Ethics in Intensive Care Medicine

Ética en medicina intensiva

Marcial Orlando Cabrera Cantarero*
Cardiocentro - Centro Cardiológico Candray, San Salvador,
El Salvador

Diana María del Consuelo Arce Sosa**
Hospital Ángeles Lindavista, Mexico City, Mexico

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The availability of advanced technology, proximity to specialized therapeutic measures and highly qualified medical staff are some of the characteristics that make Intensive Care Units (ICUs) indispensable in hospital institutions. The admission of patients with complex pathologies, situations of high emotional stress, crucial decision making and the resolution of ethically challenging problems make up the "day to day" of ICUs.

* Social Service Intern, Cardiocentro - Centro Cardiológico Candray, San Salvador, El Salvador. E-mail: marcial.cabreraca@anahuac.mx https://orcid.org/0009-0008-7610-6131

** Head of the Intensive and Intermediate Care Unit, Hospital Ángeles Lindavista, Mexico City, Mexico. E-mail: dianaasosa@hotmail.com https://orcid.org/0009-0004-2391-9543

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If we recall what we experienced some years ago with the COVID-19 pandemic, ICUs played a fundamental role in the management of thousands of patients in the context of a health emergency that took everyone by surprise and resulted in the collapse of many health systems. Needless to say, at the beginning we were not prepared for a health crisis of such proportions, and as a result, doctors, nurses and all health personnel were forced to implement measures to optimize, prioritize and rationalize health resources, which in many regions were insufficient.

All of the above, together with the lack of research lines that highlight the role of ethics in situations of adversity in hospital institutions, make us understand the objective of Michalsen, Sadovnikoff and Kesecioglu when they published *Ethics in Intensive Care Medicine*, a work that presents a wide series of reflections and recommendations supported by numerous scientific studies that support the importance of ethics in ICUs, under the supervision of the *European Society of Intensive Care Medicine* (ESICM).

Ethics and its principles, according to the authors, form a guide when "navigating" ethically complex situations, from the initial point of deciding which patient to admit to the ICU, to the limitation of life-sustaining therapies (LSTs) and the application of palliative care in the last moments before death.

During the first chapters of the book, some ethical theories are explored that can guide the health professional in decision making, especially in the ICU. Among them, utilitarianism, an approach that judges the morality of an action based on the outcome or its consequences, may conflict with the individualism of each patient. Next, deontology is described as a philosophical theory that guides acting on the basis of rules or duties, rather than the consequences of actions. One challenge facing deontology is the exceptions that can be found to the rules. For example, in proposing the rule that physicians should do no harm, it is possible to imagine scenarios where the physician might cause a certain degree of harm in order to confer a future benefit, e.g., through the physical pain involved in surgery, the patient may benefit from a better prognosis for life.

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Another ethical theory described is virtue ethics, which argues that the point of helping or doing good to a person lies in simply being benevolent. This may be insufficient in practice, since acting on the basis of virtue is not enough to guide the health professional in all possible circumstances. Consequently, the four moral principles of beneficence, nonmaleficence, autonomy and justice are highlighted, highlighting the limitations and applicability of each of them in medical practice as fundamental parts of principlism.

Chapters 2 and 3 deal with the two pillars of intensive care medicine: the medical indication for admission to the ICU and the patient's wishes and informed consent. The authors recommend considering factors such as disease severity (assessed objectively by standardized scales such as APACHE and SOFA), functional status and the availability of therapeutic measures when deciding to admit a patient to the ICU.

This decision may be confronted by external factors such as pressure from third parties, institutions or authorities and limited resources, a common denominator in several health institutions. Therefore, the intensivist physician must remain firm and indicate admission considering the factors previously described, assessing each case individually and comprehensively, according to the clinical history, severity and expectations.

Once the patient's admission to the ICU has been indicated prior to performing any procedure, the ICU team should provide informed consent that includes essential components such as decision-making capacity, voluntariness and the information provided.

Ethical decision making in the ICU is a complex task, and there are various models of decision making. For example, a few decades ago the paternalistic approach predominated, where the decision was made entirely by the physician. Today, on the other hand, medical decisions are highly questioned by family members, patients and legal representatives, who express their wishes and preferences with the aim of having a more active participation in decision making. Faced with this new reality, the authors recommend implementing

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shared decision making (SDM), an approach capable of generating an environment of collaboration and reciprocity at the physician-patient level and, on certain occasions, at the physician-family level.

SDM allows consensus building between physicians and family members in situations where the patient lacks decision-making capacity. In addition, it promotes inclusion for decision making in favor of the patient's well-being, when implemented within the interprofessional team (IP-SDM) that makes up the ICU. Thus, the authors propose SDM as a crucial element to achieve balance in the decision-making process.

Implementing SDM with patients and families requires an environment of information exchange and consensus on treatment. Some challenges that may arise in this process are emotional stress and cultural diversity, so the intensivist has the task of adapting to the cultural context of family members and communicating in an empathetic and understanding manner. Therefore, two tools that facilitate communication are: the VALUE approach (Valuing statements, Acknowledging emotions, Listening to family members, Understanding the patient as a person and Eliciting questions from family members) and the incorporation of communication facilitators and mediators to resolve conflicts.

Another highlight is that we live in a profoundly diverse world, where multiculturalism has become the norm in countries such as the United States. Chapter 6 discusses how multiculturalism can be reflected in the diversity of patients who come to hospitals for consultation. It is not uncommon for ICU teams to encounter cultural differences that can cause misunderstandings when dealing personally with some patients and families. Therefore, to overcome this cultural barrier, the authors recommend that hospitals train their staff in the skills of cultural adaptability, tolerance, respect, empathy and sensitivity, to foster an environment of tolerance and trust for patients and their families.

On the other hand, prognosis in the ICU is a highly variable factor, as it can change at any time, and its constant evaluation helps the

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intensivist physician to have an updated and accurate vision of the short- and long-term therapeutic goals, providing care that is concordant with the objective.

Chapter 7 highlights the relevance of advance planning, and the use of decision-making frameworks combined with effective communication strategies to align care with patient preferences and thereby positively impact patient quality of life after ICU discharge.

However, the mission of reversing disease and restoring health cannot always be achieved. There are severe pathologies, in which (*Life Sustaining Therapies* LSTs) are implemented for a prolonged period of time, with the sole objective of keeping the patient alive. In these diseases the prognosis for recovery is low or the condition is irreversible, so it is ethically justified to limit LSTs.

LSTs consist of therapeutic measures used in order to keep the patient alive, but do not cure the underlying disease, some examples are: cardiopulmonary resuscitation (CPR), mechanical ventilation, chemotherapy, dialysis, among others.

However, what is ethically justifiable is not always legal, so that, in many countries, the limitation of LSTs can be seen as an act of life shortening, while in others, this act is completely in accordance with the law. Regardless, the physician should be well informed about the laws of each country or region regarding the limitation of LSTs. It should be clarified that, as mentioned by the authors, limiting LSTs does not imply reducing the overall care of the patient, and it is possible to proceed with symptom relief, psychological support, palliative care, and all the necessary measures to guarantee a dignified dying process.

In Chapter 9, we discuss cardiopulmonary resuscitation (CPR), which is frequently used in situations of cardiac arrest in the ICU. CPR is not always safe, so uncertainties about its risk/benefit have always been under discussion, specifically on the issues of when to initiate, continue or discontinue CPR measures. Therefore, it is recommended that the CPR decision-making process consider the likely neurological future and the patient's already established preferences, for example, in do-not-resuscitate orders (DNARs).

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After CPR, outcomes can be favorable or unsuccessful, and conversing with family members when the outcome of CPR is not as expected is a challenge to consider, and here communication based on effective communication models such as the SPIKE protocol is key.

At some point, those patients with unfavorable prognoses for life and function will require palliative care, which complements ICU by alleviating symptoms such as pain and emotional stress, protecting ethical principles, and associating with shorter duration of mechanical ventilation and unnecessary treatments, allowing a dignified dying process.

On the other hand, a positive ethical climate in the ICU is essential for the proper development of all team members, resulting in quality care and the prevention of high levels of stress, conflicts, exhaustion and *burnout*.

Part of this ethical climate consists of guaranteeing the rights of physicians and patients. As the authors mention in Chapter 12, institutions should respect the patient's right to privacy, informed consent, refusal of treatment, non-discrimination, among others. In the case of physicians, institutions must respect their abstention from performing procedures that go against their beliefs and the right to make decisions in favor of the patient's needs.

Simultaneously, the same chapter delves into the relevance of hospital bioethics committees and legal representatives, who play a crucial role in mediation and conflict resolution.

The penultimate chapter touches on one of the most controversial issues in medical practice: the concept of distributive justice in the context of health crisis: how to ensure fair care when resources are scarce. The authors first describe the rationing approach (denying therapeutic measures for the collective welfare, in the absence of discrimination) and then the prioritization approach (allocating resources according to the probability of benefit, according to various approaches, such as first-come, first-served, severity, among others).

However, ensuring distributive justice is not simple, and the approaches described above may be insufficient to ensure compliance.

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Therefore, the book recommends acting in a transparent manner, based on principles that are applicable in most situations, such as equal treatment, maximization of lives saved, and prioritization of individuals with the highest probability of survival.

Finally, the book describes ethics as a "systematic reflection of the good", and points to it as a fundamental parameter for designing principles and decisions. The authors mention that the exercise of virtues and values in favor of the common good, communication and cooperation are fundamental aspects in the search for care oriented to the patient's integral wellbeing. However, in terms of ethics in the ICU, the authors point out that there is still a long way to go.

In *Ethics in Intensive Care Medicine*, Michalsen, Sadovnikoff and Kesecioglu, delve into the bridge that exists between medical care based on ethics and adversity in the area of intensive care medicine, building a clinical practice guide for the intensivist physician in acting during complex situations.

The book stands out for presenting and exposing multiple ethical concepts and principles in a comprehensive manner, explaining their relevance and applicability to the reader in specific contexts such as health emergencies, conflict situations, multiculturalism and decision-making processes.

The contents addressed in the fourteen chapters of the book propose a medical practice based on ethical principles, values, dialogue skills, and diverse approaches and recommendations supported and enriched by an extensive body of scientific evidence.

The presentation of clinical cases, results of scientific studies, *take home messages* and the different points of view of specialists in critical medicine throughout the chapters facilitate the reader's understanding, allowing him or her to "ground" the concepts written in the book in medical practice, strengthening the overall quality of the work.

Faced with the morals and aftermath of the post-pandemic era and the challenge of strengthening the lines of research that highlight the essential role of ethics in the day-to-day practice of intensive care medicine, the book constitutes an important starting point

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on which future authors, specialists and experts can base themselves to generate literary contributions as valuable as the one we have described.

In this way we can understand that there is neither a recipe nor a universal guideline, since each situation should be individualized, centered on the patient and his family, providing clear and effective information, for decision making in accordance with the patient's values and wishes, in a free and informed manner; however, we should not forget that according to the health and legal context, as well as other variables, this perspective may be affected. In view of this, a general approach to the different ethical currents will be a frame of reference with tools that will help to reduce conflicts between health professionals when faced with difficult decisions, without this meaning that we will stop facing ethical dilemmas that can affect us emotionally, generating feelings of frustration and guilt that can have repercussions on our professional performance. Let us remember that we are not infallible, nor are we obliged to be, and that in complex situations we can share and exchange perspectives in a multidisciplinary and interdisciplinary manner, where the bioethics committee can play a fundamental role in guidance and counseling, facilitating the search for consensual solutions.

Finally, we can conclude that *Ethics in Intensive Care Medicine* is a highly recommended book for all health professionals, especially for intensivists, nurses, palliative care specialists and all those who make up the interdisciplinary team of an ICU. Its clinical, scientific, theoretical and practical approach makes it imperative reading for both the current healthcare workforce and future generations of physicians and workers who will advocate for the well-being of tomorrow's population.

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