLS, including preparation, monitoring, symptom management, withdrawal of therapies and support for patients and families. As the literature shows significant variation in the practice of WDLS, they suggest that it is therefore reasonable to extend the use of the validated scales recommended in current pain, agitation and delirium guidelines to WDLS

Advance Care Planning Day

Canada holds a [National Advance Care Planning Day](#) on 16 April. [Speak Up](#) is the campaign aimed at promoting discussion on wishes for future health care.

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