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LETTER TO THE EDITOR

When Ethics Meet Socrates in Critical Care

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To the Editor:

We read with great interest the recently published article by Wen et al (1) in *Critical Care Medicine* regarding predictors of ICU surrogates' psychological distress, particularly noting how do-not-resuscitate orders and social worker involvement can mitigate anxiety and depression. Their findings about the emotional burden on family decision-makers parallel the experience among ICU staff when facing complex end-of-life decisions (2). While their work addresses the family ecosystem, we would like to share our experience implementing a structured approach for healthcare teams navigating challenging ethical decisions that generate significant emotional burden and disagreement among staff (2).

At our tertiary care hospital in Chile, a critically ill patient with prolonged ICU stay and complicated clinical course generated significant differences regarding management decisions among the care team. Conventional discussion methods proved insufficient, leading us to try a Socratic dialogue approach. The method represents a form of cooperative dialogue based on asking and answering questions to stimulate critical thinking and draw out ideas and underlying presuppositions (3–5). It promotes a structured inquiry where participants examine their own assumptions through systematic questioning.

Our experience divided the debate into three sessions, with voluntary participation across the entire ICU ecosystem—health professionals, administrative staff, and students (**Fig. 1**). Before the debate an open, explicit, and nonjudgmental declaration of individual viewpoints as a starting point was made. Once personal views were expressed, the initial objective of the Socratic discussion was to generate a common language through which concepts would be discussed and understood (3). For this initial case, agreements were established on the definition of what constitutes adequate post-ICU quality of life and what therapy limitation means for this patient. There was also agreement on what arguments would be sufficient to generate a change in opinion.

The second meeting examined the rationale behind different positions, exploring concepts of dignity and acceptable treatment boundaries. Discussions centered on examining core issues and their possible outcome alternatives: disease state (consolidated vs. potentially reversible damage), therapy options and their timelines, need for additional diagnostic studies, family context, and psychological support needs. Rather than debating opinions themselves, participants explored the evidence and reasoning supporting each perspective.

The final meeting focused on reaching a consensus agreement about future courses of action, once definitions and elements for discussion were established, including situations that would warrant changes to the agreed plan. We addressed practical aspects like family preparation, resource allocation, and the establishment of clear clinical milestones for decision-making. This helped transform our initial differences into a shared understanding of how to proceed while acknowledging the complexity of the situation.

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This trial based on Socratic debate was very positively evaluated by the participants, generated an agreement where each person felt they had been heard as an equal, and helped clarify concepts such as dignity, quality, and limitation in the specific context of the patient. After each meeting, a summary of the discussions was prepared and distributed to the entire team.

This process shows how structured philosophical dialogue can potentially transform confrontational scattered discussions into collaborative exploration of complex ethical issues in critical care maintaining mutual respect and potentially reducing the emotional burden.

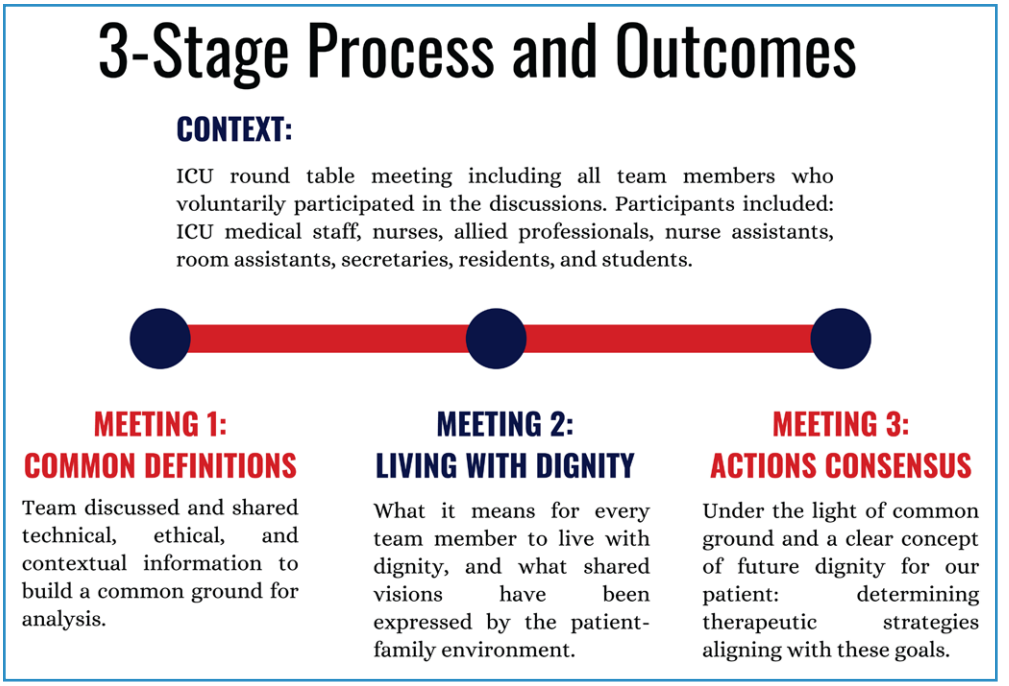

Figure 1. Three-stage interprofessional consensus process for dignity-centered care: a local ICU experience. Schematic representation of the actual sequential multidisciplinary process implemented in our ICU. The framework emerged from three structured meetings with voluntary participation from all levels of ICU staff. This figure summarizes the real outcomes of our local experience in establishing common definitions, exploring dignity concepts, and developing therapeutic consensus.

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The data that support the findings of this letter are referenced in the article.

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