In the ICU, what is a good death?

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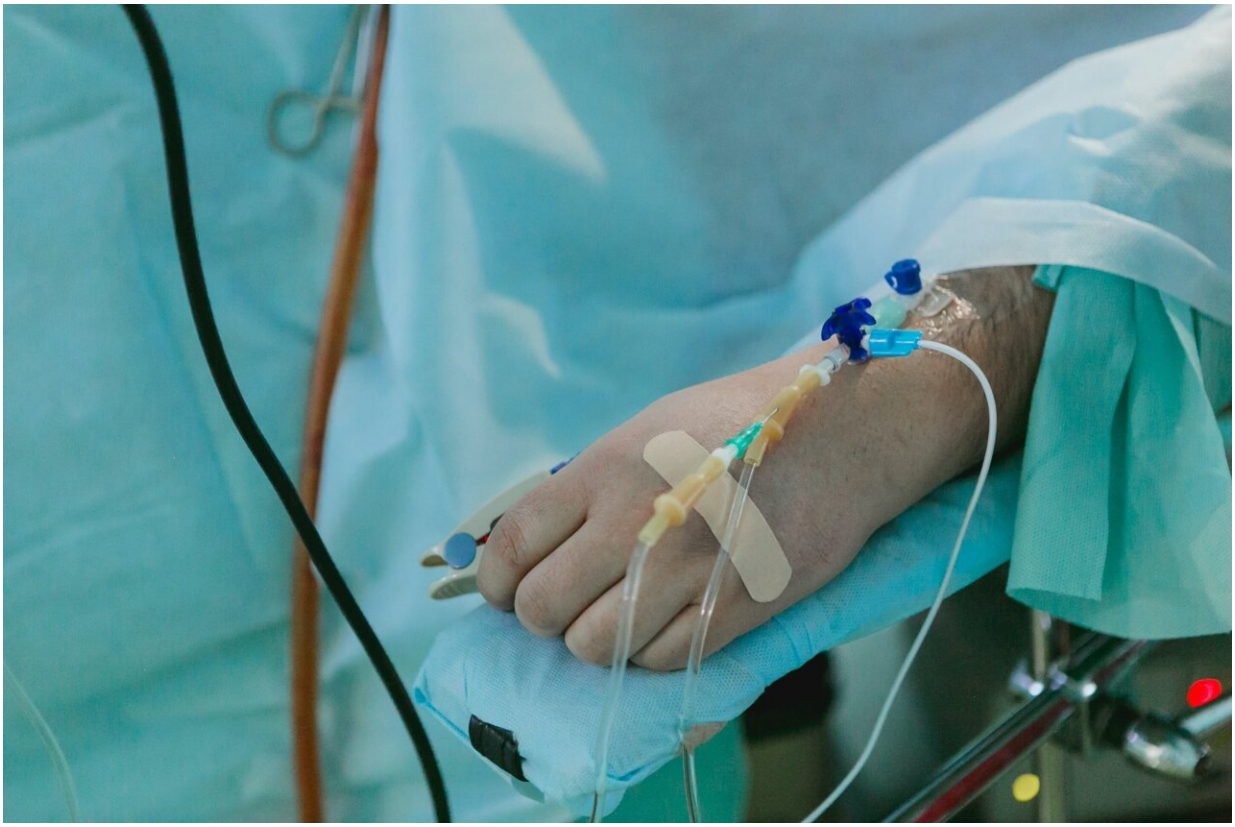

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What is a good death for a patient in the Intensive Care Unit (ICU)? The answer to that question may depend on whether you ask a family member of a patient or the physician, who are not necessarily aligned.

That discrepancy, as well as other hurdles to important end-of-life

conversations, results in frustration and confusion for families and moral distress for the clinicians, according to a new Northwestern Medicine study published recently in *Critical Care Medicine*.

Approximately 20%–30% of people who die in the U.S., die in the ICU, according to previous research. Nearly 60% of ICU admissions result in death. Wide discrepancies have been documented between a patient's stated preferences and the end-of-life care actually delivered.

The findings of the study fill a critical knowledge gap regarding why the ICU end-of-life delivery system is lacking from the perspective of frontline ICU clinicians. The study surveyed 27 ICU clinicians from three Northwestern Medicine hospitals.

The study found several barriers to end-of-life care:

Relying on palliative care physicians for end-of-life conversations

"Because many physicians in the ICU feel uncomfortable with end-of-life discussions, many of them will call the palliative care physicians instead of initiating it them themselves," said lead study author Dr. Lauren Janczewski, a researcher in quality and outcomes at Northwestern University Feinberg School of Medicine and a general surgery resident at McGaw Medical Center of Northwestern University. "That leads to more confusion on the patient and family side and delays those conversations."

"End-of-life care discussions varied greatly depending on the clinician leading the conversation," Janczewski said. "There is not a lot of training in how to communicate at the end of life. It's also a highly variable skill, where some doctors are better than others. There is no standardized

process for end-of-life care delivery. We need one."

Delayed family meetings on end-of-life care until prognosis is poor

One of the bigger barriers is deciding when to have a family meeting at end of life, the study reports.

As one ICU nurse responded in the survey: "We don't often get to the point of having family meetings until it's obvious that the patient's prognosis is very poor. And we're delayed in relaying that to family members and admitting that to ourselves.

"Having these conversations earlier is beneficial to a patient and their family members. You have more time to discuss the patient's status and ask about questions for medical care. This gives the patient and family more peace with the situation."

Clinicians experienced moral distress when they provided non-beneficial care. But when standardized end-of-life care discussions were incorporated in the work system, they reduced patient and family suffering, as well as clinician moral distress.

More information: Lauren M. Janczewski et al, Barriers and Facilitators to End-of-Life Care Delivery in ICUs: A Qualitative Study, *Critical Care Medicine* (2024). DOI: 10.1097/CCM.0000000000006235

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