# 1 How Ethics Can Support Clinicians Caring for Critically Ill Patients

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## 1.1 Introduction

As a field, clinical ethics has made significant progress in the past 50 years. There is evidence, however, that ethical conflict and uncertainty are still major contributors to challenges faced in critical care and emergency department (ED) practice, resulting in stress on clinicians and potentially detrimental impacts on patient care. Additionally, as technology continues to progress and evolve, so do the ethical questions that arise. In this chapter, we begin by providing a brief background on clinical ethics. Then, using clinical vignettes, we examine the ways in which the tools of ethics can help the bedside clinician, and where there may still be gaps.

## 1.2 Background

Ethics and ethical questions are at the basis of health-care practice [1–4]. Indeed, many authors have argued that every interaction between a clinician and patient is ethical in nature [1] arising from the fact that the health professions exist to provide a public good, namely the promotion of health, prevention of illness, and alleviation of suffering. These goals serve as the foundation for professional codes of ethics [2–4] which represent nonnegotiable ethical standards for practicing clinicians.

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Given the fundamentally ethical nature of health care, questions about what is "right" or "good" for a particular patient are commonplace, as are professional disagreements about the answers to these questions. This is particularly true in the intensive care unit (ICU) and ED environments, where the pace is fast and decisions must be made quickly, often without time for lengthy deliberation. These questions serve as the foundation for clinical ethics, which is concerned with ethical issues that arise in the care of patients [1].

Many authors have highlighted the fact that clinicians tend to feel underprepared for the ethical challenges they face in practice. This is, in part, due to the fact that clinical ethics is traditionally not a major focus of nursing education [5, 6] or medical training [7]. In 2006, Carrese and Sugarman argued that "deficiencies exist in bioethics knowledge and performance among practicing clinicians and trainees; therefore, bioethics education is needed for learners at all levels" [1]. Nevertheless, ethics education remains an underemphasized area of many health-care training curricula, and this can translate into discomfort and distress in the care of complex patients.

Research has extensively documented clinician perceptions of excessive or inappropriate care [8, 9], challenges with interprofessional communication, and conflict between the family and medical team [10] as contributors to moral distress, which has been defined "the embodied response … of an individual to a moral problem for which the individual assumes some moral responsibility, makes a moral judgment about the appropriate ethical action to be taken but, due to real or perceived constraints, participates by act or omission in what he or she regards as moral wrongdoing" [10]. Over time, these stressors, and the experience of moral distress, in particular, have been connected to burnout, attrition, compassion fatigue, detachment, and the development of dehumanizing attitudes toward patients in physicians and nurses [11–13].

Thus, in this chapter, we endeavor to examine the way the tools of ethics can help clinicians facing ethically challenging situations. The following vignettes highlight cases in which a decision with significant ethical implications must be made. Many of the issues introduced in these cases will be addressed in greater detail in later chapters in this volume. For each case, we review general ethical frameworks and consensuses that clinicians can turn to for guidance. We also highlight challenges with the prevailing frameworks, and areas where there is still work to be done.

## 1.3 Vignettes

**Vignette 1: Autonomy, Paternalism, and Shared Decision-Making**

*A 60-year-old woman with uncontrolled diabetes presents to the ED with an infected foot ulcer, concerning for gangrene, and evidence of early systemic sepsis. An amputation below the knee is the definitive way to manage this infection; however, when the ED physician presents this option to the patient,* *she refuses. Her father and sister have had amputations, and she feels their quality of life is not one that would be acceptable to her. The physician knows that without surgery, the patient will most likely develop septic shock and die. He feels uncomfortable with the thought of allowing a relatively young person with a treatable condition, to refuse treatment because that refusal will result in her death.*

Generally, it is accepted in contemporary clinical ethics that a patient with decision-making capacity has the right to make decisions for themselves about medical treatments and the plan of care, even when their decisions do not align with the medical team's recommendations [14, 15]. This argument has at its basis the ethical principle of autonomy, or "self-rule" [14], which holds that the patient's values and preferences should be central in decision-making. A focus on autonomy as the guiding ethical principle in clinical decision-making is particularly common in North America [16]. This deference to autonomy has not always been the case, however, and historically, decision-making in medicine was conducted paternalistically. In a paternalistic style of decision-making, a clinician "substitutes one's own judgment for that of another person and decide(s) in place of that person for his/her best interest" [17]. In other words, the judgment of the clinician is central, and the role of patient preferences comes secondary to what the clinician judges to be the right decision. Contemporarily, there are cultural and geographic differences in the primacy of autonomy in decision-making. For example, some authors have noted a paternalistic approach to decision-making is still more common in European countries [16] though this is not a general assessment.

The pure-autonomy approach is limited, however, and can lead to patients and families feeling left to make decisions on their own, without expert guidance. Over-reliance on autonomy as the guiding principle for decision-making may additionally lead to situations where patients or their surrogates request care that clinicians view as potentially inappropriate or even harmful. Furthermore, a pure-autonomy approach to decision-making is often limited in the case of surrogate decision-making, where the patient's advance directives may be unknown or impracticable. Many authors have highlighted the limitations of surrogate decision-making, citing individuals' propensity to change their minds over time [18] and the inaccuracy of surrogates in predicting what their loved one would want [19].

In an effort to address some of the aforementioned limitations, shared decision-making has been recommended by multiple critical care societies [16]. This model of decision-making has been defined as a "collaborative process that allows patients, or their surrogates, and clinicians to make healthcare decisions together, taking into account the best scientific evidence available, as well as the patient's values, goals and preferences" [20].

Thus, in this case, a shared decision-making approach could allow the ED physician caring for the patient to explore her refusal. In an effort to respect her autonomy, he could probe the values that underly her decision, and inquire more about her understanding of the intervention. The patient has prior experience with people who have undergone amputation, so this may be a crucial factor in her refusal. In addition to understanding her values and preferences, the physician can ensure that the medical situation is accurately conveyed to her, that his recommendation is clear, and that she has an adequate understanding of what she is refusing and the likely consequences of that refusal. The patient may have misconceptions or misunderstandings that, if corrected, could alter her decision. If time allows, he could explore whether there are important people in her life that could help her think through this high-stakes decision as a form of autonomy support. Assuming the patient retains decision-making capacity throughout the process, ultimately the choice to undergo surgery or not is up to her, but the physician caring for her can work to ensure that the decision is informed both by an understanding of accurate clinical information and by her prior experiences, her values, and her preferences.

**Vignette 2: Proportionality, Potentially Inappropriate Treatment, and Cultural Considerations**

*A 68-year-old patient from a Middle Eastern country is admitted to an American hospital for cardiac surgery. He had multiple comorbid conditions preoperatively and understood that the risks of surgery were high. Postoperatively he developed a sternal wound infection that resulted in dehiscence of his incision and ultimately removal of his entire sternum. He was persistently ventilator- and dialysis-dependent and never regained consciousness after the procedure. After weeks of attempting to treat the infection unsuccessfully, the medical team believes that he will not survive, and recommend transitioning the focus of his care to comfort. The patient's family objects, citing their religious beliefs. They want the team to "do everything," and to leave the outcome in "God's hands." There is significant distress among the medical and nursing staff as they believe the patient is suffering but want to be respectful of the family's religious and cultural views.*

The ethical principle of proportionality requires that clinicians assess the relative benefits and burdens of proposed interventions [21]. There is no ethical obligation for clinicians to offer interventions that are assessed to be overly burdensome, without a high degree of likely benefit [22]. Indeed, it could be argued that clinicians are obligated *not* to offer such interventions as an extension of non-maleficence, or the duty to avoid harm [14].

Nevertheless, requests for aggressive treatment, particularly at the end of life, are well documented in the literature [23]. In the early 1990s, this trend gave rise to the concept of futility, arising from technological advances in critical care that enabled the prolongation of life beyond what had ever been historically possible. This technological capability quickly became the genesis for questions about requests for the initiation or continuation of treatment that clinicians judged to be "futile." One early definition of futility proposed that "when physicians conclude … that in the last 100 cases a medical treatment has been useless, they should regard the treatment as futile. If a treatment merely preserves permanent unconsciousness or cannot end dependence on medical care, the treatment should be considered futile" [24]. Many authors, however, challenged this and other notions of futility as ambiguous and subjective [25], giving rise to frameworks and preventive ethics approaches to the problem, focused on resolving disputes over treatment between patients/families and clinicians [26].

In 2015, the American Thoracic Society, American Association of Critical Care Nurses, the American College of Chest Physicians, the European Society for Intensive Care Medicine, and the Society of Critical Care Medicine released a joint policy statement. In it, the groups advocated for the use of "potentially inappropriate" rather than "futile" to describe treatments that "have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing them" [23]. They further argued for reserving the word "futile" for rare situations of physiologic futility, in which the intervention cannot accomplish the intended physiologic goal, and recommended a conflict resolution process for managing intractable disagreements [23]. Today, many hospitals have developed this sort of conflict resolution process, and data suggest that these processes may improve end-of-life care and mitigate conflict [27].

Cultural and religious views are important considerations in cases of disagreement about potentially inappropriate care. Some evidence has shown that individuals who are more religious may be inclined toward preferring more intensive care and life-prolonging treatment [28, 29]. Additionally, physicians' religiosity may have bearing on preferences toward limiting treatment at the end of life [30] although there is evidence to suggest that there is widespread agreement among clinicians internationally regarding not offering cardiopulmonary resuscitation when not medically indicated [31]. The clinician's understanding of the cultural and/or religious basis for certain treatment preferences may help patients and families to feel heard and understood, which in turn may engender a willingness to consider a wider variety of treatment recommendations [32].

The team caring for the patient in this vignette could begin by acknowledging the difficult position the family find themselves in and exploring the meaning behind their request to "do everything." This is a common directive given by grieving families; however, the specifics behind this request must be elucidated. For example, the team may work toward "doing everything" to keep the patient comfortable and relieving suffering as he approaches the end of life. The family may also benefit from engagement with individuals from their religious community if it is different than that of the practitioners involved, as in this case. Ideally, such an individual can help guide the family through the decision-making process and serve as a cultural broker between them and the clinical team [33]. While respecting cultural and religious preferences is essential, the clinical course also may reach a juncture where further medical intervention no longer has the potential to benefit the patient. If not already initiated, at this point the medical team can begin conversations about withholding the escalation of interventions or withdrawing current interventions with the family, on the basis that they are causing more harm than good.

**Vignette 3: Interprofessional Teamwork and Communication**
*A 70-year-old woman is admitted to an oncology unit with advanced cancer. She quickly becomes deconditioned, unable to feed herself, and non-interactive. She is cachectic and has a large sacral pressure ulcer. The nursing staff feel strongly that this patient should have her care transitioned to a focus on comfort; however, the patient's oncologist is not in agreement. He argues that the patient was a "fighter" and has not tried immunotherapy. He offers this to the family and they readily accept. The nursing staff are frustrated because they "know where this is heading," but do not feel as though the oncology team is listening to them.*

The literature is rife with evidence about communication and teamwork challenges among members of the multidisciplinary team in the critical care and ED environments [34]. Although communication challenges are not always framed as ethical issues per se, poor communication and inadequate collaboration have been identified as major sources of moral distress [35] and even as contributors to medical errors [36]. Recent data suggest that there are differences in the way critical care physicians and nurses view the scope of their respective moral obligations, which may further hamper teamwork and give rise to conflict [37].

In light of these challenges, authors have highlighted the importance of interprofessional shared decision-making (IP-SDM), which is a collaborative process that allows for the "exchange of information, deliberation, and joint attainment of important treatment decisions" among an interprofessional team, including physicians, nurses, and other clinicians [38]. This model is particularly important where there are disagreements about the plan of care as it can highlight gaps in fact information that may be drivers of differing perspectives. For example, the nurses may have information about the patient's values or goals that the medical team has not heard, and the medical team may have information about the treatment and prognosis of which the nursing staff have not been made aware. Furthermore, IP-SDM can lead to "better-reasoned and more robust decisions" about the treatment plan [38].

Ethics consultation is one way of facilitating this type of communication, particularly in cases that are especially fraught or characterized by conflict. Ethics consultation services, and other ethics-related resources, can provide mechanisms that foster interprofessional communication around moral issues. Some authors have described "moral spaces" as a metaphor for the time, structures, and processes that facilitate this type of conversation around ethical issues and challenging clinical scenarios [39, 40], all of which can create a more robust sense of teamwork and collaboration.

In this case, the nursing staff may advocate for the convening of an interdisciplinary team meeting, where they can raise their concerns about the plan of care with the rest of the medical team, including the oncologist. If this attempt is unsuccessful, or if there are still concerns after the group meets, an ethics consultation may prove useful in helping the group sort out their disagreement, ensuring that all viewpoints are heard and that the plan of care reflects a robust consideration of the relevant stakeholder perspectives.

## 1.4 Conclusion

As these vignettes highlight, ethical frameworks have evolved in the past several decades in ways that can be practically useful for clinicians and that have been corroborated by research and scholarly work. Progress toward the model of shared decision-making and a greater sensitivity to cultural nuances can help clinicians ally with patients and families when making difficult choices about the plan of care. A heightened attention to the proportionality of care, the movement toward defining and avoiding potentially inappropriate treatment, and an increasing presence of palliative care in the critical care environment are all trends that can aid clinicians navigate ethically challenging situations with patients, particularly at the end of life. Finally, efforts to strengthen interprofessional teamwork and communication, particularly in situations of conflict, can support the development of a more ethical climate in ICUs and EDs. All that said, work remains to be done in the dissemination and uptake of existing tools and frameworks, and additional research is needed to optimally equip clinicians at the bedside. New technology will continue to give rise to new questions, but the tools of ethics can help clinicians navigate these challenging new scenarios.

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