Law and Ethics in Intensive Care
Exeter College, Oxford, 16 March 2012

Intensive care medicine, increasing in sophistication all the time, is constantly producing new legal and ethical issues. I recently spent half of my elective in an ITU in Manila, Philippines. Whilst there, I encountered a variety of issues, including confidentiality, end-of-life care and the Philippine privatised healthcare system. Reflecting on this, particularly the cultural aspects of the situations I encountered, led me to want to discover more about approaching legal and ethical dilemmas in intensive care practice. Thus, this conference, organised by Dr Andrew Lawson, greatly appealed to me.

On the front of the conference programme is the famous quote from Chief Justice Earl Warren: ‘the law floats on a sea of ethics’. I have always found this quote highly thought-provoking, and the conference reflected and built on it throughout the day. There was a great variety of speakers and delegates, mostly made up of ITU doctors and legal professionals, but also featuring ITU and transplant nurses, academics and palliative care specialists.

Two of the lectures in the first session focussed on negligence law. Paul McNeil of Field Fisher Waterhouse LLP, sponsors of the conference, presented a recent case in which he acted for the claimant1, which stimulated some fascinating discussion. Charles Foster illustrated some stark statistics, including a recent study that showed 26.8% of patients in ITU were subjected to at least one medical error2. The ensuing discussion asked what the intensivist should do if their patient is in ITU due to the mistake of another professional. All delegates felt it was not their role to judge another’s practice, whilst at the same time they must be open with patients and families. I found the considerations of ethical and professional principles when dealing with such legally difficult situations truly fascinating.

Given my experiences in the Philippines, I was very interested to hear the presentation on resource allocation in the ITU, given by Professor Chris Newdick. It became clear that assessing the vast expenses of intensive care carries two major problems; firstly, that some ITU stays could have been prevented by better initial monitoring or care, costs of which are difficult to quantify, and secondly, that exact cost breakdowns in ITU are unclear. Professor Newdick felt that if doctors need to make resource allocation decisions, they should do so on an individual patient level, and avoid any wider level decisions. However, the discussion that followed illustrated that professionals are occasionally required to make high level decisions, mainly in regards to bed management.

Another complex issue in the ITU is that of advance decisions. Dr Dominic Bell focussed on the recent case of a minimally conscious individual3. Such disability was felt by many in the audience to be intolerable, and yet a large minority agreed that artificial nutrition and hydration should be maintained for these patients. Only one delegate, a lawyer, admitted to having their own advance decision. Many felt that advance decisions were often not ethically or legally binding, but provide a useful basis for a ‘best interests’ assessment. Further, the problems with discussing future neurodisability with patients and families became clear. One delegate felt that ‘we’re almost not allowed to take a negative view on neurodisability’. Grief is often felt to be a barrier when discussing the longer term, and therefore good timing and communication skills are required.

I was also very keen to learn which, if any, ethical framework works best when applied to these situations. Many speakers explicitly mentioned the well-know principlist approach4. Jonathan Herring spoke on the role of rights in ITU care, using both deontological and consequentialist theory. Professor Charles Sprung’s research into impacts of religiosity focussed strongly on narrative ethics. In fact, throughout the day, I noticed that narrative ethics was repeatedly mentioned, though usually implicitly. I was fascinated and surprised by this, given the setting, as it may be said that many patients in the ITU have their narrative ‘paused’ during this time, for example, due to prolonged unconsciousness. Speakers and delegates frequently went beyond autonomy and beneficence, using the patient narrative to seek the best for that patient. Given the impact that a period in the ITU has on the patient and their family, whether the results is full recovery, disability or the end of life, considerations of narrative ethics are vital in the ITU.

The constant interplay between law and ethics could not be more evident when approaching dilemmas in the ITU. I thoroughly enjoyed the day, as it was a great chance to explore which issues matter to clinicians in their everyday practice. I will take many of the points, questions and discussions forward in my wider career. I am extremely grateful to the Institute of Medical Ethics for their generous support.

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3 W v M and others. [2011] EWHC 2443 (Fam).