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Critical Care in Norway

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Treatment of the critically ill is usually only infrequently debated in public in Norway. However, in the last two years there have been a few ICU cases that have generated a large amount of public interest in Norway. In these cases, the issue usually stems from a conflict between ICU physicians and relatives regarding ending life sustaining treatment. ICU physicians advise ending treatment, but the relatives-often parents, refuse to accept this. In the process, lawyers and media (newspapers and radio/television) become involved, inflaming and complicating these issues.

The most well known incident was the “Kristinacase” named after a 4-year critical ill girl. After a substantial rainfall in 2005, she was a victim of a mudavalanche on her family’s home outside Bergen. Her mother died as a result, but her father, and a brother and sister survived. She was found submerged in mud after approximately one hour, but was initially resuscitated. Unfortunately, she suffered severe hypoxic cerebral damage, and did not regain consciousness. She also was ventilator dependent, but had blood supply to the brain.

After internal discussion and utilising second opinions of external experts, the medical team at Haukeland University Hospital advised ending ICU treatment, but her father resisted. The local health authorities supported the hospital’s decision. Still the disagreement continued, and her case was taken to court in early 2006. It was the first time in Norwegian justice history that a case was before the courts during continuing ICU treatment. The court also supported the hospital’s decision, but the verdict was immediately appealed.

In February 2006, after 5 months of intensive care the hospital turned off the ventilator against the father's will. Following this action, expert groups reinvestigated the treatment given to her in hospital. The final group, an international expert panel, reached their verdict this summer and the hospital received full support of its actions. This case was extensively documented and followed by various media, including being a topic in several television debates. Politicians have also voiced their opinions, most strongly supporting her father, stating that he (and parents in general) should be responsible for making such a decision, not the doctors.

So the debate continues as to who should have the final word when relatives and doctors do not agree about life sustaining treatments. Most agree that communication is a key point, and that in most instances, good communication over time will solve discrepancies and foster agreement, but as we have experienced, this does not always happen.

After the Kristina-case, the medical community in Norway acknowledged several general questions that this case raised:

- What are the precise definitions of coma, chronic vegetative status and related terms and are they agreed by all medical specialties?
- What is the gold standard for objective testing regarding impaired consciousness and coma in adults and children?
- How should we utilise second opinions in a small country like Norway?
- What is the role of lawyers and courts in the decision-making process?
- What are the ethical issues regarding withdrawing or withholding life-sustaining therapy?

The Norwegian Medical Association established a working group to examine these issues in Autumn 2006. The Norwegian Directorate for Health and Social Affairs also decided to create national guidelines regarding withdrawal of life-sustaining therapy earlier this year after it became known that only five Norwegian ICUs had written guidelines on how to proceed regarding ending ICU treatment in the case of futility. Some politicians and one political party wanted to implement a new law, stating that stopping ICU treatment was not possible without consent from relatives. Such a law was voted down in the Norwegian Parliament, but new guidelines are expected.

At present, the discussion is focused on second opinions and whether a clinical ethical committee at another hospital should routinely intervene in cases where there is disagreement between physicians and relatives. However, as was illustrated this summer (2007), when there was a dispute in another case, this can be challenging in practice. Ethical committees are often difficult to summon on short notice, since in Norway they have more often worked with cases in retrospect or "general" medical ethical issues, not with ongoing cases.

These discussions have brought other issues to the forefront, namely intensive care capacity in Norwegian hospitals. Overall, the number of ICU beds is low in Norway with only 1 - 2% of the total hospital beds in university and regional hospitals. In addition, many hospitals lack sufficient

stepdown units, making the pressure on ICU beds very high. This debate will hopefully lead to a national discussion about the dimensions and aims for Norwegian intensive care in general. But presently a national plan or guideline regarding intensive care fails to exist. This is surprising given that one day of intensive care in ICU in Norway costs around 4000 (euros), and is among the most expensive treatments administered.

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