

## Not everything possible will benefit a patient

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“Not the application of intensive care measures but the decision about their appropriateness is the most challenging aspect of modern intensive care medicine.” Many experienced intensive care physicians will confirm this statement, although it might be true for other highly invasive and demanding medical areas as well. Intensive care has become frequently the very last resort when questions about the final phase of a patient’s life arise. Intensive care physicians have become the experts for the last days of life in many circumstances. This development is in contrast to the primary and initial aim of intensive care medicine, which is focused on the saving of lives and nothing else. While the primary concept of treating patients in acute, life-threatening but basically reversible, conditions faded away, it turned out that the promises and the success of modern medicine had changed this paradigm completely. Seriously affected by the epidemiological trend of a steadily ageing population (at least in western countries) the daily practice of intensive care medicine has shifted mainly to the care of aged patients with relevant and severe comorbidities. Acute illness on the grounds of advanced chronic diseases is the most likely scenario in a majority of today’s intensive care patients. It is, therefore, not surprising that ethical, social and philosophical questions far beyond the sole practice of medicine are frequently much more challenging than making a diagnosis or instituting mechanical ventilation in a critically ill patient.

Complex issues such as the discussion of appropriate care measures produce uncertainty in a patient’s, relatives, and often even more so in healthcare professionals. A very basic reflex response to uncertainty consists of taking action – in medicine in particular it is frequently easier to do something than to change the perspective and ask “will everything possible really benefit this patient?” It would be naive to believe that every person will answer this question in a similar fashion and it is, therefore, most important (and in most countries a legal requirement) to involve all parties concerned, first and foremost the patient concerned.

How to cope with uncertainty in difficult decision-making (as described above)? Standardisation in medicine is promoted as a key factor in the provision of high qualitative care and it might be a tool for managing such difficult decision-making as well. Nevertheless, it is of greatest importance to recognise that standardisation can guide the process of decision making but not the determination of the

decision’s content. The content of a decision regarding intensive care interventions must always be based on extensive deliberation of an individual situation.

Recommendations from scientific societies and other bodies are another source of support in difficult decision-making. These documents usually refer to commonly accepted ethical principles in medicine but may be differently focused with respect to the target audience. The Committee on Bioethics of the Council of Europe has recently issued a document titled “Guide for the decision-making process regarding medical treatment in end-of-life situations” [1]. Importantly, this guide is primarily aimed at the healthcare professionals concerned, but it should also serve as a source of information for patients, relatives and other parties involved. Consequently, significant parts of the document deal with the principles of the patient’s autonomy, the patient’s capacity, the patient’s will, his or her previously expressed wishes (e.g. advanced directives) and the role of substitutes in the process of decision-making. The patient’s autonomy is considered to be a cornerstone of the decision-making process nowadays: it is set in stone that no action must be taken without the consent of the patient concerned. But in addition, as the Council of Europe document points out, it must be recognised that autonomy does not imply the right to receive any requested treatment. A medical indication is the essential prerequisite to a medical intervention and only if a sound medical indication exists does the patient’s will come into consideration. In theory, this sequential structure of decision-making should prevent the application of inappropriate treatment. In fact, a multinational European study has revealed that up to 90% of End-of-Life decisions in intensive care medicine are reported to be based on medical reasons, such as a lack of response to maximal therapy [2]. However, there is more complexity in it than appears at a first glance. Although in this example, the reason (lack of response to maximal therapy) seems quite clear and based on facts, the question arises as to whether intensifying treatment to a level of maximal therapy might even be disputable in certain situations. Not everything possible will benefit a patient. In other words, any medical reasoning must consider the perspective of an individual patient in an individual clinical situation and balance the anticipated burden of treatment against the expected outcome.

The new guidelines on intensive care interventions of the Swiss Academy of Medical Sciences (SAMS) address these questions in a systematic and very practice-oriented manner aimed to guide medical professionals [3]. Again the appropriateness of particular interventions adding up to what we call intensive care is the key question in this document. Although a variation in the individual judgement of what is appropriate is recognised, the document comes up with a noticeable statement: “Intensive care is, however, no longer medically indicated in cases where the patient is not expected to be able at least to leave the hospital and be integrated into an appropriate living environment”. This statement demonstrates a clear shift away from the perspective “the task and aim of intensive care medicine is to sustain life but not to prolong the process of dying” [4]. It emphasises the request for a broader exploration of the patient’s perspective beyond his or her pure survival. Such an exploration requires an individual assessment of the patient’s prognosis with respect to a potential future quality of life and potential dependence on care. There is currently no way to provide such a prognosis on the grounds of an objective judgment. Consequently the experience, empathy and integrity of healthcare professionals are required to come up with a wise, human and patient-oriented decision.

It is one of the great achievements of this SAMS paper to provide guidance for decision-making in particular circumstances and, similarly important, about how to proceed after a decision is taken. This refers to different levels of care (full intensive care versus limited care) as well as the shift from intensive care to palliative care while withholding or withdrawing intensive care interventions. Finally, the paper addresses different stakeholders with recommendations on how to support the development and application of intensive care services in accordance with ethical principles in order to benefit individual patients and the fair and efficient distribution of limited resources.

Of note, the document describes the discrepancy between ineffective treatment and effective interventions that still offer little or no likelihood of benefit. Not everything possible and effective will benefit a patient. The SAMS recommendations will be an invaluable support for intensive care professionals in the search for appropriate answers. We should not forget that the consequences of inappropriate care not only constitute a violation of basic ethical rules and cause avoidable suffering of patients and relatives, but may also cause severe moral distress in healthcare professionals [5]. Not everything possible will benefit a patient. Failing to reflect on this basic consideration is even likely to cause harm.

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