Inter-field Agreement Among ICUs Medical Directors and Clinical Ethics Consultants Concerning End-of-life Decision Making in the Texas Medical Center

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Objective

- **This study assesses consensus among decision makers working in critical care settings.**
- **The focus of this work is treatment utilization at the end of life.**

http://www.georgeinstitute.org/find-an-expert/critical-care-and-trauma

Design and Methods

- **Methods**
  - Utilization of existing Likert-scale based qualitative questionnaire tool
  - Convenience sample enlisted through email outreach

Population

- **Critical care medical directors, ethicists, and intensivists**
- **Employed at institutions within the Texas Medical Center in Houston, Texas (representing 6 hospitals)**
- **n = 27**
  - Current or former critical care medical directors (n = 12)
  - Intensivists (n = 6)
  - Ethicists (n = 8)
  - Undeclared (n=1)

Preliminary Results

- Response rate was 55.1% (n = 27)
- Consensus was set at ≥80% agreement in accordance with prior uses of the survey tool
- Consensus was assessed on 36 survey items
- Consensus was revealed on 21 items
- Highest consensus on any single item was 96% (n = 25)
- Lowest consensus on any single item was 35% (n = 7)
- ≥90% consensus was reached on 9 items
- ≥80%- 89% consensus was reached on 12 items

Notable Findings:

Age

- **Age as a factor in life-sustaining treatment decision making**
  - **Age is never the sole factor** used to determine whether to withdraw or withhold life-sustaining treatments (89%)
  - **There ought not be an age-based threshold** for the mandatory withdraw of life-sustaining treatments (96%)
  - Consensus threshold was **not** demonstrated concerning the **prioritization of treatment for the young over the old** regardless of resource availability
    - However, only 12% disagreed to **prioritizing the young over the old in emergency conditions when resources are limited**

Notable Findings:

Dialogue

- **Dialogue in decision-making processes**
  - Seven out of 10 questions revealed consensus, most significantly Respondents agreed
  - withdrawing/withholding conversations ought to take place in response to a request from the patient or family (92%)
  - that a goal of care conversation ought to take place within 24-48 hours of an admission to the intensive care unit (92%)
  - **No consensus** about introducing the concepts of withdrawing or withholding care within 24-48 hours of an admission to the intensive care unit (68%, s = 3.09)

Notable Findings:

Consensus

- **Consensus in decision-making processes**
  - Four questions, none showed agreement among respondents

1. No agreement that consensus of the treating physicians is required before withdrawing or withholding life-sustaining treatments
2. No agreement that consensus of nurses is required before terminating life-sustaining treatments
    1. This item demonstrated the survey's lowest level of agreement among the respondents (35%)
3. No agreement about formal EOL meetings with all parties (only half have it!)
4. No consensus for driving WH/WD of care discussions <48 hours from admission

Notable Findings:

Timing and Triggers

- **Timing and trigger events**

  Consensus about timing and trigger events included:

  –Respondents agreed that life-sustaining treatments ought to be withheld or withdrawn if they no longer serve the patient's best interest

  – Life-sustaining treatments can be permissibly withdrawn or withheld when the net health benefit of the treatment is not improving the patient's quality of life

  –Respondents found agreement that a patient's predicted survival ought to trigger the decision to withdraw or withhold life-sustaining when the patient's survival was < 2 weeks

  - However, respondents had no consensus for the same question in patients whose life expectancy was <3 months

Notable Findings:

Involvement of Nurses and Process

- Lowest consensus
  - Our ICU has formal nurse/physician discussions/meetings about end-of life care decisions for most individual cases (48%)
  - Is consensus of nurses necessary before the withholding or withdrawing of life-sustaining-treatment? (35%)

Limitations

- **Pilot research**
  - Provides an initial assessment and suggests future areas of study
- **Survey instrument has not been internally or externally validated**
- **Cross-sectional design provides a snapshot of respondents' perspectives at the time of the survey**
- **Survey tool was designed based on a consensus discussion among predominately Europeans practitioners**

Conclusions

The is a clear:

- **Lack of homogeneity among centers practices and clinicians within the Texas Medical Center**
- **Disagreement among the practitioners about the actual process to reach EOL decisions**
- **Disagreement among practitioners about significant concepts such as "futile care" (<3 months survival)**
- **Although age alone or a specific age threshold were not considered a factor to take decisions about EOL, age plays a role when considering WH/WD life support**