THE STANDARD OF CARE AND CONFLICTS AT THE END OF LIFE IN CRITICAL CARE: LESSONS FROM MEDICAL-LEGAL CROSSROADS AND THE ROLE OF A QUASI-JUDICIAL TRIBUNAL IN DECISION-MAKING

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Introduction: End of life (EOL) decision-making is challenging especially when treatments (Rxs) are deemed non effective. As balance of potential medical benefit shifts to certainty of harm, ICU teams have found themselves providing what they deem to be inappropriate Rxs. Legal recourses are increasingly sought to resolve such conflicts. Cuthbertson et al v. Hassan Rasouli, heard by the Supreme Court of Canada in December 2012, will shape the future of critical care in Canada by ruling who defines benefit, its use in decision-making, and how conflicts should be resolved. Two lower courts have already ruled that the quasi-judicial tribunal the Consent and Capacity Board (CCB) is an appropriate forum to address such issues. Yet at the heart of these disputes lie questions of standards of care (SoC) which the CCB has no legal mandate to determine. No study has explored how SoC issues are resolved in CCB cases and none has explored what issues are considered important in legal rulings despite international calls for such research.

Objectives: The goals of this qualitative research study are to review the last 7 years of CCB adjudications in order to explore the role of SoC in ICU cases, and effects of its decisions on shaping future practice. Lessons learned at the medical legal crossroads will enable ICU teams to appreciate need to clearly and transparently define SoC, concept of medical benefit, their role in decision-making and the appropriate role of legal recourse in resolution processes.

Methods: The public online, nonprofit database of Federation of Law Societies of Canada (www.canlii.ca) was searched for relevant CCB decisions from 2003 (the time of 1st case, re JH). Search terms included: form G, ventilator, critical care, feeding tube, withdrawal, palliative. Purposive sampling collected all cases in which an application was brought to the CCB regarding medical Rxs at the EOL. 28 decisions were cross referenced with an independent research website that catalogs various CCB cases (http://consentqi.ca). Each case was independently read and analyzed. Using modified grounded theory methodology, open coding identified salient categories of information, e.g. "non medical benefit", or "inability to cure" or "inability to slow rate or extent of progression". Constant comparison between cases was performed to saturate each category. Axial coding identified inter-relationships between categories. Axial coding constructed coding paradigm/ theoretical model of roles of SoC, its inter-relationship with patient wishes as perceived by SDMs, with concepts of “best interests”and futility in legal adjudications.

Results: Medical benefit was clearly defined, and its role in determining SoC, transparent. Perceptions of variability in SoC were enhanced by physicians in intractable conflicts seeking legal validation by framing SoC issues as “best interest” determinations. Coding revealed that benefit was the potential for Rxs to result in cure, improve/stabilize progression of illness, symptoms and well-being, or slow rate or extent of deterioration of health and well-being. Patient values were important but there was a strong emphasis on role of benefit in defining SoC. Rx recommendations were made in context of reversibility of illness, response to Rx, if any, and, patient well-being. Physicians all acknowledged Rxs could sustain life yet, in face of irreversible
end stage illness, this was not consistent with the goal of critical care. In no case did SDMs make arguments regarding SoC. Best interests framing created situation in which the CCB was asked to validate physician perceptions of SoC even if in adjudicating conflicts, SoC was not directly considered. Non-beneficial Rxs were however debated as viable options and the nature of patient wishes, whether general or specific, whether reflective of patient values, or SDMs' emotions were the basis of determinations. In analysis of best interest, CCB emphasized respecting patient dignity and well-being—which encompasses life as a whole— vs continuing Rxs that would only cause further harms.