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Project eases grief during ICU end-of-life

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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. ***Reuters Health*** reports that 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%.

At **St Joseph's Healthcare Hamilton** in **Ontario** clinicians asked how to honour 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 Centre** in **Hamilton**, one of the authors of the report. "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: humanising 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 personalisation of death by dignifying the patient, extending families a voice and fostering clinician compassion.

As reported, one mother said the programme "honours 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 is quoted as saying 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, the report says, 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 said in the report. "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, said. "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."

Abstract
Background: Dying in the complex, efficiency-driven environment of the intensive care unit can be dehumanizing for the patient and have profound, long-lasting consequences for all persons attendant to that death.
Objective: To bring peace to the final days of a patient's life and to ease the grieving process.
Design: Mixed-methods study.
Setting: 21-bed medical–surgical intensive care unit.
Participants: Dying patients and their families and clinicians.
Intervention: To honor each patient, a set of wishes was generated by patients, family members, or clinicians. The wishes were implemented before or after death by patients, families, clinicians (6 of whom were project team members), or the project team.
Measurements: Quantitative data included demographic characteristics, processes of care, and scores on the Quality of End-of-Life Care–10 instrument. Semistructured interviews of family members and clinicians were transcribed verbatim, and qualitative description was used to analyze them.
Results: Participants included 40 decedents, at least 1 family member per patient, and 3 clinicians per patient. The 159 wishes were implemented and classified into 5 categories: humanizing the environment, tributes, family reconnections, observances, and "paying it forward." Scores on the Quality of End-of-Life Care–10 instrument were high. The central theme from 160 interviews of 170 persons was how the 3 Wishes Project personalized the dying process. For patients, eliciting and customizing the wishes honored them by celebrating their lives and dignifying their deaths. For families, it created positive memories and individualized end-of-life care for their loved ones. For clinicians, it promoted interprofessional care and humanism in practice.
Limitation: Impaired consciousness limited understanding of patients' viewpoints.
Conclusion: The 3 Wishes Project facilitated personalization of the dying process through explicit integration of palliative and spiritual care into critical care practice.