



CONTROVERSIES IN HEALTH CARE

Gertrude Morrow has been in hospital in Winnipeg with the after effects of polio for 32 years. She wants a guarantee, in advance, that if she is terminally ill and mentally incompetent, her life will not be prolonged unduly.

Arthur Schafer, a philosopher/bioethicist from Winnipeg who knows Ms. Morrow's case intimately, believes that law reform is necessary to reassure patients like Ms. Morrow that health care professionals will not introduce personal value systems into the decisions regarding terminal illness.

Edward Keyserlingk, who has considerable experience as chairman of the Law Reform Commission, argues that changes in the present law are unnecessary because good medical practice, including proper patient-doctor communication, will ensure that her wishes are respected.

Our readers are invited to read both articles and decide for themselves.

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Legislating the Right to Die in Peace

The Affirmative of the Proposition that the Criminal Code of Canada needs to be amended in order to ensure patient rights

ARTHUR SCHAFER

Using as a base the recent Morrow decision, the author examines current law concerning the individual patient's right to set limits on the continuation of his/her medical treatment, even when necessary to sustain life. He warns that the physician's principal role is to supply information and that no member of the health-care team should impose their values on the patient. He believes we need new legislation to secure the patient's right to set limits to the continuation of treatment.

Several important legal and ethical issues have been raised in dramatic form by the efforts of the Manitoba (Canada) patient Gertrude Morrow, who has gone to court to attempt to establish her right to "death with dignity". As a victim of polio, Ms. Morrow has been confined to hospital for 32 years. She recognizes and is grateful for the advances in medical technology which have kept her alive and have given her some limited mobility. Now she wishes to ensure that when her condition deteriorates and her life becomes even more burdensome (through kidney failure and acute diabetes) she will not be kept alive against her wishes. As a competent adult, Ms. Morrow insists on the right to autonomy: the right to control her destiny by setting limits and conditions to the continuation of the medical treatment which keeps her alive.

The Winnipeg Municipal Hospital, where Ms. Morrow resides, has taken legal advice, and acting on this advice it has refused to accede to her request. Dr. John Alcock, medical director of the hospital, insists that decisions about cessation of treatment can only be made at the time life is in danger. Herein lies the difficulty. When a patient's condition has deteriorated to the point that death is imminent, often he or she will be in great pain, stupified (or at least mentally dulled) by drugs, and emotionally distressed. In other words, patients frequently become unfit to give or withhold informed consent to treatment because attendants (and society) have doubt about their mental competence. Gertrude Morrow does not wish her fate to be left to chance. The attitudes and values of the physician who will be treating her when her condition deteriorates may coincide with her own attitudes and values. Or they may not. She is claiming the right to determine her future course of treatment now, when she is still competent.

Some physicians will object that it is never possible to anticipate every medical contingency. Hence, the physician must reserve the right to act in that manner which is most appropriate in the circumstances as they unfold. This is not an unreasonable position, and yet it leads to a usurpation by the physician of the patient's right to control his or her destiny.

Part of the difficulty is the tendency of some physicians to commit the fallacy of "generalizing technical expertise". Uncritically, many doctors assume that when they decide that such-and-such a treatment is appropriate for the patient (in the patient's "best interests") they are making a technical (medical) decision. They do not notice a fundamental error. Unwittingly they have assimilated a *value* decision to a technical (medical) one. The physician's role is to provide a patient with all the materially relevant medical information, but it is the right of a competent patient to decide for himself/herself whether the continued treatment or non-treatment is appropriate. The decision should reflect the patient's own attitudes and values, the patient's self image and their own picture of "the good life".

Deciding whether a patient is competent to give or withhold informed consent to continued life-saving

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medical treatment will sometimes be agonizingly difficult. As noted above, when death is imminent, the mental competence of the patient will often be in doubt. A request that treatment be discontinued may reflect not autonomous, rational choice, but rather temporary depression or illness. It may be the illness speaking, rather than the patient. On the other hand, if the patient gives advance instructions as to his/her wishes, one

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must ask whether these anticipatory instructions will reflect the patient's true desires once health has deteriorated. Can anyone know what he will want in a situation he has never before experienced? If the decision corresponds with one's previously articulated attitudes and values, then it probably represents an authentic wish in the circumstances. But how can we confidently distinguish between an inauthentic wish (the illness speaking) and an authentic conversion?

These considerations lead to the conclusion that the medical team and family must be granted some discretion in assessing the patient's competence and interpreting his wishes. Their role, however, is to ascertain and implement the patient's wishes rather than to substitute their own values and judgement for his. Within broad guidelines, the patient's values ought to prevail, even when family or physicians regard these as mistaken or misguided. In addition, the medical team has an obligation to ensure that the patient appreciates the salient aspects of his/her case and understands the available alternatives. Some patients, for example, may reach an irrational decision based upon exaggerated fears. Or they may, through inexperience, underestimate their own capacities to adjust to pain or disability. Assisting the patient to assess the alternatives in light of his/her own values, attitudes and life plan, is a task that requires emotional sensitivity and communication skills of a high order. The medical team would not be showing respect for the patient's autonomy if they acceded instantly to his decision to refuse life-saving treatment. Usually some time should be allowed to pass to allow the patient to assess his attitudes towards life and death. The members of the team should take care not to impose

their own value judgements upon the patient. A physician who regards every death as a personal defeat may be tempted to dismiss a decision based upon the patient's belief that in some circumstances life can become more burdensome than beneficial and, thus, death is seen, not as a defeat but as a blessed relief.

THE LEGAL DIMENSION: The Gertrude Morrow case has a legal dimension which requires some comment. Section #199 of the Canadian Criminal Code requires that everyone who undertakes to administer surgical or medical treatment continue such treatment if an omission to do so may be dangerous to life. Taken in isolation from other sections of the Criminal Code, this section appears to require of doctors that, once they begin treatment of a patient, they must not discontinue this life-prolonging treatment, even if the patient requests an end to it in order to permit a dignified death.

On the other hand, when Section #199 is interpreted in conjunction with other sections (in particular #45 which deals with criminal negligence), it appears doubtful that a physician who discontinued life-prolonging treatment would be found liable to criminal sanctions – especially if this discontinuation were in deference to the wishes of a competent patient.

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Canadian courts have never, it seems, convicted a physician for ordering the cessation of a useless treatment for a dying patient. In its 1982 Report, entitled *Euthanasia Aiding Suicide and Cessation of Treatment*, the Law Reform Commission of Canada did not find a single case on record in Canada in which a doctor was convicted for shortening the life of one of his/her terminal patients by administering massive doses of pain-killing drugs ("indirect euthanasia"). Can we advise physicians to stop worrying about possible legal repercussions of decisions to terminate treatment?

The Law Reform Commission described the problem faced by the medical (and nursing) professions in these terms: "At the present time...physicians and lawyers

are generally unable to predict with any certainty how the provisions of the present Criminal Code would in fact be applied in a case involving cessation of treatment."

This uncertainty puts the medical profession in an exposed and vulnerable position. From the legal viewpoint, frequently that course of action, which is "safest", would require physicians to act against the wishes of their patients and against their own best medical and moral judgement. Thus, in the absence of case law precedents, patients cannot be sure of their rights, and the decisions made by doctors and hospitals about treatment probably will continue to fluctuate from province to province and even from hospital to hospital within a province. As the Law Reform Commission observes: "... (A) good proportion of the medical profession and of hospital personnel are in the unfortunate position of not knowing the precise content of their legal duties, and of being entirely dependent in this respect on the Crown's discretion not to initiate legal proceedings."

At present The Criminal Code of Canada contains provisions dealing with homicide which appear to be severe and inflexible but which, in practice, are rarely if ever enforced. These provisions were drafted to govern a simpler era before the advent of medical high technology. The gap between the letter of the law and its non-enforcement creates unnecessary confusion and anxiety. There is a clear need for law reform.

The type of law reform we need should make it clear that a competent patient has the right to decide that life-prolonging treatment shall not be initiated, or shall be discontinued, when the patient judges that such treatment is not in his/her best interests. Further, it needs to be established clearly that a competent patient has the right to set limitations on future treatment, which may be needed when the patient is no longer competent to give or withhold informed consent.

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