

RESPONSIBILITY: FROM ITS CONCEPTUAL FOUNDATIONS TO ITS PRACTICAL APPLICATION IN INTENSIVE CARE UNITS

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Abstract: There has been a shift in the language of responsibility because the threat of malpractice litigation is encouraging physicians to assume a more responsible role in caring for their patients. Consequently, instead of paying attention to the moral dimension of this principle, professionals are sometimes much more concerned about legal repercussions. This article aims therefore at analyzing the recent literature on responsibility in intensive care, focusing on its ethical dimension. By analyzing the contributions of Emmanuel Levinas, Hans Jonas and Paul Ricoeur, who placed special emphasis on the theme of "moral responsibility", we will attempt to shed some light on this ethical principle within the specific context of Intensive Care Medicine. This paper underlines the importance of responsibility in order to draw attention to the need to establish an appropriate balance between autonomy and self/other-oriented responsibilities. A tridimensional approach is suggested to frame responsibility within the context of intensive care.

Key words: professional ethics, clinical ethics, end-of-life care, decision-making, inter-personal relations, professional-patient relationship

Responsabilidade: desde el fundamento conceptual a la aplicación práctica en unidades de cuidado intensivo

Resumen: Ha habido un cambio en el lenguaje sobre la responsabilidad, debido a que la amenaza de demandas por mala práctica fuerza a los médicos a asumir un rol más responsable en el cuidado de sus pacientes. Por consiguiente, en lugar de prestar atención a la dimensión moral de este principio, muchas veces los profesionales están más preocupados de las repercusiones legales. Este artículo tiene como objetivo analizar la bibliografía reciente sobre responsabilidad en cuidados intensivos, enfocándose en la dimensión ética. Al analizar las contribuciones de Emmanuel Levinas, Han Jonas y Paul Ricoeur, que pusieron especial énfasis en el tema de la "responsabilidad moral", tratamos de iluminar este principio ético en el contexto de la Medicina del Cuidado Intensivo. Este trabajo enfatiza la importancia de dirigir la atención a la necesidad de establecer un balance apropiado entre la autonomía y las responsabilidades orientadas hacia uno mismo o hacia el otro. Se sugiere una aproximación tridimensional para enmarcar la responsabilidad en el contexto del cuidado intensivo.

Palabras clave: ética profesional, ética clínica, cuidado al final de la vida, toma de decisiones, relaciones interpersonales, relación paciente-profesional

Responsabilidade: de suas bases conceituais para a sua aplicação prática em unidades de terapia intensiva

Resumo: Tem havido uma mudança na linguagem da responsabilidade uma vez que a ameaça de litígio por imperícia está incentivando os médicos a assumir um papel mais responsável no cuidado de seus pacientes. Por conseguinte, em vez de prestar atenção à dimensão moral deste princípio, os profissionais algumas vezes estão muito mais preocupados com as repercussões legais. Portanto, este artigo visa analisar a literatura recente sobre responsabilidade nos cuidados intensivos, com foco em sua dimensão ética. Analisando as contribuições de Emmanuel Levinas, Hans Jonas e Paul Ricoeur, que deram ênfase especial sobre o tema da "responsabilidade moral", vamos tentar lançar alguma luz sobre este princípio ético dentro do contexto específico da medicina de cuidado intensivo. Este artigo sublinha a importância da responsabilidade a fim de chamar a atenção para a necessidade de estabelecer um equilíbrio adequado entre a autonomia e responsabilidades orientadas para si e para o outro. Sugere-se uma abordagem tridimensional para enquadrar a responsabilidade para dentro do contexto de cuidados intensivos.

Palavras-chave: ética profissional, ética clínica, cuidados terminais, tomada de decisão, relações interpessoais, relação profissional-paciente

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Introduction

The huge technical potential of Intensive Medicine and its associated duties have created the need for an enhanced sense of responsibility and the development of new branches of medical reflection and education. Among these, the sustainable management of resources and the ethical, social and scientific considerations concerning the limits for the intervention of intensive care medicine are paramount. Indeed, this sense of enlarged responsibility leads us to question: What is responsibility? How does responsibility relate to intensive care medicine practices?

The process of deliberation, decision, and the assumption of responsibility in relationship to one's behavior is a function of the centered totality of [the individual's] being(1). Thereby, this paper questions the balance between increasing choice and autonomy and paternalistic attitudes in ethical theories, and affirms the enormous importance of responsibility in order to draw attention to the need to establish an appropriate balance between autonomy and self/other-oriented responsibilities.

The aims of this article are therefore (i) to analyze the recent literature on responsibility in intensive care, focusing on its ethical dimension, and (ii) to reflect on the context of intensive care using the ethical foundations and reflexions of responsibility. Moreover, this paper questions the balance between increasing choice and autonomy and paternalistic attitudes in ethical theories, and affirms the enormous importance of responsibility in order to draw attention to the need to establish an appropriate balance between autonomy and self/other-oriented responsibilities.

In this article, terminologies, such as, "intensive care", "intensive care medicine", "critical care" and "critical care medicine" will be used interchangeably.

Methods

We conducted a literature review with the widest possible scope, including national (Portuguese) and international (English, Spanish, French) journals on the ethical principle of responsibility.

Databases, such as EBSCO (Elton B Stephens Company) Host, Pubmed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), WOS (Web Of Science) databases were searched with no limits established as our aim was not to perform a systematic review but to obtain a theoretical, comprehensive and integrative review of the state of the art to the investigated topic. This was complemented by a thorough search and analysis of manuals, books and book chapters written by renowned philosophers and authors from the field of bioethics and who dedicated a substantial part of their work to the ethical principle of responsibility.

The context of intensive care medicine

The concept of Intensive Care (IC) that we will utilize as a background for the bioethical framework for responsibility can be defined as a multidisciplinary area in medical sciences that reports specifically the prevention, diagnosis and the way of dealing with situations of an intense illness potentially reversible in patients who present a scarcity of one or more imminent or established vital functions(2).

As from the end of the 20th Century, the physician's capacity to intervene has increased enormously, without adequate consideration regarding the impact of this new reality on the quality of life of those critically ill. Critical care is an integral part of hospital care, and the intensive care unit (ICU) is the setting where patients are given the most technologically advanced life sustaining treatments. Few areas of medical ethics raise such strong and diverse views on the issues regarding the end of life. In intensive care, as well as in other kinds of health care services, death and dying situations, previously private, traditionally spiritual or religious events involving family and friends, are in today's world often public and technological. The severity of illness of hospitalized patients has progressively increased over recent decades, whilst sophisticated technological support has allowed such patients to survive longer. At the same time, it is becoming increasingly accepted that continued aggressive care may not always be beneficial. Death in the ICU, therefore, now frequently follows limitation of life-supporting therapies. As a result, the mission of the ICU

team has expanded to encompass the provision of the best possible care to dying patients and their families(3).

Simon Blackburn stresses that all professionals must learn to become sensitive to the physical environment and to appreciate its fragility and how easily that can be destroyed. He also reminds us to be sensitive to what might be termed the moral or ethical environment and the climate of ideas relating to how we should live(4), in order for us to understand the motivations, reasons and feelings that affect us, and the network of rules or norms that support our lives, as far as possible the apparent jungle of principles and objectives needs to be structured. Clinical judgment requires the integration of medical scientific concepts into observation and perception. Being responsive to evaluative complex situations requires being sensitive to the demands of evaluative reasons. It is known that critical-care decision making is highly complex, given the need for health care providers to consider and constructively respond to the diverse interests and perspectives of a variety of legitimate stakeholders (e.g., patients, family members, healthcare professionals)(5).

This includes partly working out the combined effect of different factors that are in play at the same time. Therefore, ethical reflection on principles and good value judgment may be of utmost importance(6). This is also one of our goals, namely to clarify the notion of responsibility as one of the main principles that must guide health professionals.

According to Ladrière(7), we recognize the ethics of a situation when it begins to collide with a question of “*should it be?*”. The way a situation wobble our perception of the “other” integrity (in its corporality, temporality, and relation to others) gives it an ethical meaning. The ethical situation is the one that causes dilemmas or problems in decision making.

In the ICU, there is an objective meaning, an existential meaning and an ethical one. We talk about objective meaning, since each patient is in a clinical situation and the most objective diagnosis and most suitable therapeutic intervention must be made. These therapeutic interventions

are not merely technical because they involve the whole human being, with his/her individual life story. The ethical question in the context of the ICU is even more complex because this is where the patient is very often unable to express himself, to communicate and consequently unable to exercise his autonomy, implying dilemmas of decision-making at the end of life. The assumption of responsibility for a person who formerly possessed the capacity for agency robs that individual of essential elements of his or her humanity. Persons must be responsible for themselves; the responsibility cannot be delegated. Sartre mentioned: “every man is in possession of himself as he is; this places the entire responsibility for his existence squarely upon his own shoulders”(8). Furthermore, moral agents are responsible for what happens as a result of their choices. The process of deliberation, decision, and the assumption of responsibility in relationship to one’s behavior is a function of the centered totality of [the individual’s] being(1).

Responsibility in the philosophical context and its relation to critical care

The idea of responsibility has a long history, notwithstanding its being a relatively recent concept with a specifically moral dimension being attained only in the 20th century. The notion of responsibility was made explicit and generally accepted during the Middle Ages and used mostly as an adjective (“responsible” for an act or omission), not as an effective reality; in other words, morphologically like a noun (“responsibility”)(9).

In etymological terms, the verb “to respond” is polysemic: *res spondere*, to engage oneself (*spondere*) before somebody; to value (*ponderare*) the things (*res*). *Res-pondeo*: to respond with the meaning “to render account” (metaphorical meaning) or to make a reply in a law court.

The meaning of “responsibility” is, first and foremost, juridical (an established responsibility) being divided into two branches: “penal responsibility” with reference to suffering punishment and “civil responsibility” with reference to paying damages. According to Nordgreen(10), “in a moral context, responsibility would have then a metaphorical use with the double meaning of res-

ponding to self-consciousness or to other people or, with the financial meaning, to render account”.

We may say that there are several meanings of responsibility: the legal, the social, the moral, the professional, the political, and the historical. Responsibility could be viewed in terms of individual and societal. We take into account several meanings of responsibility: “to assume responsibility”, “to attribute responsibility, “to have responsibility”, in the sense of obligation or duty (prospective/retrospective); with a normative meaning: “to be a responsible person” (responsibility as a moral virtue).

From the philosophical point of view, the intention is not to make moral judgments but to understand and clarify the meaning of “responsibility” in order to emphasize its importance in the context of medical ethics. In one sense, responsibility can constitute a common platform for ethical behavior, since the relationship with the other, more fragile and vulnerable, is the condition that best develops the sense of responsibility in human beings(11). Regrettably, the term “vulnerable” too often gets played without any concrete meaning. Given the absence of agreed-upon standards for identifying and responding to vulnerability, a list of six types of vulnerability (cognitive, juridical, deferential, medical, allocational, and infrastructural), applicable to research subjects, have been proposed(12) and could also represent an ethically relevant features that bespeak vulnerability in the context of ICU care. The concept of vulnerability is not central in this paper and we will not elaborate further on that. However, taking into account the list of the six vulnerabilities categories five of them (cognitive, juridical, medical, allocational, and infrastructural) could be easily recognized in the ICU context. Critical care is the setting where to acutely ill patients (medical), most of them not able to make an autonomous decision (cognitive, juridical), are given the most technologically and expensive advanced life sustaining treatments (allocational) in a very stressful environment (infrastructural).

Because of the several uses of the word “responsibility”, which renders the terminology very diverse, there were authors who demanded a “res-

ponsibility grammar”(13). Incidentally, we draw attention to the fact that in some ethics dictionaries, the definition of Responsibility does not exist, namely in the ‘New Bioethics Encyclopedia’(14) (where other ethical bases and principles are defined), and even in philosophy dictionaries. Atlan(15) states that the word “responsibility” has no proper place in the Cambridge Dictionary of Philosophy. Therefore, bearing in mind that the principle of responsibility must be at the core of medical practice, in this article we analyze the contributions of some philosophers who have placed special emphasis on the theme of “moral responsibility”, and thus attempt to shed some light on this principle within the specific context of Intensive Care Medicine.

In the work of Paul Ricoeur we find an extensive ethical reflexion regarding the concept of responsibility. To this author, responsibility exceeds the frame of compensation and punishment (of retribution). It is under this meaning that nowadays the word is imposed in the moral philosophy to such an extent that it has become a “principle” in Hans Jonas and, in a great measure, in Emmanuel Levinas(16). Paul Ricoeur corroborates the concept of responsibility when he states that, for an agent, to act is to exercise power over another agent who then becomes a patient, i.e. the one who is the object of our intervention. It is in this unequal relationship between agents that ethical problems occur, because the power that might grow out of this dissymmetry could lead to perversions of the physician-patient relationship. This asymmetry establishes the ethical relationship, which, if not abused, is not necessarily problematic. Therefore we should recognize the ethicalness of a situation according to the structure of the action. According to Ricoeur, it is the extent to which I act towards the other in a responsible manner that validates my ethical behavior(16).

Emmanuel Levinas emphasizes his concern with the Other. It is at that moment when “I am before” the Other, that the ethical question is settled, because the Other imposes that responsibility on me(17). An essential asymmetry is involved in this kind of relationship, particularly in the context of critical care, in front of critically ill, vulnerable patients. Levinas endeavors to conceptualise the preconscious experienced responsibility for

the other, which is the fundamental ethical layer of the responsible self. According to Levinas, it is the rupturing of indifference that makes the “ethical event” possible. In fact, each one of us is responsible with a total responsibility, being responsible for all the others and for all that is of the others, even for our own responsibility. The “I” has always a greater responsibility than all the others(17). The simple fact of being human must lead to one’s preoccupation with the Other. Levinas endeavors to conceptualize the preconscious experienced responsibility for the other that is the fundamental ethical layer of the responsible self. It is at the moment when I assume my humanity that I recognize the Other’s humanity and become responsible for him or her. For Levinas, ethics happens, or not, when the self-certain ego becomes disturbed, shaken and fundamentally questioned by the proximity, before me, of the absolute Other(18). Therefore, the physician being confronted by the face of a critically ill “other”, his/her first ethical task is to accept the extraordinary “otherness” of the patient, expressed by that patient’s visible vulnerability, which constitutes an ethical cry for help and care, and to fully assume responsibility.

Levinas’ ethics keeps redefining the terms of an unlimited personal responsibility that would start and end beyond ontology and therefore reach, beyond the Being of the other, the existent of the other’s radical otherness and thus the infinite humanity of humans beings(19). However, by sacrificing the possibility of building ethics on a reciprocal kind of relationship between me and the other, we must ask about the possibility of developing a medical ethics if one approaches to responsibility in the footsteps of Emmanuel Levinas. Therefore, because an insurmountable distance between the self and the Other, without the concept of Aristotle *Phronesis*(20). Ricoeurian prudence Levinas’s approach to responsibility proves quite risky if applied to the practical context; this distance between the self and the Other could represent the denial of the responsibility(21).

Hans Jonas, by declaring responsibility as an ethical principle, constitutes another landmark in the reflection on its moral dimension and in its importance for the ethics in life sciences(22). Responsibility as imputation or accountability, in the

classic sense, seems to imply a special relation to the past – to be considered responsible for a past action is to be ready to render account. The word “imputation” was commonly used long before the term responsibility. In this sense, «the one who signs the order is morally and legally responsible»(23). However, this definition of responsibility as imputation is a “minimal conception of responsibility” that doesn’t fit-in with the problem of human action in the technological age, in which what is demanded is guidance openly directed towards a distant future that surpasses the more limited ability to foresee more immediate consequences. Jonas talks about responsibility in a much more all-encompassing sense.

The concept of responsibility by Hans Jonas could be identified in the context of intensive care in two different roots: the responsibility towards future generations (of all future patients) and the responsibility towards the future of each patient in particular (of my patient, the Other in front of me in his/her uniqueness and vulnerability)(22).

The most sensitive mission that one can entrust to an agent who is declared responsible for the future is the protection of some fragile, perishable reality. The concept of “intergenerational justice” by John Rawls and Hans Jonas focuses on this idea(24). It includes both questions of social justice between different generations, within the same life cycles (intra-temporal intergenerational justice) and also in a long-term perspective (inter-temporal intergenerational justice). The concepts of intergenerational justice currently discussed differ in the extent to which the present generation is expected to make provisions for future generations. The most common criticism when it comes to utilitarian models of intergenerational justice focuses on the expectation that earlier generations should make sacrifices in order to improve the welfare of future generations is that it could represent an intolerable unfairness of intergenerational distribution; therefore, Aristotle *Phronesis*(20) or Ricoeurian prudence must be applied in order to guarantee that the obligations of earlier generations do not exceed defined limits of reasonableness. Even if, from an ethical point of view, this standard could be considered minimalistic the current generations are obliged to preserve the stock of available resources and to secure, even,

this minimum standard of sustainability.

Until recently, a period in an ICU was deemed a success if patients survived up to being discharged from the ICU. As critical care has evolved, it has become evident that understanding long-term survival, morbidity and quality of life (QOL) after critical illness is as important as dealing with short-term survival(25). Understanding the consequences of critical illness informs preventive measures that can be integrated into patient management and enable improvements in the quality of care. Whatever model is chosen, appropriate follow-up for survivors of intensive care, their families and healthcare teams/professionals is worth pursuing. So, in this context, responsibility is a social relationship of equal and reciprocal recognition of rights, which, in order to operate, requires an established context in which the true story behind how an act occurred can be ascertained. It implies both reciprocity and accountability(26). A new concept of accountability is also required: one that is rooted in a shared concept of truth that sets out how agents must take responsibility for the long-term effects of their current activities. Therefore, physicians' responsibility concerning patients' difficulties following critical illness and the willingness of intensive care teams to accept extended responsibility during the recovery period have led to the development of different follow-up programs which are in line with the concept of responsibility for the future proposed by Jonas.

According to Schramm and Kottwo(27), Emmanuel Levinas and Hans Jonas are two highly significant landmarks for the reflection regarding the moral dimension of responsibility and its importance for ethics. The former explains ethics as responsibility; the latter affirms responsibility towards the future. Hans Jonas' concern for macro-responsibility with the "Human Being" and Emmanuel Levinas' concern for micro responsibility with the "Other" share common features, since both result from an explicit request from vulnerable beings or others.

In "Le Juste", Ricoeur states that the essay is caused by the kind of perplexity left by the examination of the contextual, contemporaneous uses of the word responsibility(16). He also states that,

nowadays, we still feel responsible for the others, for the environment, for ourselves, for all the most vulnerable; we are also responsible for those other who are in our care. Here we establish a link with responsibility in the ICU. Physicians' responsibility for the vulnerable in their hands in the ICU must consist of taking decisions regarding what is best for the individual. Therefore, their main ethical obligation must be to take all their decisions having regard to the most solid and up to date scientific concepts. In circumstances in which the individual is most vulnerable, as happens in the ICU, the responsibilities of the health team are greater, in that they are going to be involved in deciding and acting upon what is best and most suitable on behalf of somebody else. Whenever appropriate, the construction of the decision should envelop the patient, his or her relatives, the health professionals and the family doctor. However, the responsibility of the decision belongs to the physician in charge of the team that takes care of the patient(28).

According to Paul Ricoeur, I am responsible for the other vulnerable person/human being(16). It extends to the relation between the author of the action and the one that suffers it, to the relation between the agent and the patient of the action. The direct object of responsibility expands to the fragile, to the vulnerable one. It is from the other in his fragility, more than from our own judgment, that the moral responsibility comes. There is a second displacement of the responsibility, more related with Jonas's responsibility towards the future, related to the unlimited extension of the responsibility's reach; the man's future vulnerability and his environment as a preoccupation of responsibility(16).

Responsibility versus autonomy in the context of intensive care

In former times, patients relied on physicians to tell them what to do when faced with a medical decision, and for the most part, the latter gladly accepted this responsibility. Eventually (however), patients and physicians came to realize that this paternalistic approach to medical decision-making placed far too much power in the hands of physicians, however beneficent their intent(29).

The individualistic model of medical decision making, the so-called “autonomy paradigm”, has achieved prominence in the United States, and also plays a significant role in the countries of Anglo-Saxon culture. The reliance of the medical community on patient-centered decision making, serving as the cornerstone of informed consent, has been referred to by Pellegrino as a “cultural artifact” which may lead to complications and interference with the care of certain patients, particularly those from countries and cultural groups in which the family or other social unit plays a more pivotal role in treatment decisions(30). The promise of increased choice is now one of the key influences on new medical technologies. Despite the high regard for the principles of patient autonomy in most North American and European countries, in reality most patients are too ill or too sedated to participate meaningfully in decision-making in the ICU(31). Evidence shows that patients are rarely involved in the decision-making process concerning end of life decisions in intensive care units, mainly due to their lack of capacity in assessing and making the decision adequately(32-34).

Most of the time, decisions are made by physicians who, depending on the context, may or may not involve other healthcare professionals and surrogate decision-makers in the decision-making process. Hence, a shared decision-making takes place, most of the time, having physicians, other healthcare professionals and families as stakeholders. This process, however, can be experienced by family members with a high degree of psychological distress and suffering, and family members may not always fully understand the information given by professionals(5,35).

Different studies from both the United States and Europe challenge the concept of shared decision-making and question the quality and validity of this process(35,36). Furthermore, most surrogate decision-makers for ICU patients wanted to share decision-making responsibility with physicians and that overall they were satisfied with their decision-making experience(37). Greater autonomy also involves greater responsibility concerning the options taken by the patient or the health professional(38,39). However, the relationship between the two principles is much more profound and

complex. On this point, it is essential to replace the concept of autonomy by the concept of responsible autonomy(40). Relational accounts encourage clinicians to consider patients’ autonomy in decision-making situations. In our opinion this relational component of autonomy is just the same as the aforementioned concept of responsible autonomy being aligned with the so-called “alternative model of autonomy”, i.e., relational autonomy. This concept highlights the social and interpersonal extend within all individuals exist and acknowledges the emotional and embodied aspects of decision-makers(41-44). A relational autonomy approach takes full consideration to the central role of ‘others’, including their narratives(45), in the decision-making process, highlighting the complex dimension and framework of end of life decisions and including physicians and health professionals’ role and their responsibility.

Conclusion

As presented throughout this article, the principle of responsibility in the context of intensive care medicine can be analyzed and framed within a philosophical contour, as the one underlined by the three philosophers previously quoted. This contour can be defined into three distinct categories, which are linked to philosophical approaches and reflections about responsibility, namely: current, future and retrospective responsibility. Current responsibility involves the physician’s duty to act in a responsible manner in the immediate situation. Future responsibility involves evaluating the post-ICU patient situation, resulting from the interventions of health professionals during patients’ ICU treatment. Retrospective responsibility involves post-evaluation of the actions previously undertaken together with team reflections concerning appropriate treatment choices. All these forms of responsibility are interconnected. The question here is how far a physician is responsible, not only for the current effects of his/her action, but also for the possible future effects, as well as for the prevention and the avoidance of possible future occurrences(1,38,39).

According to the Levinas’s ethics of hospitality, we are in an impossible situation where we have continually to “compare the incomparable”- the

“Other”. The hierarchy of values can no longer ‘simplify’ ethics for us. The insurmountable weight of our ethical responsibility is exactly what gives to hospitality its force. To live a moral life in the shadows of the difficulty of decision-making is to realize that the decision is terrible; clearly we must make very difficult choices regarding someone’s day-to-day life(18).

Nordgreen presents us with a proposal suggesting what responsible professionals should do both as individuals and as communities(10). The moral responsibility of the ICU professional must be to find common ground or even a common ethical platform, in order to build a consensual policy for people with different values and principles. Paul Ricoeur perspective includes both Levinas and Hans Jonas’ theories.

Following the reasoning of the aforementioned authors, we might suggest that this idea of responsibility in the context of intensive care medicine could be applied across three dimensions: First, to the *object* of responsibility, “the other” (similar to the Levinasian formulation) who is in a situation of vulnerability, fragility, in a critical circumstance, often unable to communicate either due to the effect of his own illness or due to the effects of necessary medication or treatments. Second, to the responsibility in the future (similar to the Jonassian designation), either concerning this patient follow-up or of the others who may come to need an intervention in intensive care. Finally, to the prudence that must be exercised in decisions through recourse to admission and care guidelines of patients in the intensive care unit and through the assessment of patient outcomes (similar to the aristotelic prevision).

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