加護病房「不施行心肺復甦術」醫囑之相關因素探討

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摘要

背景：加護病房裡有關生命末期醫療照護的抉擇往往非常困難及複雜，施予心肺復甦術常造成處於生命末期病人極大的痛苦，對家屬而言，亦為兩難的決策過程。

目的：本研究探討加護病房施行「不施行心肺復甦術」（Do Not Resuscitate，DNR）醫囑的現況及相關因素，並瞭解開立「不施行心肺復甦術」醫囑後對病人所接受的醫療處置的影響。

方法：採病歷回溯性調查。以 2001 年 1 月 1 日至 2006 年 12 月 31 日止，東部某醫學中心成人內、外科加護病房所有病危、留一口氣出院或死亡病人之病歷為調查基礎，共計收集簽署「不施行心肺復甦術」同意書之病歷 211 本，未簽署之病歷 204 本，以自擬結構性資料擷取表進行病歷資料收集及統計分析。本研究經慈濟醫學中心人體試驗委員會審查通過（編號：IRB096-36）。

結果：本研究發現，病人年齡愈長及有宗教信仰者有較高比例簽署「不施行心肺復甦術」同意書。211 位有「不施行心肺復甦術」醫囑病人的資料顯示，在加護病房平均住院天數 9.0 天，由入住加護病房至開立該醫囑期間為 5.8 天。在有開立「不施行心肺復甦術」醫囑者當中，由填寫同意書到死亡的時間為 3.2 天；約 68%的病人於該醫囑開立後一天內死亡；而有 72%病人是由醫師建議開立「不施行心肺復甦術」醫囑；超過半數（58%）的「不施行心肺復甦術」同意書是由子女填寫；開立「不施行心肺復甦術」醫囑時，有 83%病人本身處於昏迷狀態；較之於未簽署「不施行心肺復甦術」同意書的病人，簽署「不施行心肺復甦術」同意書的病人在死亡前 48 小時仍接受體外心臟按摩、心臟電擊、氣管內管及升壓劑的比例有明顯下降。

結論：由於開立「不施行心肺復甦術」醫囑的時間多在病人入住加護病房後，造成病人在生命末期遭受到不必要的治療及痛苦，為免無效醫療及改善病人臨終的照護品質，針對社會大眾及醫療人員進行預立「不施行心肺復甦術」決策宣導與相關教育課程是刻不容緩。

關鍵字：不施行心肺復甦術、加護病房、生命末期

Factors influencing Do-Not-Resuscitate orders among patients in Intensive Care Unit

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Abstract

Background：Making decision of life saving treatment among end-of-life patients and their families is a dilemmas choice in any setting and this is in particular difficult in the intensive care unit. There were many patients in intensive care unit suffering from the administration of cardiopulmonary resuscitation.

Objectives：The purpose of this study was: 1) to investigate the prevalence of a DNR order among patients in intensive care unit; 2) to explore factors that influence decision making of Do-Not-Resuscitate (DNR） among patients in intensive care unit; 3) to explore the impact of a DNR order on the treatment following the order.

Methods：This was a retrospective study. A stratified random sample of 415 participants, who expired or Discharged Due to Terminal status (DDT) from a medical or surgical intensive care unit of a medical center in eastern Taiwan. Participants were recruited from January, 2001 to December, 2006. Among the 415 participants, 211 who received a Do Not Resuscitation (DNR) order were classified into DNR-order group and 204 who did not receive a DNR order were classified into no-DNR-order group. A data extraction form was designed to collect relevant data from charts. Ethical approval was obtained from Tzu Chi Medical Center(No.IRB096-36).

Results：Among 211 patients who were in DNR-order group, 210 patients received DNR orders after ICU admission. In total, the length of stay in ICU is about nine days. The average durations from admission to be prescribed DNR order and from being prescribed DNR order to expiration were 5.8 and 3.2 days, respectively. Most of patients in ICUs (68%) were expired within one day after signing a DNR consent form.

The majority of the DNR decisions(72%) were initiated by physicians and the informed consent for a DNR order was mainlysigned by patients' adult children (58%) instead of patients themselves. Most of patients (83%)were comatose when DNR consent was signed. After prescribing a DNR order, patients were less likely to receive life-support therapies, including vesopressors, cardio massage, cardio defibrillation, and biochemistry blood test. Increasing age and religious belief were significant predictors of the decision of receiving a DNR order.

Conclusion：Factors of increasing age and religious belief among intensive care unit participants in the current study were found to be significant predictors when signing a DNR consent form. The timing of prescribing a DNR order was usually in an end-of-life stage, in which patients might not be able to make decision on their behalf and may cause them suffered from unwanted medical treatment. For considering patients' optimal benefit, dissemination of the concept of "Do Not Resuscitate" to both public and health professionals is warranted. Only then, quality of end-of-life care can be further improved.

Keywords：Do Not Resuscitate (DNR)、Intensive Care Unit (ICU)、End-of-life care