Trauma Death

Views of the Public and Trauma Professionals on Death and Dying From Injuries

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Objectives: To determine the values and preferences of the general public and trauma professionals regarding end-of-life care due to injury so as to inform practice guidelines.

Design, Setting, and Participants: Surveys of the general public sampled by random-digit dialing between June 6, 2005, and July 5, 2005, and of a convenience sample of trauma professionals during fall 2005 in the United States were conducted regarding preferences for care in the prehospital, emergency, and critical care settings.

Main Outcome Measures: Responses to the survey questions.

Results: Most of the public and trauma professionals would prefer palliative care when doctors determine that aggressive critical care would not be beneficial in saving their lives. During resuscitation of an injured loved one, 51.9% of the public and 62.7% of the professionals would prefer to be in the emergency department treatment room. Most of the public believes that patients should have the right to demand care not recommended by their physicians. Most of both groups trust a doctor's decision to withdraw treatment when futility is determined. More of the public (57.4%) than the professionals (19.5%) believe that divine intervention could save a person when physicians believe treatment is futile. Other findings suggest further important insights.

Conclusions: The results pose challenges that will require societal discourse to determine the best practice. Resolutions will need to be included in educational curricula and incorporated into practice to ensure that dying trauma victims and their families receive quality end-of-life care.

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ALTHOUGH THERE HAVE BEEN several national initiatives to improve end-of-life care, none have specifically addressed the needs of trauma victims and their families.1-4 Trauma poses unique issues to clinicians. Victims are unknown to them prior to the injury event and the clinicians frequently need to make rapid life and death decisions with little time to determine victims’ values and preferences for care.5

Surveys of the general public and trauma professionals were conducted to learn their preferences for care when a life-threatening or fatal injury occurs. The purpose of these surveys was to compare and contrast these preferences so as to inform practice guidelines for comprehensive end-of-life care for trauma victims. This article presents the results of the surveys.

METHODS

STUDY DESIGN

Researchers under the direction of Christopher Barnes, MA, at the Center for Survey Research and Analysis, University of Connecticut, Storrs, conducted and statistically analyzed a national telephone survey of the general public. The same survey, with some minor conversions from telephone survey language to written survey language, was mailed to trauma professionals.

SURVEY OF THE PUBLIC

One thousand six members of the public residing in the United States completed the survey over the telephone; all were aged 18 years or older. The sample was obtained by random-digit dialing between June 6, 2005, and July 5, 2005. The mini-
mum response rate was 19%. It was calculated as the number of complete interviews divided by the number of all interviews (complete plus partial) plus the number of noninterviews plus all cases of unknown eligibility.\textsuperscript{6} When an estimate of the eligible proportion of cases of unknown eligibility was included, the response rate was 22%. The margin of error was ±3.2 percentage points. No financial incentive was offered to respondents.

**SURVEY OF TRAUMA PROFESSIONALS**

The same survey was piloted with 15 trauma professionals who offered feedback on wording. It was mailed via the US Postal Service to all medical directors at level I and II trauma centers in the United States, to the entire membership of the Society of Trauma Nurses, and to groups of emergency medical services personnel in New Orleans, Louisiana, Chicago, Illinois, and Hartford, Connecticut. An addressed stamped envelope was provided. Seven hundred seventy-four surveys were returned for a response rate of 51%. This was calculated as the number returned divided by the number sent. No financial incentive was offered for completion.

**SURVEYS**

The surveys were tested to take approximately 15 to 20 minutes to complete. The topics for questions in the survey were based on recommendations generated by an expert panel of national trauma experts at a Trauma Leadership Forum convened by the American Trauma Society.\textsuperscript{7} Topics relevant to care in the prehospital setting, emergency department (ED), and intensive care unit were queried. Forty-three questions asked for opinions on issues such as futility, advanced directives, organ donation, and beliefs related to culture and spirituality.

**STATISTICAL ANALYSIS**

Responses of the public and the professionals were compared using 2-sided \(z\) tests by the Center for Survey Research and Analysis. To ensure a representative sample of the public, their responses were weighted based on US Census data for sex, age, race, educational level, and number of people in the household.

**RESULTS**

Tables 1, 2, 3, 4, and 5 provide the percentages of the general public and the trauma professionals who chose each option for selected survey items. The questions in the Tables have been abbreviated from the telephone interview and the paper survey.

**EXPERIENCE WITH EMERGENCY CARE AND TRAUMA**

Similar percentages of the public (46.2%) and the professionals (47.4%) indicated that they had received emergency medical care in the past 10 years. Similar percentages of respondents in both groups (12.4% of the public and 12.7% of the professionals) had a close friend or family member die as a result of a serious accident.

**TRAUMATIC DEATH ON SCENE**

Responses of the public regarding care in the prehospital environment indicated that about one-half (50.1%) prefer that a loved one fatally injured in an accident be taken to a hospital (Table 1). Their reasons for this are almost evenly divided between hoping that further treatment might be done and feeling more comfortable at a hospital (47.3% vs 48.1%, respectively). The professionals were more accepting of a place other than a hospital or morgue to take their deceased loved one than the public (13.6% vs 1.7%, respectively). If religious and counseling services were offered at an alternative facility, 29.4% of the public and 63.4% of the professionals would prefer this option. However, most of both groups would not be willing to pay extra for insurance coverage for use of such a facility. Most of the public would be willing to pay an extra fee to bring their deceased loved one to the hospital. This was not true for the professionals.

**TREATMENT IN THE ED**

Most of the public (51.9%) and the professionals (62.7%) would prefer to be present in the treatment room as opposed to the waiting room in the ED during resuscitation of a loved one (Table 2). This preference endured even when respondents may witness disturbing sights. If the victim were a child, the preference for being in the treatment room increased to 79.0% of the public and 78.7% of the professionals.

**Table 1. Preferences Regarding End-of-Life Care in the Prehospital Environment**

<table>
<thead>
<tr>
<th>Question and Responses\textsuperscript{a}</th>
<th>Public, % (n=1006)</th>
<th>Professionals, % (n=774)</th>
<th>(P) Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a person is dead at the scene of an accident, to which facility would you prefer that your loved one be transported?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>50.1</td>
<td>36.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Morgue</td>
<td>41.1</td>
<td>35.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Other</td>
<td>1.7</td>
<td>13.6</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>If you prefer that the person be taken to the hospital, what is the main reason?\textsuperscript{b}</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You hope something might be done</td>
<td>47.3\textsuperscript{c}</td>
<td>13.4\textsuperscript{d}</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>More comfortable with a hospital</td>
<td>48.1\textsuperscript{c}</td>
<td>84.6\textsuperscript{d}</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>If there were an alternative facility with religious and counseling services, which would you prefer?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New facility</td>
<td>29.4</td>
<td>63.4</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Hospital</td>
<td>37.9</td>
<td>11.4</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Morgue</td>
<td>26.1</td>
<td>13.6</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Would you pay for insurance coverage for a new facility?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>34.8</td>
<td>28.4</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>No</td>
<td>56.7</td>
<td>50.9</td>
<td>.01</td>
</tr>
<tr>
<td>Would you pay an extra fee to bring your loved one to the hospital?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58.5</td>
<td>29.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>No</td>
<td>36.8</td>
<td>52.2</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Responses of do not know or refused to answer are not included.
\textsuperscript{b}Asked only of those who indicated hospital in the previous question.
\textsuperscript{c}Sample size was 500.
\textsuperscript{d}Sample size was 292.
In the event that respondents were critically injured and expected to die despite life-saving interventions, 57.3% of the public and 72.7% of the professionals would prefer a treatment focus on comfort (Table 2). If the patient were a loved one, the percentages of respondents selecting the comfort focus dropped to 46.8% of the public and 67.8% of the professionals.

**GOALS OF CARE AND LIMITED RESOURCES**

When physicians believe there is no hope of recovery for a patient, most of the public (72.8%) and the professionals (92.6%) believe that life-sustaining treatments should be stopped and the focus of care should be on comfort (Table 3). Of those indicating that all efforts should continue indefinitely, 86.2% of the public and 72.7% of the professionals say efforts should continue regardless of the financial cost. Of those who originally said that all efforts should continue indefinitely, 86.2% of the public and 72.7% of the professionals believe that life-sustaining treatments should be stopped and should focus on comfort.

**FUTILITY AND TRUSTING PHYSICIANS**

Most of both groups highly rated their level of trust in a doctor’s decision to stop life-saving treatment when futility is determined. On a scale of 1 to 10 where 1 was do not trust at all and 10 was trust completely, professionals were found to almost completely trust the physician’s recommendation (mean score, 9.4); the public’s score was slightly lower (mean score, 7.0).

**DEMANDING CARE AND PAYING FOR CARE**

A majority of the public (72.4%) believes that patients should have the right to demand care even when doc-
Editors think it is not indicated, and 48.5% believe that insurance companies should pay for such care (Table 4). The professionals disagree; 44.3% believe that patients have the right to demand care that doctors think will not help.

Regarding persons in a persistent vegetative state, 33.6% of the public and 31.3% of the professionals believe that the government should pay for their long-term care (Table 4). Most respondents, 84.8% of the public and 94.2% of the professionals, would prefer to die as opposed to receiving continued life-sustaining care if they were ever in a persistent vegetative state.

**ORGAN DONATION AND ADVANCE DIRECTIVES**

Half of the public respondents (50.6%) are organ donors, whereas a more significant majority of professionals (78.9%) are organ donors. Most of both groups believe that their family should not be able to reverse their decision to be an organ donor. The percentage of public respondents with living wills is 35.7%, whereas slightly more professionals (40.4%) have them. Most of both groups believe that their family should not be able to change their living will. Most of the public and professionals strongly support or somewhat support children aged 15 years or older having living wills. More than half of the public (59.3%) and 45.7% of the professionals have designated someone as their health care proxy.

When asked how well they understand medical issues faced by their family, living wills, and the wishes of their family, most of both groups indicated they understood. Mean scores for these questions, rated on a scale of 1 to 10 with 1 being do not understand at all and 10 being understand completely, were greater than 7.0 for the public and the professionals.

**CULTURAL AND RELIGIOUS SENSITIVITY**

Responses of the public indicated that they were either not too concerned (22.8%) or not at all concerned (32.0%) that ED and intensive care unit staffs are sensitive to their race and culture (Table 5). Of the professionals, 26.2% were not too concerned and 22.0% were not at all concerned regarding the same issue. Most respondents in both groups (65.3% of the public and 78.5% of the professionals) were either not too concerned or not at all concerned that a doctor of a different race or ethnicity might not give them the best care. 84.8% of the public and the professionals.

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n=1006)</th>
<th>Professionals, % (n=774)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How concerned are you that ED and ICU medical staffs are sensitive to your race and culture?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very</td>
<td>17.1</td>
<td>7.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Somewhat</td>
<td>26.1</td>
<td>28.6</td>
<td>.74</td>
</tr>
<tr>
<td>Not too much</td>
<td>22.8</td>
<td>30.0</td>
<td>.07</td>
</tr>
<tr>
<td>Not at all</td>
<td>32.2</td>
<td>22.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>How concerned are you that medical personnel might not understand how your culture affects the type of treatment you would like to receive?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very</td>
<td>17.1</td>
<td>7.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Somewhat</td>
<td>25.6</td>
<td>28.6</td>
<td>.17</td>
</tr>
<tr>
<td>Not too much</td>
<td>22.7</td>
<td>35.3</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Not at all</td>
<td>32.1</td>
<td>25.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>How concerned are you that a doctor of a race or ethnicity other than yours might not give you the best care?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very</td>
<td>16.3</td>
<td>5.9</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Somewhat</td>
<td>16.4</td>
<td>13.6</td>
<td>.12</td>
</tr>
<tr>
<td>Not too much</td>
<td>22.3</td>
<td>37.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Not at all</td>
<td>43.0</td>
<td>41.0</td>
<td>.34</td>
</tr>
</tbody>
</table>

Abbreviations: ED, emergency department; ICU, intensive care unit.

a Responses of do not know and refused to answer are not included.
spondents indicated that they are very concerned or somewhat concerned that ED and intensive care unit staffs are sensitive to their race and culture. Also, 60.5% of nonwhite respondents and 37.0% of white respondents are very concerned or somewhat concerned that medical personnel might not understand how their culture affects the treatment they would like to receive. Furthermore, 48.3% of nonwhite respondents and 27.4% of white respondents are concerned that a doctor of a race or ethnicity different from their own might not give them the best care.

For 41.0% of the public and 30.6% of the professionals, religious beliefs would be very important in guiding their decisions about medical care if they were critically injured. Another 25.8% of the public and 30.6% of the professionals said religious beliefs were somewhat important in making medical decisions related to critical injury. More of the public (61.3%) than the professionals (20.2%) believe that a person in a persistent vegetative state could be saved by a miracle (Table 4). Similarly, more of the public (57.4%) than the professionals (19.5%) believe that divine intervention from God could save a person even when the physicians have determined that treatment is futile (Table 5).

The number of deaths due to intentional injuries (eg, homicides, suicides) and unintentional injuries (eg, motor vehicle crashes, falls, burns) has made trauma the third or fourth leading cause of death in the United States for the past 17 years. In 2003, there were 163,988 deaths due to all injury. This steady rate suggests that even though prevention strategies may reduce the number of nonlethal injuries, trauma professionals will still be confronted with a significant number of persons who die from their injuries.

The Institute of Medicine cites breaking-point rates of ambulance diversions, ED visits, and closures of EDs as a national epidemic. Therefore, the appropriateness of transporting patients with no likelihood of survival to trauma centers and implementing aggressive resuscitation efforts can be questioned. Transportation of the traumatized dead to a morgue or a new facility may be the right action to take. A better alternative might be to develop a facility in the hospital that does not initiate medical therapy but provides psychosocial and religious support for the next of kin. With almost 30% of the public preferring this option, it might be that with careful and sensitive implementation, these other facilities could be made acceptable to an even greater percentage of the public.

The preference to be in the treatment room during resuscitation of a loved one, especially a child, has implications for professionals who would prefer that family members not be present. Recommendations from the National Consensus Conference on Family Presence During Pediatric Cardiopulmonary Resuscitation to support family attendance at resuscitation of children have been promoted with representation of many organizations, including the American Trauma Society, the American College of Surgeons, and the American Academy of Pediatrics. Reasons for not wanting family presence should be explored and policies decided in advance to reconcile these different preferences.

Concerning decision making in the event of critical injury and a high likelihood of death, our findings indicate that persons have a harder time selecting an option for loved ones than for themselves when it comes to comfort vs doing everything to sustain life. This finding reinforces the need to ask persons what they believe their loved one would want. This may relieve some of the burden of making a decision by focusing on what decision the loved one would make for himself or herself.

Regarding patients who doctors believe have no chance of survival, the results suggest that the public and professionals appreciate the necessities posed by limited intensive care resources and understand the need to achieve fair and just use of scarce resources.

Regarding medical futility, the results indicate that physicians can be reasonably sure they are trusted to make those decisions. However, they need to be prepared to deal with families who are waiting for a miracle. Pellegrino, one of the national experts at the American Trauma Society Trauma Leadership Forum, has suggested that futility is best determined by identifying the end or purpose of a particular treatment through shared decision making involving the physician and patient or surrogate. The process ought to balance the treatment's effectiveness (the physician's decision), its benefits (the surrogate's decision), and its burdens (decided by both).

The large percentage of people who indicated that religious beliefs are important, including the potential for miracles to change futile outcomes, should be appreciated by health care professionals. Sensitivity to this belief will promote development of a trusting relationship that is critical to convey the scientific basis for the conclusion that there is objective, overwhelming evidence that continued medical interventions will not lead to a successful outcome.

The perceived right to demand care that doctors do not think is indicated and the belief that insurance companies should pay for such care pose challenges to society as a whole. Although Americans are accustomed to having rights, demanding and receiving care that in the physician's best medical judgment will not be effective could overwhelm the entire health care system. This entitlement mentality has been cited as one of many reasons a family may request care that the health care team believes is futile.

Opinions regarding organ donation have important implications for trauma professionals. If patients meet the legal criteria to be organ donors, their wishes should be honored as justified by the principles of respect for personal autonomy and justice. Letting families know that most people do not want their decision to be reversed should lessen the families' angst. Adhering to this practice of not requiring family consent when a person is a professed donor should increase organ donation substantially.

Regarding children aged 15 years or older having living wills, the results suggest that it might be time to
promote the completion of living wills by younger individuals, including children as young as 15 years. Establishing this behavior at a young age will not only benefit children and their families if the need arises but may create a mindset for lifelong attention to advance directives.

Results regarding questions about race and culture highlight the need for sensitivity and recognition of persons as unique individuals. Professionals need to be aware that their race, if different from the patients’, may create some insecurity for the patients.

**CONCLUSIONS**

The findings of the surveys pose challenges for trauma professionals, hospital administrators, insurers, and society as a whole. Issues need to be discussed in the clinical and public arenas and within the curricula of health professional education. Rich and sensitive dialogue is needed so that all dying trauma patients and their families receive quality end-of-life care.

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**Author Contributions:** Dr Jacobs had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. *Study concept and design:* Jacobs, Burns, and Bennett Jacobs. *Analysis and interpretation of data:* Jacobs, Burns, and Bennett Jacobs. *Drafting of the manuscript:* Jacobs, Burns, and Bennett Jacobs. *Critical revision of the manuscript for important intellectual content:* Jacobs, Burns, and Bennett Jacobs. *Obtained funding:* Jacobs, Burns, and Bennett Jacobs. *Administrative, technical, and material support:* Jacobs. *Study supervision:* Jacobs.

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**REFERENCES**