

DEBATING THE LIMITS OF CARE

Paul Cunningham asks when and who should pull the plug?

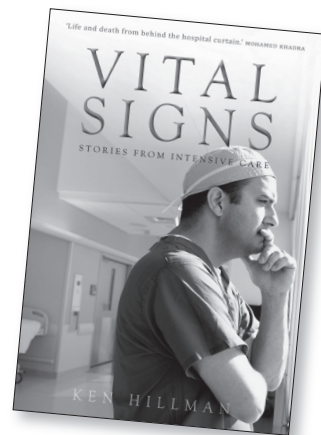
Vital Signs: Stories from Intensive Care

By Ken Hillman

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Ken Hillman's *Vital Signs* details his professional life as an intensive care specialist and academic, but does much more than this.

The book explores two important themes in an ethical and emotional grey area in the medical and palliative care sectors. The first is the often devastating impact that critical illness has on patients, family and the health workers involved in intensive care. The second is the ethical and social issues involved in a field of practice where medical efforts can be questionable, at best, and futile, at worst.

Hillman is professor of intensive care at the University of NSW. Some general readers may find his descriptions of intensive care treatment a little harrowing. But the case examples, drawn from his own experience in a semi-chronological order, are used to describe how his thoughts on his field have developed.

Hillman's youthful enthusiasm for the technical capacity of modern medicine has evolved into a far more reflective attitude. The clinical power he wields has not diminished. Stories of 'great saves'

and accounts of the intensivist's extraordinary capacity to keep people alive for a time therefore feature in the book.

The heart of the matter is how he has become progressively concerned that in many cases his patients can only remain alive whilst receiving intensive technological support and there is no cure at the end. In many cases, the poor outcomes can be accurately predicted based on age, illness severity and other risk factors. The confronting conclusion is that many (too many?) patients (one-third of terminally ill Americans, we are told) are being transferred to intensive care to die.

The conundrum highlighted by Hillman is that doctors have become so clever at providing intensive care, and can frequently and accurately predict when it will not be beneficial, to the point of frustration and even a sense of powerlessness.¹

Dr Paul Cunningham is an emergency medicine specialist working in Sydney.

Why, he asks, do 'up to 70 per cent of people now die in acute hospitals surrounded by well meaning strangers, inflicting all that medicine has to offer: often resulting in a painful, distressing and degrading end to their life'?

Hillman's list of the factors that have led to this situation are all valid in my opinion.

The growth of the medical industry has involved a total emphasis on intervention and cure. Systems have been set up for rapid intervention, often within the first 'golden hour' of treatment and assessment. This is because retrospective analysis of critical illness has shown that delay is commonly fatal. But rapid response and marshalling of a complex multi-staff service is not easily coordinated with time for reflection, communication, and cautious decision-making.

The principle, unless there is iron clad indications to the contrary, is to resuscitate first and hope to learn and discuss further when the patient is stable. This means that a subsequent decision to provide only humane palliative care means the intensive treatments must be actively withdrawn.

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One might think we should ask the patient, but this is often impossible in practice. Efforts are then made to hazard 'what they would have wanted.' Hillman discusses do not resuscitate orders in a patient's file and advanced care directives, where the patient has made a 'no intensive care' decision in advance, along with some of their failings. He accurately describes the growing expectation of families that 'everything must be done,' even if it is in contravention of the patient's own wishes and against the medical advice of specialists, which puts pressure on hospital staff. The other option of thrusting life or death decisions totally onto family members who may or may not have been close to the patient is rightly recognised as unfair.

Hillman also examines how the modern trend to medical 'super-specialisation' (meaning each

specialist group is only vaguely aware of the role and capabilities of the others) has led to excessive cross consultation. It has also led to confusion about who is actually in charge of a case and who can make or avoid hard decisions.

Hillman argues that doctors commonly request patient admission to intensive care because it is easier than dealing with the complex issues surrounding terminal patients. He also argues the medical profession is complicit in society's focus on eternal youthful health and the lack of social awareness and discussion on the inevitabilities of physical decline and death.

As a question of social policy and health planning, the basic problem is clear and not new. The potential for technological medical care has outrun our capacity to decide as a society who should use it and for how long. Professor Hillman implies that it is unfair for medical experts to be expected, on their own, to decide who will (or not) be treated. Yet he also believes the decision should not be solely left to families or bureaucrats.

One approach is to form in-hospital groups to vet each case. This has been attempted at some institutions, including children's hospitals, under the purview of the Medical Appropriateness Review Committee.² This begs the questions who should sit on the committee and who should have the casting vote? It is unlikely politicians would accept life and death decision being made without input by ethicists, psychologists, and of course, family members. And how would such a group respond when time is of essence and the decision must be made? Thirty five years of experience in acute hospital care has led me to regard any 'committee' solution with great apprehension.

An alternative is formal protocols. The US state of Oregon bit this bullet in the early 1990s.³ The Oregon Health Plan extended health cover to the uninsured and implemented a more objective approach to evidence based rationing of health care, including a website that details the circumstances in which care can and cannot be provided.⁴ For example, it was decided that no chemotherapy, surgery or radiotherapy would be funded for cancer cases unless there was a better than 5% chance of five-year survival. Not draconian, you might think, but it led to the inevitable headlines about care being denied to cancer patients.

The controversy intensified when the letter declining funding of expensive anti-cancer drugs was sometimes accompanied by another letter offering information about state sponsored assisted suicide and how to get the necessary pills from doctors under Oregon's unique Death with Dignity Law.⁵

Professor Hillman is right to say that a wider public debate is needed regarding death and dying and the limits of technological health care. This will probably be forced upon us in the near future for economic reasons although one can wonder whether the Kevin Rudd's plan for Commonwealth intervention into public hospitals will hasten or delay the process. Doctors and nurses at the frontline must be supported in working through these challenges and should not be made to feel isolated or legally exposed in practising their professions. Surely we have enough medical consultative groups at the state and federal levels to start the discussion.

The US health care reforms could well set off the debate we have to have about the limits of care. A nation that already spends around 15% of GDP on healthcare will face some difficult questions when the bulk of citizens have medical coverage under the 'government plan.'

Endnotes

- 1 'Dying by inches,' *Sunday Program*, Channel Nine (Sydney: 17 July 2004).
- 2 E.B. Eason, R.J. Castriotta, V.D. Gremillion, and J.W. Sparks, 'Withdrawal of life sustaining treatment in children in the first year of life,' *Journal of Perinatology* 28:9 (September 2008), 641–645.
- 3 Jonathan Oberlander, Theodore Marmor, and Lawrence Jacobs, 'Rationing medical care: rhetoric and reality in the Oregon Health Plan,' *Canadian Medical Association Journal* 164:11 (29 May 2001), 1583–1587.
- 4 'Prioritized list of health services,' (1 April 2008).
- 5 Susan D. James, 'Death drugs cause uproar in Oregon,' ABC News (6 August 2008).