Ethics consultations reduced hospital, ICU, and ventilation days in patients who died before hospital discharge in the ICU


Q Does offering an ethics consultation reduce non-beneficial life sustaining treatments or hospital days more than usual care for patients in the intensive care unit (ICU) who subsequently die before hospital discharge?

**MAIN RESULTS**

Analysis was by intention to treat. 67 patients (24%) in the treatment group did not receive an ethics consultation, and 77 patients (28%) in the usual care group received an ethics consultation. The groups did not differ for mortality rate. Among patients who died before hospital discharge, those who received ethics consultations had fewer hospital, ICU, and ventilation days than those who received usual care (table). The groups did not differ for outcomes among patients who survived to hospital discharge (p>0.5).

**CONCLUSION**

Ethics consultations reduced hospital, intensive care unit, and life sustaining ventilation days for patients in the intensive care unit who died before hospital discharge.

*A modified version of this abstract appears in ACP Journal Club.

**Commentary**

This well executed, large, multisite randomised controlled trial (RCT) by Schneiderman et al compared the offer of ethics consultations with usual care (family meetings or other conferences as judged to be appropriate by the healthcare team). This study builds on previous research from a single centre RCT by the same authors, which also found that ethics consultations reduced hospital, ICU, and life sustaining ventilation days without increasing mortality. Schneiderman et al did not use a standardised protocol for the intervention because the participating hospitals had pre-existing ethics consultation services. Although broad guidelines were presented, it remains unclear what effect ethics consultations might have in hospitals with start-up services. It is clear, however, that even in hospitals with established ethics support, the routine offer of an ethics consultation can still reduce futile interventions in situations where conflict over treatment is likely.

The findings of this study are important for nurses who work in critical care settings where withdrawal of life sustaining treatment is common and subject to value laden conflict between health professionals, patients, and patient surrogates. Ethics consultations in the ICU are not routine services in many countries, and given that ethical principles are cultural artefacts, further research in healthcare settings outside of the US would be appropriate. However, the findings of Schneiderman et al suggest that opportunities for moral conversations about treatment should certainly be considered. The positive views expressed by nurses, physicians, and patient surrogates who found ethics consultations helpful suggests that this service could be embraced by those who are faced with ethical dilemmas in critical care.

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Source of funding: Agency for Healthcare Research and Quality.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Mean change from baseline to death in hospital</th>
<th>Difference in mean change from baseline to death in hospital</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ethics consultation</td>
<td>Usual care</td>
<td></td>
</tr>
<tr>
<td>Hospital days</td>
<td>8.66</td>
<td>11.62</td>
<td>−2.95</td>
</tr>
<tr>
<td>ICU days</td>
<td>6.42</td>
<td>7.86</td>
<td>−1.44</td>
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<tr>
<td>Ventilation days</td>
<td>6.52</td>
<td>8.22</td>
<td>−1.70</td>
</tr>
</tbody>
</table>

*Data were analysed using non-parametric permutation.