Ethical issues a major focus as Canada hosts intensive and critical care meeting

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Features

Chroniques

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En bref

LE CANADA A ÉTÉ L'HÔTE, cet été, du 7e Congrès mondial de médecine de soins intensifs. L'éthicien John Williams, de l'AMC, rapporte que les question d'éthique y ont tenu une place cruciale.

Ethical issues occupied a central position at the 7th World Congress of Intensive and Critical Care Medicine, held in Ottawa this summer. Hosted by the Canadian Critical Care Society, the meeting attracted 2500 participants from around the world.

An increasingly serious ethical problem facing intensivists is the allocation of resources as they grow scarcer. Dr. Dan Roberts of the Health Sciences Centre in Winnipeg reported on his facility's information-based approach to cost containment in the intensive care unit (ICU), which has resulted in annual savings of $200 000 to $300 000 by eliminating unnecessary tests. He argued that many routine ICU practices are performed ritually, without evidence of effectiveness, and these are not only wasteful but also may be harmful. A first step in the ethics of resource allocation is to eliminate such practices.

Given the high mortality rate in ICUs, avoidance of futile treatments is a major concern for intensivists. Dr. René Chang, director of transplantation at St. George's Hospital in London, England, defined futility as "prolonging the process of dying at great expense." Chang, who argued that medicine must develop indicators for identifying patients who are unlikely to survive intensive care, described the Riyadh algorithm for predicting which patients won't survive but noted that it needs further refinement. Although some patients do survive intensive care unexpectedly, the care is very expensive and to treat every patient with a poor prognosis in the hope of unexpected survival entails enormous opportunity costs.

Organ transplantation continues to be a major ethical issue, largely because of the shortage of donor organs (see *Can Med Assoc J* 1997;157:160-1). A Belgian physician, Dr. Paul Michielsen, described his country's "presumed-consent" approach to organ retrieval, through which organs are taken from suitable donors unless they have explicitly refused permission. Adoption of this policy in 1986 led to a doubling of the supply of organs. However, some physicians oppose the policy and routinely ask relatives for permission to harvest organs from the dying.

Another ethical issue related to transplantation concerns management of the brain-dead patient for organ donation. Dr. Malcolm Fisher of Australia, president of the World Federation of Societies of Intensive and Critical Care Medicine, described the pathophysiology of brain death and difficulties surrounding the management of brain-dying patients who are potential organ donors. He asked whether consent needs to be obtained to maintain organs before permission is received to transplant them.

During a plenary session, Daniel Callahan, PhD, cofounder of the Hastings Center, a New York State bioethics think tank, identified 4 major dilemmas facing medicine:

- the financial cost of many innovations in the face of fiscal restraint;
- medical research's view of death as an enemy versus clinical medicine's goal of facilitating a peaceful death;
- individual health versus population health; and
- equity of access versus market forces.

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Resolving these dilemmas requires re-examination of the goals of medicine. In particular, Callahan suggested that the desire for progress be reduced, that quality be subordinate to equity, that length of life be subordinate to quality of life, that funds for critical care be reduced in favour of education and other determinants of health, and that governments ensure equitable access to health care. In short, medicine must become sustainable: it must be affordable, equitable and limited.

Four speakers addressed the contentious issue of withholding or withdrawing life support. Judge Jean-Louis Baudouin of the Quebec Court of Appeal described several Canadian court cases in which the right of a competent patient to refuse life-sustaining medical treatment has been firmly established. He stated that courts should intervene only in cases involving incompetent patients when there is conflict in the family or when the family's decision is clearly not in the patient's best interests.

Dr. Ronald Cranford, a Minneapolis neurologist, characterized the US situation concerning dying patients as a race between the provision of good palliative care and the legalization of assisted suicide. He fears that the latter will prevail.

Abbyann Lynch, PhD, a Toronto ethics consultant, asked whether ICUs could incorporate palliative care measures for dying patients, while Christine Mitchell, an American nurse ethicist, described the difficult position critical care nurses are in: they have a major role in any withdrawal of life-sustaining treatment but may have no say in the decision to withdraw it.

A lively panel discussion on advance directives revealed considerable disagreement about the prerogative of the physician in making decisions about life-sustaining treatment for incompetent patients. Dr. Charles Sprung, who has practised in both the US and Israel, noted that Israeli families are much more inclined to have the physician make such decisions than in the US. The "if this were my own child, I would. . ." approach was defended by some panellists and criticized by others. Both the legal status and professional acceptance of advance directives differs from country to country and even within some federations such as Canada. An additional issue raised, but not answered, was whether physicians are obliged to honour requests from patients or their families for futile or inappropriate treatments.

A provocatively entitled workshop, "Is there a science to ethics?", featured a unanimous critique of the "scientific model" from all 3 speakers, not only in relation to ethics but also to clinical medicine. Dr. Nuala Kenny of Dalhousie University argued that medicine is not a science because it is surrounded by uncertainty. Moreover, it deals with individual patients while science deals with generalizations. However, medicine must be based on good science.

Dr. Robert Truog, an American physician–ethicist, described ethics as a systematic way of thinking, although it does not share the evidence-based approach of the sciences. Franco Carnevale, PhD, a nurse–ethicist at the Montreal Children's Hospital, stated that ethical propositions ought to be empirically verifiable, but ethics is not scientific because it involved virtues as well as techniques.

In response to a challenge from the audience, however, all 3 speakers agreed that ethics is a science in that it is an organized body of knowledge bearing on a distinctive subject matter.

To prevent conference participants from focusing too much on advances in critical care therapies, a session entitled "Four horsemen of the modern apocalypse" reminded physicians that the age-old causes of critical illness — plague, famine, war and the population explosion — are still very much with us.

Dr. Ken Scott, a Canadian military physician, described in detail 2 forms of modern plague: emerging pathogens and biological warfare. Austen Davis, a British nutritionist who works with Doctors Without Borders, discussed recent famines and their causes — war and regressive economic policies. Food aid can either help or hinder famine relief, he said, depending on how it is conceived and delivered. Dr. Julius Toth, a Canadian who has also served with Doctors Without Borders, spoke about the limitations of critical care medicine in wartime conditions, including the necessity of triage.

Professor Tim Evans of Harvard University provided a ray of hope concerning population pressures. With the exception of Africa, he noted, the rate of population increase worldwide has decreased drastically since the 1960s.

Until recently the principal outcome measure for intensive care was patient survival, which is relatively easy to determine. Two conference sessions dealt with a newer and considerably more complex outcome measure, quality of life. Dr. Kathy Rowan of the UK discussed methodologic issues concerning the way quality of life can and should be measured. Several instruments have been developed, but all need considerably more refinement. Dr. Daren Heyland of McMaster University doubted whether objective standards of functional status can be combined with patients' subjective assessments of their own well-being into a single quality-of-life table. A further difficulty was raised by Dr. Murray Pollack, a Washington, DC, pediatric intensivist, concerning the applicability of any quality-of-life measures to babies.

Dr. Daniel Teres of Tufts University in Medford, Mass., was more optimistic. He said that the use of a patient diary, combined with a new measurement system, could bring together subjective and objective factors in an meaningful index. It was noted that some drug companies are interested in quality-of-life measures as a means of distinguishing pharmacologically identical drugs.

The next congress will be held in Sydney in 2001.