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Practical ethical rules of behavier Critical Care Unit (ICU) (Beer Sheva,Israel)

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In the last decades we witness an exponential increase in the literature dealing with various ethical aspects of the critically ill patient management in the intensive care units.The development of the life-preserving technology created a multitude of ethical dilemmas, most of them related to the end-of-life situations and the need for clear recommendations and guidelines with the aim of respecting patient's autonomy, but also avoiding futile treatments and unnecessary prolongation of vital functions in the absence of cerebral functions.All these aspects produced a large series of studies, analyses and reviews and most of the principal ethic aspects regarding the ICU patient are already solved.The present paper deals with less crucial, but not less important, items related to ethical behavior of the ICU staff towards the patient and his/her family.It recommends practical rules of attitude, to be respected on a daily basis.It refers to the responsibility of the physician as a team leader and a role model, and presents some data about how his/her presence near the patient's bed could make the team work easier and better understood by the patient's family.It deals with the relations inside the ICU team, the need for open discussions and clear decisions.The paper emphasizes the importance of sedation of the ICU patient and thus alleviating his/her sufferance.Finally, it includes practical advises regarding the relationship between ICU staff and patient's family. The lack of patient's ability to express his/her own wishes and decisions oblige the ICU team to keep the family daily updated and closely involved in the decision-making proce

Kewy Words: Intensiv Care Unit, , Critical Care Unit, Ethical rules, The Team.Treatment.

Introduction: The goal of ICU management is a double one: returning the patient as soon as possible and as close as possible to his/her previous medical condition and relieving suffering during treatment.Both these ideals are to be fulfilled, among other things, by respecting ethical principles , which in the ICU environment have some specific aspects.The literature deals in the last couple of decades with the ethical concerns in managing critical ill patients, among them the lack of autonomy, need for informed consent (especially for including a patient in a research study-1), source of authority, patients rights, futile treatments (2), etc.Many studies have been performed in various parts of the world in regard with end-of life ethics and decision-making process , which include the "do not resuscitate (DNR)" rules, as well as the withdrawal and withholding policies (3-5).Main is the availability of ICU beds and the policy of priorities regarding patients' admittance in such units, even in those countries where the number of ICU beds seems to be enough (6).The four more explicit obligations of the physician towards his/her patient are included, directly or indirectly, in the Hippocratic writings: beneficence, nonmaleficence, fair allocation or justice and respect for a person's autonomy (7).Some years ago we dealt with the regional differences regarding the ethical attitude towards the ICU patient, attitude influenced by cultural and religious realities of each place (8).The simple fact that the ICU patient is kept, in the vast majority of cases, sedated and sometime paralyzed, creates a situation in which the critical care team is obliged to take decisions in the absence of any communication with the patient. This reality produces a multitude of situations in which ethical principles could be easily neglected. This could lead to misunderstanding, lack of confidence and even malpractice suits.But this paper would deal with another kind of reality, that one in which the ICU team has to respect practical, daily rules of behavior, which might have only a tangential connection to the classical and well known ethical principles, but are crucial for a decent attitude towards the patient and his/her family.This practical rules are clear, self-explanatory, but unfortunately they are not, yet, reflected in the papers published and research done in the field of critical care and most probably not entirely respected in the daily routine.In an interesting article published in 2006 by Hawryluck (9) the author complains of the fact that the current position papers and recommendations "do not provide definitive guidance in the day-to-day difficult decision making faced by frontline clinicians"The aim of this paper is to deal with those daily aspects of our routine ICU activity and tries to establish some practical rules of behavior of the ICU staff in its

permanent contact with patients, their families and also with other healthcare providers involved in the care of the critically ill patient.

The main directions of dealing with the practical rules in ICU

The physician.

The natural leader of any ICU activity is the physician. He/she is not only the main decision-maker, but also a model of attitude, the person responsible for the attitude of all the personnel. This is why his/her activity should be led by simple but important criteria of behavior, which would also be followed and copied by those who work with him/her in the premises of the ICU.Among the most important rules regarding the physician behavior is that one which obliges the ICU practitioner to keep a permanent contact with the primary care physician (surgeon, internal medicine specialist, etc) who decided to send the patient to the critical care unit. Another rule deals with the obligation to keep a strict, correct and up to date record of data for each patient and also to be able to ask for advise in case the medical condition of the patient exceeds his/her own expertise.Ratpalan et al study (10) presented a very well known fact by the usual practitioner. Intensivists' documentation of their communication with substitute decision makers frequently outlined the proposed plan of treatment, but often lacked evidence of discussion relevant to whether the treatment plan was expected to improve the patient's condition. In other words, documentation must deal not only with strict absolute data, but it has to include references about the staff's expectations about the patient management results.Like in any medical environment, ICU too is a place where divergence of opinions rise from time to time. The first rule is not to bring the debate to the patient's bed. Differences of opinions are to be solved in the conference room, in a proper atmosphere, during which a right to expose one's own opinion is respected for every member of the staff. But eventually the final decision belongs to the hierarchic authority in that moment, e.g. the ICU chief or the attending specialist.

ICU staff

The second set of rules are to be directed towards the personnel. Critical Care is a multidisciplinary field, it involves not only physicians and nurses but many other professionals, like pharmacists, physiotherapists, social workers, administrative clerks, etc. They all are supposed to have an ethical and respectful attitude toward the patient, and their behavior is open to criticism not less than those who are directly involved in the daily routine management of the critically ill. It is the ICU staff obligation to offer other professionals all the necessary data regarding the patient's condition and thus to assist the efforts to find the best solution in each individual case. The language used for this purpose has to be understood by every single member of the team and explanations are to be offered when necessary.This rule is obvious for emigration countries (for instance like Israel) in which the staff includes members speaking a large variety of languages.Frequent discussions with all staff about each patient's condition is crucial. Fisher (11) , quoting a well known paper of Sternberg (12) describes the importance of regular meetings with the nursing staff at which patients and the appropriateness of their care are discussed in depth, much more efficient than during the ward rounds.One rather unsolved problem in ICU is the impact of collaborative care on treatment cost. Critical care, by definition, is a domain in which a variety of specialists contribute to patient management, either directly or by offering (sometimes costly) consulting advises and participating to some technical procedures.. It is a well known fact that ICU care is commonly influenced by multiple physicians, coming from various specialties. In some units, the practical decisions are almost always taken by the attending intensivist in strict cooperation with the primary care physician.The question is how this kind of cooperation does influence the cost of care. In this respect, the data in the literature do not give a uniform answer.Auerbach et al (13) showed that comanagement of neurosurgical patients reduces hospital cost. But Huddleston (14) and later on Garland (15), studying the same topic, although they emphasized the importance of cooperation between physicians for the sake of the patient outcome, failed to prove any financial benefit, e.g. decrease in cost of treatment.

The patient

The third group of rules concerns the patient him/herself. As already mentioned, the ICU patient is in most cases in a condition which does not allow him/her to take decisions or to select management possibilities. The practical ICU rules are to be implemented for the sake of the patient, taking into consideration the obligation to find the best therapeutic solution and in the same time to respect the patient rights, among them the right not to suffer. A very crucial ethical rule of behavior includes the obligation to sedate every single patient who is suffering and to offer analgesia for every single painful procedure. This principle also , or mainly, apply to those terminal patients, which medical condition is beyond any therapeutic resources (16).Sedation of the ICU patient seems to be part of the basic management of the critically ill. There is no clear answer if application of uninterrupted sedation of continuation of sedation 24 hours a day , up to the clear improvement of patient's condition would influence the psychological outcome of the patient discharged from an ICU ((17,18)As Croxall specifies in his paper (17) "it remains unknown if and how sedation is related to post-ICU psychological outcomes". His finding highlighted the fact that reduced sedation levels did not significantly reduce the outcome of post-traumatic distress syndrome, yet reduced ICU length of stay and length of mechanical ventilationBut one has also to be alert to the fact that even a comatose patient could collect information from what is done and (especially) said near him/her. This is why a clear principle obliges the ICU staff to restrict conversations near the patient's bed, mainly those dealing with his/her situation.

Patient family.

Finally, an important component of an ICU activity is represented by the patient's family. In the absence of patient's ability to use his/her own autonomy and possibility to decide, the family plays a very important role for assuring the positive outcome of treatment. A correct and also human staff attitude towards the family would avoid not only misunderstanding but also unfortunate situations, which might easily lead to complains , and even medicolegal suits. The staff obligation is to meet the patient's family on a regular basis and give it a chance to get updated and ask questions.Explanations are to be offered in a language free of complicated medical terms.Unfortunately this desiderate is not always respected and sought of. A French study, done in 113 ICUs and published some 15 years ago, (19) indicated that the patient's family was involved in the decision-making process in only 44% of casesAbove everything, one must avoid the natural tendency of discussing with the family items related to long term prognosis of their relative. As a well known fact, ICU patient's condition might change from one hour to another, and this is the reason why the staff has to refrain from discussing the patient chances beyond the next hours or day.Some data from recent literature provide data about the ICU patients families' attitude regarding the access to information .In Shenkner et al study (20**)** surrogates experienced a tension between wanting to know what to expect and needing to remain hopeful. This tension underlined their experience receiving prognostic information and could lead to behaviors that allow continued hope in the face of bad news, including: 1) focusing on small details rather than the big picture, 2) relying on gut instincts or personal beliefs about the patient, 3) seeking more positive prognostic information from other sources, and, for a minority, 4) avoiding or disbelieving prognostic information. Surrogates emphasized the importance of frequent communication and called on physicians to gently help them prepare for the worst and hope for the best.A very well designed (and recommended) paper is that of the Swiss Academy of Medical Sciences (21) in which various ethical aspects of ICU care are discussed and specific guidelines are elaborated. In the chapter dealing with the relationship between the ICU staff and patient's family, a special place is kept to the so called conflict situations. The paper advises repeated discussions and clear explanations and, if necessary, the recommendation for a second opinion or even the transfer of the patient to another hospital.

Conclusions: The practical rules of daily behavior in the critical care environment are part of the whole ethical concept which considers the patient a living human being in sufferance, and who is entitled to get the best management in the most appropriate atmosphere.This can be done only by understanding the patient's special situation, by respecting his/her rights and by assisting the family in distress. We cannot

die with every single patient, but we, for sure, must be able to understand his/her sufferance.The ICU staff attitude is to be an objective one, free of personal feelings and ready to take the most dramatic measures in order to save the patient's life.Witnessing death on an almost daily basis demands a special attitude of behavior. By respecting them one can ease the complicated situation of the ICU patient.Finally it is worthwhile to reproduce the a very useful opinion of Tidswell and collab included in their chapter as part of Irwin and Rippe's excellent textbook (17) "by raising awareness of these important current issues, we hope to stimulate further discussions and self-examination in order to enhance the care of the ICU patients".

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