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REPORT OF SCIENTIFIC MEETING

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Exploring Ethical Issues in Critical Care Medicine

A 1-day symposium, "Exploring Ethical Issues in Critical Care Medicine," was held March 13, 1987, at Memorial Sloan-Kettering Cancer Center, in New York City. Jointly organized by the services of Critical Care Medicine and Psychiatry at Memorial Hospital, the symposium dealt with topics including cardiopulmonary resuscitation, limitations of medical care, and the societal costs of critical care services.

After pointing out both the progress that has been made in resuscitation technology and the extraordinary costs that accrue from such critical care services, Dr. Jeffrey Groeger (Memorial Hospital) indicated that prolongation of life may, on occasion, conflict with the physician's responsibility to relieve pain and suffering. Nowhere is this more true than when the physician is treating a hospitalized patient with pre-existing progressive multisystem failure or chronic disease, who is incapable of leading an independent life and who may not be capable of expressing his or her desires clearly.

To date, the evolution of medical policy has always favored aggressive intervention. According to Dr. Robert Baker (Union College, Schenectady) this has resulted in cardiopulmonary resuscitation becoming virtually mandated in hospitalized patients. He indicated that resuscitation is often performed without regard to the resulting morbidity, mortality, and great financial cost. Dr. Baker emphasized the need for physicians to develop a mechanism for allowing patients to refuse resuscitation before the maximum treatment regimen becomes inevitable. While there is much agreement that patients should be involved in these decisions, in only a small minority of cases is this type of discussion ever inaugurated. When it does occur, the discussion often is restricted to the family and physician when the patient is no longer competent.

Dr. Jimmie Holland (Memorial Hospital) indicated that feeble or self-serving excuses such as "the time is never right," "it's easier to do everything than to stop," the "uncertain prognosis," and the fear of legal liability all contribute to the physician's failure to deliver a realistic message. Added to this is the hubris of modern technology that encourages physicians to forge ahead with aggressive therapy despite insurmountable odds, even if only to prove that it can be done.

A "Do Not Resuscitate" policy reverses the usual process of informed consent. Dr. Daniel O'Hare (Memorial Hospital) noted that it shifts the presumption from unquestioned aggressive therapy to one in which the physician needs permission from the patient before instituting aggressive treatment. He concurred with Dr. Baker's suggested resolution for this issue: obtaining advance directives and consent for resuscitation and aggressive medical therapy prior to admission to an ICU, or even prior to hospitalization. The patient and physician could thus enter into a specific "what if" discussion; at the same time, patients could indicate a surrogate who might make decisions for them if necessary. Patients must also be reassured that they would continue to receive a level of care agreed upon at the time of the resuscitation decision.

During the discussion period, lead by Dr. Robert Bedford (Memorial Hospital), the speakers expressed that only a small number of patients do not want to shoulder responsibility for their own fate. To avoid jeopardizing the doctor-patient relationship and to avoid isolating or alienating individual patients, it was proposed that this discussion take place with all patients coming to a hospital for treatment, and not just those who were most likely to become critically ill.

Physicians must recognize that patients hospitalized in an ICU raise issues that cross multiple boundaries. Dr. Michael Rie (Massachusetts General Hospital) pointed out that 80% of all deaths (U. S.) occur within hospitals or chronic care facilities. Furthermore, fully 1% of the gross national product of the United States is spent within high-technology ICUs. After years of uninterrupted growth in the numbers of ICU beds, it has now become apparent that there is an inverse relationship between the cost of ICU care and patient survival. Not only may the extreme costs harm patients and their families, but Medicare prospective reimbursement under existing DRGs results in substantial losses to hospitals that care for critically ill patients.

Can cost-containment and efficiency obviate the need for rationing of beneficial medical services? If not, what role should the physician play as society's agent? With regard to the first question, many argue that society does not need to ration care if only the nonbeneficial and futile diagnostic and therapeutic procedures are eliminated. Others argue that society should restrict expensive and marginally beneficial services. Dr. Rie attempted to resolve these opposing views by presenting an "ICU entitlement index."

ICU entitlement = PQL/C, where P = probability of successful outcome; Q = quality of success; L = length of life remaining; and C = costs required to achieve therapeutic success.

The entitlement index explicitly accepts the reality of scarce resources and acknowledges the responsibility to ration them.

Can we deprive individuals of access to health care resources? Dr. Martin Strosberg (Union College, Schenectady, NY) pointed out that Medicare is financially limited by an increasingly older population, and that these individuals, acting as a major franchised political block, will not allow their medical care to be restricted. Corporations buy medical care through private contracts specifically to be certain that they

have access to health care. Although it is is widely accepted that we should ration care based on societal benefit, our political system is unable or unwilling to explicitly engage this issue.

Cost-containment and budget cuts turn ICU physicians into de facto bureaucrats who provide life-sustaining services to an involuntary clientele who may have inadequate resources and inappropriate performance expectations. If physicians must triage these patients, Dr. Graziano Carlon (Memorial Hospital) indicated that it must be done with great discretion. Physicians may choose to triage either by embracing rules or by embracing decision criteria based on prognostic indicators. Tools that measure severity of illness, extent of therapeutic interventions, and probability of survival, he felt, must be assessed to help define recognized marginal therapies.

During the general discussion session, lead by Dr. Robert Timberger (Memorial Hospital) it was made apparent that, given our fragmented and pluralistic society, it is unlikely that our political institutions can be forced to take responsibility for rationing medical care. Susan Wolf, J.D., of the Hastings Center, Hastings-on-Hudson, NY, projected a potential collision between the individual's right to self-determination and computer-based prognostic indicators.

Physicians must take a stand on ethical issues in critical care medicine and initiate a discussion of these issues with the public, with the politicians, and with their patients.

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