

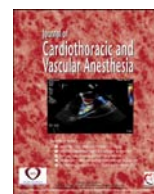
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ORAL ABSTRACT PRESENTATIONS

Oral Presentations 103

Wednesday, 19 April 2017

11:00 - 13:00, Auditorium 3

OP01

The decisions we make - end of life on the ICU

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Introduction: Intensive care physicians are frequently required to make treatment decisions on behalf of patients who lack capacity. In the UK, these decisions are taken under the 'best interests' principle, unless the patient has appointed a power of medical attorney or has a valid and relevant advanced directive.

Although it is impossible to accurately predict the course of any one patient's critical illness, there exists a plethora of data and scoring systems that can be applied to aid prognostication. In addition physicians have their own inherent beliefs and biases, based on experiential data that have been shown to be highly accurate¹. Despite this potential for accurate outcome prediction, many incapacitated patients, with sequentially worsening prognoses, undergo prolonged periods of organ support without recovery. The absence of pre-morbid data of the patient's own wishes makes decisions on the escalation of treatment particularly difficult.

The aim of this study was to use a simulated scenario to explore differences in end-of-life decision-making between intensive care physicians and lay members of the public, as potential future patients.

Methods: Following REC (Research Ethics Committee) review and waiver, structured interviews were performed on convenience-sampled groups of intensive care consultants (n=15) and members of the public between 30 and 50 years old (n=15). Both groups were taken through a hypothetical patient journey on intensive care and asked to play the role of care provider or patient, respectively. The script described a step-wise deterioration in the patient's condition with both

groups receiving odds of death, disability or full recovery based on an evidenced-based model designed for this study. Interviewees were given the choice of further intervention or withdrawal of care at each of the five points of deterioration ending in cardio-pulmonary resuscitation (CPR). Responses and reasons were recorded.

Results: In the intensivist group, no interviewees limited treatment until a final CPR decision, with 80% continuing treatment even at this final stage. This is in stark contrast to the lay group where decisions to withdraw treatment were distributed throughout all, but the earliest, stages. Only 14% chose to continue treatment to CPR.

Discussion: This small qualitative study indicates a potentially large gap between the wishes of patients who lack capacity and the actions of the intensivists caring for them. Prolonged supportive therapies, instituted in the face of dwindling survival odds, may have a negative impact on patients, relatives, ICU staff and the wider health economy. Further ethnographic work is required to better understand decision making on the ICU.

REFERENCE: 1. Minne, L, Toma, T, de Jonge, E. & Abu-Hanna, A. Assessing and combining repeated prognosis of physicians and temporal models in the intensive care. *Artif. Intell. Med.* 57, 111–117 (2013)

OP02

Higher model for end-stage liver disease scores are associated with worse survival in patients with mechanical circulatory support

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Introduction: Liver dysfunction in heart failure patients is mainly due to congestive hepatopathy. Model for End-stage Liver Disease (MELD) score was originally developed for liver transplantation, but recently it is applied for risk stratification in end stage heart failure. We hypothesized that perioperative