Introduction:

Physician-related variability in End of life (EoL) decisions have been previously described. We aimed to investigate physician-related factors contributing to individual variability in EoL decision-making in the intensive care unit (ICU).

Methods:
Qualitative study with semi-structured interviews with 19 specialists in critical care, (experience 2-32 years) from 5 Swedish ICU’s. Data was analyzed in accordance to principles of thematic analyses.

Results:
Most of the respondents felt that the intensivist’s personality played a major role in EoL decisions. Individual variability was considered inevitable.

Views on acceptable outcome: Respondents experienced that the possible outcome for patients was interpreted very differently and subjectively among colleagues, and what seemed an acceptable patient-outcome for one doctor, was not acceptable for another.

Values: Most of the respondents were well aware that they might be affected by their own values and attitudes in the decision-making process. Interestingly, several respondents mentioned that they thought that patients that were marginalized by society, especially drug-abusers could be at risk for receiving decisions to limit life sustaining treatments (LST) more often than others. None of the respondents thought that their own religious beliefs played any part in decision making.

Fear of criticism: Among the less experienced respondents there was a clear sense of fear of making a questionable assessment of the patient’s medical prognosis. There was a fear for criticism from colleagues that were not directly involved in the decision-making, and may have made another decision. This created a wish among younger respondents to defer or avoid participating in decision-making.

Conclusion:
Physician-related, individual variability in EoL decisions primarily consisted of differing views on acceptable outcome, values and fear of criticism.

References:
Wilkinsson & Truog, Intensive Care Medicine, 2013 Jun;39(6):1128-32

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Physician-related individual variability in end-of-life decisions