

## **SPECIAL ARTICLE**

# **Medical ethics in ICU patients: conflicts and their resolution**

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## **ABSTRACT**

The patients admitted to an ICU are special in many respects; they may have one or more than one organ failure, old age or an irreversible or a terminal illness. The cost of standardized intensive care is high and many families find it impossible to sustain the cost of prolonged intensive care of their near and dear ones. Difficult decisions may have to be taken by the patient, families or the treating physician. This is the point when medical ethics get involved into it. This special article addresses some of the dilemmas related to ethical issues.

**Key words:** Intensive care; Intensive care units; Quality of life; Comorbidities; Ethical Dilemmas; Autonomy; Beneficence; Maleficence; Nonmaleficence; Bioethics; DNR; End of life decisions

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## **INTRODUCTION**

The practice of medicine is rooted in a covenant of trust among patients, healthcare professionals, and society. The ethics of medicine must seek to balance the healthcare professional's responsibility to each patient and the professional, collective obligation to all who need medical care.

Critically ill patients admitted to intensive care units of tertiary care, county care and public hospitals with different background of their terminal illness, poor or good quality of life, more than one organ failure, psychiatric & psychological illness including dementia, geriatric patients with multiple co morbidities, their socioeconomic background, patient wishes and belonging to difficult families in terms of understanding medical issues and decision making. The critically ill patients develop acute illness which needs immediate medical rescue for example sepsis, shock, pre arrest condition, multi organ failure and major trauma, poisoning or cardiopulmonary arrest along with above mentioned background seeks admission in ICU and later on develop certain ethical dilemmas.

**Pre admission decision making process to avoid ethical dilemmas in ICU**

Patients admits in ICU with acute illness mentioned

above with irrespective of background of his or her terminal illness , co morbidities, psychiatric illness including dementia, geriatric age, socioeconomic background, poor quality of life and his or her wishes including difficult families through either accidents & emergency , wards, operation theatre or transfer from other hospitals and outcome of these patients either withdrawal or withholding treatment, discharge, transfer to other hospital, or death after staying in critical care unit with all supportive treatment. During all this, the physician may come across different ethical dilemmas. It is imperative to make an early decision rather to make late decision to avoid ethical dilemmas.

But who makes early decision or delayed among the healthcare providers regarding patients or takes responsibility by having effective communication about decision making process.

The principles of bioethics (autonomy, beneficence, maleficence, and justice) have conflicts among themselves where end of life care issues arise. The limits of medical sciences influence decisions towards end of life care issue. The philosophical, religious and cultural beliefs also play a role in the end of life care towards withhold or withdrawal of the management of critically ill patients; hence face ethical dilemmas.<sup>1-4</sup>

## ETHICAL DILEMMAS : THE POSSIBLE ENTITIES ?

There are some conflicts developed among various bioethical principles lead to ethical dilemmas. There are certain possible entities which become the part of these ethical conflicts specially patients admitting in critical care units including ; early or late decisions regarding admissions in ICU , multidisciplinary team conflicts , incompetent or inappropriate patients , surrogate decision makers and their nomination, Informed consent issues regarding procedural interventions in intensive care, withdrawal or with holding supportive care issues in critically ill patients , communication issues , advance directive of critically ill patients and finally end of life Issues. Research, payer's interests, dual obligations, patients' wishes and family interests also contributes these conflicts and affects ethical principles. They all contribute in the development of these dilemmas and think about their resolution.<sup>4</sup>

## CONFLICTS OF ETHICAL PRINCIPLES & ETHICAL DILEMMAS

Conflicts arise between various principles and important other entities described as follows;

**Autonomy Vs Beneficence:** In the United States a consensus has been achieved that Autonomy takes precedence over other considerations: (therefore the patient refusing potentially life-sustaining therapies must be allowed to die if cardiac arrest or other life-threatening conditions should occur). The legal and ethical limits of patient autonomy have not been well defined. Many "ethical dilemmas" involving the withdrawal or withholding of life support can be traced to this issue.<sup>5-8</sup>

Feinberg notes that autonomy minimally requires the ability to decide for the self free from the control of others and with sufficient level of understanding as to provide for meaningful choice.<sup>9</sup> To be autonomous requires a person to have the capacity to deliberate a course of action, and to put that plan into action. This creates problems in the delivery of health care, especially when patients are comatose, incompetent (whether due to age or to mental ability) specially in intensive care setting.<sup>6,9</sup>

The practice of beneficence is challenged by the respect for autonomy. It is not possible to act without the permission of a free moral agent without that patient's consent. Patient's autonomy determines good is a personal decision, and the good that a patient may determine can often differ from that of his or her physician or caregiver. Beneficence therefore must overlap in part with autonomy; patients wish to be provided various levels of information, and may wish

to select a particular direction for their care because in their view that is the greatest good. Because this may differ from the physician's perspective, a tension is created.<sup>6,8</sup>

**Autonomy vs Non maleficence:** The principle compels the physician to consider the harm an intervention may cause to a patient and weigh that harm against the potential for benefit. The principle of nonmaleficence requires that persons refrain from providing interventions, which in their judgment, are likely to be of more harm than benefit. Ethical dilemmas may arise between non maleficence and autonomy when patients request interventions which are without benefit and are harmful or dangerous. Nonmaleficence is a right of the physician (or other health care provider) to refuse to participate in practices which are judged to be harmful to the patient.<sup>8</sup> However, patient's wishes or autonomy should prevail.

**Non-abandonment vs Nonmaleficence:** Non-Abandonment is core of medical ethics. Judgments made regarding the appropriateness of a specific intervention are not always unanimous, and it may not be possible for the patient, family, and physician to reach a consensus regarding particular therapy.<sup>8</sup> Physician is obliged to refrain providing inappropriate treatment to patients. However, physician must not abandon the patient Physician helps patient or surrogate decision maker to understand the issue. If fails: morally wrong to continue the proposed care plan. It is imperative that he or she attempt to find another physician willing to continue care of the patient. However till then, he or she must continue care until other physician take over.<sup>10</sup>

**Disclosure and beneficence:** There are two ethical guidelines to be observed in regard to disclosure: appropriate degree of information and humane behavior. Because most patients or relatives including surrogate decision maker do not have backgrounds in medicine. Physicians should disclose information in a way that is meaningful to patients on their own terms. Some medical information is easier to disclose than others. When disclosing hurtful news, it is important that physicians communicate with patients , relatives or surrogate decision maker in humane and respectful ways in ICU setting considering principle of beneficence.<sup>8</sup> The moral doctrine of diagnosis disclosure is derived from a respect for the patient's autonomy as well as the patient's beneficence. These two goals are not necessarily incompatible, but they often lead to different decisions about what information needs to be shared with patients.<sup>11</sup>

**Bioethics vs Legal Obligations :** Law and Medical Ethics are disciplines with frequent areas of overlap,

yet each discipline has unique parameters and a distinct focus.<sup>12</sup> Medical ethics and the law are not the same, but often help define each other. Breach of ethical obligation may not necessarily mean breach of law. Breach of ethical obligation may be used to prove medical malpractice or medical negligence.<sup>8</sup> In intensive care setting different ethical issues arises regarding patient's autonomy, beneficence, non-maleficence, non abandonment, disclosure, communication issues and end of life issues may lead to legal obligation on certain aspects.

### **Communications & ethics in intensive care setting**

Multiple reports suggest that clinicians' communication in the ICU is inadequate.<sup>13,14</sup> Nurses and physicians underestimate the information needs of ICU patients and their families and frequently lack the skills to communicate complex medical information or to address a family's emotional needs.<sup>15</sup> Attempts to communicate are often ineffective, half of family members fail to understand even basic information about the patient's diagnosis, prognosis, or treatment. As a result, anxiety and confusion among family members are widespread.<sup>16-18</sup> Health care professionals can help patients and families greatly by redirecting their focus toward achievable goals.

### **Ethical Conflicts Resolution**

Most conflicts involve issues of autonomy and beneficence principles. The patient's right to refuse therapy must be protected, recognizing that most patients are concerned about their families and do not wish to have family members undergo unnecessary anguish. Physicians should be sensitive to such family concerns, but in the end, it is the patient's wishes that must prevail.<sup>5,6,8</sup> In principle, families do not have the right to reverse patients' advance decisions when the patient loses consciousness. Physicians may concede to the family's demands for aggressive therapy after the patient loses decision-making capacity due to reasons in case of withdrawal or withholding treatment when end of life issue arises.

The principle of non abandonment is also important when the patient requests an intervention or refuses a therapy (such as CPR) and the physician does not agree. Patients may refuse treatment for reasons that seem irrational to health care professionals, frequently on the basis of fear or misinformation. The health care professionals must remain engaged and supportive of the patient even though this conflict exists. So affective communications & discussions among multidisciplinary teams of physicians caring patient, that provide information and allay fears can resolve many such problems.<sup>19,20</sup>

### **Conflicts over the withholding or withdrawing of life support**

Conflicts over the withholding or withdrawing of life support may occur among any of a number of interested parties, including patients, families, health care professionals, hospitals, the state, and other "third parties".<sup>8</sup>

Most conflicts can be avoided by considering and setting the goals of therapy in intensive care and to consider both the principles that underlie ethical decisions and the quality of communications among the relevant parties.<sup>8</sup>

### **Goals of therapy early after ICU admissions**

Within first 2 to 3 days after ICU admission, the ICU team should discuss current therapy and its goals with surrogate. They should ask the surrogate if he thinks that the patient would want the current ICU treatment and plan and should routinely check with surrogate and family that the patient would want level of interventions that automatically comes with ICU admission.

### **DNAR (End of life issue)**

DNAR decisions can become ethical dilemmas and are implemented on the assumption that cardiopulmonary arrest will be a spontaneous event that is the culmination of the dying process in a patient who has a terminal illness or a poor quality of life. These decisions arose out of the realisation that resuscitation, including cardiopulmonary resuscitation, is inappropriate in such cases: as it has a poor outcome and is against the wishes of patients and families.

The AAGBI Joint Statement provides a framework for the decision making process in the formation, consequences and implications of a DNAR decision. In the implementation of a DNAR decision the patient, proxy decision maker or senior clinician in charge of the patient are indicating that it is in the patient's best interests to die naturally without resuscitative interventions that would be considered unnecessary and undignified.

If the patient is not competent to make their own decisions, and has not appointed a proxy decision maker or made an advance decision, then the senior clinician in charge of the patient's care must make the decision, based on the patient's best interests.<sup>8</sup>

### **Consent issues in intensive care patients**

AAGBI laid down the principles of consent which are as relevant to patients in ICU as they are to general population. The specific problem for many ICU patients is the fact that many of them may lack

competence either because of disease or sedation. The provisions of MCA 2005 are particularly relevant to ICU patients.

Patients in ICU should not be considered to lack the competence to decide about their medical treatment merely because they are gravely ill, receiving sedative drugs or lack ability to communicate orally. These patients should be allowed to indicate their consent and where possible written documentation of consent discussions should be recorded. Exceptions do occur when emergent, life-saving procedures are required (e.g., endotracheal intubation) and usually there is "blanket consent" for routine ICU procedures (e.g., central lines).<sup>21,22</sup> It is the responsibility of individual units and institutions to establish guidelines for which procedures require formal written consent.<sup>23</sup>

#### **Checklist for surrogate decision maker (SDM)**

Surrogate Decision Maker can be member of family or any nominated by patient when patient is competent has very important role in decision making process of incapacitated patient. In section 9.2.4 of AAGBI guidelines on consent issues of any setting where another individual is providing substituted judgment for an incapacitated patient he or she will need to act against the following checklist of requirements.<sup>21</sup>

#### **Advance decisions ('advance directives', 'living wills')**

AAGBI in section 8.1-4 gives guidelines about advance directives which help to avoid certain ethical issues regarding advance directives of geriatric, psychiatric, and patients having multiple co morbidities. Many Jehovah's Witnesses carry with them an Advanced Decision forbidding the administration of blood or blood components. Advanced Decisions are legally binding on healthcare workers if they are made voluntarily

by a competent, adequately informed patient, who expresses an explicit refusal of treatment under certain defined circumstances. When a situation falls fully within the terms of the Advanced Decision, clinicians should respect the terms unless there is evidence that the patient may have changed his or her mind since signing it. Advance Decisions cannot authorize doctors to do anything outside the law, or compel them to carry out a specific form of treatment.<sup>21</sup>

## **CONCLUSIONS & RECOMMENDATIONS**

There is no clear cut answers for these arisen ethical issues or dilemmas in intensive care patients as so many factors and personals involve in this including primary team of physicians, multidisciplinary teams in healthcare involves, other healthcare providers, patient, his or her wishes, surrogate decision makers and difficult families sometimes. However one should set certain goals of therapy, interventions, decisions regarding fate of patient critical illness the sooner possible to avoid on developing ethical issues producing complex ethical dilemmas. The better communication among the teams members involved in the patient care in ICU and also effective and meaningful communications with patient if competent, appointed surrogate decision maker and other family members regarding patient's further treatment, interventions and decisions regarding withholding or withdrawal of supportive measures is important. The institute or effective training bodies should develop Ethical codes and guidelines and should try to resolve of ethical conflicts developed earliest the possible by certain set goals and affective communication among concerned parties involved.

## REFERENCES

1. Prendergast TJ, Claessens MT, Luce JM. A national survey of end-of-life care for critically ill patients. *Am J Respir Crit Care Med*. 1998 Oct;158(4):1163-7.
2. Fisher M. Ethical issues in the intensive care unit. *Curr Opin Crit Care* 2004;10:292.
3. Manara AR, Pittman JA, Braddon FE. Reasons for withdrawing treatment in patients receiving intensive care. *Anaesthesia* 1998;53:523.
4. Sprung CL, Cohen SL, Sjøkvist P, et al. End-of-life practices in European intensive care units: the Ethicus Study. *JAMA* 2003;290:790.
5. Beauchamp TL, Childress JF. *Principles of biomedical ethics*, 5th ed. New York City, NY: Oxford University Press; 2001.
6. Lawrence D.J. The Four Principles of Biomedical Ethics: A Foundation for Current Bioethical Debate. *Journal of Chiropractic Humanities* 2007;35-36.
7. Thomasma DC. A philosophy of a clinically-based medical ethics. *J Med Ethics* 1980;6:190-196.
8. Kellum JA & Dacey MJ. Ethics in the intensive care unit: informed consent; withholding and withdrawal of life support; and requests for futile therapies; up to date. .com 2011.
9. Feinberg J. Harm to self. In: *The moral limits of criminal law*. New York, NY: Oxford University Press; 1986.
10. Quill TE, Cassel CK. Nonabandonment: a central obligation for physicians. *Ann Intern Med* 1995;122:368.
11. Figueroa G. Diagnosis disclosure: the place of beneficence, autonomy and veracity in medical ethics; *Rev Med Chil*. 1998;126(5):569-76.
12. Lisa A and Vincler JD. *Law and Medical Ethics; ETHICS IN MEDICINE*. University of Washington School of Medicine. ©1998
13. McDonagh JR, Elliott TB, Engelberg RA, et al. Family satisfaction with family conferences about end-of-life care in the intensive care unit: increased proportion of family speech is associated with increased satisfaction. *Crit Care Med* 2004;32:1484.
14. Arnold RM, Kellum J. Moral justifications for surrogate decision making in the intensive care unit: implications and limitations. *Crit Care Med* 2003;31:S347.
15. Kutner JS, Steiner JF, Corbett KK, et al. Information needs in terminal illness. *Soc Sci Med* 1999;48:1341.
16. Azoulay E, Chevret S, Leleu G, et al. Half the families of intensive care unit patients experience inadequate communication with physicians. *Crit Care Med* 2000;28:3044.
17. Levy MM. End-of-life care in the intensive care unit: can we do better? *Crit Care Med* 2001;29:N56.
18. Kellum JA, Devita, M, Lombard, JJ, Grenvik, A. Ethical and Legal Considerations. In: Weil, MH, Tang, W (Eds), *CPR: Resuscitation of the Arrested Heart*, Chapter 18, WB Saunders, Philadelphia, 1998.
19. Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. *Ann Intern Med* 1996;125:763.
20. Prendergast TJ. Resolving conflicts surrounding end-of-life care. *New Horiz* 1997;5:62.
21. General Medical Council. Withholding and withdrawing life prolonging treatments. Good practice in decision-making. 2002 <http://www.gmcuk.org/guidance/library>.
22. Davis N, Pohlman A, Gehlbach B, et al. Improving the process of informed consent in the critically ill. *JAMA* 2003;289:1963.
23. Schweickert W, Hall J. Informed consent in the intensive care unit: ensuring understanding in a complex environment. *Curr Opin Crit Care* 2005;11:624.



## Anesthesia Aphorisms

Collected by Mark Lema and published in the January and July issues of ASA Newsletter see 2002

- If you can't manage the surgeon, you have no business managing the anesthetic.
- Friends come and go, but enemies accumulate.
- You can either lead the disease or let the disease lead you.
- There is a direct relationship between the number of tattoos and the propofol dose.
- There is an inverse relationship between the number of tattoos and the tolerance to regional anesthesia.
- There is an inverse relationship between a surgeon's ability and the frequency that he/she asks for more muscle relaxant.
- There is no condition that cannot be made worse by surgery (and/or anesthesia).
- It's easier to do it right the first time than to do it over.
- Beware of colleagues with no sense of humor—they are not very bright and will blame you for their errors.
- Sick people die! (use in place of self-flagellation when a negative outcome occurs).
- Every patient is a "preop"—it's just a matter of figuring out for what!
- Practice is the best of all instructors.
- Numbers are tools, not rules.
- If you can feel a pulse, don't panic.
- Fibrillation is a sign of life.
- The better you are, the luckier you become.
- Be wary of patients whose risk exceeds their ejection fraction. Treat the patient, not the monitor.