Appendix 1 (as supplied by the authors): Other issues relevant to the Supreme Court of Canada's decision in the *Rasouli* case

List of abbreviations (in alphabetical order):

CCB	Consent and Capacity Board
CPR	Cardiopulmonary resuscitation
EOL	End of life
HCCA	Health Care Consent Act
ICU	Intensive care unit
LS	Life support
PACW	Prior applicable capable wish
SCC	Supreme Court of Canada
SDM	Substitute decision-maker
WDLS	Withdrawing life support
WHLS	Withholding life support

Has the Supreme Court of Canada created a legal or ethical distinction between withholding and withdrawing life-sustaining therapy?

The moral equivalency between WHLS and WDLS is widely accepted in Western biomedical ethics. This position followed earlier debate regarding the responsibility of the physician as the cause of death in WDLS (the death is caused by the underlying disease, as it is in WHLS), and to distinguish it from euthanasia and assisted suicide, in which the physician has a clear responsibility for causing the death. In practice, some North American physicians prefer not to WDLS for dying patients,[1] and international studies demonstrate a strong aversion to WDLS in certain regions and cultures.[2,3] WDLS is illegal in many Middle Eastern countries where the religious principles of *Halacha* or *Sharia* prevail. But the principle of equivalency between WHLS and WDLS is very important in North American ethics.[4]

In *Rasouli*, the SCC did not question the moral agency of the physician as the cause of death in either WHLS or WDLS. Instead, the SCC was asked to consider the ability of physicians to make decisions about WDLS without obtaining the consent of the

SDM. The SCC indicated that physicians must seek consent for WDLS in cases such as *Rasouli*, and their rationale suggests that consent might be needed in other situations where treatment is withdrawn, and even in some cases of WHLS.

There is no distinction between withholding and withdrawal of treatment at common law.[5] On the face of it, the HCCA does not differentiate between the 2. However, the SCC has created a climate in which such a distinction could be made in future decisions by its discussion of physical contact with patients. If physical touching is found to be a necessary ingredient for the requirement of consent in other instances, this could create such a distinction. Given their comments about withholding, it seems difficult to draw the conclusion that touching is a necessary factor. On the other hand, if that is the case, it begs the question: why did they consider physical contact before reaching their conclusion?

It is important not to draw a distinction between the 2 as this will lead to debates over whether certain proposals are related to a WHLS or WDLS. The physicians pointed this out in their arguments to the SCC about CPR (where a plan may be characterized as either a withholding or withdrawal of treatment). There are other examples, such as that of the implanted defibrillator in the withholding section of the paper (the authors had discussions about whether this should be in the withholding or withdrawal section). Ventilator timers, at use in certain parts of the world, are another illustrative example.

We suggest that the SCC has not established a new legal or ethical distinction between WHLS and WDLS, either in terms of the moral agency of the physician, or the need for consent. However, as part of their underlying basis for requiring consent in *Rasouli* seemed to relate to the necessity to make physical contact with the patient when

withdrawing life support, future decisions re the applicability of *Rasouli* may make a distinction between withdrawal and withholding. It is hoped this distinction will not be made, or, if it is, that the implications of doing so are fully understood and that the decision-makers have the necessary evidence before them before reaching their conclusions.

Do Ontario physicians need consent to provide palliative care at the EOL?

Palliative Care is a specialty of medicine that is focused on comfort, decision-making, and psychosocial support for dying patients and their family members. In the ICU, palliative treatments are often used to provide symptom control when life support is being withdrawn, or when patients are dying despite life support. While most such medical care can be provided under the heading of 'implied consent', physicians usually explain the role of palliative treatments (e.g., opioids, sedatives) separately. Many patients, family members and even physicians are hesitant to use comfort medications because they are concerned that these might hasten death. In fact, multiple studies have shown that appropriate doses of comfort medications do not shorten life,[6,7] and the doctrine of double effect holds that it is ethically permissible to give medications for comfort even if they may unintentionally shorten life.

As the administration of palliative care clearly falls within the definition of "treatment" in the HCCA,[8] consent will normally be required. Physicians might be worried, then, that palliative care may not be appropriately provided if families refuse consent. However, physicians should remember that the HCCA specifies that treatment can be provided without consent when an emergency exists and they are of the opinion that the SDM is not making the decision based on the best interests of the patient [s.27].

The HCCA defines emergency, in part, as a situation where an incapable patient is "apparently experiencing severe suffering…" [s.25] and the delay involved in obtaining consent would prolong their suffering. The emergency treatment provision cannot be invoked if there are reasonable grounds to believe that the patient had a PACW and would not want this particular treatment [s.26], but this is highly unlikely in the case of refusing comfort medications while dying. The emergency provisions also apply in cases where physicians believe that palliative care should be provided immediately, the SDMs are not available, and the delay involved in contacting the SDM to obtain consent would prolong the patient's suffering [s.25].

Will *Rasouli* allow incompetent patients with a PACW to demand continuation of nonbeneficial life-sustaining treatment?

It is a well-established right at common law that a competent adult can refuse treatment for any reason, even if refusal will lead to death.[9,10] A competent adult can use an advance directive to attempt to ensure that specific treatments will not be provided if he/she loses decision-making capacity through a clear and relevant instruction. However, competent patients do not have the right to demand treatment at common law. Neither would incompetent patients through an advanced directive, unless legislation allows for this.

If a competent patient wants a treatment that a physician is unwilling to provide on the basis that it is not appropriate, an application may be made to the courts. The courts will decide whether or not to support the physician's position by considering the standard of care, and deciding whether or not the physician has acted as a reasonable physician would in the circumstances.

If the patient is incompetent and dependent on life support, and the SDM wishes to continue the life support but the physician disagrees on the basis that is not appropriate, *Rasouli* has made it clear that the case should be directed to the CCB and not to the courts. If there is a PACW, the physician can make 2 types of applications to the CCB. The first is an application to determine whether or not the PACW is truly applicable; a statement that "no heroic efforts be made" or that "everything be done" may be inapplicable because it is too vague to know whether it would apply to the specific treatment decision in question. The second is an application to grant the SDM permission to depart from a wish that is clearly applicable. Such permission may be granted if the CCB "…is satisfied that the incapable person, if capable, would probably give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed." In the latter case, the SDM must be willing to depart from the PACW.

As a result of *Rasouli*, it is possible that a clearly written and specific PACW, coupled with an SDM that is unwilling to depart from the PACW, could result in maintaining the patient on LS indefinitely, regardless of the best interests of the patient, the standard of care or the lack of medical benefit. Ontario physicians should be prepared for an increase in the use of advanced directives demanding specific life-support treatments (as opposed to those refusing such treatments). Individuals and their lawyers may develop these with the aim that they could be used to force physicians to continue therapies regardless of the physicians' judgment about medical benefit or the best interests of the patient.

References

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9. *Starson v. Swayze* (2003), 225 D.L.R. (4th) 385 (S.C.C.)
10. *Fleming v. Reid* (1991), 82 D.L.R. (4th) 298 (Ont. C.A.)