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### Critical Care in Canada

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The Canadian national health insurance program for many Canadians represents a fundamental and defining value of our society. The “Medicare” Program has as its key values those of public administration, comprehensiveness, universality, portability and accessibility for all insured services across the country including critical care. As in other countries, Canadian critical care units struggle to meet ever- increasing patient needs and requests for care. This struggle is felt even more intensely than in other countries though, in view of the deep-seated founding values of our healthcare system, its nearly entirely public nature and the multicultural diversity of our society. Critical care services thus need to balance respect for individual autonomy, multicultural and religious diversity – concepts central to the Canadian notion of a just society – with the equally vital need to ensure appropriate and fair access to a limited resource.

To meet these challenges, recent efforts have focused on the development of a system approach to critical care delivery. Regionalisation networks have done much to break down traditional hospital based silos and have helped to address the problem of placing “the right patient in the right bed at the right time”. The creation of Critical Care Response Teams (also known as Outreach or Medical Emergency Teams) have also helped facilitate patient transfers in and out of intensive care units (ICUs), better inform decision-making regarding the use of life-sustaining treatments, and decrease overall hospital mortality (University Health Network 2007). The Canadian Critical Care Trials Group continues to provide new knowledge that serves to improve the quality of patient care worldwide.

However referring healthcare and intensive care teams still struggle with decision-making regarding the appropriate use of life-sustaining treatments (Sibbald et al. 2007), a struggle that is also shared worldwide. Patients diagnosed with a lifethreatening illness may engage the healthcare system in a number of different ways and must be informed of life-sustaining and palliative treatment options at various times, in different places and stages of illness. The recent emphasis on autonomy, patients’ rights and the societal emphasis on respecting various cultural and religious beliefs has led to a reluctance to make recommendations against patients’ or their substitute decision-makers’ (usually family members) request for ICU admission or continued ICU treatments even when potential benefits are marginal at best or when death is inevitable. Two provinces, Manitoba and, more recently, Ontario, are attempting to standardise best practices to improve decision-making in these challenging situations and hence trying to improve the quality of care received by critically ill patients.

In Manitoba, the College of Physicians and Surgeons proposed a “Statement on Withholding and Withdrawing Life-Sustaining Treatment” in June 2006. The purpose of the proposed statement is to “assist physicians, their patients and others involved with decisions to withhold or withdraw life-sustaining treatment by establishing a process for physicians to follow”. The statement specifies that life-sustaining treatment must “recover or maintain a level of function that enables the patient to achieve awareness of self and environment and to experience his/her own existence”. A physician may withhold or withdraw treatments if it is not medically indicated (has no chance of achieving the minimum goal) or is not medically appropriate (defined as treatment that may achieve the minimum goal however chances of doing so are poor or there are significant negative effects – such as pain and suffering or expected short duration of effective treatment). The statement details the roles and responsibilities of physicians in communicating information, facilitating decision-making, seeking a second opinion when the benefits are unclear or when conflict arises, and in transferring care and/or even withholding/withdrawing treatments against patient or substitute decision-maker’s wishes. It is not clear yet if and how this statement is being used in clinical practice.

In Ontario, The College of Physicians and Surgeons’ policy, titled “Decision-Making for the End of Life”, also provides some guidance in dealing with the withholding or withdrawal of treatment, and in resolving conflicts. The policy states that “physicians are not obliged to provide treatments that will almost certainly not be of benefit to the patient” where “recovery or improvement is virtually unprecedented”, or any permanent benefit would not be experienced. What constitutes a benefit, and decision-making processes surrounding such issues (e.g. who decides and how, the likelihood of success, its duration) should be factored into decision-making are not clearly addressed, particularly in cases of intractable conflict failing to clearly answer the ethical dilemmas that arise in daily practice.

For these reasons, the Critical Care Secretariat, Ministry of Health and Long Term Care has initiated the Ethical Issues of Access component of its transformation strategy with a goal of engaging a broad platform of key professional and public stakeholders in developing province wide access and utilisation guidelines for critical care services.

These guidelines will

- 1) Define and respect patients' rights and ability to consent to treatment;
- 2) Define healthcare providers' obligations to facilitate development of reasonable goals and treatment plans regarding the use of life-sustaining treatments;
- 3) Inform patients about the risks and benefits of treatment and provide reasonable alternatives; and
- 4) Ensure fair access of all people in Ontario to reasonable and competent healthcare; all in a manner that will enable the healthcare system to deliver sustainable ICU services over the long-term.

Ontario is the first province to use the ethical model of accountability for reasonableness (Daniels and Sabin 2002) to attempt to facilitate a widespread informed discussion detailing when life-sustaining treatments may be of benefit, when they will not, and what standards and processes must be met in decision-making with patients and families—both before and during ICU admission, and at the time of ICU discharge. Furthermore, it is the first province to attempt to devise an evaluation schemata to assess the impact of its guidelines on quality of care. Ontario is thus the first to initiate a comprehensive practical process to support patients, families and ICU teams as they navigate these challenging dilemmas that arise on the front lines.

Critical care in Canada is starting to address on a systems' level how to improve the quality of patient care at the end of life, and how to improve access and utilisation of an expensive resource whose benefits are not always certain. Without these efforts, ICU services will not be sustainable over the long-term and patients, who would most likely benefit, will not receive them. Hopefully our current Canadian experiences and transformation efforts will serve to help others in the field in achieving our common goal: to provide the best care to critically ill people.

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