When Medical & Legal Advocacy and Best interests collide

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Objectives

• Explore the concept of advocacy in clinical practice and how it may actually create conflicts

• Discuss perspectives of patient and SDM lawyers on intractable conflicts

• Discuss how the insights these provide can help prevent and resolve future conflicts

• Discuss how professional standards and changes to current conflict resolution system can improve trust and result in better patient care
What We know

- Most conflicts in ICU between healthcare team and family members are based on a fundamental disagreement about how to balance a low probability of survival against the harms caused by LST/ CPR
- Patients and SDMs fail to understand limits of ICU care
- Other healthcare providers tend to view CPR and LST as interventions that must always be offered
- Conflicts lead to burnout among the healthcare team, PTSD and complicated bereavement
- Conflicts result increasingly in interpersonal violence
- Conversations are often avoided, information incomplete or misrepresented, establishing Rx goals is seen as stressful
- Tendency to follow “default” pathways that include more aggressive treatment, which ultimately contributes to conflict situations.
What the courts have said

- Vulnerable people need to be legally protected from prematurely ending their own lives or from having their lives inappropriately ended by healthcare teams predisposed to negatively assess QOL.
- Two Supreme Court of Canada (SCC) rulings in Rasouli and Carter emphasized the role of consent in providing legal protections.

  - In Rasouli, the SCC ruled that LST cannot be withdrawn from incapable patients without consent of their SDM
    - Chief Justice McLachlin opined that the “blunt instrument” of the MSoC alone could not provide sufficient protections unless consent is also engaged.
  - In Carter, the SCC ruled that s. 14 (consent to have death inflicted) and s. 241 (assistance with suicide) of CCC violated s 7 of the Charter
    - Consent alone is insufficient protection for MAiD without a MSoC.
    - No consideration of section 15 Charter rights.
• In its new legislation, Canada restricted access to MAiD on the grounds that some people—those who lose capacity, with mental illnesses and mature minors—are so vulnerable that this potential choice at the EOL must be denied.

• In simple terms, for some, consent and the medical standard of care are insufficient protections.

• It defies credulity to claim that, on a prima facie basis, all members of such ‘vulnerable’ groups lack capacity and the ability to provide a legally valid consent.

• It defies humanity to claim that medical interventions, for they are no longer Rx, that are only causing increasing harm, should always be continued unless there is consent to withdraw in order to protect the vulnerable.
Conflict Resolution processes

• When intractable, conflicts have been referred to the legal system, either the Consent and Capacity Board (CCB), a quasi-judicial tribunal, or the courts, to achieve resolution.

• Previous research exploring physicians’ perspectives on this system revealed problems with the process and the risk of changing MSoC in ways that fail to protect it’s most fundamental principle- to help more than hurt

• CPSO’s is charged with protecting the public by defining and upholding the MSoC/medical standards of practice yet its policy on EOL care fails its mandate to protect the public
  – Defines a MSoC but fails to uphold it by requiring resuscitation in cases of conflict
• Advocacy *protects* people
  – made vulnerable from illness,
  – confronted with power imbalances created by differences in access to knowledge and treatment options,
  – facing high stakes Rx decisions and
  – who, in situations of conflict, need access to justice

• *Medical* advocacy engages clear, consistent communication, a discussion of potentially achievable treatment goals and recommendations regarding potential treatment options.

• *Legal* advocacy engages the pursuit of the clients’ interests within the boundaries of the law, balanced with duties to the court, to opposing counsel and the administration of justice
The Problems

- What happens when medical or legal advocacy fails, or is too aggressive in its nature?

- What happens when the duties of a legal advocate to his/her client conflict with the best interests of the patient?

- What are the implications for conflict resolution?
• Qualitative study exploring the perspectives of lawyers who represent SDMs and patients

• Explored issues in medical and legal advocacy at EOL in order to better prevent some conflict situations and improve the quality of resolution.
Purposive sampling with criterion and snowball techniques was used for the recruitment of legal community members for one on one interviews between May and June 2016.

Included current and former chairs of the CCB, and lawyers whose practice involves health law cases heard by the CCB or the Ontario Superior Court.

Semi-structured interviews were conducted to explore respondents’ beliefs, views, and experiences, yielding more extensive and nuanced information about the individual’s professional practice. Interviews were conducted using an interview guide, audio-recorded and transcribed.

NVivo Qualitative Software was used for data management and storage. Transcripts coded inductively and iteratively following interpretive analysis, and recurring themes were identified. Approved by University of Health Network’s REB and all respondents provided informed consent to participate.
## Results

### Characteristics

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Perceived failures in Medical Advocacy

• Failing to appropriately represent the patient’s situation by being clear, firm, and consistent when communicating

...the difficulty so many doctors have of being firm and honest and candid in a way that can be heard by family members in these highly unusual circumstances. So I know a great deal of work has recently and is still being done to teach doctors better communication skills, but there’s a fundamental disconnect between a family who will grasp any straw and a physician who realizes there is no straw.

• ‘Masking’ suffering from families and the ravages of

But another problem is that many people think that medicine is magic, and it is not. And we cannot cure some people. And people, inevitably, will die. And some people just cannot recognize that. And some of the problem is completely internal, but some of it is supported by the healthcare system that does not give people the bitter truth. So as an example of that, if you have a relative in an intensive care – say it’s your grandfather, okay? And say he’s in a coma and he’s never going to recover. You can’t go visit him before 10:00 o’clock in the morning because they want to shave him and bathe him and comb his hair and trim his moustache and change his dressings and, and, and all of those things that need to be done. And then, they pull the covers up to here and you don’t see the bruises on his arm. You don’t see the bedsores.

....And then, someone says, why kill him? Look, he’s resting peacefully.
# Failures in Medical Advocacy

## Failure to help families grasp medical realities of a patient’s sudden critical illness
- The family says something like that. Well, yesterday dad was golfing and today they want to kill him. It’s a little hard to get over that. But then, the family says, “But he was fine yesterday.” “Well, yeah, but he’s not fine today.” “Well, but he was fine yesterday.” “But he’s not fine and he’s not going to recover. It’s time to let him go.” “Well, but can’t he have a few more days?”

## Misunderstanding the role of the MSoC and role of non-offers of Rx
- Because doctors have concluded that they need consent for everything, and if they don’t get it, then they must do what the family says. [...]  
- An available treatment is not in the legislation. The legislation starts from a point of basically treatment will be proposed

## Lack of commitment to patient’s best interests
- And if anything, we see people just caving in to the families, to the substitutes for the patients, if they demand things. And ...that doesn’t make sense to me  
- He has no skin in the game. It’s not his nickel. He’s getting paid regardless of who the patient is, and if he can ignore the moral distress of torturing a patient without doing anything about it, then he can go home and sleep well at night

## Failure to engage the legal system to adjudicate the patient’s best interests
- Doctors frequently leave the application to the CCB longer than they have to. That means they will spend a month trying to reason with the family, instead of realizing on the second day that this family will not be reasoned with.  
- If they don’t want to make the decisions all they have to say is I’m not willing to make this decision an then the decision could go to the Public Guardian and Trustee. Which would eliminate the need for all this, for lack of a better word, bullshit.
Overaggressive Medical Advocacy

- **Over-emphasis on distressing symptoms to influence decision-making**
  - you know, sometimes I need to have a heart-to-heart strong discussion with people to say really, if what you want is actually achieved, the risk is you're going to cause mom the worse agony ever. Imagine her fighting for air. Imagine her drowning in her ... right? And so I think that discussion, too, has to be done in a respectful, non-coercive way so that the discussion continues to be respectful around standards and not dragged into the emotion of how could you let this happen to your mother if you don't agree with me, which is really what is being said

- **Use of non-offers/ MSoC to close down dialogue and failure to disclose viable options**
  - It's difficult to have a conversation about what should be done when the doctor's will just say well, nothing's available because I'm not offering it. I'm not offering it because there's no benefit. I mean, there's a lot going on in the background of their decision to characterise something as that, but it's completely inaccessible to a patient or a non-doctor
  - I don't have a problem with physicians saying that certain things are their decision and not the decision of a substitute decision-maker, as long as the SDM is not being bushwhacked, ambushed, and as long as if there is any significant disagreement, it gets adjudicated instead of the SDM being overrun

- **Failure to acknowledge patient/ SDM knowledge of potential treatments**

- **Aggressive declaration of treatment plan without obtaining consent**
  - So they'll say something like well, we're doing it. Even if there's a mechanism for a dispute resolution. And figuratively, that's saying basically, try and stop me
Issues in Legal Advocacy

• **Client interests and advocacy are different than advocating for patient’s best interests**
  - Your client doesn’t know the law. The lawyer knows the law...And the lawyer’s job is to figure out how to achieve the client’s goal through the law
  - I’m acting according to your instructions. That’s the lawyer’s job. So when my substitute decision-maker client says to me, “Keep grandpa alive,” they’re not saying it’s in dad’s best interest to be kept alive. They’re saying “keep him alive.” They don’t want me to argue with them. They want me to keep grandpa alive.

• **Use of all legal means to represent client’s interests**
  - And I feel even worse about it for the physician if he doesn’t understand the legal nuances. Now, I’m obliged, to some extent, to take advantage,
  - So strategically, even if your case doesn't have a lot of merit, even if you think you're going to lose your appeal there might be strategic in appealing it to the Board of Appeal, because it’s going to take the time.
  - but my obligation in these cases, I think, is to be harsh to the extent necessary to convey the message that this is probably not a successful case. You’re paying for delay. And from the doctor’s perspective, of course, well, now we’ve got grandpa for six more months of torture, as we work our way through the appeal system.
**Issues in Legal Advocacy**

- Obtaining more information for SDM to base decisions upon
- Explaining legal standard of decision-making
- **Role as negotiator**
  - And if I see that there's room for negotiate some issues, like if I see that there is room for negotiation. Sometimes it doesn't work and sometimes it does. You actually find out that the doctor and the family were not that far apart and can reach a decision that they can live with]. And it is much nicer
  
  - So, when you factor all of that into the mix, and a substitute decision maker says look, all I want you to do is try this one last treatment. If it doesn't last, I'll agree with you. Let's give it a try. For how long? Three weeks.....So now we're going to have this whole process before the Consent and Capacity Board because I have all these resources. Keep this person on life support for what amounted to approaching 6 months. There could have been a very simple resolution within a three week period
Legal Advocacy: incapable patients

**Difficulty in obtaining instructions from incapable patients/ issues of personal biases**
- And I believe this is where lawyers get themselves into difficulty in accepting representation for individuals who practically are unable to instruct, but legally are deemed to be able to. Yeah. So, the wrong approach is for the lawyer to say to the consultant, well the law deems this person capable of instructing me, so I'm going to do what's right for this person. Very noble. But completely wrong.
- Because now you're representing yourself, you're representing this person in accordance with your instructions.

**Detective skills: Obtaining more information about patient as person**
- And the only thing that's right that I can see is to, number one, almost become an investigator of sorts. To try to determine, number one, whether this person ever spoke about this type of circumstance to anyone. And of course you can't ask the person, so you have to ask family members, friends.

**Advocating for SDM when representing patient**
- And sometimes, the patient's lawyer either misapprehends himself or herself, or gets lopped into helping the SDM beyond what would be appropriate for a patient's lawyer. representation.
- But sometimes it gets into a situation where the lawyer, knowing that the funds are coming from a certain party to pay their bill, may be more inclined to be sensitive to that party's needs.
System limits on legal advocacy at EOL

• **Litigation costs**
  – So for example, if the substitute decision-maker retains me and says, “Keep my father alive,” then here is my answer. “Okay. I’ve looked at the case. I think you’re going to lose. It will cost you $10,000 in legal fees to lose at the Consent and Capacity Board. It will cost you another 10 to $15,000 to appeal that decision and lose at Superior Court, but that will buy 1 to 3 months. And then, it will cost you a further $30,000 to lose at the Court of Appeal, and that will add another 2 to 6 months. How much do you want to spend on grandpa’s life?”

• **Access to medical experts**
  – You need an expert. You need to hire a doctor who’s a specialist in ECMO machines to come to the hearing and say, “No, there might be a chance.” And those people can’t afford that
  – Access to second opinions would be good. And I mean, legitimate second opinions from independent doctors, not from the guy who probably goes golfing with his buddy on the weekend and has the office next to him.

• **Availability of Skilled legal representation**
  – It’s such a fragile state to be in. The last thing you want is a lawyer coming in and adding to that. I mean, it’s the worst case scenario. And if the lawyer is not aware of the law and how to apply the law, then you have people becoming very confused because they may not know the laws, and in picking the lawyer, the substitute decision maker may not have the funds
  – And this is a lawyer’s perspective, but I think at the end of the day I just feel that – like it’s not like a real estate transaction where you can screw up, when someone can compensate, like can’t – you really have to get it right, you know?
How do we move to a system in which the patients’ best interests are truly paramount in seeking resolution?
Legal Professional standards

• Advocates’ Society: *in their conduct of litigation and in their advice to clients, advocates should have regard for the principle of proportionality*. 
  – Advocates must "raise fearlessly every issue, advance every argument, and ask every question." Yet "the duty of zealous representation must be balanced with duties to the court, to opposing counsel and to the administration of justice"

• In the recent common law case *Abrams v. Abrams*, Justice D. M. Brown stated at para 70
  – Proportionality signals that the old ways of litigating must give way to new ways which better achieve the general principle of securing the "just, most expeditious and least expensive determination of every proceeding on its merits".

• *Ornstein (Litigation Guardian of) v. Starr*, [51] Lord Woolf further noted:
  1. The overall aim of my Inquiry is to **improve access to justice by reducing the inequalities, cost, delay and complexity of civil litigation and to introduce greater certainty as to timescales and costs**. My specific objectives are:
     (a) to provide **appropriate and proportionate means of resolving disputes**;
     (b) to establish "**equality of arms**" between the parties involved in civil cases;
     (c) to assist the parties to resolve their disputes by **agreement at the earliest possible date**; and
     (d) to ensure that the **limited resources available to the courts** can be **deployed** in the most effective manner **for the benefit of everyone involved** in civil litigation. (Emphasis added)
Medical Professional standards of practice/fiduciary duties

- Fiduciary duties: physicians will use their knowledge and skills for the patients’ best interests.

- Best interests: serve and help the patient by trying to achieve the best possible state of health and well-being.

- Best interests may, in some cases, mean making difficult decisions that ongoing Rxs will not offer any medical benefits.

- Fiduciary duties protect and expand the current narrowly codified best interests by ensuring:
  - 1) high stakes EOL decisions are based on as complete a perspective of the medical realities as possible,
  - 2) a sound rationality for decision-making, not unduly influenced by emotions, psychological distress, grief or pain and distressing symptoms,
  - 3) a request is not fleeting in nature,
  - 4) the decision is internally consistent within the context of the patient’s past decisions and who the patient is as a person and
  - 5) any SDM whether formally appointed or designated by statute is meeting their legal responsibilities and making the correct decision.

- This structure of *expanded* best interests may not yet be codified in law, however it is integral to the fiduciary nature of the physician-patient relationship.
Implication for proportionality for conflicts at EOL

- Conflict resolution systems should
- 1) make the patient’s best interests and their interests alone paramount in achieving resolution,
  - Explore that physician fiduciary duties were met
- 2) provide access to independent experts with a duty to the ‘court’ to provide an unbiased opinion on any Rx options that may help more than harm
- 3) be timely and cost effective and
- 4) seek to end conflicts at the earliest possible date.
Conclusions

• Access to justice is a fundamental value worldwide.

• The best advocacy does not mean that the approach must be highly aggressive in substance and demeanour.

• Current adversarial approach-- which promotes the taking of positions by the parties involved---- has not been not helpful and should be changed

• **Core principle of best interests of the patient** should be seen as essential whether conflict resolution processes be court or tribunal based, mediation or arbitration in nature.