Occasional essay

The management of death in the ICU. “The South African perspective”

South Africa is a culturally and economically diverse country that is reversing the legacy of the Apartheid years. This process is being significantly hampered by two “epidemics” that have a profound impact on provision of intensive care services:

1. HIV/AIDS
2. Trauma – due to
   a) Motor vehicle accidents
   b) Interpersonal violence

The population of South Africa currently stands at approximately 45 million people, made up of 85% Black, 10% White and 5% Indian and Coloured South Africans. Twenty percent of the population is covered by medical insurance and is cared for in private hospitals that consume 60% of the healthcare expenditure and employ 70% of medical specialists in South Africa. The State Healthcare system consumes 40% of South Africa’s healthcare expenditure and employs 30% of the medical specialists to care for 80% of the population, half of whom are not formally employed. The State healthcare system also provides the majority of training for healthcare professionals in South Africa.1

Critical Care has been recognised as a medical subspecialty in South Africa for more than 10 years. Sub-specialists from primary specialties, including Medicine, Surgery, Paediatrics and Anaesthesia are registered with the Health Professionals Council of South Africa (HPCSA) after two years of training in an intensive care unit (ICU) accredited by the HPCSA. For the past three years a fellowship in Critical Care has been recognised by the College of Medicine of South Africa, requiring not only two years of training but the completion of a written and oral examination.

In the State sector the majority of units are “closed” and managed by an intensivist, as opposed to the private hospitals, where the majority of units are “open” with very limited intensivist input.

End-of-life (EOL) decisions in State ICUs
The State hospital ICUs are limited in their effectiveness by a number of factors including:

1. Staff shortages, due to personnel losses to the private hospitals and other countries,
2. Resource shortages due to,

a) Limited budgets for healthcare resulting in a decline in the number of ICU beds to less than 1:100,000 population,2 compared with the recommendation of 5 per 100 000,3 and
b) High demand due to the HIV/AIDS and trauma “epidemics”.

3. Increased severity of illness due to delays in treatment at many levels, including:
   a) Pre-hospital rescue and resuscitation,
   b) Emergency room management, and
   c) Operative management.

State hospital ICUs typically have occupancy close to 100%, resulting in up to half of all requests for admission being refused on the basis of “no beds”.4

In South Africa, continued intensive therapy for a dying patient will prevent the resource being utilised by that patient from being used by another critically ill patient who will die without it.5

State hospital intensivists must make decisions to maximise the utility of the resource on the basis of:

1. Triage – refusal of patients with a low likelihood of survival with or without intensive therapy, and
2. Futility – withdrawal of therapy in patients who are failing to respond to intensive interventions.

Triage decisions are typically made during a consultation between a referring clinician and the ICU physician. These decisions are usually based on criteria that are understood within the hospital and/or centre but are seldom described in a written guideline. Should an ICU admission be considered inappropriate by the clinicians involved, this decision may or may not be raised with the family depending on the circumstances of the case.

In Durban, decisions on futility are made by the ICU team with the patient’s nurse as a central participant. A critical decision required of every intensivist every day on every patient treated in their ICU is whether the efforts and resources being expended on each patient are saving the patient’s life or prolonging his or her death. This is not a simple or easy decision and generally requires wide consensus, not only between the treating clinicians,6 but must include the patient and his/her family.

Discussions with families in South African state ICUs may be hampered by:

1. Language barriers – Interpreters are often needed and misinterpretation is common. This may be particularly relevant if family members act as interpreters.
2. Cultural barriers – South African society is still largely based on a paternalistic system where decisions are devolved to a senior (usually male) family member.

A study from France has suggested that many family members do not want to be involved in
decision-making in the ICU setting. There is no similar study in South Africa, but the impression of State intensivists is that the results would not differ substantially.

Despite these barriers it is still possible and desirable for families to be involved in the decision-making process. Every attempt is made to speak with the family as early as possible, especially where death is deemed a possible, or likely, outcome. The first thing the intensivist does is attempt to determine what role families want to play in medical decision-making. Members of the care team from a similar cultural background to the patient are invaluable in assisting in this decision. Every attempt is made to avoid placing the family in a position where they feel they are being called upon to make a momentous/irreversible decision, so that they are not left with a burden of guilt.

The legal validity of a medical decision to limit therapy in the face of family demands for continued treatment has not been tested in the South African context. The attitude of the South African legal system may be inferred from a case in which renal dialysis was denied by a state hospital to a patient with chronic renal failure. The hospital argued that the patient did not meet the criteria for transplantation and thus had an incurable disease that should not be treated further as this would deny treatment to patients in whom cure was possible. The patient argued that his right to life guaranteed by the constitution was being infringed. The Constitutional Court found in favour of the hospital and the patient subsequently died. Cases involving medical decisions in South Africa are heard by a judge with two appropriately qualified medical practitioners acting as assessors.

End-of-life (EOL) decisions in private ICUs

Private ICUs in South Africa have facilities very similar to those in non-teaching ICUs in the USA. In terms of staffing there are a very limited number of “closed”, intensivist-led ICUs in South African private hospitals. The majority of units are “open” and do not have an intensivist director or appropriate junior medical staffing. The interventions applied in these ICUs, often by specialists such as cardiologists, pulmonologists, nephrologists, neurologists, etc., result in improvement in surrogate endpoints while likelihood of survival often does not improve. Efficient preservation of vital organ function over prolonged periods means that death in the ICU is increasingly becoming a process initiated by withholding or withdrawal of organ support. Clinicians in South African private ICUs are generally not specialist intensivists and thus have limited experience in initiating appropriate EOL discussions regarding withholding or withdrawing therapy in the ICU. Usually an overly-optimistic attitude to outcome is prevalent in private ICUs.

Initiation of EOL discussions is extremely stressful. Continued therapy regardless of prognosis is generally well accepted, both by hospital administrators and families. This acceptance may be reversed at the point where health benefits (funds) are exhausted. At this point hospital administrators are concerned by ongoing potential financial losses and families are concerned by generation of potentially crippling debt. This may result in requests for transfer to a State institution for continued therapy or limitation of therapy, followed by transfer out of ICU or death. Transfer to a State ICU is very unlikely, given the fact that the patient is already in an appropriate institution and State facilities are severely constrained. Limitation of therapy may be appropriate, but families should not be left with the feeling that therapy was withheld due to their inability to pay. Funding issues nevertheless may be the initiator of EOL discussions.

Intensivists working in State institutions have a role to play in Private ICUs:

1. Regular rounds – The aim is primarily to improve outcome for patients surviving their ICU admission, but patients in whom withdrawal may be appropriate could be identified and the necessary discussions between the care team and family initiated.

2. Specific EOL consultations – Private clinicians who identify patients in whom withdrawal may be appropriate could discuss such cases with State intensivists. The intensivist could then assist in facilitating the process of withdrawal by achieving consensus within the care team and initiating appropriate communication with the family.

CONCLUSION

At present, South African intensive care faces a dichotomy of a State ICU service with reasonable systems in place but severe resource constraints and a Private service with adequate resources but largely deficient systems. With better communication between the services the needs of dying patients may be more appropriately met.

R. E. HODGSON
Department of Anaesthetics, Nelson R Mandela School of Medicine, Durban, KwaZulu-Natal, SOUTH AFRICA

REFERENCES


8. Thiagraj Soobramoney vs. Minister of Health, Province Of Kwazulu-Natal, South Africa. Durban Supreme Court Case Number 5846197, August 1997.