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A RESPONSE TO “WHY WITHDRAWING LIFE- SUSTAINING TREATMENT SHOULD NOT REQUIRE ‘RASOULI CONSENT’”

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I read Professor Young’s article with great interest.¹ In this reply, I aim to clarify key issues surrounding the “Hawryluck proposal.”² From my perspective as a practicing intensivist and bioethicist, I would also like to highlight key challenges of end of life care for frontline clinicians. To begin, Professor Young slightly misconstrues the Hawryluck proposal. She states that even if “minimal criteria” (terminology that does not exist in the actual proposal) were met, physicians would still have unilateral discretion to withdraw life-sustaining treatments.³ Far from promoting unilateral withdrawal, the Hawryluck proposal calls for effective communication; transparent decision making; disclosure of rationale for recommendations; second opinions; and procedures for conflict resolution, with ultimate adjudication through the courts.⁴

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¹ Hilary Young, “Why Withdrawing Life-Sustaining Treatment Should Not Require ‘*Rasouli* Consent’” (2012) 6:2 MJLH 54.

² Laura Hawryluck, Redouane Bouali & Nathalie Danjoux Meth, “Multi-professional Recommendations for Access and Utilization of Critical Care Services: Towards Consistency in Practice and Ethical Decision-Making Processes” (2011) 39:2 JL Med & Ethics 254.

³ Young, *supra* note 1 at 101.

⁴ *Supra* note 2 at 258.

The Hawryluck proposal does draw a distinguishing line to determine if life-sustaining treatments are treatment options at all. Only viable treatment options should be presented to patients or their substitute decision makers for consideration. This distinction is based on standard of care considerations, which in turn are founded on a clear concept of patient benefit.

Critical care medicine is very aggressive and invasive. It has to be to respond to the very nature, severity, and aggressiveness of the illnesses it seeks to stabilize. The potential harms are greater than those seen elsewhere in medicine, and the risk of harm does not decrease over time. For these reasons, life-sustaining treatments must be able to benefit any given patient. The Hawryluck proposal states that if life-sustaining treatments will not be of benefit, they should not be offered or continued, as they would fall outside of the standard of care.⁵ This approach is consistent with statements and policies of critical care societies nationally and internationally.⁶

The Hawryluck proposal seeks however to further clarify the concept of benefit within the field of critical care medicine. Life-sustaining treatments are defined as being of benefit when they constitute part of a treatment plan that (a) could result in a cure; (b) improves or stabilizes progression of illness, symptoms, and well-being; or (c) slows the rate or extent of deterioration of health and well-being.⁷ Physicians must consider whether potential benefits outweigh risks, and how to minimize invasiveness to achieve these results before recommending one treatment plan over another. The following criteria were provided to define when life-sustaining treatments will not be of benefit:

1. there is no reversible cause for the need for the ICU admission;
2. the patient would not be expected to survive an ICU admission:
 - a. due to very poor baseline quality of life [*the concept of poor quality of life as used here reflects the patient's per-*

⁵ *Ibid* at 257.

⁶ College of Physicians and Surgeons of Ontario, "Policy Statement #1-06: Decision-making for the End of Life", online: CPSO <www.cpso.on.ca> [CPSO "Policy Statement"]; Graeme Rocker & Scott Dunbar, "Withholding or Withdrawal of Life Support: The Canadian Critical Care Society Position Paper" (2000) 16 *Supple J Palliat Care* S53; Robert D Truog et al, "Recommendations for End of Life Care in the Intensive Care Unit: A Consensus Statement by the American College [corrected] of Critical Care Medicine" (2008) 36:3 *Crit Care Med* 953.

⁷ Hawryluck, Bouali & Meth, *supra* note 2 at 256-57.

- ception/opinion and not the biases of the healthcare provider*];
- b. if the patient was or will be in a permanently unconscious state; or
 - c. if the patient is in very end-stage of life due to illness;
3. the patient’s quality of life is expected to be extremely poor should the patient survive the ICU, such that the patient would:
 - a. be in a state of severe irreversible dependency in all activities of daily living;
 - b. have severe irreversible functional limitations *that the patient would not want to endure* (as expressed in previous wishes or based on the SDM’s interpretation of the incapable patient’s wishes, values and beliefs).⁸

Such considerations of benefit are crucial to determine if offering, continuing, withholding, or withdrawing life-sustaining treatments are options to be presented to the patient or substitute decision maker. It should also be noted that this definition of non-benefit also clearly incorporates patient values and wishes.⁹

If life-sustaining treatments are among the treatment options for a given patient, the physician would then be expected to fulfill their ethical and legal obligations to make a recommendation regarding their use in the context of the patient’s state of health and values.¹⁰ At this stage, patient values and wishes prevail as they would in any other situation.¹¹ In cases of uncertainty, the value of a trial of life-sustaining treatments and the re-evaluation of the response to treatments is emphasized. This approach errs on the side of caution, by placing patients on, or continuing, such treatments until lack of benefit is certain.¹² This approach was elaborated precisely to enhance flexibility in the outcomes of decision making. High quality, patient-centered care is ensured by mandating that each patient be seen as a person, whose particular situation is considered.¹³ In the event life-sustaining treatments would not be

⁸ *Ibid* at 257 [emphasis as in original paper].

⁹ *Ibid* at 256-57.

¹⁰ CPSO “Policy Statement”, *supra* note 6.

¹¹ Hawryluck, Bouali & Meth, *supra* note 2 at 256-61.

¹² *Ibid* at 256-57, 260-61.

¹³ This is different than the outcomes in the Downie proposal that Professor Young (*supra* note 1 at 101) suggests would be more simple and predictable. I am unclear that “simple and predictable” are values we should target as the loss of

of benefit, the proposal mandates this be fully disclosed in order to facilitate open discussion of the rationale and to allow a second opinion to be obtained where desired. Patient self-determination and wishes are still important factors determining the standard of care. Ultimately, our proposal sought to achieve an explicit balance between benefit and patient values, and also to make these criteria for decision-making publicly available so as to ensure fairness and transparency reflective of the plurality of values within a just, multicultural society.

The purpose of medicine has never been to prolong life indefinitely, but to prevent, diagnose, and treat illnesses to the fullest extent possible that is desired by patients. The College of Physicians and Surgeons of Manitoba describes medical criteria of benefit and the achievement of “minimal goals,” 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.”¹⁴ Downie argues that these determinations of benefit are moral judgments, not medical ones.¹⁵ It follows according to her reasoning that decisions to withdraw life-sustaining treatments are not to be made by physicians, because they do not have the “specialized knowledge to make moral assessments” to determine whether life-sustaining treatments are worthwhile.¹⁶

What Downie fails to recognize is that physicians are not making moral judgments in these circumstances. The test they are applying seeks to assess the ability of life-sustaining treatments to help a patient. Such a test is simply and transparently based on the same considerations of potential benefits, and the same process of treatment trials and evaluation of response to treatment I described above. Furthermore, they are usually made in consultation with other healthcare teams and, within the ICU itself, in consultation with a multi-professional team. These considerations are used in decision making re-

individuality, and the loss of recognition of personhood is not one we have embraced within our society; rather we have sought to promote individuality within limits of its infringement on others.

¹⁴ Jocelyn Downie & Karen McEwen, “The Manitoba College of Physicians and Surgeons Position Statement on Withholding and Withdrawal of Life Sustaining Treatment (2008): Three Problems and a Solution” (2009) 17:1 Health LJ 115 at 116.

¹⁵ *Ibid.*

¹⁶ Jocelyn Downie, “Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment: a Violation of Dignity Under the Law in Canada” (2004) 20:3 J Palliat Care 143 at 147.

garding all medical treatments across all fields of medicine. Why are physicians suddenly making moral judgments simply because decisions about life-sustaining treatments are perceived to be decisions about life versus death?¹⁷ Death is and always will be an integral part of life and the reality is that medicine can only do so much. Moreover, such decisions are not truly "unilateral": physicians must consider principles of benefit defined by legislation,¹⁸ and given weight in common law. These definitions reflect society's values and expectations of its healthcare providers.

When life-sustaining treatments are without or can no longer provide benefit and hence no longer a treatment option subject to patient or substitute decision maker choice, this does not mean that patients are abandoned and ignored. A patient's dignity must be respected at all times. Dignity in the medical setting means caring for a patient as a person, no matter their illness impairment or vulnerability. If a patient's illness were to progress to the point of needing life-sustaining treatments in the future, it may very well be that under his or her particular circumstances, such treatments would be of no benefit. Conceivably before the illness reaches this point, however, there may remain any number of other treatment options that can be potentially pursued according to the patient's values and wishes. The difference is in the ability of life sustaining treatments to always cause harm, the magnitude of such harms, and the continued ability of such treatments to harm even when they cannot benefit. If critical illness ultimately ensues, treatments would focus exclusively on pain and symptom control so as to improve the quality of life in the time remaining.

I agree that physicians should have a voice in resource allocation in the healthcare system, for the reasons argued effectively by Professor Young. In the Downie proposal, however, the only real constraints on a patient's right to self-determination are those concerning resource limitations.¹⁹ This would create even greater variability in the standard of care than the use of the concept of benefit. Decisions under the Downie proposal would not be "predict-

¹⁷ In circumstances where initiating or continuing life-sustaining treatments are deemed outside of the standard of care, it is a fallacy to view these decisions as life versus death. A more appropriate way of looking at these situations in the clinical context is that death is the only possible outcome and the question is more how will the patient die, i.e. how much pain and suffering will the patient be asked to undergo? How prolonged will the dying process be?

¹⁸ See e.g. *Health Care Consent Act*, SO 1996, c 2, Schedule A, s 21.

¹⁹ *Supra* note 14 at 134.

able and simple,”²⁰ as Professor Young suggests. On the contrary, they would be subject to considerable regional variability in resources. This would, if anything, promote more inconsistencies in ensuring the fundamental value of our healthcare system – that of fair access to those in need – is achieved. While overarching values and policies may be helpful in macro-resource allocation decisions within the healthcare system, their application in practice when caring for an individual patient is far less clear. Resources can vary day to day within a given hospital, between hospitals, and between regions across Canada. Why should patients trust hospital resource allocation policies²¹ more than the physicians who have a fiduciary obligation to seek and advocate for the best possible healthcare for their patients? Such a proposal would make access to life-sustaining treatment dependent on the vicissitudes of an individual hospital’s financial situation and expenditure decisions. Are patients now supposed to investigate each hospital’s use of funding to know where to go to seek care? The Downie proposal requires a *prima facie* shift in values. The fundamental question becomes how hard physicians should try to find resources for a given patient, not whether medicine can help a vulnerable person in a time of need. Is this truly the core value we wish to emphasize in the Canadian healthcare system? Such a shift would undermine the trust central to the physician-patient relationship.

In clinical practice, when conflicts arise when treatments are deemed no longer of benefit, the transfer of care to another physician, as suggested by the Downie proposal, is not a credible solution.²² Physicians rarely accept such patients in transfer. They do not want to willingly engage to provide care that offers no benefit, but retains its ability to cause significant harm.²³ Such care is a violation of the fundamental oath of medicine to “first do no harm.” This implausible, yet blithely suggested solution, points to a significant lack of appreciation for the reality of medical practice: the standard of care and the concept of benefit are far less variable and nebulous than critics would suggest. Instead, the variability seen in clinical practice is rooted in how patients’ and substitute decision makers’ insistence and demands for non-beneficial treatments are handled.

²⁰ Young, *supra* note 1 at 101.

²¹ Downie & McEwen, *supra* note 14 at 134.

²² *Ibid.*

²³ Judith E Nelson et al, “Chronic Critical Illness” (2010) 182:4 *Am J Respir Crit Care Med* 446; Kathleen A Puntillo et al, “Symptoms Experienced By Intensive Care Unit Patients at High Risk of Dying” (2010) 38:11 *Crit Care Med* 2155.

Resolution of such cases with negligence considerations would require physicians to meet a robust standard of care that incorporates whether (1) the proposed treatment plans are justified under clear criteria of potential benefit; (2) the option of trials of treatment are proposed in cases of uncertainty; and (3) patients’ wishes and best interests prevail in cases of potential benefit when life-sustaining treatments are among the treatment options offered. Physicians are not the sole arbitrators of the standard of care. While it must reflect and recognize medical knowledge, research, and skill, the standard of care is also critically shaped by legislation and case law, which reflect societal values and bring out the best practices within medicine. We need to guard against their ability to bring out the worst.