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

Colleen Gallagher, PhD, FACHE
Alina Bennett, MA, MPH, PhD
Charles Sprung, MD
Joseph L. Nates, MD, MBA
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%, $s = 3.09$)
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
   - 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