



MEETING GiViTI 2023  
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# Comunicazione ed *ethical climate*

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No conflict of interest



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Io patisco molto quando il paziente marcisce letteralmente nel letto, uno di quelli anasarcatici a cui dobbiamo cambiare cinque traverse per turno perché macerano nel loro stesso siero e il medico che lo segue dice cose tipo "La PCT è in discesa!" "Però i lattati sono stabili!"... capisco che si debbano **oggettivare le scelte e non andare a sentimento**, ci mancherebbe, ma spesso penso anche che manipolando di più i malati, **sentendone l'odore** oltre a guardarne i numeri, ci sarebbe **meno inerzia**. Perché spesso è **sofferenza fine a se stessa**, ma standone a distanza la si riesce a **tollerare** più facilmente. E anche la mia la chiamo distanza eh, perché sì sì, li tocco i pazienti, ma se ci fosse meno **distanza emotiva**, col cavolo che riuscirei a tollerarlo. Alcuni mesi fa avevo chiesto a uno specializzando di stare con noi durante il nursing e poi andare a dire la sua alle consegne mediche; non stava facendo nulla e si era offerto di dare una mano a girare un paziente... inizialmente avevo rifiutato perché preferivo un collega, poi avevo pensato che potesse essere utile anche a lui. Su alcuni pazienti vorrei che fosse il responsabile della TI a offrirsi di farlo.

Un'altra cosa che trovo assurda è che a volte, presi singolarmente, i miei medici sono tutti concordi su situazioni di questo tipo, ma poi è come se ci fosse un'entità superiore che **blocca l'agire**. Ed è frustrante somministrare il diuretico prescritto dalla stessa persona che ti fa la battuta "Tanto non andiamo da nessuna parte..." o il giorno dopo veder aumentare la noradrenalina da qualcuno che dice "Mah, tanto è morto". Perché se almeno uno tra tutti ci credesse davvero, se almeno uno dicesse "Secondo me non ce la fa, ma magari invece risponde..." allora potrebbe ancora **avere un senso**. Intendo, anche di fronte all'evidenza, se uno va avanti perché ci crede o perché un minimo dubbio gli è rimasto, allora si può non essere d'accordo, lo si può contestare, ma almeno un minimo di coerenza ci sarebbe... Quando anche **l'unanimità non sblocca l'inerzia**, allora sembra proprio soltanto uno scarico di **responsabilità**. Con questo non voglio assolutamente dire che sia una responsabilità che si possano prendere a cuor leggero oppure che sia facile, me ne rendo conto. Però è una responsabilità scegliere di **traghettare le decisioni** al turno dopo, al giorno dopo, al lunedì dopo, a quando rientra un certo collega...

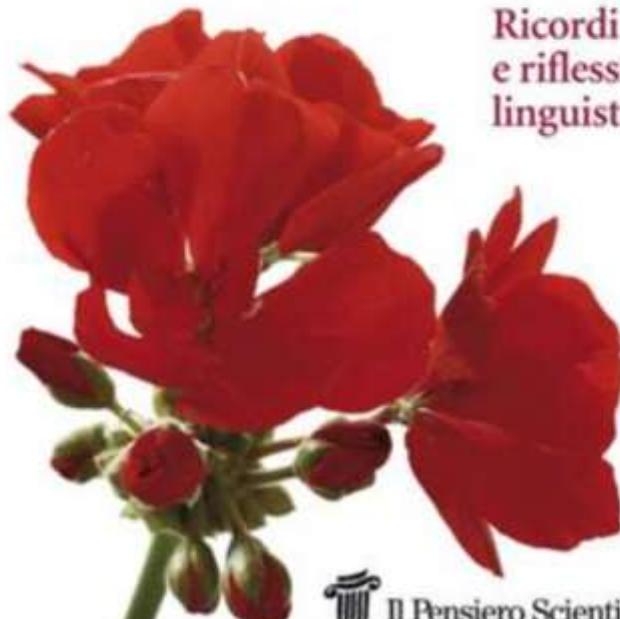
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Lucia Fontanella

# La comunicazione diseguale

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Ricordi di ospedale  
e riflessioni  
linguistiche



Il Pensiero Scientifico Editore

Dove gli interlocutori non sono sullo stesso  
livello (scuola, tribunale, ospedale...)

Lo sbilanciamento è determinato dal  
**possesso unilaterale** di **tre elementi**:

**Spazio**

**Tempo**

**Lingua**

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# prognostic uncertainty

[ Original Research Critical Care ]



CHEST 2014; 146(2):267-275

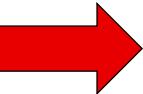
Inappropriate Care in European ICUs

Confronting Views From Nurses and Junior and Senior Physicians

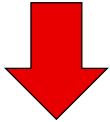
The **most commonly reported reason** for **disproportionate care** was **prognostic uncertainty**, reflecting the well known difficulties raised by mortality prediction in ICU patients

Many physicians, as shown in this study, thus **seem to retreat to the world of “prognostic uncertainty,”** in which everything remains possible, so that **waiting seems the best and safest option**

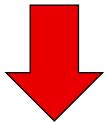
“Wait and see” strategy



Moral distress (nurses)



Bad communication



Interpersonal conflicts (staff)



Complicated grief (families)

«Systematically using this “wait and see” strategy is **inadequate** and even **harmful**; however, when there are good reasons to postpone decisions, **better communication of the prognostic uncertainty** to the team and the families is warranted»



## IN FAVOUR OF MEDICAL DISSENSUS: WHY WE SHOULD AGREE TO DISAGREE ABOUT END-OF-LIFE DECISIONS

*DOMINIC WILKINSON, ROBERT TRUOG AND JULIAN SAVULESCU*

The process of **reasoned discussion**, elucidation of **facts**, and exploration of **values** is worthwhile even if agreement is not forthcoming.

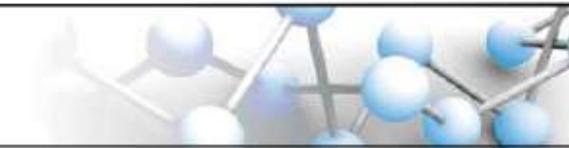
**End-of-life decisions** are, by their nature, difficult, unsettling and sometimes **distressing**.



## IN FAVOUR OF MEDICAL DISSENSUS: WHY WE SHOULD AGREE TO DISAGREE ABOUT END-OF-LIFE DECISIONS

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Professionals, understandably, have **different views** about them, and will sometimes reach **different conclusions**. However, such **disagreement** is not necessarily a sign that we are on the wrong track, and should not be taken to preclude **withholding** or **withdrawing** treatment if that is consistent with the patient's/family's wishes.



## **IN FAVOUR OF MEDICAL DISSENSUS: WHY WE SHOULD AGREE TO DISAGREE ABOUT END-OF-LIFE DECISIONS**

*DOMINIC WILKINSON, ROBERT TRUOG AND JULIAN SAVULESCU*

**Let's agree to disagree!**

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2021

VIEWPOINT

Open Access



# Why and how to open intensive care units to family visits during the pandemic

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## Abstract

Since the lockdown because of the pandemic, family members have been prohibited from visiting their loved ones in hospital. While it is clearly complicated to implement protocols for the admission of family members, we believe precise strategic goals are essential and operational guidance is needed on how to achieve them. Even during the pandemic, we consider it a priority to share strategies adapted to every local setting to allow family members to enter intensive care units and all the other hospital wards.

**Keywords:** Professional/family relations, Social isolation, Health communication, Information dissemination, Family health, Intensive care units, Communicable diseases, Pandemics

# The benefits of ICU families visits

## for the critically ill patients

- Respected patient's rights
- Stress reduction
- Psychological reassurance
- Reduced sense of abandon
- Prevented/reduced delirium
- Increased patient motivation
- Increased compliance to care
- Respect for patient's willingness

## for the healthcare team

- Better information collection
- Help in decision making
- Increased appreciation and trust
- Reduced moral distress
- Prevented litigation



## for the patient' families

- Increased understanding of patient condition and treatment options
- Respect of demand for closeness
- Less anxiety and depression
- Better acceptance of bad news
- Help in working through grief
- Prevention of complicated grief
- Less feeling of powerlessness

## for the whole ICU community

- Better and simpler communication
- Guaranteed transparency
- Shared decision-making
- Psychological wellbeing
- Creation of a family-centered ICU
- Improved patient and family satisfaction

**greatly overcome the pandemic risks.**

**Fig. 1** The physical presence of families into the ICU brings significant advantages for critically ill patients, for their families, and for the healthcare team

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## Ethical climate: definition

**individual perceptions of the organisation that influences attitudes and behaviour and serves as a reference for employee behaviour**

# Ethical Climate

Influenced by multiple factors:

- Local laws, cultures, practices
- Communication and collaboration
- Leadership styles and priorities



*Courtesy of Victoria Metaxa and Aimee Milliken*

# Ethical Climate and Moral Distress

- Moral distress occurs when a provider believes they are doing something wrong and have little power to change the situation
- Increased levels of moral distress associated with greater intention to leave
- Nurses tend to have higher levels of moral distress and rates of burnout than physicians

# **Root causes of moral distress**

As identified by the Measure of Moral Distress for HCP's:

- Following the **family's insistence** to continue **aggressive treatment** though I believe it is **not in the best interest** of the patient
- Continuing to provide aggressive treatment for a person who is **most likely to die** regardless of this treatment when **no one will make a decision** to withdraw it
- Being **required to care** for more patients than I can safely care for
- Having **excessive documentation** requirements that **compromise patient care**
- Experiencing compromised patient care due to **lack of resources / equipment / bed capacity**

# Perception of inappropriate care

Perceptions of inappropriate care are widespread

Physicians often cite prognostic uncertainty

Nurses cite poor intra- and inter-disciplinary communication; lack of initiative in goals of care conversations

1. Van Den Bulcke B, Piers R, Jensen HI, et al. Ethical decision-making climate in the ICU: Theoretical framework and validation of a self-Assessment tool. *BMJ Qual Saf.* 2018;27(10):781-789. doi:10.1136/bmjqqs-2017-007390
2. Bosslet GT, Pope TM, Rubenfeld GD, et al. An official ATS/AACN/ACCP/ESICM/SCCM policy statement: Responding to requests for potentially inappropriate treatments in intensive care units. *Am J Respir Crit Care Med.* 2015;191(11):1318-1330



# Ethical climate and intention to leave among critical care clinicians: an observational study in 68 intensive care units across Europe and the United States

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# Ethical Climate and Intention to Leave

Nearly **25%** of ICU clinicians have considered leaving their jobs

Intent to leave is greater in areas with high ICU workload, increased moral distress, and burnout

**Burnout** is common in **high stress jobs**:

- Compared to all high school grads, physicians are **36%** more likely to develop burnout
- Critical care professionals have some of the highest rates of burnout (>50%)
- **86%** of critical care nurses have at least one symptom of **burnout**

# burnout

/'bə:naut/

Noun

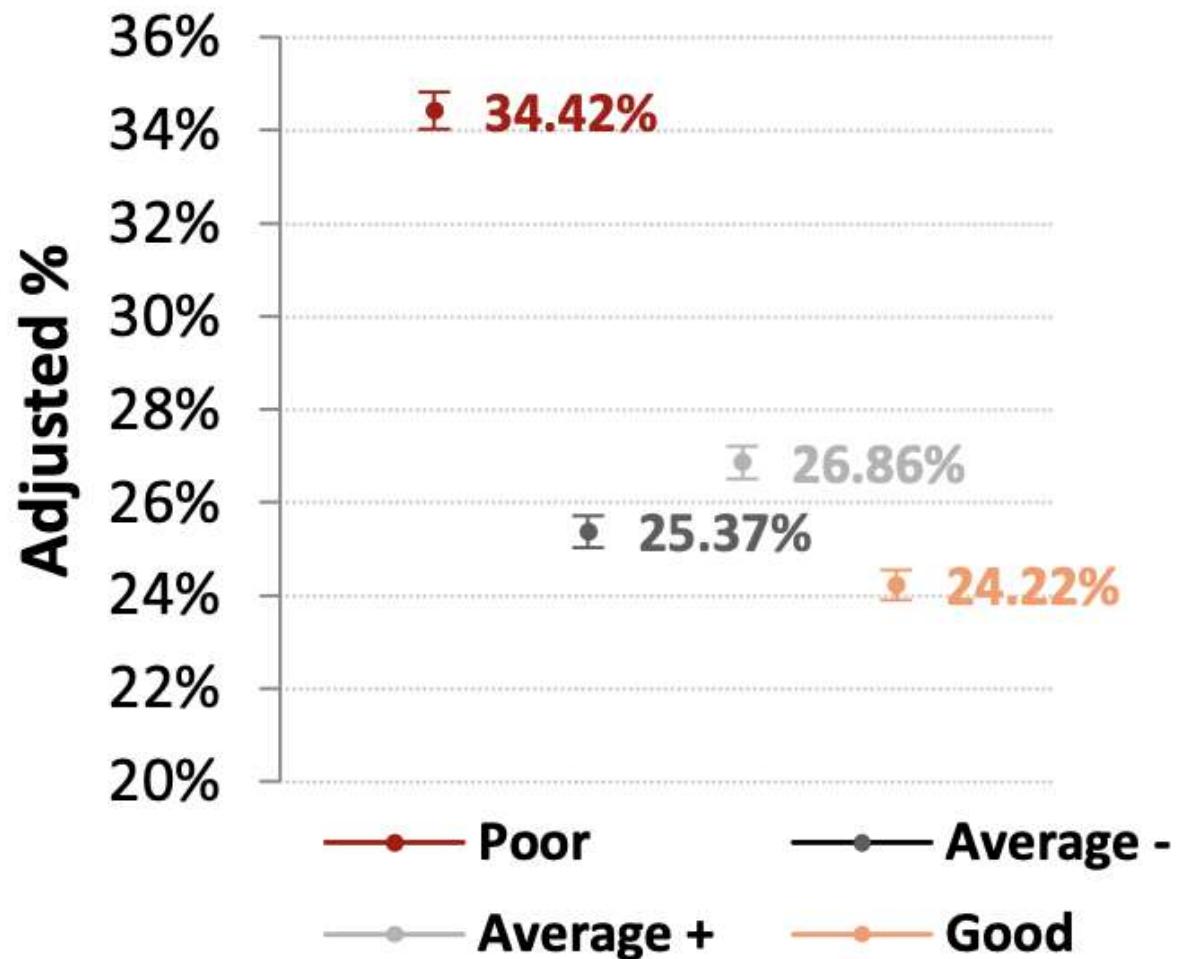
*noun: burnout; noun: burn-out*

1. the reduction of a fuel or substance to nothing through use or combustion
2. the failure of an electrical device or component through overheating  
*"an anti-stall mechanism prevents motor burnout"*
3. physical or mental collapse caused by overwork or stress  
*"high levels of professionalism which may result in burnout"*



# Ethical climate and intention to leave among critical care clinicians: an observational study in 68 intensive care units across Europe and the United States

## Ethical decision-making climate



# Protective Factors

Improved ethical climate may reduce intention to leave, decrease burnout, and mitigate moral distress

Specifically:

- Mutual respect
- Interdisciplinary reflection
- Active decision-making at end-of-life

# References

1. Van den Bulcke B, Metaxa V, Reyners AK, et al. Ethical climate and intention to leave among critical care clinicians: an observational study in 68 intensive care units across Europe and the United States. *Intensive Care Med.* 2020;46(1):46-56. doi:10.1007/s00134-019-05829-1
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