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Fulfilling 'three wishes' helps ICU staff honor dying patients

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(Reuters Health) - Doctors and nurses in a Canadian intensive care unit found that asking dying patients – or their families – to make three simple wishes, and then fulfilling those wishes, helped bring peace to the end-of-life process and ease grief.

Patients and families were invited to participate in the “Three Wishes Project” after a decision was made to withdraw life support, or when the patient’s probability of dying in the unit was believed to be greater than 95 percent.

At St. Joseph's Healthcare Hamilton in Ontario clinicians asked how to honor patients by eliciting at least three wishes from them or their families. Then, they worked to implement those wishes - such as allowing a pet to visit, facilitating a Skype reunion, hosting a wedding vow renewal, providing Scottish bagpipe music at death or deferring life support withdrawal until after a holiday.

“We are trying to improve the quality of the dying experience in the cold, technological, efficiency-driven intensive care unit,” said Dr. Deborah Cook of McMaster University Health Sciences Center in Hamilton, one of the authors of a report on the Three Wishes Project.

“This is a time when compassion is called for from everybody,” she said.

To study the effects of the project, she and her colleagues enrolled 40 patients, and 159 of their 163 wishes were implemented. The cost ranged from nothing to $200 dollars per patient. Wishes were classified into five categories: humanizing the patient (for example, recreating date night in the ICU), personal tributes (providing a final meal for the family in an ICU conference room), family reconnections (dying with all family members present), rituals and observances (bedside memorial service) and “paying it forward” (organ donation).

Within six months after a patient’s death, the researchers interviewed at least one family member. In addition, within two weeks after a death, three clinicians who had cared for that patient responded to emailed questions. A qualitative analysis of transcripts, letters and field notes reflects a personalization of death by dignifying the patient, extending families a voice and fostering clinician compassion.

As reported in Annals of Internal Medicine, one mother said the program “honors the everyday hero: someone who may go unnoticed but whose life counted.”

A patient's daughter responded that "it struck a chord because it allowed me to talk about her, and . . . . give the staff . . . a vision of who she was."

A nurse wrote, "This is putting the absolute human side into the whole experience. I think this project is so powerful."

Dr. Anne Woods, a co-author and palliative care physician, told Reuters Health that the project's strength was in making the dying visible.

"It let them be seen as people, not as patients," she said. "The family knew they were seen, and the patients who were alert knew they were seen as people, and that they mattered."

In fact, solicitation of patient wishes was rare. Due to impaired consciousness, 33 of 40 dying patients could not express desires. Family members requested wishes for them.

Because of this, and because there wasn't a comparison group of patients and families who didn't make wishes, the project is "worthwhile" but "proves little," said bioethicist Craig Klugman, chair of DePaul University's Department of Health Sciences in Chicago.

"They conclude that this does something for the dying person, but in fact, of 40 dying people, only seven were able to speak," Klugman told Reuters Health. "It's impossible to claim any benefit for patients."

But Patrick Cullinan, medical director of critical care services at Metropolitan Methodist Hospital in San Antonio, Texas, feels that any intervention that allows families to feel cared for is valuable.

"It's giving a face to a faceless process," Cullinan, who was not involved in the study, told Reuters Health. "The patient is being told indirectly that we care about you, we care about your loved one and we want to help you with the grieving process."

Perhaps the project's best result is the recognition by ICU staff that they can offer meaningful gestures at any time.

"They now know to ask 'What can I do for you?' and 'What could make this a good day?' and they do that," Woods said. "There's never a time when someone can say now 'There is nothing more I can do for you.' There is always something more for you to do."

Funding for the Three Wishes Project came from the Hamilton Academy of Health Science Research Organization, the Hamilton Chapter of the Canadian Intensive Care Foundation, the Canadian Tire Foundation (Hamilton Branch), several physicians and from some of the relatives, friends and colleagues of the patients.

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