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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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ABSTRACT

Purpose: The goals of this qualitative study were to review the last 7 years of end of life legal decisions within the critical care field to explore how medical benefit is defined and by whom and the role of the standard of care (SoC) in conflict resolution.
Methods: A public online, non-profit database of the Federation of Law Societies of Canada was searched for relevant Consent and Capacity Board decisions from 2003 to 2012. In total, 1486 cases were collected, and purposive sampling identified a total of 29 decisions regarding use of life-sustaining treatments at end of life. Using modified grounded theory, decisions were read and analyzed from a central SoC concept to understand definitions of benefit, rationales for case adjudication, and repercussions of legal recourse in conflict resolution.
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. The results reveal some key problems in recourse to the Consent and Capacity Board for clinicians, patients and substitute decision makers in such conflict situations.
Conclusions: This study can help improve decision-making by debunking myth of variability in determinations of medical benefit and the standards of care at end of life and reveal the pitfalls of legal recourse in resolving intractable conflicts.

1. Introduction

Decision-making at the end of life between clinicians, patients and substitute decision makers (SDMs) have been described as challenging especially when treatments are determined to be no longer medically beneficial and physicians want to withhold and/or withdraw life support [1]. Such situations are often perceived by patients and families as choices between "life or death" even though such treatments are invasive, painful and not able to help cure, stabilize, improve or alleviate symptoms of the underlying condition. At end of life, the ability of life support to help diminishes as a patient's overall state of health worsens and at the same time treatments provided retain their ability to cause harm. This contributes to an unbreakable spiral of declining physical condition [2,3]. As this balance of potential medical benefit shifts towards that of the certainty of harm, critical care teams internationally have found themselves providing what they have determined to be inappropriate treatments [4-6]. Such situations have been recognized as one of the main causes of conflict, moral distress and burnout [7-13].

In Ontario, Canada when such disputes become intractable, a legal, quasi-judicial tribunal known as the Consent and Capacity Board (CCB), composed of legal, psychiatry (reflecting its origins under the Mental Health Act) and general public members, has the ability under the Healthcare Consent Act [14] to adjudicate some such conflicts. Under the Healthcare Consent Act, the onus on physicians is to first decide what treatments might be indicated taking into account patients' diagnosis and prognosis, their wishes, values and beliefs and then make treatment plans and recommendations (Fig. 1). Where SDMs refuse to consent to such treatment recommendations and the team believes that this refusal is not reflective of patients' previously expressed wishes, or is not in the patient's best interests then the physician may bring cases forward to the CCB [14-16]. This quasi-judicial tribunal is viewed as a neutral third party that can adjudicate

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☆☆ Dr Hawryluck has been involved in 2 of the CCB cases reviewed, has written an affidavit to the Supreme Court that discusses how a pending critical care case raises issues of national importance to all Canadians, and has worked with the Canadian Critical Care Society on its application for intervenor status in the Brian Cuthbertson et al v. Hassan Rasouli by his Litigation Guardian and Substitute Decision-Maker Parichehr Salasel (Ontario) (Civil) (By Leave) 34362.

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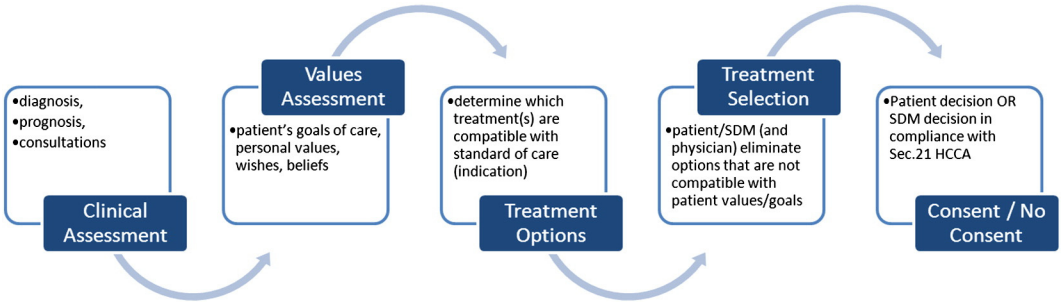

Fig. 1. The Consent Pathway. Sibbald R, Chidwick P, Cooper P, Consent Pathway, Healthcare Consent Quality Collaborative. Date retrieved: 02/03/2013, Url: (http://consentqi.ca/positions-interpretations/consent-pathway/).

whether the SDM is fulfilling his/her legal obligations [14,16]. Determining which treatments are indicated and ought to be offered to critically ill patients falls, however, to the professional judgment of each physician. Such proposed treatment options take into context each particular patient's situation and are guided by professional standards, legal frameworks and case law. According to professional standards, the concept of medical benefit is key to determining whether a treatment falls within a standard of care (SoC) [17-20].

After a treatment or treatment plan has been offered to an SDM, there are 2 kinds of disagreement that may ensue. First, the SDM may refuse this treatment where the physician feels that such a refusal is not in accordance with the principles of substitute decision making. These disputes may be resolved by the CCB. On the other hand, an SDM might disagree with which treatment has been offered, and request a "different" treatment plan instead. These situations cannot be resolved by the CCB because it is not within their mandate. Physicians are obligated to offer alternatives when considering treatment plans but any alternatives must be within the medical SoC. The medical SoC is determined by the reasonable physician practicing within a given field of medicine. The SoC is also reflected in professional body's guidelines which articulate that treatments should not be offered where they will not benefit. To have medical benefit, treatments should have the potential to result in, cure, or slow the rate or extent of deterioration of health or well-being from illness and alleviate symptoms all while minimizing harms). Therefore, if a treatment plan cannot provide medical benefit, it would fall outside the SoC, and a physician should not offer it. The law respects this medical SoC as it reflects medical expertise acquired after long years of study and clinical practice. The law may question whether treatments would fall within the medical SoC and may even modify the SoC through legislation or common law to reflect changing societal values. As such, the law does not set the SoC; rather, it determines whether the SoC was breached.

Such disputes that focus on what ought to be offered, in other words what falls within the SoC of a prudent physician, can only be resolved at the courts, and not the CCB, and physicians should be turning to the courts and not to the CCB to resolve such conflicts.

In a historic critical care case, Cuthbertson et al v. Hassan Rasouli, heard by the Supreme Court of Canada on December 10, 2012, 2 lower courts [21,22] have however decided that the CCB should be the legal recourse to resolve conflicts in decision-making even if these conflicts revolve around non-beneficial treatments. The Supreme Court's decision will likely frame the future of critical care medicine in Canada by ruling who defines benefit, its use in decision-making regarding life-sustaining treatments, and how conflicts should best be resolved. Such dilemmas are common in critical care practice around the world and court rulings are often sources of international news headlines. The Canadian Supreme Court decision may, therefore, influence practice internationally to the extent that countries seek guidance from others to help address best practices in a very costly field of medicine.

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

2. Methods

A public online, nonprofit database managed by the Federation of Law Societies of Canada (www.canlii.ca) was searched for relevant CCB decisions available from 2003 (the time of the first reported case, re JH appealed to Ontario Superior Court as Scardoni v. Hawryluck). Search terms included: form G, ventilator, critical care, feeding tube, withdrawal, palliative. This purposive sampling methodology aimed to collect all cases in which an application was brought to the CCB regarding medical treatments at the end of life. In total, we identified 29 decisions which were cross referenced with an independent research website that catalogs various CCB cases (http://consentqi.ca) (see Table 1). Each case was independently read and analyzed by 3 researchers (RS, PC, and LH). Using modified grounded theory methodology, open coding was used to identify salient categories of information, for example "no medical benefit", or "inability to cure" or "inability to slow rate or extent of progression". Next, constant comparison between cases was performed to saturate each category; that is, we continued to code until no new categories were identifiable. Axial coding was used to identify the inter-relationships between other categories. The authors then compared coding schemes before identifying higher order themes. A higher order theme is one which encapsulates several other coding themes. SoC was identified as the central phenomenon of interest by the investigators. Axial coding helped us construct coding paradigm/theoretical model of the roles of SoC, its inter-relationship with patient wishes as perceived by SDMs, with concepts of "best interests" and futility and its role in legal adjudications. The theoretical model describes how the physicians determine what treatments are medically indicated and ought to be offered to their patients. Implications of the model and how it relates to the medical SoC are considered in the discussion.

3. Results

All patients were incapable of consenting to proposed treatment plans and all cases brought to the CCB therefore, involved conflict with SDMs. Cases related to the proposed withdrawal of life-sustaining treatments in situations in which continuing or escalating such treatments was felt to be medically non-beneficial.

In most cases, physicians reported consensus among the health-care team that continuing or initiating life-sustaining treatments was "futile" and would be of no benefit to the patient. Physicians all acknowledged such treatments could sustain life yet this, in face of irreversible end stage illness, was not consistent with the purpose of