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Ethics in the ICU: Can Policies Help Resolve Conflicts?

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Decisions to admit a patient to the Intensive Care Unit (ICU), to continue or withdraw potentially life-sustaining treatments, are inherently challenging due to scientific uncertainty, ongoing advances in knowledge and technology and our limited abilities to accurately predict individual patient outcomes. The manner in which such technology is perceived in increasingly multicultural societies and, how this diversity of beliefs affects communication and decision-making, challenges the knowledge and understanding of front-line clinicians. The need for broad-based and respectful approaches to critical care delivery and for conflict resolution is becoming essential in the context of appropriate utilisation of resources. The question is, can policy help?

Ethical Principles for Policy Development

To be effective, any conflict resolution policy needs to have a clear and specific purpose. In the ICU, this purpose is to develop a treatment plan establishing clear goals of patient care, using impartial, respectful and transparent processes to resolve disputes in a timely manner. Some guiding ethical values to consider in the development of such policies include autonomy, justice, flexibility, accountability and public interest.

Autonomy includes consideration of the patient's wishes, beliefs and rights to make healthcare choices. It calls for collaboration, the exploration of common ground and appeals to participants to consider the "costs" of ongoing conflict. Principles of justice are essential to ensure that the process is fair, open, and transparent and that participants are, and perceive themselves to be, treated fairly. Moreover any policy must respect current legal frameworks. Flexibility is a value particular to a multicultural society that reflects the many paths that can be used to achieve resolution. Accountability, as with autonomy, mandates that participants are responsible for the outcomes of any resolution process. Accountability also reflects the value placed by the hospital administration and the broader public on achieving successful outcomes and providing high quality patient care. Indeed the best conflict resolution policies would explore how the entire organisational structure of the hospital can prevent conflicts with patients and families and among healthcareteams. Finally, the ethical dilemmas and quality of care concerns involved almost always engage broader public interest. Crucial to the notion of a "just society" and "equitable access to high quality healthcare", there is a need in any developed policy to balance respect for individual autonomy and multicultural and religious diversity with the need to ensure appropriate access to appropriate care.

Existing Policies

In the past few years, the ethics sections of Canadian, American and European Critical Care Societies have issued position statements describing the appropriate use of critical care services. These papers describe the goals of this field - to support a patient through an acute, potentially reversible, life-threatening illness and provide broad guidance on medical diagnoses, physiological and haemodynamic criteria that

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require the specialised monitoring, skills and technologies of an ICU environment (Thompson et al. 2003). Yet existing policies fall short of meeting the pressing need of front-line clinicians and of answering the fundamental question that gives rise to conflict situations.

Described best practices for conflict resolution include facilitating discussion and elucidating goals of treatment, listening to and addressing the concerns of patients and families, as well as clarifying misinformation and misunderstandings. It is often times useful to involve and enlist other members in the multidisciplinary ICU team such as ICU nurses, social workers, bioethicists and pastoral care services or community religious leaders in resolution efforts.

Existing policies recognise the unique skills of each member of the ICU team and how they may be helpful in building understanding and discoveringnew courses of action. A second medical opinion is recommended to ensure issues of diagnosis, prognosis, treatment options and recommendations are reviewed. Finally current policies for conflict resolution clearly describe the professional obligations to seek resolution and emphasise that while patient care responsibilities may be transferred to another, they cannot be abandoned.

Challenges in Clinical Practice

Despite the application of such best practices, it remains unclear how many conflicts are deemed intractable. Second opinions may be difficult to obtain in smaller communities. Family members may have concerns that second opinions will be biased. These concerns may be valid as intensivists are apt to call upon colleagues with whom they have a good relationship. Moreover, often those providing the second medical opinion do not interact with the family and a potentially important opportunity to help resolve the conflict is thereby lost.

How Can Policies Help Conflict Situations?

Increase Access and Utilisation Policies' Clarity and the Quality of Guidance Provided

Any described process for conflict resolution is usually found as part of ICU policies on admission, discharge and triage. Such policies need first to refocus on the development of a consistent standard of care for access and utilisation that respect individual autonomy, multicultural and religious diversity, balanced with the equally vital need to ensure respect for the public's interest in appropriate access to a limited critical resource.

Promote Development and Communication of Goals of Care

Policies regarding critical care access and utilisation should promote open communication and means to develop clear treatment goals with the patient or their substitute decision-maker in collaborationwith involved subspecialty teams. Policies should describe processes to re-evaluate the patient's condition and the effectiveness of potentially life-sustaining treatments at clear time intervals or when the clinical condition changes. In situations of uncertainty, policies should detail the role of a trial of therapy with clear goals and reasonabletime frames set a priori.

Once the goals of treatment have been agreed upon with a patient they must be adhered to unless there is a change in the patient's diagnosis. The policy needs to ensure that changes in the most responsible ICU physician do not result in a drastic change of treatment plan.

Broaden Stakeholder Engagement

Develop processes to promote skilled and open communication of access and utilisation policies and to educate patients, substitute decision-makers and key stakeholders (Gibson et al. 2005) on what ICU care entails and to provide input on what the standard of care is for its use.

Mandate Consistent Fair and Transparent Second Opinion Processes

Policies should describe who can give a second opinion in ways that promote transparency and fairness and best practices regarding how a second opinion should be provided and documented. Furthermore, the role of the second intensivist towards the patient and substitute decisionmaker should be delineated. If the policy mandates that the second intensivist meet with the patients/substitute decision-maker it would ensure their active participation in the consultation process and potentiate resolution with the development of reasonable expectations, goals and treatment plans.

Describe Clear Processes for Conflict Resolution that Support Front-Line Clinicians

Current policies outline a list of professionals who may be consulted in order to help achieve resolution.Such involvement may be effective, or it may serve to further entrench positions. As their final recommendation, policies often suggest transferring care of a patient to another hospital in the case of intractable conflict. In practice, such an option rarely exists and serves only to leave clinicians feeling unsupported. Policies would be greatly improved if instead they explored how organisational structures could support conflict resolution. Such support is particularly important if legal recourses are to be undertaken.

Conclusion

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Carefully developed policies that delineate a clear standard of critical care utilisation, promote processes to develop and communicate reasonable goals of care and describe practical processes to resolve disputes can improve the quality of care of any given patient. Limited critical care resources mean that not every patient and their family can receive every treatment they desire despite potential benefits. To provide practical guidance, policies must not shy away from providing ethical and legal frameworks and standard of care criteria to support clinicians and families facing difficult decisions. Such support can be an important step in preventing conflicts from arising. A system-wide approach to policy development and implementation is required otherwise such policies, despite being practical will still sit on the shelves of the ICU.

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