

Ethics consultations in the intensive care unit (ICU) reduced duration of ICU stay and time on aggressive, life sustaining treatments with no change in overall mortality

Schneiderman LJ, Gilmer T, Teetzel HD. *Impact of ethics consultations in the intensive care setting: a randomized, controlled trial. Crit Care Med* 2000 Dec;28:3920-4.

QUESTION: Do ethics consultations in the intensive care unit (ICU) reduce length of ICU stay and aggressive, life sustaining treatments in patients who ultimately die before discharge?

Design

Randomised [allocation concealed]*, unblinded, controlled trial with follow up to hospital discharge.

Setting

Medical and paediatric ICUs in a university medical centre in San Diego, California, USA.

Patients

74 patients identified by nurses when value based treatment conflicts arose during the course of treatment. Types of conflict included disputes with family members or among the healthcare team about changes to patient resuscitation status, intubation or extubation, or the use of aggressive life saving measures. 70 patients (95%) were included in the intention to treat analysis (mean age 49 y, 61% men).

Intervention

37 patients were allocated to the intervention, in which the responsible physician was offered an ethics consultation to be led by 1 of 4 members of the ethics consultation service who had qualifications at an advanced level of skills and knowledge. A summary of the team's consultation and recommendations was then added to the patient's medical record. 37 patients were allocated to usual care (ie, no offer of ethics consultation was made by the researcher, although providers could request a consultation at any time).

Main outcome measures

Main outcomes were duration of ICU stay and percentage of patients receiving treatments in the ICU (and the duration of treatments) among patients who ultimately died before discharge.

Main results

Analysis was by intention to treat. 42 patients (60%) died before discharge; the ethics consultation and usual care groups did not differ for overall mortality (60% for both groups). Among all 70 patients, the groups did not differ for the percentage of patients who had cardiopulmonary resuscitation, do not attempt resuscitation orders, gastrostomy, tracheostomy, transfusion, artificial nutrition and hydration, and ventilation. Among the 42 patients who died before discharge, the groups did not differ for the percentage who had cardiopulmonary resuscitation, do not attempt resuscitation orders, gastrostomy, tracheostomy, transfusion, artificial nutrition and hydration, and ventilation; patients in the ethics consultation group, however, spent fewer days in the

ICU (4.2 v 13.2 d, $p=0.03$) and fewer days receiving artificial nutrition and hydration (4.1 v 12.0 d, $p=0.05$) and ventilation (3.7 v 11.4 d, $p=0.05$).

Conclusion

Ethics consultations in the intensive care unit (ICU) reduced duration of ICU stay and duration of time receiving artificial nutrition and hydration and ventilation in patients who died before discharge, but did not change overall mortality.

*Information provided by author.

COMMENTARY

This study by Schneiderman *et al* is the first randomised controlled trial of ethics consultations with follow up of participants. Patients and families allocated to the intervention group were offered ethics consultations when value based treatment conflicts arose (eg, whether treatment should be primarily aimed at saving life or providing comfort). The study took place in the US, where opportunities for providing ethics input to clinical decision making may differ from other countries. In the UK, a service like this would be novel; most decisions about treatment are discussed among clinicians during clinical review, often without the involvement of patients and surrogates.

The findings that ethics consultations were associated with fewer ICU days and life sustaining treatments, but no difference in mortality, are relevant to nurses who work in adult and paediatric intensive, high dependency, and critical care units. The findings imply that patients for whom treatment was futile died earlier in the ethics consultation group, probably as a result of the withdrawal of life prolonging treatment. The absence of a difference between the groups in overall mortality supports the idea that the patients who died would have died anyway.

In this study, 12 of the 35 participants assigned to the ethics consultation group did not actually receive the consultation; reporting of the results of a subgroup analysis of the outcomes for the 23 who did receive the consultation would have been informative. Furthermore, follow up interviews were not done for 15 of the families, which weakens the results for patient satisfaction.

Future research should include measurement of the quality of life and opinions of survivors, given that 40% of patients in this study survived. Furthermore, because there is considerable variability in the configuration and methods of ethics consultations, standards should be clarified.

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