The Withholding or Withdrawal of Life-Sustaining Treatment

From a Legal Perspective

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DISCLAIMER: This presentation is a summary of some of the legal and ethical issues relating to the Withholding or Withdrawing of Life-Sustaining Treatment and euthanasia. It is not an exhaustive discussion of all issues or legal applications or results that may arise in respect thereto, and is not to be construed as legal advice. Specific legal advice from a qualified, practising lawyer ought to be sought by any individual or entity having questions or concerns in respect of such matters and/or facing a particular end of life decision-making situation.
Ethical Dilemma for Physicians

Physicians take the Hippocratic oath as a promise to help their patients and preserve human life.

In its modernized form, the oath includes the promise:

“To practice and prescribe to the best of my ability for the good of my patients, and to try to avoid harming them.”

It also requires a physician

“To keep the good of the patient as the highest priority.”
End-of-life decisions involve the choice between taking all steps to preserve life and withdrawing or withholding life-sustaining treatment altogether.

Conflict among actual or perceived duties of care – duty of care to patient versus duty of care to patient’s loved ones versus duty of care to society.

Balancing patient’s dignity and autonomy with physician’s professional autonomy and integrity.
Dilemma: How does the physician reconcile the necessity of making end-of-life decisions with the oath to not harm the patient?

Dilemma: Consider the oath to keep the good of the patient as the highest priority. If treatment is futile or medically inappropriate, and we assume a natural human desire to die with dignity, is “the good of the patient” not met by conceding to the reality and choosing to end life?
Patient’s Right of Self-Determination

- The *Canadian Charter of Rights and Freedoms* (the “Charter”) gives all Canadians basic legal rights, some of which the Courts have determined include protection in respect of medical treatment – ss. 7 and 15(1)
Patient’s Right of Self-Determination, cont.

Right to Life, Liberty & Security of the Person

- **Section 7.** Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

- The Courts have held that this right encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted.
Equality before and under the Law

- **Section 15.** (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
There was debate in the past as to whether the *Charter* applies to health care providers when they are administering treatment to a patient.

The Supreme Court of Canada ("S.C.C.") answered this question in the affirmative when it held, in *Eldridge v. British Columbia (Attorney General)*, that the *Charter* does apply to hospitals when they are engaged in the administration and delivery of health services, and that they must exercise their discretion afforded under provincial health care legislation in a manner consistent with s. 15(1) of the *Charter*.
Patient’s Consent

- Health care providers must seek, and a patient has the legal right to give consent to medical treatment
- Right to consent includes the right to accept treatment and the right to refuse it
- Giving treatment without consent is an assault under the *Criminal Code*
Patient’s Consent, cont.

- Proper consent requires four elements:
  - **Voluntariness**
  - **Capacity**
  - Must be **specific** as to both the treatment and the person providing it
  - Must be **informed** consent – i.e. patient must understand the nature of the procedure and any alternative treatments available, and must comprehend the risks and benefits associated with the treatment
Patient’s Consent, cont.

- Elements of consent that cause legal disputes:
  1. Issues of capacity
  2. Lack of consent to withhold or withdraw treatment – Who has the final say? Patient or physician? Court?
“Capacity” requires both legal capacity and mental capacity to make decisions.

A patient who is mentally competent and over the age of majority may give consent to medical treatment.

Each relevant statute has its own “test” for mental and legal capacity, and often lowers the requisite age.

Difficulty arises when a patient is unable to give consent due to lack of legal or mental capacity or inability to communicate. A physician must then look to another individual with legal authority to give consent on behalf of the patient.
In Manitoba, the only person who has the legal right to give consent to medical treatment on behalf of another person is:

- Individual appointed by the patient as proxy under a health care directive ("living will"), pursuant to *The Health Care Directives Act*

- Individual appointed by the court as committee of property and personal care under *The Mental Health Act*
Patient’s Consent, Issues of Capacity, cont.

- Individual appointed by the Vulnerable Persons’ Commissioner as substitute decision maker under *The Vulnerable Persons Living With a Disability Act*

- “nearest relative” of patients in facility, as defined in *The Mental Health Act*

- The Public Trustee, in certain circumstances; or

- Parent or legal guardian of a minor
Legislative Framework

The Health Care Directives Act

- Enacted in 1992 and proclaimed in force on July 26, 1993, it has never been amended since.

- The test for capacity to make health care decisions under The Health Care Directives Act (“HCD Act”) (s. 2) is whether the person “is able to understand the information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.”
Anyone age 16 or over is deemed to have capacity to make health care decisions; conversely, assumed that those <16 yrs of age do not have capacity.

- Any person with capacity to make health care decisions has capacity to make a health care directive.
- By making a health care directive under this Act, a person may:
  - appoint a proxy
  - express health care decisions or wishes;
  - or both
Legislative Framework,
The Health Care Directives Act, cont.

- **Specific execution requirements under the HCD Act in order for the HCD to be valid:**
  - must be in writing and dated;
  - must be signed by the maker or some other person at the direction and in the presence of the maker, in which case
    - (i) the person signing shall not be a proxy appointed in the directive or a proxy's spouse,
    - (ii) the maker shall acknowledge the signature in the presence of a witness, who shall not be a proxy appointed in the directive or a proxy's spouse, and
    - (iii) the witness shall sign the directive as witness in the maker's presence.
"proxy" means a person appointed in a directive to make health care decisions on behalf of the maker of the directive.

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment.

"health care decision" means a consent, refusal to consent or withdrawal of consent to treatment.
A health care decision expressed in a directive by the "maker" of a HCD is as effective as if made by the patient when he/she had capacity.

HCD becomes effective once patient becomes incapacitated and lasts for the duration of the incapacity. Thus, it may be effective intermittently where patient has capacity at certain times and/or in respect of certain treatments but not others [s. 6(1)].

Note that HCD Act does not allow "nearest relative" to make decisions.
A Proxy:
- must be mentally competent and at least 18 years old
- becomes entitled to receive health care information
- is statutorily prohibited from delegating his/her authority to make health care decisions on behalf of the maker of the HCD
Legislative Framework, The Health Care Directives Act, cont.

- **Effect of decision made by a proxy**
  
  7(2) A health care decision made by a proxy on behalf of a maker in accordance with a directive and this Act is as effective as if made by the maker when the maker had capacity to make the decision.

- HCD Act sets out the principles that a proxy is legally bound to observe and specifies limitations on the consent that a proxy may give on behalf of a patient
Principles

13 A proxy shall act in accordance with the following principles:

1. If a directive appointing the proxy expresses the maker's health care decisions, those decisions must be complied with, subject to principle 3.

2. If the maker's decisions are not expressed in a directive, the proxy shall act in accordance with any wishes that he or she knows the maker expressed when the maker had capacity, and believes the maker would still act on if capable.

3. If the proxy knows of wishes applicable to the circumstances that the maker expressed when the maker had capacity, and believes the maker would still act on them if capable, and if the wishes are more recent than the decisions expressed in a directive, the wishes must be followed.

4. If the proxy has no knowledge of the maker's wishes, the proxy shall act in what the proxy believes to be the maker's best interests.
Limitation on proxy's consent

14 Unless a directive expressly provides otherwise, a proxy cannot consent to
(a) medical treatment for the primary purpose of research;
(b) sterilization that is not medically necessary for the protection of the maker's health; or
(c) the removal of tissue from the maker's body, while living,
   (i) for transplantation to another person, or
   (ii) for the purpose of medical education or medical research
Legislative Framework, The Health Care Directives Act, cont.

- *HCD Act* is subject to *The Mental Health Act* and where there is conflict between them, the latter prevails.

- Notwithstanding that provision, both *The Mental Health Act* and *The Vulnerable Persons Living With a Disability Act* defer to advance health care directive, if any, signed by the patient.

- No legal presumption arises from the fact that a person has not made or has revoked a directive (s. 26 of HCD Act).
The Vulnerable Persons Living With a Mental Disability Act

- Came into force October 4, 1996
- "Vulnerable person" is defined as "an adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care or management of his or her property."
- Based on definition of "mental disability", this Act applies where the disability existed prior to age 18 and where patient not admitted to psychiatric facility (then The Mental Health Act applies)
Remains subject to HCD Act, which prevails

“Supported decision making” is fundamental

6(2) Supported decision making by a vulnerable person with members of his or her support network should be respected and recognized as an important means of enhancing the self-determination, independence and dignity of a vulnerable person.
"support network" means one or more persons who provide advice, support or assistance to a vulnerable person and may include:

(a) the vulnerable person's spouse or common-law partner,
(b) other members of the vulnerable person's family, and
(c) others chosen by the vulnerable person
Where vulnerable person is “incapable of personal care”, an application may be made to be appointed as substitute decision maker, whether for personal care or property, or both.

Test for “capacity” under this legislation (s. 46) is that the patient "is not able to understand information that is relevant to making a decision concerning his or her own health care, or his or her own physical, emotional, psychological, residential, educational, vocational or social needs, or similar needs, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.”
Section 53(1) allows for a substitute decision maker to be appointed for personal care for a person if the person for whom the application is made:

(i) is a vulnerable person,

(ii) is incapable of personal care by himself or herself or with the involvement of a support network, and

(iii) needs decisions to be made on his or her behalf with respect to personal care;

and the appointment of a substitute decision maker for personal care is reasonable in the circumstances.
substitute decision maker for personal care must:
- be an adult who consents to act
- appear capable, suitable and able to act
- not be in a position where his/her interests conflict with the vulnerable person's interests

If no such person, then the Public Trustee may be appointed.
Legislative Framework, The Vulnerable Persons
Living with a Mental Disability Act, cont.

- No application may be made for a person for whom a committee of both property and personal care has been appointed under *The Mental Health Act*

- Application may be made once person is 17, but no effect until they reach 18 yrs of age
Legislative Framework, The Vulnerable Persons
Living with a Mental Disability Act, cont.

- Act sets out what powers may be granted to the substitute decision maker, including the power “to give, refuse or withdraw consent to health care on the vulnerable person's behalf”
- Specific limitations on powers including same as HCD Act
- Commissioner cannot grant power to give, refuse or withdraw consent to health care if the vulnerable person, when capable, made a health care directive that appoints a proxy or expresses a decision of the vulnerable person respecting the proposed health care
The Mental Health Act

- Presumption of competence at age 16
- Part 9 of the Act allows for application to court to be appointed as committee of a person’s property only, or both property and personal care (not personal care alone)
- Applies where disability arose after age 18; Committee cannot be appointed for a “vulnerable person”
- For the purposes of Part 9, the test (in s. 3) for incapacity in respect of personal care is that the person is: “repeatedly or continuously unable, because of mental incapacity, (a) to care for himself or herself; and (b) to make reasonable decisions about matters relating to his or her person or appreciate the reasonably foreseeable consequences of a decision or lack of decision.”
To make an order of committeeship in respect of personal care, Court must be satisfied that the patient:

- because of mental incapacity, is incapable of managing his or her property;
- needs decisions to be made on his or her behalf about that property
- is incapable of personal care; and
- needs decisions to be made on his or her behalf concerning personal care.
Section 28(1) deals with patients admitted to a “facility” and provides that, where a patient is not mentally competent to make treatment decisions, treatment decisions may be made on the patient's behalf by (a) the patient's proxy, (b) if there is no proxy, the patient's committee under subsection 75(2), (c) if there is no proxy or committee, the patient's nearest relative; or (d) if the patient is a minor, the patient's guardian.
Powers of committee of personal care include: ...subject to section 91, the power to consent or refuse to consent to medical or psychiatric treatment or health care on the incapable person's behalf, if a physician informs the committee that the person is not mentally competent to make treatment decisions.

s. 91 precludes committee from giving or refusing consent if the patient, when capable, made a health care directive that appoints a proxy to exercise that power or expresses a decision of the patient about the proposed treatment or health care.

Similar restrictions on powers as under HCD Act.
Does a Patient have a Legal Right to Demand Treatment?

- Two scenarios that will give rise to this question:
  - A patient who wishes to demand that a physician administer treatment that will cause his/her death (Euthanasia)
  - A patient (or their family) who demands that a physician continue to administer treatment prolonging his/her life when the physician believes such treatment is medically inappropriate

- In the first scenario, the law states that a patient does not have the right to demand to be euthanized.
- The law with respect to the second scenario is less clear.
Under the Criminal Code of Canada, s. 241(b), euthanasia or assisted suicide is illegal and considered culpable homicide.

Recommendations that exceptions be made and specified in the Code in respect of health care providers have been rejected.

Government’s objective in this section is to protect the vulnerable, and is grounded in the interest of protecting life and not deprecating human life by allowing life to be taken.
Does a Patient have a Legal Right to Demand Treatment?, Euthanasia, cont.

In the case of *Rodriguez v. British Columbia (Attorney General)* (1993), an application was made to the S.C.C. by a terminally ill patient who was demanding physician-assisted suicide and sought a declaration that s. 241(b) of the *Criminal Code* is unconstitutional on the grounds that it violated her rights under ss. 7, 12 (cruel and unusual punishment) and 15(1) of the *Charter*.
Appeal was dismissed, and, by majority decision, the S.C.C. held that s. 241(b) is constitutional. It held that, even though “security of the person” under s. 7 encompasses notions of personal autonomy, and that s. 241(b) deprives her of such autonomy, “…any resulting deprivation…is not contrary to the principles of fundamental justice.” Thus, it does not infringe s. 7.

The Court noted that “distinctions between passive and active forms of intervention in the dying process continue to be drawn”, and cited concerns about “abuse and the great difficulty in creating appropriate safeguards”. 
Does a Patient have a Legal Right to Demand Treatment?, Euthanasia, cont.

- S.C.C. also held that s. 241(b) does not infringe s. 12 of the Charter, basically finding it inapplicable on the facts.

- The Court chose not to make a decision on whether s. 15(1) was infringed, choosing instead to assume that the prohibition on assisted suicide does infringe s. 15(1) of the Charter but that such infringement is clearly justified under s. 1 of the Charter ("demonstrably justified in a free and democratic society").
The S.C.C. stated in the *Rodriguez* decision that “The difficulty with recognizing a right to treatment is that it creates a positive obligation on the health care provider. It requires the health care provider to do something that may go against his or her professional judgment”. 
Does a Patient have a Legal Right to Demand Treatment?, cont.

Where No Consensus on Withholding or Withdrawing Life-Sustaining Treatment

- The law is not entirely settled in respect of the right of a patient or patient’s family to demand continuing treatment to prolong life.
- There is no Manitoba legislation regulating the right to withhold or withdraw treatment.
- No Canadian court has yet recognized a positive right to life, but the case law to date is not necessarily determinative of the issue.
While preserving human life at all costs is a seemingly desirable goal, physicians and often society ask, “What if treatment offers no therapeutic benefit? Or may threaten additional harm? What about financial and human resource constraints? What about a duty to other patients whose prognosis more clearly warrants continuing treatment?”
Does a Patient have a Legal Right to Demand Treatment?, No Consensus, cont.

- May include foreseeable circumstances and/or unforeseen medical emergencies
- In the past, discussions and policies cited the determining factor as futility
- Physician had no legal duty to provide treatment that he/she determined was futile
Both the S.C.C., in the *Rodriguez* decision (above), and the Manitoba Court of Appeal have held that a physician has the final decision as to whether to withdraw or withhold treatment, regardless of patient consent – *Re Child and Family Services of Central Manitoba v. Lavallee et al.* (1997) 154 D.L.R. (4th) 409 (Man. C.A.)
Does a Patient have a Legal Right to Demand Treatment?, No Consensus, cont.

- *Lavallee* decision involved an infant child in a persistent vegetative state after a severe beating, possibly by his parents. Our Court of Appeal held that neither parental consent nor court approval in lieu of consent is required to issue a “DNR” order where an infant patient is in an irreversible vegetative state. “Whether or not a DNR direction should be issued is a judgment call for the doctor to make...” As such, the C.A. set aside the order allowing the doctor to enter DNR on the chart, stating that court approval was not necessary and thus the order ought not to have been made.

- Though bound by this C.A. decision, some Justices of the Court of Queen’s Bench have commented that *Lavallee* can be distinguished on its facts and because it failed to consider *Charter* or human rights legislation.
Does a Patient have a Legal Right to Demand Treatment?, No Consensus, cont.

- Physician’s right to decide to withhold or withdraw treatment is subject to significant legal duties and ethical obligations.
- Legal duties of a physician in making end-of-life decisions include following the doctrine of informed consent (above), confidentiality requirements, duty to exercise reasonable care and duty not to expose patient to unreasonable risk of harm.
- Specific ethical obligations are set out in the Code of Conduct by which physicians are bound.
In 2002, the Manitoba Law Reform Commission ("LRC") undertook a project to review and make recommendations in respect of the law pertaining to the withholding or withdrawal of life-sustaining medical treatment. It was also asked to review and comment on a Policy proposed by the College of Physicians & Surgeons of Manitoba ("CPSM") on this issue.

LRC discovered inconsistency in policies regarding end-of-life decisions in Manitoba and inconsistency in how those policies were being applied by various health care institutions; in fact, some had no policies at all. LRC recommended that in making decisions to withhold or withdraw life-sustaining medical treatment, whether in the form of DNR orders or otherwise, there needs to be a uniform approach and process, which must be uniformly applied by all physicians to all patients, and in particular elderly and disabled patients.
Law Reform and CPSM, cont.

- LRC decided that emphasis should be on the process of making those decisions rather than specific rules to dictate a decision.
- LRC also recommended that the profession and the policies not refer to the notion of “futility” because of the pejorative connotation of that word and the fact that it necessarily requires a subjective assessment of the quality of one’s life.
- Proposed Policy referred instead to a physician determining that the treatment would be “medically inappropriate or professionally unethical”.

Among its 5 recommendations, No. 1 was that the suggestions made in its report be included in the proposed CPSM Policy and that the Policy be formulated into a by-law or Statement of the CPSM.

A formal Statement of the CPSM forms part of the mandatory clinical and ethical standards of practice physicians must meet. Guidelines, on the other hand, provide information about recommended practices.
In 2008, LRC’s Recommendation 1 was followed when CPSM issued a formal Statement on January 30, 2008, under its “ethics” statements.

Statement 1602 - Withdrawing and Withholding Life-Sustaining Treatment - became effective February 1, 2008 (see www.cpsm.mb.ca/statements/1602.pdf)

Statement 1602 is binding on all Manitoba physicians.
Part of the goal of Statement 1602 was to create “greater transparency, clarity and consistency in cases where the withholding or withdrawing of life-sustaining treatment is being considered.”

Strives to create a uniform process for decision-making, with an emphasis on communication with the patient and family, and offering further input by way of a second medical opinion and means of alternative dispute resolution.

Sets out “guiding principles” to be considered in situations involving end of life decisions.
Again, the health care directive is paramount inasmuch as this Statement is to apply when a patient lacks capacity to give consent and has not executed a health care directive.

Specifically states that it does not create any legal rights for patients or any legal duty for physicians. It also cannot create ethical or legal obligations on other health care providers or institutions.
Requires physicians to follow an established process vis-à-vis the patient and his/her family when making end-of-life decisions – including General Requirements (where consensus is obtained) and Specific Requirements (where consensus is not possible).

Physicians must use their best clinical and ethical judgment to tailor their approach to the particular concerns and circumstances of each patient and to recognize that decisions concerning life-sustaining treatment may need to be revisited as circumstances change.
General Requirements are all that must be complied with where there is consensus with the patient/family. The four main components of the General Requirements are:
- Clinical assessment
- Communication
- Implementation
- Documentation

Where consensus has not been reached, Specific Requirements must be followed to supplement or modify the General Requirements. The Specific Requirements are divided into 5 sets of requirements that the physician must follow, differing depending on whether the “minimum goal is realistically achievable” and whether emergency treatment is required.
Samuel Golubchuk, the patient, is an elderly man of the Jewish faith

Admitted to ICU at Grace Hospital in Winnipeg with aspiration pneumonia in or about October 2007, he has been connected to a ventilator with a tube surgically inserted into his throat; family and physicians disagree as to whether the tube “assists” him in breathing or “enables” him to breathe; Feeding is done through a tube inserted into his stomach; minimal (almost vegetative) brain function is present

Pleadings indicate that, after being admitted, the patient’s condition continued to deteriorate and the doctors concluded that he was dying, that his life was only sustainable through artificial means, that there would be no benefit to him in continuing treatment and that, in fact, continued aggressive therapy may pose a hazard to him.
Golubchuk, Samuel v. Salvation Army Grace General Hospital et al.

- The patient’s daughter and son disagreed with the care team’s assessment and insisted on continued aggressive therapy. The doctors felt that the family’s requests were not consistent with appropriate standards of care as set out by the WRHA Medical Advisory Committee.

- In disagreement with the doctors’ recommendations, the patient’s family sought a second medical opinion.

- At end of November 2007, the patient’s daughter and son (son appointed as committee on behalf of his father in 2003) were informed of the attending physicians’ intention to remove their father from life support.
An ex parte motion was brought by the son and daughter seeking an injunction preventing the doctors from removing life support, ventilation, tube feeding and medication. A temporary injunction was granted by Mr. Justice Schulman on November 30, 2007, pending a motion to be heard in December 2007.

The hospital and doctors each filed a Statement of Defence in March and April 2008.

In their defence, the hospital and the physicians stated, inter alia, that they owe no duty of care to the patient’s family, that the patient has sustained no damages as a result of their conduct, that they have followed appropriate standards of care in the circumstances and that the plaintiff’s claim is anticipatory only.
Schulman J. reserved decision in December 2007, ultimately providing his decision and reasons for judgment on February 13, 2008 (Order entered April 30, 2008).

The motions court judge held that the injunction would continue until trial. Citing similar comments made by Madam Justice Beard in the case of Sawatsky v. Riverview Health Centre Inc. (1998), 167 D.L.R. (4th) 359 (Man. Q.B.), Justice Schulman stated that it is not settled law that a doctor has the final say on whether to terminate life support without patient/family consent, and that prior case law to the contrary (Lavalee) could be distinguished on its facts and because it had not considered Charter or human rights legislation.
Golubchuk, Samuel v. Salvation Army Grace General Hospital et al.

- These issues have presumably been left to the trial judge to determine on a final basis.

- Query how the Court will distinguish Rodriguez, which did specifically consider Charter arguments. Query also whether the parties’ positions will change or the Court’s decision will be influenced by the recent issuance of Statement 1602.
In the End, Have We Made Any Progress?

- Statement 1602 has been received as a welcome change by some, but met with strong disapproval by others and highly criticized by many professionals as giving doctors too much power to make inherently subjective “quality of life” decisions.

- Consider as well, for yourself, the argument by some that health care directives are merely a back door method of effecting euthanasia.

- Euthanasia and end-of-life decision making have historically been, and will undoubtedly continue to be difficult issues from a legal, ethical and medical perspective. They will continue to be highly controversial issues and of particular concern to disabled persons, the elderly and those with certain religious beliefs, who may all challenge the authority to determine futility, to judge a person’s quality of life and to decide whether one person’s life is “more valuable” than the next.
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