Ethical issues in resuscitation and intensive care medicine

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Abstract

Both legal and ethical issues may be encountered by intensive care practitioners on a regular basis. A keen knowledge of the law and of professional guidelines will assist decision-making in challenging clinical cases. Four bioethical principles can be utilized in ethical dilemmas to provide a framework upon which to base moral decisions. Being able to assess mental capacity and ascertain a patient's best interests are both key requisites for the intensive care practitioner. The application of these principles to common scenarios is discussed.

Keywords autonomy; DNAR; ethics; futility; intensive care; organ donation; rationing; restraint; resuscitation

Learning objectives

After reading this article, you should be able to:

- appreciate the ethical and legal issues surrounding resuscitation and intensive care medicine
- use basic ethical principles to guide you in difficult decision-making
- understand why autonomy is considered to be the most important ethical principle.

Introduction

As doctors we are bound by the law and by the guidelines of professional bodies such as the General Medical Council (GMC), and are strictly governed by legal frameworks to ensure that patient welfare does not fall below an acceptable standard. In addition to this legal code of conduct, we should aim to adhere to an ethical code of conduct. This may be based on past experience, intuition or what we imagine to form our own personal moral integrity. Although it is necessary to comply with the law and professional guidelines, conflicts may still arise in clinical practice. As a result there may be situations in which ethical analysis may help decision-making.

Ethics and the law, although linked in many ways, will often clash. It is not difficult to imagine situations in which personal moral integrity may be undermined by the prescriptions set down in law, and we should be wary of basing moral values on current legislation. However, we always need to maintain a balance of both seeking the most ethical solution to a situation whilst ensuring that we do not stray from the boundaries of legality (Figure 1).

Four principles provide a useful framework when dealing with ethical dilemmas:

- Autonomy
- Beneficence
- Non-maleficence
- Justice

These principles will often come into conflict with one another and there is no universally accepted philosophy by which to prioritize one over the other. They should be used as a lens through which to view clinical problems rather than providing answers in themselves.

Autonomy

The principle of autonomy represents a person's capacity and desire for 'self-government' or 'self-rule'. People are autonomous

The key components that guide us in making difficult clinical decisions

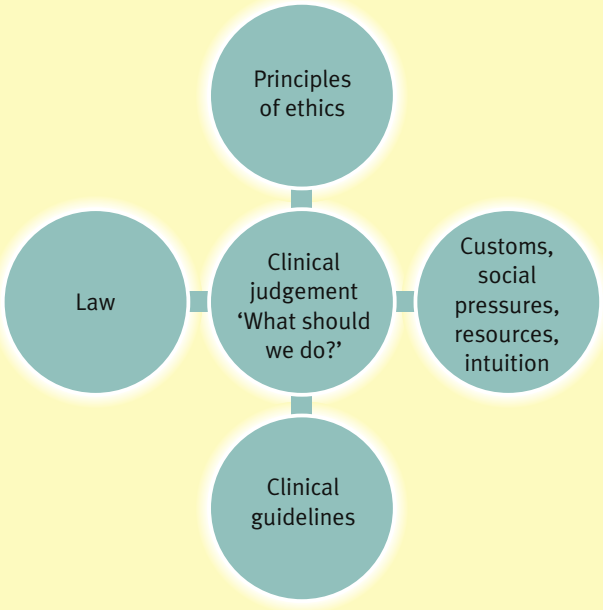

Figure 1 Adapted, with permission, from Professor Raymond Tallis.

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to the extent to which they are able to control their own lives by the exercise of their own faculties. Thus, *full* autonomy is very much an ideal notion, for there are many things that undermine our capacity for autonomous choice (e.g. physical disability). Instead we should aim for *maximal* autonomy, which is the level of autonomous choice possible considering the given circumstances. An individual's capacity for autonomous choice may be reduced due to defects in the individual's ability to control their desires/actions (e.g. unconsciousness), in reasoning (e.g. mental incapacity) or in the information upon which the individual will base their choice (e.g. being told lies). Eliminating these defects will allow the patient to be maximally autonomous. To respect an autonomous agent is to acknowledge the individual's desire to make choices and take action based on their own beliefs and values. The principle of autonomy is particularly relevant with regards to issues of informed consent, advance directives and refusal of treatment.

Beneficence and non-maleficence

These two principles share an intimate relationship: 'As to disease, make a habit of two things — *to help, or at least to do no harm*.' (Hippocratic oath)

Beneficence

The principle of beneficence refers to the moral obligation to act for the benefit of others, and reflects the duty of a doctor in making his patients his first concern. For example, beneficence may dictate moral rules in the following scenarios:

- Preventing harm from occurring to others
- Helping persons with disabilities
- Rescuing persons in danger
- Removing conditions that will cause harm to others

Beneficence is a *positive requirement* of action. The principle of beneficence is relevant when the patient is unable to act autonomously and when considering the potential futility of treatment.

Non-maleficence

This principle imposes an obligation on the caregiver to inflict no harm on the patient. Many therapeutic interventions (drugs, surgical procedures) carry with them a degree of harm or risk of harm. As clinicians, however, we should strive to seek out the least harmful option from amongst many. Non-maleficence differs from beneficence in that the former requires *refraining* from actions that may cause harm. Non-maleficence may be relevant in areas involving harmful procedures or withdrawal of life support.

Justice

Principles of justice are most commonly invoked in discussions of resource allocation, challenging utilitarian philosophy; this is known as distributive justice. Both utilitarianism and justice require that we do not make clinical decisions based on arbitrary social value judgements (age, race, sex, social status) as this would be *unfair*. Thus, if justice requires *fairness*, admission to the Intensive Care Unit (ICU) would be based on clinical need alone (or some other society-defined rules for the distribution of finite resources) if we are using *ethically* sound reasoning in isolation. In clinical practice, however, our judgement is guided by additional factors as already outlined in Figure 1.

Competence/mental capacity

All patients should be assumed to be competent until proven otherwise. A clinician who suspects that a patient may lack mental capacity should refer to the Mental Capacity Act (MCA) 2005 (Box 1). A person should not be treated as lacking capacity simply on the basis of making an unwise decision and all possible practical steps should be made to help them prove their mental competency.

An important aspect of competency is that it is decision specific. For example, someone may not have the necessary competence to give consent to surgery, but may be competent to express the desire for a cup of tea. Thus, it is erroneous to label someone as lacking capacity without giving the context in which they lack it. In medicine, this will often be applicable with regards to consent to care.

Section 3 of the Mental Capacity Act 2005

A patient may lack mental capacity if they are unable:

- to *understand* the information relevant to the decision
- to *retain* that information
- to *use or weigh* that information as part of the process of making the decision, or
- to *communicate* his decision (whether by talking, using sign language or any other means).

Box 1

Best interests

Under the MCA, a clinician must act in a patient's best interests when that patient lacks capacity to consent to a particular aspect of care (Box 2). The modified best interests test requires decision makers to focus on the individual patient and make a judgement to promote their welfare: a judgement that takes proper account of any prior views that they may have expressed and involves the people most likely to know about their views.

Section 4(6) of the Mental Capacity Act 2005

The MCA 2005 requires that we consider as far as reasonably possible:

- the person's past and present wishes and feelings (and in particular any relevant written statement made by him when he had capacity).
- the beliefs and values that would be likely to influence his decision if he had capacity.
- the other factors he would be likely to consider if he were able to do so.

Box 2