

Ethics consultation reduced hospital, ICU, and ventilation days for ICU patients who died before hospital discharge

Schneiderman LJ, Gilmer T, Teetzel HD, et al. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial. JAMA. 2003;290:1166-72.

QUESTION

In intensive care unit (ICU) patients who died before hospital discharge, is ethics consultation better than usual care for reducing nonbeneficial life-sustaining treatments?

DESIGN

Randomized (allocation concealed*), blinded {patients and data collectors}†,* controlled trial with follow-up to in-hospital death or discharge.

SETTING

ICUs of 7 hospitals in the United States.

PATIENTS

The initial cohort consisted of 551 ICU patients (mean age 68 y, 54% men) who had conflicts that could lead to incompatible courses of treatment. Conflicts occurred among the health professionals and the patient's family or friends; and included whether to pursue aggressive life-sustaining treatment or comfort care, whether treatments were futile, who should serve as surrogate decision maker, and which treatments were in the patient's best interest. Of the 546 patients (99%) included in the follow-up, 329 patients (60%) died before hospital discharge.

INTERVENTION

278 patients were allocated to a consultation offer within 24 hours of randomization.

Consultation consisted of "ethics data" collection; ethics diagnosis; such recommendations as improving communication by sharing information, addressing emotional discomfort and grief, and correcting misunderstandings; documenting the consultation in the medical record; following up to provide ongoing support to the process; evaluating the consultation; and record keeping to enhance future learning and quality improvement. 273 patients were allocated to usual care (family meetings, other conferences, and ethics consultations only when initiated by the health care team).

MAIN OUTCOME MEASURES

Hospital days, ICU days, and nonbeneficial life-sustaining treatments in patients dying before hospital discharge.

MAIN RESULTS

Analysis was by intention to treat. 67 patients (24%) in the intervention group did not

receive ethics consultation, and 77 patients (28%) in the usual care group did receive ethics consultation. Nonsurviving intervention patients had fewer hospital, ICU, or ventilation days than did nonsurviving usual care patients (Table). The groups did not differ for outcomes among patients who were discharged ($P > 0.5$).

CONCLUSION

Ethics consultation was associated with reduced hospital, ICU, and life-sustaining ventilation days in ICU patients who died in the hospital.

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*See Glossary.

†Information provided by author.

Ethics consultation vs usual care for intensive care unit (ICU) patients who died before hospital discharge‡

Outcomes	Mean days from study entry to death in hospital Ethics consultation	Usual care	Difference in mean change between groups	P value
Hospital days	8.66	11.62	-2.95	0.01
ICU days	6.42	7.86	-1.44	0.03
Days receiving ventilation	6.52	8.22	-1.70	0.03

‡Data were analyzed using nonparametric permutation.

COMMENTARY

Ethics consultation has arrived. Many hospitals, spurred by accreditation requirements, offer it. However, skeptics still ask, does it help patient care?

Complicated cases and consultation variability have bedeviled past studies addressing this question. Schneiderman and colleagues now report the most rigorous study yet. Its strengths include multiple sites, prospective design, randomization, expert consultants, and quantifiable outcomes. Its limitations include atypical settings, inadequate severity-of-illness measures, sketchy information on process, perhaps overly favorable evaluations, and no probes into why consultation offers were declined. The authors conclude that ethics consultation helped decision makers and was "associated with" reduced hospital and ICU stays. This conclusion is consistent with other studies and is plausible. Consultations may focus therapeutic goals and thus prevent delays in comfort care (1). However, competing explanations exist. For example, health professionals may accept a consultation offer most readily whenever the patient is imminently dying, or whenever they seek discharge under "ethics cover."

This study warrants cautious interpretation. While intervention

patients averaged shorter stays than did control patients, the differences were modest (1 to 3 d), were greater at 1 hospital than others, and had large overlapping CIs. Furthermore, statistical significance is not human significance. The study addressed futility judgments, the ethics issues that health professionals recognize best. Yet consultations apparently did not affect no-resuscitation orders, an outcome that is important to health professionals. The study also did not address overly aggressive laboratory investigations and inappropriate proxy decisions, outcomes that are important to patients. Moreover, requestors' evaluations may not reflect consultation worth. Requestors may rate consultations by how comforting, not by how sound, they are. Thus, even when justified, consultants may not disagree with requestors.

This thought-provoking study should stimulate further rigorous evaluation of ethics consultation.

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Reference

1. Perkins HS, Saathoff BS. Am J Med. 1988;85:761-5. 3195600