Chapter 5
Critical Illness and the Emergency Room

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ABSTRACT

The care of the critically-ill patient in the acute setting, an 'everyday' occurrence in most urban emergency departments, often proceeds through the dictates of Parsonian paternalism: the Physician knows best. But through a discussion of three such 'everyday' encounters, we hope to complicate this notion and find a place for healthcare users in the decision making process while developing a language and analytic basis for thinking seriously about the clinical dyad and the construction of knowledge in relationship economies. Finally, we discuss the escalation and de-escalation (terms derived from the military industrial complex) of care as it relates to medical futility.

INTRODUCTION

Unlike most medical problems that trade in years or decades, critical illnesses manifest themselves in the short span of hours or days. From a knife wound to the left chest cavity of a young man to an amniotic fluid embolus in a thirty-six week gravid expectant mother to a large hemorrhagic stroke in a hypertensive older woman returning home from her grandchild's first ballet recital, critical illness is not limited by demography, pathophysiology or organ system. While in clinical practice it is often apparent to even the most neophyte practitioner, critical illness avoids easy definition and like the fog at dawn escapes a unifying grip. Faced with critically ill patients, physicians unconsciously fall back on time-worn forms of 'evidence' like intuition, anecdote, animal and cell-based research, common sense and personal bias. While

there is a burgeoning literature on critical illness and clinical evidence that is most developed in the ongoing research on sepsis and septic shock (Jones et al, 2008), many physicians taking care of critically ill patients perceive an impossibly wide chasm between everyday practice and the availability of results from clinical research (Marik, 2001). In addition to the lack of a clear definition, critical illness seems to resist clinical research in its perceived and real time constraints, as attested by concepts like the golden hour, for the lack of time is thought to be a barrier both to the production of new clinical knowledge and to the search for existing literature. Because of the critically ill patient's liminal position, often hovering at the limits of mortality, practitioners may grasp for and apply unproven or experimental treatment strategies. And finally, these very sick patients are thought to be voiceless, treated more appropriately as physiologic bodes than as still sentient human beings. Through this chapter, we hope to complicate these notions and find a possible place for evidence-based medicine, especially as recently re-theorized by the critical intervention of narrative medicine (Charon, 2006), in the critically ill clinical dyad and in the co-construction of knowledge.

From its inception, Evidence Based Medicine purported to be a clinical decision and practice model that unified three variously defined arenas of criteria for informing clinical decision-making. One iteration of these criteria specified: clinical expertise, research evidence and patient preferences and values (Haynes, Sackett, Gray, Cook, Guyatt, 1996). But of these three, EBM has focused almost exclusively on the second: the development of the positivist and empiricist methodologies that underlie clinical research evidence, especially as it pertains to highly sophisticated statistical analyses and tools, to the near neglect of the other two foundational pillars, doctors and patients (Silva & Wyer, 2009). Clinical expertise was assumed to encompass all of the experiences that constitute the formation of expert knowledge: an

education in the pathophysiologic basis of disease followed by a period of post-graduate training and the accumulation of experiential knowledge that could seamlessly be stitched into rich patterned tapestries. While patient values and preferences were seen as merely transparent—ask and ye shall receive. Neither the complexities of cognitive development nor the ontological vagaries of what it means to be a sick patient confronted by impossible choices received the theoretical and practical study needed to pursue the original mandate: the unification of clinical expertise, research evidence and patient preferences and values. A recent reworking of EBM, entitled narrative-evidence based medicine, attempts to correct some of these imbalances (Goyal et al, 2008). By treating the medical encounter as a truly iterative and relational event, at the same time as connecting care assessment and decisions to relevant clinical evidence, NEBM bridges the gap between the general and the particular, between the population and the patient and localizes knowledge production and the process of decision making squarely in the dyadic space co-created by the physician and the patient.

The care of the critically-ill patient in the acute setting, an 'everyday' occurrence in most urban emergency departments, often proceeds through the dictates of Parsonian paternalism: the Physician knows best (Parsons, 1951). In the 1950s, Talcott Parsons published the most extensive sociological analysis of the practice of medicine yet extant. For Parsons, the legitimation of the 'sick role' was predicated upon passivity: the understanding that the patient's sickness is not something that he or she is in control of, not something that he or she can will away, but rather something that incapacitates him and removes him from social obligation. For Parsons, within the social system, an obligation was placed on the sick patient to seek out and submit to medical care: "The obverse of the physician's obligation to be guided by the welfare of the patient is the latter's obligation 'to do his part' to the best of his ability" (Parsons,

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