ADVANCES IN INTENSIVE CARE ARE POSING DIFFICULT ETHICAL PROBLEMS

DYLEMATY ETYCZNE INTENSYWNEJ TERAPII W ŚWIETLE JEJ POSTĘPÓW

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Summary

High – technological branch of clinical medicine – intensive therapy is one of the most efficient ways of treatment of critically ill patients. However, exhaustive information about patient obtained by means of electronic and laboratory monitoring is indispensable for an effectiveness of intensive care. Together with therapeutic technology they create premises for asymmetric physician – patients relations and treating people like objects. Abuse of these technologies may have place in patients without biological reserves to survive. Economical restrictions in health care concern also intensive care and may be also the sources of ethical problems. Finally questions of both essential and ethical nature in intensive care are also the result of progress in medical sciences (genetics, e.g.).

KEY WORDS: intensive care, critically ill patient, subjective treatment of patient.

SŁOWA KLUCZOWE: intensywna terapia, chory krytycznie, przedmiotowe traktowanie chorego.

Introduction

Contemporary European and American cultures introduced the term “the fight against death”. This transformation of the former desire “to be eternally young”, as expressed in Goethe’s “Faust” is, in a way a manifestation of the contemporary emphasis on the essence of life and its fulfilment [1]. It is also possible that the current profile of education for physicians and nurses leads them to the conclusion that they will be dealing with damaged machines (rather than human beings), which can be repaired by means of sophisticated technology [1]. Thanks to Pasteur’s theory of the specific etiology of (infectious) diseases, Western medicine has become a technological science using increasingly complex techniques to defeat every disease. Death caused by disease is the Number 1 enemy to be fought by the physician technologist. For this reason the language of physicians has become a military one and their ethics have turned into the ethics of struggle [2].

The changes in post – Pasteurian medicine described above culminated, after World War II in the so-called hospital ideology (Alichniewicz, 2) in which the physician – disease relationship began to take precedence over the physician-patient relationship [2]. This has been confirmed by everyday practice in several branches of clinical medicine, including the youngest one, that of intensive therapy. The cradle of intensive therapy in Europe was Denmark [3] where, during poliomyelitis epidemic in 1952, several patients had to be artificially ventilated due to the bulbar form of the disease and, in consequence, a special centre to collect all the patients with respiratory failure was set up. At that time an increasing number of American and European physicians came to the conclusion that the management of critically ill patients was beyond the capabilities of standard hospital wards. Resuscitation and antishock rooms and, ultimately, intensive care units (ICU) were therefore established, as a result of this change in awareness.

Intensive therapy is an interdisciplinary design concept which transgresses the traditional boundaries of medical specialties. This reflects the necessity to solve problems beyond the limits of individual specialties. Indications for intensive therapy include the immediate need to introduce life-saving measures, equipment and techniques, the need for continuous monitoring of the patient because of the risk of life-threatening complications, and the need for intensive care procedures impossible in the setting of a standard hospital ward.

Intensive therapy as a high-technology branch of clinical medicine

The success of intensive therapy is, to a large extent, due to advanced diagnostic and therapeutic measures, as
The so-called ICU syndrome was first described more than twenty years ago when mental disturbances were reported in about 30% of ICU patients [5].

The effectiveness of intensive therapy

The effectiveness of intensive therapy is, in a way, the main cause of the fact that technological progress in clinical medicine can also be a source of iatrogenic complications. Ventilator-associated pneumonia (VAP) is a clear example. Recognition of the pathomechanisms of shock in its various forms and aetiology, and the importance of restoring fluid and electrolyte balance resulted in the practical elimination of a fatal outcome in patients in shock, except for those in septic shock. In the northern hemisphere sepsis and its complications are the fourth main cause of death, after atherosclerosis, cancer and trauma. Despite recognition of the pathogenesis of this syndrome and real progress in chemotherapy the mortality rate of septic patients did not significantly decline for more than forty years. However, the recent introduction of recombinant activated human C protein (drotrecogin) in treatment of severe sepsis has improved survival rates. Perioperative intensive therapy has reduced the mortality rates, particularly of those suffering from serious complications of surgery. The effectiveness of intensive therapy is, however, also conditioned by financial considerations. These involve an increasing conflict between novel and fascinating technological advances on the one hand and financial limitations in the health service on the other. There are justified fears that not everything that is possible from the medical point of view is simultaneously available for economic reasons [6].

Psychological problems

In 1997, Marek Sych, the late professor of anaesthesiology at the Jagiellonian University in Cracow, presented his opinion concerning the limits of intensive therapy [7]. He wrote: “An analysis of the improvement in therapeutic results shows that, in the first decade of the last 30 years, this increase was very rapid. However, following this initial steep rise, the improvement almost levelled out and then grew only slightly.”

This shows that we may be approaching the therapeutic limit. When analyzing this phenomenon one should be aware of the possible limiting factors. An ability to survive is one of these factors”. The technologies involved in intensive therapy do not favour an objective evaluation of this ability, especially when a patient only survives as a result of these technologies. Indeed, some physicians are therefore of opinion that medical technology can support biological life almost permanently and this belief is sometimes strongly promoted by the mass media [8]. On the other hand the ethically frustrated, but logically thinking, physician is aware of the fact that frequently all he is doing is carrying out treatment on a “warm cadaver” [8]. Therefore for conscientious and experienced intensivists problems related to the scope and application of medical technolo-
In recent years, advances in intensive care are posing difficult ethical problems. The achievements of intensive therapy in saving health and life are undeniable. If, however, we are approaching the limits of therapeutic success, then it is our task to create intensive care which is more compassionate and individualized, especially for our dying patients [9].

The success of intensive therapy should not be measured only by the statistics of survival, as though each death was a medical failure [8]. The reasonableness principle, i.e.: “to do all that is reasonable, not what is possible”, should be recommended in ICU from both practical and ethical points of view.

Asymmetry in the doctor-patient relationship in the ICU setting can make attentive listening by the doctor to what the patient is really saying very difficult. We should remember that listening is one of the indispensable conditions for the proper care of our patients [13].

Final remarks

The success of intensive therapy should not be measured only by the statistics of survival, as though each death was a medical failure [8]. The reasonableness principle, i.e.: “to do all that is reasonable, not what is possible”, should be recommended in ICU from both practical and ethical points of view.

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Actions which support the life of a dying patient but which result in his/her unreasonable suffering are now being defined as inappropriate treatment [8]. Such situations may occur in any ICU setting. Doing everything possible for the physical and emotional needs of the patient, is therefore an imperative for the intensivist. G.R. Dunstan, emeritus professor of moral and social philosophy at the University of London, stated [8]: “The success of intensive therapy is to be measured by the quality of lives preserved or restored, the quality of the dying of those in whose interest it is to die and by the quality of relationships involved in each death”.

Progress in medical sciences continuously creates new ethical questions. An example is the relatively recent work on the polymorphism of single nucleotides which are probably responsible for differences in the predisposition to both the incidence and chances of survival of patients with similar diseases. This information probably allows us to define individual characteristics of reactivity and survival potential but, at the same time, it also raises questions concerning the more effective use of resources, including those in intensive care. In other words – should resources be addressed exclusively to those patients with the greatest chances of survival? [14].

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