

Anticipating the role of the intensive care unit in healthcare and life trajectories

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Abstract: Many people think that the intensive care unit is reserved for patients with extreme and life-threatening disease, and as such, it remains hypothetical in the collective conscience, and not something that can be predicted or anticipated. Yet, intensive care can be required in a number of situations, and raises many questions depending on whether the illness is chronic, or of sudden onset. It is essential, in this context, to ask whether, and how potential patients are informed, and prepared for the eventuality of intensive care unit (ICU) care. In this view, anticipating ICU admission is a key, yet new issue, and it raises questions about the place of the ICU physician and ICU teams in the healthcare pathway, and in life trajectories overall.

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The intensive care unit (ICU) in the collective imagination largely overlaps with that of extreme and life-threatening situations. A lot of people think that the ICU is only for people who experience a serious and unexpected health event, for example a traffic accident, or acute cardiac or neurovascular disease, or shock caused by an infection, and indirectly, assume that this “only happens to other people”. Accordingly, the idea of being admitted to the ICU remains hypothetical for most people, and not something predictable.

But in fact, intensive care can be required in a number of other situations, and for many different patient groups, in lots of other contexts. For example, chronic disease, at various stages of its progression, may give rise to what in medical terms is called “acute decompensation”, or sudden worsening, requiring admission to the ICU, once or maybe even several times.

Therefore, the question of anticipating what may happen to an ordinary citizen who has no notion that he/she is sick, is fundamentally different to the questions that arise for people with chronic disease whose likely progression is known and expected.

It is essential, in this context, to ask whether, and how potential patients are informed, and prepared for the eventuality of ICU care. In this view, anticipating ICU admission is a key, yet new issue, and it raises questions about the place of the ICU physician and ICU teams in the healthcare pathway, and in life trajectories overall.

Failing to anticipate the eventuality of ICU admission is tantamount to denying the need for, or the right to information (in this case, information aimed at anticipating the event), or to denying the patient’s appropriation of their future path.

Anticipating such an event calls for the caregiving team to change the way they talk, and be prepared to put words on and dialogue about the future. Is it the role of the treating physician to talk to the patient about this when he/she meets the patient alone? Should the question of ICU admission be integrated into structured therapeutic education programmes for patients? Would it be feasible to organise meeting between the patient and the intensivist, and maybe also the ICU team (either individual or group meetings) before acute situations arise, to talk about the meaning of intensive care, and openly discuss its

possibilities, advantages and limits? In this way, the world of intensive care could become a more everyday player in the care environment, and cast off its shroud of exclusivity, and its image as the ultimate, last-stop where dialogue and exchange are always highly complex, precisely because they have not been adequately prepared.

These questions that we ask ourselves underline how important it is that we no longer neglect the need to share knowledge. In this day and age, it is difficult to justify why, although medicine can tell us what may and will happen, the physicians cannot put words on this in the form of dialogue with the patient well in advance, before the expected actually happens.

Attitudes in society have been progressive over the last 15 years towards greater “democratisation” of health, with a move towards greater freedom of choice for the patient and the respect of individual preferences becoming central themes. The role of respect for the person’s autonomy is increasingly debated. Autonomy here should be understood to mean the person’s right to self-determination, defined as the respect of that person’s freedom and attitudes allowing him/her to act directly on their own life by making informed choices (1). For many years, medical decisions were implemented without consulting the patient, and without informing the patient, or in certain cases, the family. This approach is generally termed the “paternalistic” model of healthcare. According to Nilstun’s definition (2), this paternalistic attitude consisted in treating a person in accordance with what the physician considered to be for that person’s good, regardless of any preferences the person may have had and/or expressed.

In France, the introduction of new legislation dated 4 March 2002 regarding the rights of patients and the quality of the healthcare system (3), dubbed the “healthcare democracy law”, recalled the compelling need to put the patient at the centre of the healthcare system, and to include the patient in the decisions about, and the organisation of care affecting him/her.

In clinical practice today, this acknowledgement of the patient’s autonomy is reflected in a process of joint decision-making, a process commonly termed “co-decision” (4,5). Anticipating decisions and management pathways requires a new organisational structure for healthcare teams, and also requires new relations to be established between teams that previously worked in isolation. Accordingly, the units in charge of following a patient with chronic disease, the ICU team, and the treating physician will all have to revisit

their methods of communication in the future, and move away from the traditional management pathway in the purely medical sense of the term, to move towards shared knowledge and information, and joint meetings in the aim of explaining the future steps in the management process, and to discuss the choices that will have to be made. To achieve this, the structural organisation must be conducive to discussion and debate on these topics, between units, and between specialties, for example during dedicated multidisciplinary meetings, with the overriding aim of promoting an ethic of discussion (with its inherent rules) that is shared by all. Indeed, Habermas (6) reminds us that the first rule in an ethic of discussion is to give appropriate importance to each person’s point of view, then to reach a common solution together, in the interest of the person (i.e., the patient, in this case).

To anticipate what will happen to a patient is to put that patient’s autonomy into action. It is a fundamental prerequisite to the respect of the patient’s liberty. Autonomy is the individual’s freedom to have their own preferences, and to know enough to be prepared—in other words, to wield their freedom over their own destiny.

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Footnote

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