case study

Refusal of termination of life support in the intensive care unit of Mulago Hospital (Kampala, Uganda)

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ABSTRACT

A lot of research and debate has taken place on refusal of termination of life support systems in developed countries. Little however has been done from less developed nations with resource limited settings and in which the concepts of death and dying differ significantly from those of the West. These differences arise in part from factors such as culture, norms and religion that define how individuals view death and hence decisions relating to the dying process. There may also be significant differences in health care systems, family and community relations and how clinicians relate with proxy decision makers of dying patients. Furthermore, there is often lack of formal institutional frameworks or policies related to the handling of dying patients. To illustrate these differences we describe below a case of refusal by relatives to terminate life support in the Intensive Care Unit of Mulago Hospital, in Kampala, Uganda.

Keywords: Life support care, Intensive Care Unit, life support systems, moral policies, situational ethics, developing countries, Africa.

INTRODUCTION

We report a case of refusal of termination of life support in a brain dead patient in the Intensive Care Unit (ICU) in Mulago Hospital (Kampala, Uganda), which is a unit with resource limited settings. Ethics approval was obtained from the Ethics Committee of Mulago hospital for the publication of the present case study. The aim of this case study is to pose ethical concerns among developing countries, for the degree of contemplating these challenges that may vary from one place to another, according to resourses availability, educational level and national cultural differences.

CASE PRESENTATION

A 72 year old female Ugandan was admitted at 6 pm to a district hospital more than 150 miles from Kampala with sudden loss of consciousness. Four years earlier, she had been diagnosed with a posterior cerebral aneurysm. Physical examination revealed very high blood pressure and a Glasgow coma scale of 6/15 and unequal pupil sizes. Management for an unconscious patient with hypertensive stroke was initiated. The following day she was transferred to the national referral hospital in Kampala for further care. Upon arrival at 4.45 pm a CT scan of the brain showed massive intracerebral and intra-ventricular haemorrhage with severe cerebral edema. She was received at the ICU at 5 pm. At this time the Glasgow coma scale was 7/15 with systolic blood pressures swinging between 130 and 190 mmHg and diastolic between 70 and 110 mmHg without intervention. She had irregular breathing and was intubated, and started on synchronized intermittent mandatory mechanical ventilation. The following day at 11.00 am the blood pressure crashed to 70/40 and the patient was started on vasopressor support with dopamine. At this time she had declining respiratory effort and was started on continuous mandatory ventilation. One hour later she had evident clinical features of brainstem death: dilated non-reacting pupils, absent corneal, cough, gag reflexes and dolls eye movements. Brain death was further confirmed by EEG at 2 pm which showed flat tracings. The entire medical team which comprised of a neurosurgeon, a neuro-physician, a general surgeon, an anaesthesiologist, an internal medicine physician and the nurse in-charge of the ICU proposed to terminate the life support system at a single meeting. The hospital ethics committee was not consulted since it only handles research issues. The relatives were informed about the findings of brain death by the medical team at 2.30 pm and were allowed to see the patient who was still on the life support machines. They included the husband, two daughters, and two in-law relatives. The information was delivered in English well over 30 minutes and adequate time was allowed for questions. The relatives, who had strong Christian beliefs, understood the explanation of brain death but maintained that since the heart and other organs were still functional, the life support systems should not be switched off. They argued that since it is God who gives and takes life they had no mandate to terminate the life of another. The medical team did not press them to change their mind. The patient was allowed to continue on life support as well as other components of medical care including vasopressor support and feeding. At 5 pm the patient had a cardiac arrest with ECG tracings showing asystole. At this time the medical team decided not to do any cardiac resuscitation using in house operational guidelines which are still in the process of being developed. The relatives were told that the heart had stopped and therefore the patient was dead. They agreed with this new position and were in agreement with switching off the machines. The life support machines were switched off at 5.30 pm.

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