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THE MANITOBA COLLEGE OF PHYSICIANS AND SURGEONS POSITION STATEMENT ON WITHHOLDING AND WITHDRAWAL OF LIFE-SUSTAINING TREATMENT (2008): THREE PROBLEMS AND A SOLUTION

Jocelyn Downie & Karen McEwen***

Introduction

The College of Physicians and Surgeons of Manitoba (CPSM) recently issued a Statement on Withholding and Withdrawal of Life-Sustaining Treatment (2008).¹ The College should be given enormous credit for trying to provide guidance with respect to physicians' obligations in an area of great confusion and controversy. Unfortunately, however, there are some very serious flaws in the Statement. In this paper, we describe three major problems with it that we believe make the case for the claim that the Statement must be revised. We then provide a revised Statement that, if adopted, could represent significant progress as it would provide: greater clarity for physicians and the public; much needed emphasis on the critically important issue of communicating with patients and their families; an ethically and legally defensible position on conflict resolution; and reassurance to many individuals who are feeling very threatened by this policy (that is, many individuals with disabilities).² In addition, the revised Statement could serve as a model

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1 Manitoba College of Physicians & Surgeons, *Withholding and Withdrawal of Life-Sustaining Treatment*, Position Statement 1602, online: <<http://www.cpsm.mb.ca/statements/SH602.pdf>> [CPSM Position Statement].

2 Manitoba League of Persons with Disabilities, "Letter to the College of Physicians and Surgeons of Manitoba", online: Manitoba League of Persons With Disabilities <<http://www.mlpd.mb.ca/publications.html>>.

for other colleges of health professionals to use as the basis for developing their own position statements to help guide their members.

Problems with the CPSM Statement

There are at least three major problems with the CPSM Statement.

First, the Statement says that the “minimum goal of life-sustaining treatment” is “clinically defined as the maintenance of or recovery to a level of cerebral function that enables the patient to: achieve awareness of self; achieve awareness of existence; and experience his/her own environment. For paediatric patients, the potential for neurological development must be factored into the assessment.”³ However, the minimum goals of life-sustaining treatment are not something to be clinically defined. The minimum goal of life-sustaining treatment should be a goal you are trying to achieve based on value judgments. The definition requires a moral and not a medical judgment and, as such, does not rest with physicians but rather with patients, their surrogate decision-makers (if they are incompetent), and society. A reverse scenario would be a group of philosophers getting together and defining hypertension. The philosophers cannot turn this into a moral issue simply by saying “it is morally defined as...” The absurdity of the reverse scenario reveals the illegitimacy of the attempt to “clinically define” the minimum goal of life-sustaining treatment.

Second, the Statement says that physicians can unilaterally withhold or withdraw treatment if they conclude that the minimum goal of life-sustaining treatment is not realistically achievable or that it is realistically achievable but there are likely to be significant negative effects on the patient including, but not limited to, pain and suffering. The significant negative effects are to be determined by physicians, and they are not defined, so they could include various forms and degrees of disability or dependence. The College should not have allocated authority to make unilateral decisions based on the minimum goal of treatment and significant negative effects as assessed by a physician. Although physicians have privileged access to medical information, knowledge, and analytical skills and are well-situated to make medical judgments, assessing someone’s best interests is not a medical matter. I can have awareness of myself, awareness of my environment, awareness of the fact that I exist, a level of pain and suffering, and a level of disability or dependence that someone not used to living with those conditions views as

3 *Supra* note 1 at 15-6.

“significant negative effects” and yet I can be completely happy to live with those conditions. My life could well be worth living to me but, as per the Policy Statement, a physician could unilaterally withhold treatment. This is profoundly disturbing.

Third, the College’s description of the law is not accurate. It is arguably correct to say that, in Manitoba, physicians have the legal authority to unilaterally withhold resuscitation for a patient in a persistent vegetative state. However, it is not correct to say that the law, even in Manitoba, is settled beyond the application of Do Not Resuscitate (DNR) orders for patients in a persistent vegetative state. A review of cases from across Canada is in order here.

The first wave of cases in which Canadian courts were confronted with a unilateral withholding issue began with the 1997 Manitoba case of *Child and Family Services (Manitoba) v. R.L.* (sometimes known as the *Lavallee* case), a case involving an infant in a persistent vegetative state.⁴ The doctor placed a DNR order on the child’s chart based on the assessment that resuscitation was not in the best interests of the child. The parents objected to the DNR order. The physician went to court to obtain an order to support the placement of the DNR order. The order was granted as the judge agreed that attempted resuscitation would not be in the child’s best interests. The case was appealed, and the Court of Appeal agreed with the physician’s assessment but went further than the trial judge, stating that physicians did not need to go to court in order to get such an order. This decision supports the narrow proposition that physicians have the authority to place DNR orders unilaterally on the charts of patients in a persistent vegetative state – “[n]either consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction where, in his or her judgment, the patient is in an irreversible vegetative state.”⁵

The next case, *London Health Sciences Centre v. R.K.*, also in 1997, took place in Ontario.⁶ This case involved an elderly man whose health care team believed should have a DNR order placed on his chart. The patient’s family initially objected but then agreed. The healthcare team went to court seeking

4 *Child and Family Services of Manitoba v. R.L.*, unreported (Q.B.).

5 *Child and Family Services of Manitoba v. R.L.*, [1997] M.J. No. 568, 154 D.L.R. (4th) 409 (C.A.) at para. 17 [*Lavallee*].

6 *London Health Sciences Centre v. R.K.* (Guardian ad litem of), [1997] O.J. 4128, 152 D.L.R. (4th) 724 (Gen. Div.).

immunity for any subsequent proceedings against them. The court refused. The court did not rule on the issue of unilateral decision-making authority.

In 1998, the decision in the Manitoba case, *Sawatzky v. Riverview Health Centre Inc.*, was released.⁷ This case involved an elderly man with advanced Parkinson's and other health conditions. The physicians put a DNR order on the patient's chart without telling his wife. She objected and asked the court for an injunction against the order. The judge issued the injunction and indicated that the issue of unilateral decision-making authority had not been settled by the *Lavallee* case. In a related decision involving a motion for intervenor status made by the Manitoba League of Persons with Disabilities, the judge also indicated that the *Lavallee* decision might even need to be revisited as the *Charter* issues had not been addressed in it.⁸

The second wave of court cases began with *Scardoni v. Hawryluck* in 2004 in Ontario.⁹ The doctor of a woman with advanced cancer wanted to withhold treatment and admission to the ICU, but the patient's daughter objected, stating that the patient would have wanted all medical treatment possible. The case got tangled up in the Ontario health care consent legislation. What matters for this review is that the court again explicitly left open the question of unilateral decision-making authority.

In 2006, in *L.I.C. (Re)*, the Court of Queen's Bench in Alberta was confronted with a case involving a patient who had been a resident of a long term care facility for fifty years and had had the Public Guardian as her guardian for more than 25 years.¹⁰ She had a cardiac arrest and was taken to hospital and the physicians placed a DNR order on her chart. The Public Guardian asked the court whether the Public Guardian had the authority to consent to the withdrawal of treatment. After reviewing the relevant case law, the court explicitly left open the question of unilateral decision-making by physicians: "Many of the foregoing authorities deal with whether doctors have the authority to make life and death decisions for their patients. That is

7 *Sawatzky v. Riverview Health Centre Inc.*, [1998] M.J. No. 506, 167 D.L.R. (4th) 359 (Q.B.).

8 "This case has the potential to revisit that decision [*Lavallee*] to determine whether it breaches any of the Charter rights of the patient and/or his/her family, as the question of Charter rights was not considered in the *Lavallee* decision." (*Sawatzky v. Riverview Health Centre Inc.*, [1998] M.J. No. 574, 9 W.W.R. 73 (Q.B.) at para. 38 [*Sawatzky Intervenor*]).

9 *Scardoni v. Hawryluck*, [2004] O.J. No. 300, 69 O.R. (3d) 700 (S.C.J.).

10 *L.I.C. (Re)*, [2006] A.J. 190, 2006 ABQB 130 (Q.B.).

not the question to be determined on this application.”¹¹ However, the court also stated “The decision to withdraw life sustaining treatment is a medical decision. As a result, it is entirely possible that the consent of the Public Guardian is not necessary”¹² and “[b]ased on case law cited above, it appears that the decision of whether or not to withhold or withdraw life sustaining medical care is inherently a medical decision, within the sole purview of a patient’s treating doctors.”¹³ Finally, adding to the confusion, the court concluded that the Public Guardian does have authority to consent to the withdrawal of treatment.

Yeung v. Capital District Health Authority arose in Nova Scotia in 2007.¹⁴ Mr. Yeung had advanced cancer and his wife wanted him to continue to receive treatment long enough to try traditional Chinese remedies and allow them a chance to work. The hospital insisted on the placement of a DNR order. Mrs. Yeung went to court seeking an injunction against the DNR order but Mr. Yeung died before the court could render a decision on the injunction.

In *Jin (next friend of) v. Calgary Health Region*, a case from Alberta in 2007, an elderly man suffered a traumatic brain injury.¹⁵ His family sought an injunction against a DNR order (and the withholding of other treatment) and the judge issued the injunction. Again, the court said that there remain issues that need to be addressed by a court and that the locus of decision-making authority remains unclear.

I.H.V. (Re) is a 2008 Alberta case in which a woman was dying of cancer.¹⁶ The court in this case found that the physicians could unilaterally withhold or withdraw treatment. They distinguished the case from *Jin* (making reference to such factors as the certainty of the woman’s diagnosis and prognosis) but provided no legal arguments to support the conclusion.

Perhaps the most famous case in this area is *Golubchuk v. Salvation Army Grace General Hospital* from Manitoba in 2008.¹⁷ Physicians in this case wanted to withhold and withdraw potentially life-sustaining treatment

11 *Ibid.* at para. 28.

12 *Ibid.* at para. 34.

13 *Ibid.* at para. 36.

14 *Yeung v. Capital District Health Authority* (Dec. 15, 2006), Halifax HFX273970, (N.S.S.C.(T.D.)).

15 *Jin (next friend of) v. Calgary Health Region*, [2007] A.J. No. 1100, 2007 ABQB 593.

16 *I.H.V. Estate (Re)*, [2008] A.J. No. 545, 2008 ABQB 250.

17 *Golubchuk v. Salvation Army Grace General Hospital*, [2008] M.J. No. 54, 2008 MBQB 49.

and the family objected. The family went to court and the judge issued the injunction, holding that the law on unilateral withholding and withdrawal is unsettled and needs to be addressed by a court through a full trial. Mr. Golubchuk died before the case could get to trial. Justice Schulman stated that the *Lavallee* case did not resolve the issue of who has the right to decide to withdraw treatment, or if the patient has the right to continuation of treatment through common law or the *Charter*: “[c]ontrary to the assertion of the defendants, it is not settled law that, in the event of disagreement between a physician and his patient as to withdrawal of life supports, the physician has the final say.”¹⁸

In 2008, in *Children’s Aid Society of Ottawa-Carleton v. M.C.*, the Ontario Superior Court of Justice was presented with the issue of whether the Children’s Aid Society (CAS), through its authority to consent to treatment, has the authority to consent to the withdrawal or cessation of treatment for a child in its care.¹⁹ The court found that the CAS has the authority but “if the medical practitioners decide to propose or withdraw treatment because they no longer believe that the child has any chance of survival, the CAS does not need to make use of its authority under s.62(3) of the *Child and Family Services Act*. Consent is not needed for the doctors to make use of their professional judgment and discretion to cease treatment or give only palliative care.”²⁰ The conclusion regarding unilateral authority for physicians is also found in Métivier J.’s statement that “Justice Acton in *Re L.I.C.* (*supra*) stated the principle correctly in my view when he says that the decision to withdraw or withhold life-sustaining treatment is inherently a medical one, ‘within the sole purview of a patient’s treating doctors.’”²¹ However, the conclusion is undercut by a direction to the CAS to continue to seek orders from the court:²²

18 *Ibid.* at para. 25.

19 *Children’s Aid Society of Ottawa-Carleton v. M.C.*, [2008] O.J. No. 3795, 301 D.L.R. (4th) 194 (S.C.J.) [M.C.].

20 *Ibid.* at para. 33.

21 *Ibid.* at para. 26.

22 The conclusion is further unsettled by some baffling mistakes made by the judge. For example, she refers to the *Ontario Consent to Treatment Act, 1992* rather than the *Ontario Health Care Consent Act, 1996* (in force at the time of her judgement). She fails to note that the relevant legislation includes a definition of “treatment” but also of “plan of treatment” which directly addresses the issue of how the withholding and withdrawal of treatment should be treated. She also fails to

However, until further clarification of this issue and particularly in cases where the parents of the child disagree or the medical opinions diverge, the CAS should continue to seek an order from the court. As stated by Lord Keith, in *Airedale, supra*, at page 862 'Court endorsement of medical decisions can protect patients and doctors while at the same providing reassurance for both the patients' families and the public. As well, all interested persons would have an opportunity to be heard.'²³

In *Rotaru v. Vancouver General Hospital Intensive Care Unit*, a 2008 case from British Columbia, a woman sought a court order to compel the VGH Intensive Care Unit to resume previously discontinued treatment for her mother. The health care team believed the treatment requested would be counter-productive or of no effect and was also inconsistent with their ethical obligations.²⁴ Burnyeat J. claimed that "this decision does not involve the consideration of whether medical advisors can be prohibited from withdrawing forms of treatment or life-support systems" and sought to distinguish this case from *Golubchuk* (by asserting that there is a difference between withdrawing treatment (as in *Golubchuk*) and resuming treatment that had already been withdrawn (as in *Rotaru*)). While agreeing with the view of the court in the 1992 English case *Re J*²⁵ ("they could not conceive of any circumstances in which it would be other than an abuse of power to require a medical practitioner to act contrary to the fundamental duty which that practitioner owed to his or her patient"²⁶), Burnyeat J. did not base his decision on that conclusion as he ruled that, "even assuming that such an intervention [an order] could be undertaken by the Court, I am satisfied that such an intervention would be inappropriate in this case."²⁷ Again, the ultimate issue of unilateral decision-making by physicians remained unanswered.²⁸

note the contributions to the case law made by decisions between *Lavallee, supra* note 5 and *Golubchuk, supra* note 17, most notably in *Sawatzky, supra* note 7.

23 *Supra* note 19 at para. 34.

24 *Rotaru v. Vancouver General Hospital Intensive Care Unit*, [2008] B.C.J. 456, 2008 BCSC 318 at para. 4.

25 *Re J.*, [1992] 4 All E.R. 614 (C.A.).

26 *Supra* note 24 at para. 16.

27 *Ibid.* at para. 18.

28 It should be noted here that again, as in *M.C., supra* note 19, the court seems strangely unaware of the relevant Canadian cases (other than *Golubchuk, supra* note 17).

The most recent relevant case is that of *Barbulov v. Cirone* from the Ontario Superior Court of Justice in 2009.²⁹ In this case, a series of issues relating to processes under the Ontario *Health Care Consent Act (1996)* were argued in relation to a conflict between the health care team and the son of an incompetent patient in the intensive care unit of St. Joseph's Health Centre. While much is not directly relevant to the issue of unilateral withholding and withdrawal (rather, much of the case dealt with the validity of Mr. Barbulov's power of attorney for health care and the Consent and Capacity Review Board findings re: reasonableness of a substitute decision-maker's decisions), the implication of the decision is that physicians do not have unilateral decision-making authority; while the court found that the son had not acted appropriately as his father's substitute decision-maker, the decision-making authority nonetheless rested either with him or, if he did not give or refuse consent as ordered by the court, the authority rested with the Public Guardian and Trustee.

In the end, contrary to what is indicated in the CPSM Statement, we can conclude that the law on unilateral withholding and withdrawal of potentially life-sustaining treatment is acutely unsettled. Would a Manitoba court presented with a *Charter* argument effectively revisit the *Lavallee* decision? Would a Manitoba court extend *Lavallee* to withdrawal (instead of just withholding) of treatment? Would a Manitoba court extend *Lavallee* to conditions other than persistent vegetative state? Would *Lavallee* or a similar case from any other jurisdiction finding unilateral authority for physicians be upheld by the Supreme Court of Canada? There are no clear answers to these questions.

In sum, then, the CPSM Statement claims moral decisions as medical ones, overstates physician authority, and gives false or misleading guidance on legal obligations.

A revised CPSM Statement

In an effort to be constructive rather than merely critical and in order to advance the protection of patients' and society's interests, what follows is a suggested redrafting of the CPSM Statement.³⁰

29 *Barbulov v. Cirone*, [2009] O.J. No. 1439 (S.C.J.).

30 This redraft is based upon the following: the CPSM Statement (*CPSM Position Statement*, *supra* note 1); a Template Policy on Decision-Making about the Use of Potentially Life-Sustaining Treatment drafted by the authors and previously

In general, we offer the following recommendations to the Manitoba College of Physicians and Surgeons:

- correct the misstatements on the current law;
- keep the emphasis on communication and conflict resolution;
- remove the claims about the authority for unilateral withholding and withdrawal; and
- advise physicians that in the face of an ultimate inability to resolve a conflict with substitute decision-makers and in the absence of an applicable resource allocation policy, they should go to court to seek an order to withhold or withdraw treatment.

More specifically, we would recommend the adoption of the following revised Statement:

BACKGROUND

Purpose

The purpose of this Statement is to assist physicians, their patients and others involved with decisions to withhold or withdraw *potentially* life-sustaining treatment by establishing a process for physicians to follow when withholding or withdrawing *potentially* life-sustaining treatment is being considered. *It describes the law in Manitoba, stipulates the ethical obligations of physicians, emphasizes open communication aimed at achieving consensus, and establishes procedures to be followed including in circumstances where consensus cannot be reached.*

Legal Context

It is well-established in Canadian law that health care providers may treat only when they have a valid consent unless there is an exception to the

posted on the End of Life Project website, online: Dalhousie University <http://as01.ucis.dal.ca/dhli/cmp_welcome/default.cfm> and currently on file with the authors; and a review of the literature. Inasmuch as possible, it retains the CPSM text (to stay true to the objective of revising the CPSM Statement). CPSM text is indicated in regular font and revisions are indicated in italics. While this may make the paper more difficult to read, it is essential to make it clear where passages have been taken directly from the CPSM text.

consent requirement set out in legislation³¹ or if there is an emergency situation. Emergency situations are situations in which treatment is immediately necessary to preserve the life or health of the patient and the patient (or surrogate) is unable (or unavailable) to give consent (and there must not be a valid advance directive indicating that he or she would not want the emergency treatment). Treatment given in emergency situations must be limited to that needed to preserve life or health. Non-emergency treatment must be postponed until consent can be obtained.

It is also well-established law in Canada that patients may decline treatment proposed by health care providers even where the treatment is potentially life-sustaining. Free and informed refusals made by competent individuals must be respected (unless the refusal is explicitly overridden by a court or statute³²).

No one, including the patient's next of kin, has the legal authority to consent to or refuse medical treatment, including life-sustaining treatment, on behalf of an adult patient, unless that person has been granted that authority by the patient in a valid health care proxy or by Court appointment or pursuant to legislation.³³

31 E.g., *Mental Health Act*, C.C.S.M. c. M110, s. 29(2); *Public Health Act*, C.C.S.M. c. P210, s. 38; *Private Hospitals Regulation*, Man. Reg. 58/93, s. 5(2).

32 E.g. under the *Child and Family Services Act*, C.C.S.M. c. C80.

33 "Persons who may be legally authorized to consent to or refuse medical treatment may be:

a. statutorily authorized, including:

i. a health care proxy appointed by the patient in accordance with *The Health Care Directives Act*, C.C.S.M. c. H27 ;

ii. a Committee appointed under *The Mental Health Act*, C.C.S.M c. M110 ;

iii. a substituted decision maker appointed under *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90 ;

iv. the Public Trustee, in limited circumstances.

b. recognized by the common law, including:

i. a parent or other legal guardian of a patient who is a minor;

ii. a person with authority pursuant to a decision or order of a Court with jurisdiction".

That said, physicians often treat patients who lack capacity to make their own health care decisions and who have not completed a health care directive expressing their wishes or appointing a health care proxy. In such circumstances, the common practice is to consult with and/or seek consent to treatment from a member of the patient's family. Though this practice is not specifically sanctioned by legislation or the common law in *Manitoba*, it is consistent with physicians' ethical obligations.

*The law is unclear when patients or their surrogate decision-makers request treatment which is not recommended by the health care providers.*³⁴

*The Manitoba Court of Appeal has stated that physicians have the authority to place a Do Not Resuscitate order on the chart of a patient in a persistent vegetative state without the consent of the patient or the patient's surrogate decision-maker.*³⁵ *Manitoba courts have not stated that physicians have the authority to withhold or withdraw any other potentially life-sustaining treatment without the consent of the patient or the patient's surrogate decision-maker, nor have they stated that physicians have the authority to place a DNR order on the charts of patients who are not in a persistent vegetative state without the consent of the patient or the patient's surrogate decision-maker. Indeed, they have explicitly stated that the law, even as it relates to DNR and patients in a persistent vegetative state as it did in Lavallee, is unsettled.*³⁶

The law does not draw distinctions between decisions about stopping or not starting cardiopulmonary resuscitation, artificial hydration and nutrition or other forms of potentially life-sustaining treatments and any other treatment decisions.

34 *Supra* notes 5, 6, 7, 9, 14, 15.

35 *Supra* note 5.

36 *Sawatzky Intervenor, supra* note 8; *Golubchuk, supra* note 17. "This case has the potential to revisit that decision [Lavallee] to determine whether it breaches any of the *Charter* rights of the patient and/or his/her family, as the question of *Charter* rights was not considered in the Lavallee decision." (*Sawatzky Intervenor* at para. 38) and "Contrary to the assertion of the defendants, it is not settled law that, in the event of disagreement between a physician and his patient as to withdrawal of life supports, the physician has the final say." (*Golubchuk, supra* note 17 at para. 20).

The law does not view decisions about stopping or not starting potentially life-sustaining treatments any differently in the presence or absence of terminal illness or imminent death.

Terminology

The following terms are defined for the purpose of this Statement. The definitions do not necessarily reflect the meaning of the terms used in other contexts.

Best interests – *what appears most likely in the circumstances to be the physical, psychological, spiritual, social, and other important interests of the individual.*

Best interests judgment – *a judgment made by a surrogate decision-maker on behalf of an incapable person based on what is in the incapable person's best interests. This type of judgment shall only be made when a substituted judgment cannot be made.*

Capacity – *the ability to understand information that is relevant to the making of a decision about the withholding or withdrawal of potentially life-sustaining treatment and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.*

Competent – *capable of understanding and appreciating the nature and consequences of the decision to be made and capable of communicating this decision.*

Family – *Persons recognized by the patient as being closely linked to the patient in knowledge, care and affection, including biological family, those linked by marriage or common-law (same or opposite sex) and any other person chosen by the patient as his/her family.*

Health care directive – *a document in which a competent person sets out what, how, or by whom health care decisions are to be made in the event that he or she becomes incapable of making health care decisions. The two types of health care directives are proxy directives and instruction directives.*³⁷

37 Health Care Directives Act, C.C.S.M., c. H27.

Health care team – all personnel who are actively involved in the health care of the patient and to whom the physician may turn for input in accordance with this Statement.

Informed choice – *a choice made following disclosure of: the proposed treatment plan; the expected benefits of the treatment plan; the material risks of the treatment plan; the likely consequences of not following the proposed treatment plan; who will be providing the treatment plan; and any alternatives to the proposed treatment plan.*

Instruction directive – *often called a living will, this type of health care directive allows the maker to specify what treatments or care he or she wishes to receive or not.*

Maker – *a person who makes a health care directive.*

Mature minor – *a competent individual under the age of majority.*

Patient – *the subject of the decisions with respect to potentially life-sustaining treatment.*

Physician – a member of the College who is providing medical care to the patient. Where there is more than one physician involved in the patient's medical care, the physician who is the coordinator of the patient's medical care is responsible for ensuring that the requirements of this Statement are met.

Potentially life-sustaining treatment – *any treatment that may sustain the life of the patient.*

Proxy – the person who is legally authorized to make health care decisions on the patient's behalf in circumstances where the patient lacks capacity to make such decisions, including, but not limited to, a health care proxy appointed in a health care directive.³⁸

Proxy directive – *a document (sometimes referred to as an "enduring" or "durable" power of attorney) in which a competent person names a proxy*

38 This person's authority is limited to that legally granted to him/her by the patient, court, legislation, or *other source of legal authority.*

to make health care decisions for him or her in the event that he or she is no longer capable of making those decisions.

Representative – the person who represents the patient and/or the patient's family in discussions about the patient's health care where the patient lacks capacity to make health care decisions and there is no proxy or it is not possible to communicate with the patient or the proxy for any reason. This person is usually a member of the patient's family. If the patient is in a health care facility, the representative may be determined in accordance with that facility's internal policy. In the absence of an applicable policy, or if the patient is in the community, it will be up to the physician to use his/her best judgment to identify a member of the patient's family who has the *greatest support of the family members* to assume this role.

Substituted judgment – *a judgment made by a surrogate decision-maker for an incompetent person based on the wishes or values expressed by the presently incompetent person while previously competent.*

Surrogate decision-maker – *a person with the legal authority to make decisions on behalf of an incompetent individual (for example, a proxy named pursuant to a health care directive, a guardian appointed by the court, a person listed in a hierarchy of surrogate decision-makers set out in legislation).*³⁹

Treating physician – *the physician bearing primary legal responsibility for the patient's care.*

Treatment – *anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purpose.*⁴⁰

Treatment plan – *a plan that: (a) is developed by one or more health practitioners; (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition; and (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the with-*

39 *Ibid.*

40 Based on the Ontario Health Care Consent Act, S.O. 1996, c. 2, Sch. A, s. 2(1) with treatment plan clause deleted.

*holding or withdrawal of treatment in light of the person's current health condition.*⁴¹

Voluntary decision – *a decision not obtained through fear, coercive force, or undue influence.*

Will not work – *will not lead to the physiological result the treatment is used to achieve (e.g., cardiopulmonary resuscitation in a case of severe cardiac rupture will not restore cardiac function and antibiotics will not cure a viral infection).*

SCOPE

This statement applies to all physicians *under the jurisdiction of the College of Physicians and Surgeons of Manitoba.*

PROCESS REQUIREMENTS

When a physician is confronted with a clinical scenario in which withholding or withdrawing of *potentially* life-sustaining treatment is being considered, *the following steps shall be taken:*

Information gathering

Gather and assess the relevant clinical information. This includes information about the patient's physical condition, diagnosis, prognosis, treatment options (including palliative), and the anticipated consequences (both nature and probability) of each possible treatment plan. The assessment must be based on the best available clinical evidence including, where [...] the physician has any uncertainty about any aspect of the assessment, consultation with another physician.⁴²

Assess the competency of the patient. A competent patient must be capable of understanding what it means to consent to or reject a treatment plan, the nature of his or her condition, the information and opinions given and

41 *Ibid.*

42 "Recognize your limitations and the competence of others and when indicated, recommend that additional opinions and services be sought." (College of Physicians and Surgeons of Manitoba, *Code of Conduct*, Article 6, online: College of Physicians and Surgeons of Manitoba <<http://www.cpsm.mb.ca/bylaws/By%20Law%201%20Schedule%20G%20Code%20of%20Conduct.pdf>>).

the treatment plan being suggested. Competency is presumed unless there is evidence to the contrary or legislation directs otherwise.⁴³ Where competency is difficult to assess or is not agreed upon by those treating or making decisions for the patient, then a psychiatrist shall be consulted to assess the patient's competency.

Identify the person with decision-making authority. If the patient is competent, the person with decision-making authority will be the patient.⁴⁴ If the patient is not competent, identify the surrogate decision-maker. If the patient has a court-appointed guardian, the guardian will be the surrogate decision-maker. If the patient does not have a court-appointed guardian and has a valid proxy directive, the proxy will be the patient's surrogate decision-maker as established by the directive. In other situations, the surrogate decision-maker will be established by provincial legislation or by a court order or, in Manitoba, by established practice.

Assess the voluntariness of the decision. Ensure that there is no fear and there are no coercive forces or undue influences operating on the patient or surrogate decision-maker that are undermining the voluntariness of the treatment decision. If the voluntariness is in doubt, work to remove barriers and/or pressures to create an environment where decision-making will be voluntary.

Determine the person with decision-making authority's opinion of the wishes or best interests of the patient. If the patient is competent, ask the patient his or her wishes. If the patient is not competent, ask the surrogate decision-maker what the patient's previously expressed wishes were. If the patient is not competent and the previously expressed wishes are not known, ask the surrogate decision-maker what he or she believes is in the patient's best interests.

43 For example *Child and Family Services Act*, *supra* note 32.

44 An exception here is for competent children under 16 years of age. Their decision-making authority can be limited by operation of the *Child and Family Services Act* as upheld and discussed by the Supreme Court of Canada in *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181.

Communication

Every effort must be made to communicate with the patient as early as possible, while the patient has the capacity to make *and communicate* his/her own health care decisions.

Where there is a proxy, the physician must share personal health information and *communicate* with the proxy, unless he/she is made aware of limits on the proxy authority (*in which case those limits shall be respected*).

In some cases, patients/proxies/representatives can be assisted by *individuals with other areas of expertise* including, *but not limited to, medical sub-specialties, social work, spiritual care, clinical ethics, and patient advocacy*. *In addition, the assistance of available members of the health care team, should be sought by the physician where bringing such individuals into the case is acceptable to the patient/proxy/representative.*

The physician must comply with reasonable requests of the patient/proxy/representative to include other person(s) in the discussion described below.

The physician must ensure that *material* information is exchanged and strive for understanding and consensus when discussing withholding or withdrawing *potentially* life-sustaining treatment from a patient. The discussion shall, at a minimum, include:

- a description of the underlying condition or ailment and prognosis;
- *the* treatment options (*including non-treatment*) and their expected outcomes, including potential benefits and harms;
- where the physician *believes* that treatment should be withheld or withdrawn, an explanation of the basis for this *belief*;
- assurances that the patient will not be abandoned if treatment is either withheld or withdrawn, including an explanation and offer of palliative care;
- *an exploration of the patient's needs, goals, and expectations of treatment*;
- where welcomed by the patient/proxy/representative/family, *an exploration of the patient's personal, cultural, religious, and other deeply-held beliefs as well as family issues* insofar as they are relevant to the decision;

- where there is a need or a request for additional assistance with psychosocial, cultural, spiritual, and/or informational needs by the patient/proxy/representative and/or family members, an offer to seek support from institutional resources such as *individuals with expertise in social work, spiritual care, or clinical ethics*;
- where appropriate, an exploration of potential guilt or regret associated with end-of-life decision-making.

Health care team conference

A health care team conference allows the members of the team to discuss among themselves the information gathered and express their opinions on proposed treatment plans. In many cases, a consensus treatment plan may be developed but when a consensus cannot be achieved, an ethics consultation or other conflict resolution process shall be engaged. Ultimately, however, the treating physician will be responsible for the treatment plan presented to the patient or surrogate decision-maker at the patient care management conference.

Patient care management conference(s)

The treating physician has the responsibility of ensuring that patients or surrogate decision-makers understand the kinds and levels of treatment which the patient might receive. The patient or surrogate decision-maker has the responsibility for making a decision about the patient's treatment plan. In most cases, this decision will be arrived at easily in the following manner:

If the patient has decision-making authority, the treating physician and nurse(s) shall meet with the patient (and anyone else the patient names to be present) to review all material information about the patient's condition and treatment plan options. Where the patient requests the presence of those who are not readily available, the patient shall be informed of any likely consequences that may arise due to the delay caused by waiting for the named individual(s) to arrive.

If the patient does not have decision-making authority, the treating physician and nurse(s) shall nonetheless involve the patient in the discussions insofar as the patient is capable of involvement. The treating physician and nurse shall also meet with the surrogate decision-maker and anyone else that the surrogate agrees to be present to review all material information regarding the patient's condition and treatment plan options.

Where there is disagreement between those participating in the patient care management conference(s), more information may be needed about a diagnosis, prognosis, or the impact of the illness. The possibility of missing information shall be explored and, insofar as is possible, the information shall be provided.

In other cases, the disagreement may be the result of differing views on such things as:

- *the patient's actual status or prognosis;*
- *the impact of the illness and/or the proposed kinds and levels of treatment on the quality of the patient's life;*
- *religious beliefs, cultural mores, or other strongly held values and beliefs;*
or
- *professional responsibilities and obligations.*

Further respectful (and sometimes externally facilitated) discussion and sharing of information and opinions will, in most cases, lead to a resolution of the disagreement.

Where there remains disagreement between the health care team and the patient or surrogate decision-maker regarding the decision, the conflict resolution section of this policy must be engaged.

Where there is disagreement among the family members about the decision made, the health care team may want to recommend or offer support services to them while acting in accordance with the treatment plan decision made by the legally-authorized decision-maker.

Conflict Resolution

Refusal by the patient or surrogate decision-maker of treatment that the treating physician believes should be provided

Where a competent patient makes a voluntary and informed refusal of treatment, the physician must not treat the patient.

Where a competent surrogate decision-maker makes a voluntary and informed refusal of treatment, the physician must not treat the patient unless the physician believes that the surrogate decision-maker is acting outside his or her authority (for example, is making a substituted judgment that is not in accordance with the patient's previously expressed wishes or is making a best interests judgment that is not in the patient's best interests) and the physician has sought and been given authorization from a court to treat the patient.

Insistence on treatment by the patient or surrogate decision-maker that the treating physician believes should not be provided

The rules

When a competent patient or surrogate decision-maker makes a voluntary and informed request for treatment that the treating physician believes should not be provided, the physician must provide that treatment unless:

- *the exception spelled out below is made out; or*
- *provision of the treatment would contravene a written, explicit, and publicly available institutional resource allocation policy which includes a justification for any mandatory or permissive withholding or withdrawing of treatment against the wishes of the patient or surrogate decision-maker⁴⁵; or*
- *the physician believes that the surrogate decision-maker is acting outside his or her authority (that is, is making a substituted judgment that is not in accordance with the patient's previously expressed wishes or is making a best interests judgment that is not in the patient's best interests) and the physician has sought and been given authorization from a court to withhold or withdraw treatment from the patient.*

The physician may offer to transfer the patient to another physician or institution willing to take on the care of the patient. The reason for such a transfer and the specific arrangements for such must be clearly documented in the patient's health record. However, if no other physician or institution will accept the patient, and the patient or surrogate decision-maker continues to request the treatment, in the absence of an institutional resource allocation policy or court order, the treatment must be provided.

45 It is essential to allow for such a policy – it must be permissible because institutions must allocate scarce resources and must be able to do so without seeking court approval every time (for example, establishing clinical conditions for admission to the ICU). It is also essential to require that the conditions mentioned in this bullet be met. Such a policy must be “written, explicit, and publicly available” and must include “a justification for any mandatory or permissive withholding or withdrawing of treatment against the wishes of the patient or surrogate decision-maker” so that the public can know about any such policies and so that institutions can be held accountable for such policies under the *Charter* and human rights legislation if they are discriminatory.

The exceptions

In some very limited circumstances, a particular treatment will not work and there will not be sufficient time to follow the conflict resolution process set out above. The most common example would be in a situation involving an unexpected actual or imminent cardiac arrest for which cardiopulmonary resuscitation (CPR) or advance cardiac life support (ACLS) will not achieve return of circulation. Actual or imminent cardiac arrest often occurs unexpectedly and without sufficient time to communicate and/or achieve consensus before either initiating or withholding resuscitative efforts.

In cases involving unexpected actual or imminent cardiac arrest, a physician is not required to initiate or continue CPR and/or ACLS if, based on his/her clinical assessment, the physician determines that CPR/ACLS will not achieve return of circulation. In such cases, the physician must: inform the patient/proxy/representative of his or her determination as soon as possible; and document in the patient's health record the evidence for his or her conclusion that CPR and/or ACLS would not have achieved return of circulation.

If the physician is uncertain about his/her clinical assessment, he/she must consult with another physician, where possible. If the second physician concludes that CPR/ACLS will not achieve return of circulation, then the physician is not required to initiate or continue CPR and/or ACLS. If the physician is uncertain about his/her clinical assessment and is not able to consult with another physician or if the second physician does not conclude that CPR/ACLS will not achieve the return of circulation, then the physician is required to initiate or continue CPR and/or ACLS and follow the process set out in the preceding sections of this Policy Statement.

Other unexpected clinical situations involving treatment that will not work without sufficient time available to follow the conflict resolution process set out above may arise. The key criteria for falling within the exceptions are: insufficient time; and only treatment options that will not work (as opposed to being viewed by the health care providers as "not worth it" or "not in the best interests of the patient" or "not standard practice"). For all exceptions, the waiver of the consent requirement would apply and the process with respect to informing and documenting outlined in this statement shall be followed.

Documentation

Accurate and complete documentation of the pertinent details of the physician's assessment and his/her interactions with the patient

and others involved in decisions whether to withhold or withdraw *potentially* life-sustaining treatment is essential.

At a minimum, the physician must clearly record in the patient's health record:

- sufficient details about the assessment of treatment plan options to identify the basis *for the decision*;
- pertinent details regarding consultations with others and second opinions;
- if it is determined that the patient *is incompetent*, the basis for that determination and the identity of the proxy or representative designated in accordance with this Statement;
- particulars of the communications required by this Statement, including:
 - ❑ identity of the participants in the discussion;
 - ❑ where there is a proxy or representative, any limits on that person's authority to make decisions on the patient's behalf;
 - ❑ *material* information communicated by the physician;
 - ❑ concerns raised by others and the information provided by the physician in response;
 - ❑ whether or not consensus was reached;
 - ❑ where consensus was not reached, the nature of the efforts made to reach consensus; *and*
 - ❑ the implementation plan.

Review of decisions

In the face of a significant change in the patient's clinical status, prognosis, or treatment options or the acquisition of any new information that might affect the decision that was made, the patient/proxy/representative or the physician can request a review of the decision. The process laid out above shall be reengaged. The treating physician is responsible for ensuring that all members of the health care team are informed about any changes in the treatment plan subsequent to a review.

LEGAL INTERVENTION

If at any time a physician becomes aware of anything such as a legal proceeding and/or a Court Order that may impact the legal rights of a patient, proxy or representative *with respect to the patient's medical*

treatment, that physician must take steps to ensure that he/she is aware of any obligations on him/her arising from the proceedings or Court Order and should consider seeking legal advice.

A statement is a formal position of the College with which members shall comply.

Conclusion

Across Canada, there is enormous uncertainty, confusion, and controversy about the legal status of unilateral withholding and withdrawal of treatment. This represents a serious failing in our health system and it must be taken up immediately by those with the power to fix this failing. This state of affairs must not be allowed to continue. We must seek de-escalation and de-polarization, respectful engagement, and constructive dialogue leading to reformed policy and practice and an open and transparent system based on mutual respect, care, and trust. A useful first step would be for regulators of health professionals to develop position statements to guide their members when confronted with cases in which the withholding or withdrawal of potentially life-sustaining treatment is contemplated. The revised version of the Manitoba College Statement presented here would be a good place to start.

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