ETHICAL ISSUES IN ICU

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Ethical Problems in ICU

1. Introduction of new diagnostic and therapeutic methods
2. Prognostic assessment of individual patient. Extend and mode of treatment
3. Admission and discharge of patients
4. Benefits and risk of our treatment
5. Relations of ICU with other departments and services in hospital
6. Relation of ICU with hospital administration
7. Relation with pharmaceutical and technical companies and their services
8. Relation between physicians and technicians in ICU
   - Education: senior physicians, residents, interns, nurses, students
9. Controls of knowledge of attending physicians
10. Relatives of a patient and informations
11. Clinical research
Criteria for admission to ICU

Patient who is in immediate life danger and whose disease is not apparently hopeless in the near future
<table>
<thead>
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<th>Elective</th>
<th>Emergency</th>
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<tbody>
<tr>
<td>Valvular surgery</td>
<td>1963</td>
<td>1990</td>
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<tr>
<td>CABG</td>
<td>1971</td>
<td>1990</td>
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<td>Echocardiography</td>
<td>1972</td>
<td>1986</td>
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<td>PTCA</td>
<td>1980</td>
<td>1997</td>
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THE VALUE OF PROGNOSTIC DEFINITION

• Enables decision for additional diagnostics and treatment
• Enables appropriate ethical relation of medical personnel to the patient and his relatives
• Rationality in treatment
• Relieves psychological burden of patient, his relatives and medical personnel
PROGNOSTIC PRINCIPLES

• Without precise diagnosis correct prognosis is impossible

• Therefore often seemgly “too broad” diagnostic procedures are necessary

• In severely jeopardized patient constant verification of diagnosis, prognosis and effects of treatment is essential
INDIVIDUAL PROGNOSTIC CLASSES IN ICU

1. The worst outcome

2. Serious prognosis - fatal outcome is highly probable

3. Severe disease without bad prognostic criteria
PROGNOSTIC ASSESSMENT IN ICU
1. THE WORST OUTCOME

- BRAIN: absent signs of brain stem function, corneal, oculocephalic reflexes missing. No spontaneous breathing, no reaction on respiratory tract aspiration, seizures. > 5 days
Caution: not valid in metabolic coma and poisoning !!!
Attention: T Ploj: Hypothermia after cardiac arrest !!!

- HEART: severe heart failure (EF < 10 %), low cardiac output.
   Not valid in reversible causes: myocarditis, drugs !!!

- LUNG: severe respiratory insufficiency in patient with previously known severe pulmonary disease

- MALIGNANCY in final state

- COMBINATION OF ABOVE PATHOLOGY
2. SERIOUS PROGNOSIS

Severe, but not irreversible failure of more organs and organic systems. Combination of pathology is considered very likely fatal.
PROGNOSTIC ASSESSMENT AT ADMISSION AND SURVIVAL

SURVIVAL, %

586/668

p < 0.01

17/84

p = NS

2/26

PROGNOSIS AT ADMISSION
Prognosis should always be established for the patient and not for disease

The right prognosis enables the use of the basic ethical principles: **beneficience**, **nonmaleficience**, **autonomy**, and **social justice**
Principle of beneficience: “paternalistic approach” governed the relation between patients and doctors until 80 of 20. century

Nowadays pendulum swings toward “partnership” (principle of patient’s autonomy) in these relations

However, overemphasis on autonomy exists in many ways
Physician should not abandon his or her traditional responsibility to protect the patient against inappropriate therapy in favor of complete autonomy
RELATIONS WITH FAMILY OF CRITICALLY ILL PATIENT

30% of family members of seriously ill patient who died were dissatisfied with communication and decision making.

- Inadequate time spent communicating with doctors
- Lack of consistent information
RELATIONS WITH FAMILY

INVOLVEMENT OF PRIMARY CARE DOCTOR WHO KNOWS THE FAMILY AND THE PATIENT

MEETING WITH THE FAMILY OF THE CRITICALLY ILL PATIENT IS VERY IMPORTANT AND CAN PREVENT SERIOUS MISUNDERSTANDINGS AND CONFLICTS
MEETING WITH FAMILY

Health care team must have a meeting before family meeting and reach agreement in the major medical facts, prognosis and possible treatment plan.

Nurse caring for the patient should always be invited.

Introduce all the providers: name, position, role, and the level of involvement in the patient’s care. Knowing physicians’ roles correlates with family satisfaction.
CONVERSATION WITH FAMILY

Never give more than three pieces of information without stopping and checking comprehension.

Detailed patophysiologic information (e.g., urine output, ventilator settings, pressure) does not increase family understanding of the clinical situation.

Family should not focus on details and exclusion of the bigger picture.
CONVERSATION WITH FAMILY 2

The discussion should focus on the treatment goals rather than treatments in isolation

“Hoping for the best and preparing for the worst”