FROM THE INSIDE

What does it mean for a critically ill patient to fare well?

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As clinicians and medical professionals, we are responsible for the well-being of our patients. This obligation demands more than the mere reparation of injured or diseased bodies, evidenced in our respect for patient autonomy and our goals to pair therapeutic options with the patient's own values. While the fundamental ideal of promoting patient welfare is widely accepted, we believe that individual clinicians have different understandings of what constitutes patient well-being. These different understandings of well-being can then shape our priorities for patients in the intensive care unit (ICU).

What makes a person fare well? Traditionally, the literature on well-being describes three basic theories as an answer to this question: hedonism, desire-satisfaction, and the objective list. We suspect that clinicians likely adhere to combinations of these three theories—although they may not think or speak of their views in these terms. The first theory, hedonism, is the view that an individual fares well if she experiences more pleasure than pain over the course of her life. The greater the proportion between pleasure and pain, the better she fares. Desire-satisfaction theorists argue that an individual's life goes well when his desires are fulfilled, and poorly when his desires are frustrated. An objective list theorist argues that there are some things that are just good for persons—health, or certain intellectual achievements, as examples—and when a person has achieved these then her life goes well. If she does not, then her life goes poorly.

Each theory carries intuitive weight in explaining a good life or a bad life, yet each implies that clinicians should prioritize elements of a patient's care in different ways. To illustrate this point, consider how each theory motivates patient care in the ICU.

Hedonism The pillars of hedonism—the avoidance of physical pain and psychological suffering in favor of comfort—are also pillars of good intensive care. In the ICU, clinicians manage pain with appropriate analgesia and address psychological suffering with anxiolytics, sedatives, and psychosocial support. Early involvement of palliative care is recommended to assist with the above and to also improve the communication and care provided to families and surrogates. Families and surrogate decision-makers are (and ought to be) deeply concerned about the avoidance of suffering regardless of overall prognosis. While the values of hedonism are an indispensable part of care in the ICU, this theory provides limited guidance in terms of setting long-term plan-of-care goals. The management of pain generally serves as a baseline for more robust care, since the mere absence of pain does not indicate that a patient is faring well. Often, rehabilitation requires significant physical discomfort for the goal of restoring an individual's more general capabilities. Indeed, when palliation is the only remaining goal of care, this often signals that the patient faces a grim prognosis and all other appropriate treatment options have been exhausted.

Desire-satisfaction The satisfaction of desires is an important element of a person's well-being. In order to satisfy patients' desires, however, clinicians must be *aware* of their patient's desires and they must also be *willing* to fulfill them. Desire-satisfaction is challenging in the context of critical care where many patients lack capacity all together, or they only have limited capacity due to pain, the effects of sedation, or by experiencing a wildly unfamiliar position about which they have not formed rational or reflective preferences. For example, a preference such as "I would never want to be on a ventilator" may be an ill-informed desire when uttered by a person who is unaware of the various contexts in which mechanical ventilation is appropriate, such as when this form of support is temporary and lifesaving. Other patients may express refusal of certain treatments on account of

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psychological distress, although it is clear that such treatments would greatly improve their long-term well-being.

Objective list Some things just are good for individuals, even if individuals choose not to recognize the benefit, or are incapable of recognizing the good in them. In the clinical setting, objective list theories commonly appear under the guise of “best interests”. When clinicians act in the best interests of their patients, they are making claims about a good life, about what makes the patient fare best. In many cases physicians act without any knowledge of the patient’s values or desires; in certain other cases, clinicians are justified in acting according to the best interests of the patient even over the patient’s requests, specifically when patients are deemed to lack medical decision capacity. Like the other theories, however, the objective list has its limitations, many of which become particularly salient in the ICU. The most fundamental problem is what items should be on the list? The ICU patient population poses a uniquely challenging version of this question: what does it mean for a brain-injured patient, or a patient with ICU-acquired weakness, or a patient recovering from severe acute respiratory distress syndrome to fare well? Most would agree that what is considered low-functioning for healthy individuals like ourselves may be high-functioning for patients who are recovering from the above conditions. Is then a single objective list appropriate for all persons, irrespective of a person’s functionings and capabilities?

Such a question may sound abstract and distant from the everyday decision-making in the critical care unit; however, the importance of this question is evident when we consider that (a) approximately 20% of deaths in the USA occur in the ICU, and (b) the vast majority of these are preceded by a decision to withhold or withdraw life-support. These facts suggest that clinicians, in conjunction with surrogates, are frequently faced with judgments regarding the burdens and benefits of continuing artificial support—and life itself. On the basis of the preceding analysis, we speculate that often these judgments primarily spawn out of a version of the objective list that corresponds to ingredients of the “good life” for normal healthy adults; examples would be full independence in activities of daily living, or high levels of professional functioning. These achievements may not be possible for a number of ICU survivors; nevertheless, their assessment of their own well-being may be significantly higher regardless of their inability to achieve these functionings. Thus, determining what makes a good life for individuals with distinct functionings and capabilities on account of illness or injury is a powerful and neglected challenge in intensive care medicine.

Compliance with ethical standards

Conflicts of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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