Withholding and Withdrawing of Life-Sustaining Treatment: The Canadian Critical Care Society Position Paper

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SECTION 1

1.1 Purpose

This document offers a guide and an educational tool for all members of intensive care unit (ICU) multidisciplinary teams, and those involved in end-of-life (EOL) decision-making. The aim is to improve the understanding of ICU EOL issues and to provide guidance to facilitate the process. Accordingly, the document can be adopted, or adapted, for local usage in accordance with legislation and provincial College statements/guidelines, or institutional requirements/policies.

1.2 Definitions (as applied in this document)

Life sustaining treatments (LST) are medications or medical devices (also known as "life-support") using mechanical or other artificial means to support or replace vital organ function, either on a temporary or permanent basis. LSTs are distinct from "therapy" in that LSTs merely sustain organ function rather than restore it. Moreover, LSTs are not routine but rather specialized medical interventions that require specialized medical staff, specialized locations and significant resources. Accordingly, ongoing use of LSTs necessitates admission to a specialized area such as an ICU within an acute care hospital. LSTs can include mechanical ventilation, pharmacological or mechanical hemodynamic support, and hemodialysis.

Cardiopulmonary resuscitation (CPR) is an intervention with the potential to prevent premature death or to prolong inevitable death, and is applied following cardiac or respiratory arrest. CPR may include chest compressions, bag-and-mask positive-pressure ventilation, intubation and/or defibrillation. Despite originally being intended for select cases it is now applied in many cases of sudden death unless a contrary order (e.g. a "No CPR" or "Do Not Attempt Resuscitation") has been recorded in the health record. CPR is not clinically indicated in all cases and therefore should not be considered a default intervention (1). Furthermore, CPR is not an all-or-none intervention. Certain components of CPR (i.e. intubation) may be clinically appropriate, whereas others (chest compressions, defibrillation) may not.

Withholding and withdrawal of life sustaining treatment (WWLST) are processes by which medical interventions are forgone or discontinued, often with the understanding that the patient will most probably experience natural death from the underlying disease or related complications. WWLST is not equivalent to physician-assisted death or euthanasia, as outlined in Section 2.5.

Competence, in the medical consent context, refers to a patient's capacity to understand the information presented, and to appreciate the reasonably foreseeable consequences (including the potential risks and benefits) of a decision or lack of decision. A competent patient or their substitute decision-maker can provide or refuse informed consent for a treatment plan when he/she reasonably understands the diagnosis, risks, benefits, and clinically indicated alternatives.

Substitute decision-maker (SDM), also referred to as *proxy* or *representative*. When a patient is no longer competent to make health care decisions, then an appropriate SDM should be identified and afforded the same opportunity to fully discuss the patient's care plan. This representative should be chosen based upon the willingness and ability to make decisions that reflect the patient's most recent wishes if explicitly stated, or their likely wishes if not. In some instances, a SDM may have already been legally declared. It is important to refer to local legislation to ensure the appropriate process (2).

Standard of Care follows the ruling in Crits v. Sylvester [1956] S.C.R. 991. This held that a physician is "…bound to exercise that degree of care and skill which could reasonably be expected of a prudent practitioner of the same experience and standing..." This means a physician would be expected to propose or provide treatments that most physicians with similar training and experience and situation would propose or provide. Conversely, it means that a physician would not be expected to propose or provide a treatment that most physicians with similar training and experience would not propose or provide in this individual situation.

1.3 Ethical Principles

Four basic ethical principles (3) outlined below are related to and complement one another. These principles are intended to frame discussions, but do not mandate what health care providers (HCPs) "should" or "must" do, either individually or collectively. Not infrequently these principles may come into conflict; typically between respect for autonomy and the principle of beneficence, between beneficence and non-maleficence, and between respect for autonomy and justice. No single principle supersedes others, and broader familiarity with these elements is meant to assist in the management or resolution of dilemmas and conflicts.

Beneficence means that actions are intended to benefit patients by treating illness, promoting health, and/or relieving pain, suffering and distress.

Non-maleficence, the principle of "primum non nocere" or "first do no harm", requires that HCPs strive to minimize patient suffering, harm or distress. A proposed treatment may involve unavoidable harm, suffering and distress, in which case it must be justified by a reasonable expectation of patient benefit.

Respect for autonomy asserts the right of competent patients/SDM to accept or refuse medical treatments. This includes the right to accept or refuse LSTs. Consent requires reasonable explanation of the nature and implications of proposed interventions, and provides an understanding of the consequences of any decisions to accept or forgo these interventions. Competent patients may preserve their autonomy in future states of incapacity by declaring their goals, wishes and treatment preferences, or by designating a SDM to represent those values following incapacity (see Section 2.4).

Justice is the principle by which all patients should have equitable access to health care. This includes LST unless that treatment has no reasonable expectation of an outcome acceptable to the patient, or is determined to be merely delaying inevitable death. In extraordinary situations such as pandemic or disaster triage, medical resources should be allocated in order to maximize the chance of success, consistent with standards of medical practice.

SECTION 2

2.1: The Distinction between Withholding and Withdrawing Life Sustaining Treatment in Canada

Western biomedical ethics does not distinguish between withholding life sustaining treatment (WHLST) and withdrawing life sustaining treatment (WDLST). In some countries, WHLST may be permitted but WDLST is considered unethical or illegal regardless of consent. In Canada, neither WHLST nor WDLST is considered the cause of death as it is the underlying disease process that is responsible for the death. However, there can be a psychological difference between WHLST and WDLST. Many patients, family

members, and some HCPs are uncomfortable with the moral agency involved in withdrawing LST (an active act of commission) and more accepting of withholding LST (a passive act of omission).

It is important not to overstate the moral or legal distinction between WHLST and WDLST, as there may be no clinically meaningful distinction between withdrawing a treatment and withholding the next dose or escalation. Withdrawal of treatment can usually be reframed as withholding treatment and vice-versa. For example, discontinuing intermittent hemodialysis could be considered a withdrawal of hemodialysis or a withholding of further dialysis. A "Do Not Attempt Resuscitation" order would withhold future CPR; alternatively, it could be framed as a withdrawal of a previous care plan that had included CPR in the event of an arrest.

Second, any form of LST should be considered to be a trial that should continue as long as it is desired by the patient and involves a reasonable prospect of recovery to a meaningful patient-centered quality of life. If at any point the patient withdraws consent, or the health care team assesses that there is no realistic prospect of a meaningful recovery, then the trial should be discontinued or modified.

In practical clinical terms, treating WDLS differently from WHLS could adversely affect patients. It could prevent appropriate discontinuation of resuscitation once it is clear that it has not restored life, and LST could become open-ended despite patient suffering or lack of meaningful benefit. Moreover, if WDLS or WHLS are deemed morally distinct and separate, then patients, families or physicians may hesitate to initiate a trial of LST in indeterminate cases. In other words, when there is a reasonable but not absolute likelihood of a poor outcome, there may be reluctance to start a trial if there is no subsequent option to stop.

In short, it is central to medical practice that all medical interventions, not just LSTs, are individualized to patient benefit, are routinely reassessed, and are open to discontinuation. This approach minimizes inappropriate suffering and distress for patients and caregivers, burnout in HCPs, and the inappropriate use of finite resources.

In Ontario, the legality of the equivalence of WDLST and WHLST has been reviewed by the Supreme Court of Canada (4). The Court held that consent is required for the WDLST for a patient who would be expected to die imminently without that LST. However, the 5-2 split ruling is problematic:

i) It did not explicitly state whether WDLST and WHLST are equivalent.

ii) The court referred to provincial legislation for resolving the disagreement between HCPs and family/SDM regarding WDLST. Not every province/territory has relevant legislation to follow.

iii) It specified that the need for consent for WDLST is specific to the Rasouli case (namely, the discontinuation of mechanical ventilation in a severely brain injured patient), and also that not all forms of treatment withdrawal may require consent. However, the decision did not further delineate when consent is required for other forms of WDLST.

Cases in other provinces have also not clarified the role of consent in WWLST. As such, the legality in Canada regarding decision-making in WHLST remains undetermined and only narrowly defined in regards to WDLST in the province of Ontario (5).

2.2 Withholding and Withdrawal of Life Sustaining Treatment (WWLST): Decision Making Considerations

(i) Using best clinical judgment, members of the health care team should determine whether or not LST have a reasonable chance of restoring the patient to a quality of life that he/she would find meaningful. When it is clear treatment will not be medically effective, and is not in accordance with the Standard of Care, the physician is not obliged to begin, continue, or maintain the treatment (1).

(ii) LST is not an "all or none" treatment plan. As such, an order to withhold CPR (or DNAR) should not necessarily exclude patients from receiving other appropriate LST, or admission to the ICU. Likewise, patients who refuse, or are not offered LST may still receive aggressive medical care, which can include treatments (i.e. antibiotics, procedures, radiological tests, laboratory work), comprehensive efforts at rehabilitation (feeding and hydration, physiotherapy) and full attention from HCPs (analgesia, spiritual care, regular patient and family updates). It should not be interpreted or represented that a limit on LST will result in a patient being neglected.

(iii) If it is not clear whether individual patients could recover to a meaningful quality of life, a trial of LST could be offered, but regularly reviewed for appropriateness. The ICU team should communicate clearly and consistently with patient and SDM/family members about the goals and objectives of LST. It is possible for LST to be initially appropriate, but become inappropriate due to changes in the patient's condition. If this occurs, the ICU team should propose that LST be withdrawn and palliation prioritized.

(iv) There should be consensus among ICU team members about the options (including palliation) and the recommended plan before anyone approaches the patient/SDM regarding WWLST. In some circumstances, it may be advisable that at least one additional ICU physician's opinion be sought to ensure that all reasonable options have been explored, and that WWLST is consistent with the Standard of Care. The team may also seek additional consultation of other relevant clinicians, or ethicists, to determine whether providing/continuing LST is appropriate.

(v) It is important that HCPs maintain consistent communication with the patient/SDM. There should be structures in place to facilitate comprehensive and regular sign-over between HCPs.

(vi) When assessing whether a particular medical problem is likely to be *reversible/recoverable, the* appropriateness/desirability for initiation or continuation of LST should be interpreted in the context of the patient's overall prognosis, values, and longer-term goals.

(vii) When planning discussions of WWLST, other members of the health care team should be involved. It may also be appropriate, if the patient/SDM or family agrees, to seek the additional presence of an appropriate Spiritual Health provider and/or Social Worker. Importantly, it should be clarified which family members/ friends are to be present during discussions.

(viii) Good communication is central to decision-making. Where possible, the patient, SDM and family should all participate in the decision making process, as each will have to deal with the consequences and potential distress arising from the decision. Good communication between the ICU team, patient/SDM, and family can enhance mutual trust and support, and reduce the possibility of

disagreement or confusion. Therefore, both clinicians and SDMs should commit to keeping communication lines open.

(ix) Every effort should be made for patients to be involved in discussions about their own medical decisions and treatment. However, the nature of cardiopulmonary collapse means that many patients will be comatose, non-communicative, or only partially communicative. When able to communicate directly with patients, it may be appropriate to disclose information judiciously to avoid imposing a severe emotional burden on a person who may already be distressed. This may involve asking the patient how much they wish to know or providing limited information initially while awaiting a more appropriate setting, additional support and readiness of the patient to receive information. In so doing, trust can remain intact, and enable subsequent discussions where full disclosure can take place.

(x) Some patients may not wish to know their medical condition or be involved in treatment decisions. The ICU team may want to recommend that the patient be involved in their own treatment decisions, but ultimately they should respect a patient's clear decision not to be involved. A physician who overrides this preference is not respecting patient autonomy. Physicians could determine this in a non-threatening and non-judgmental manner by asking the following: "When I talk with patients, some want to know all about their condition and the treatment options. Others prefer not to know, and want me to make treatment decisions with their family. I am agreeable to either approach, but I would like to know which you prefer."

(xi) It is important to recognize the influences of non-medical factors in discussions concerning WWLST. Patients may have cultural/religious/spiritual beliefs which have shaped their attitudes to life, illness and death, and which will influence their feelings about WWLST. Individual views of the ICU team members must not interfere with the provision of unbiased and non-judgmental care. Multiple faiths and beliefs are practiced in Canada, and HCPs frequently deal with patients whose faiths and beliefs differ from their own. Spiritual Health services should be considered a resource for exploring and valuing these perspectives.

(xii) Since families, SDMs, and members of health care team may need time to come to terms with the impending death of a patient/loved one, any recommendation to withdraw or limit ICU care should be discussed respectfully and compassionately. HCPs may seek the advice of the ethics consultation service, the Spiritual Health service, Social Work and/or other available resources. In addition the following considerations apply:

• Beneficence and compassion require that the decision-making process be unhurried when possible. Since patients/SDMs and family members may need time to come to terms with the proposed WWLST, this process may require more than one meeting.

• Discussions should be calm, honest, respectful and compassionate. Medical jargon should be avoided so that everyone can understand the terms being used.

• Family/SDM may recognize that agreeing with the medical plan offered is in the best interest of the patient but - for various personal, psychological, cultural reasons - do not want the burden of decision-making and cannot explicitly provide consent (or "give permission"). It is important the ICU team recognize those situations where implicit consent is preferred.

• Patients/SDMs and family members may perceive WWLST as a form of abandonment. Every effort should be made to provide support, and emphasize that care, including symptom management, will be continued to minimize patient distress. Where appropriate, it should be emphasized when WWLST is beneficial as it allows a full focus on patient comfort that may not be possible otherwise.

(xiii) Documentation should occur that includes names of those present, the content of the discussion, and the plan and timeline related to WWLST. In discussions that raise significant concern, it is advisable that senior physicians co-sign or document the encounter themselves.

(xiv) When the above considerations are applied, disagreement over WWLST between the ICU team and patient or SDM is less likely. However, when disagreement arises it is usually in two distinct situations: 1) a discussion about a patient who is deteriorating and expected to die imminently, and 2) a pre-emptive discussion for a patient without imminent expectation of deterioration.

- In the first situation, if a significant escalation of care (i.e. the provision of chest compressions in the setting of deteriorating condition despite ongoing LST) is considered outside the Standard of Care then patients/SDMs should be informed that it will not be provided. It should also be clarified that in the event of that deterioration, the patient will not be neglected, ignored or abandoned, and will receive full care to minimize discomfort and treat/prevent suffering as required. These efforts are not intended to hasten the dying process, but rather to focus on maximizing patient benefit and minimizing harm. See 3.2 for further discussion.

- In the second situation, it is prudent to not rush decisions and to emphasize that the decision affects only the care that the patient would receive if he/she were to deteriorate despite all reasonable therapeutic efforts. The goal is to pre-emptively explore the situation, allow time to discuss and revisit, and maximize the likelihood of the patient communicating his or her own wishes. The goal is to minimize subsequent communication gaps, and to achieve consensus without the added difficulty of decision-making under time pressure. The plan should reflect the patient's best interests and be respected by the SDM/family and the health care team.

- In either case, the ICU physician should consider using all available resources to inform the decision. This may include confirming consensus among other members of the health care team and considering additional opinions from colleagues, either in person or remotely.

- Institutions/Health regions should establish a reporting process among the health care team that regularly reviews these issues in real time and retrospectively. Especially for the stable patient, when there is not significant time pressure, disputes in goals of care should be addressed with additional physician opinions. This increases transparency and adherence to practice standards. It also eliminates the perception of unilateral decision-making.

- HCPs should also be familiar with their local conflict resolution processes (see 3.4).

(xv) It is important to be cognizant of local differences and follow applicable provincial College policies and provincial legislation (where available) as they relate to WWLST (6,7,8,9).

(xvi) Decisions regarding LST are to be reviewed if there is a significant/unexpected change in the patient's condition which might alter the previously stated prognosis on which the previous care plan was based.

2.3 Withholding and Withdrawing Life Sustaining Treatment at the Request of a Competent Patient

(i) A competent patient has the right to forgo or request withdrawal of all forms of medical intervention, including LST. Decisions should be informed and voluntary, and without coercion, and made preferably when the patient's competency and ability to communicate are not compromised. Complying with a patient's wishes to forgo offered intervention is distinct from physician-assisted death (see Section 2.5).

(ii) When an SDM/family member expresses opposing wishes/views to those expressed by a competent patient, these views should be noted and discussed, but do not override the choices expressed by the patient. If the patient subsequently loses capacity, the SDM/family member may not substitute his/her own wishes for the patient's known wishes.

(iii) If a competent patient changes his/her mind regarding their expressed wishes, the latest expressed wishes prevail in the context of offered treatment, whether or not they confirm or contradict earlier decisions.

2.4 Withholding and Withdrawing Life Sustaining Treatment using Substituted Decision Making

Advanced Care planning is a process of pre-emptive discussion and communication for patients to establish their goals, values and preferences for care. It involves naming a SDM and often written documentation. This documentation can take the form of Directives, Living wills or Care Plans. Further elaboration of this process is not the intent of this position paper but the following provides guidance:

A) Directives

(i) A Directive is a document executed by a competent individual concerning health care decisions to be made in the event that the individual becomes incompetent to make such decisions. The purpose of the Directive is to maintain the autonomy of the patient even when he/she loses decisional capacity. It is directed to the SDM/family and the health care team. A copy of the Directive should accompany the patient when he/she is admitted to a health care facility.

A Directive usually specifies an individual, SDM, whom the patient has chosen to make health care decisions in the event that he/she loses decisional capacity. It may also specify the patient's values or instructions that should be used to guide health care decisions, or indicate specific treatments that the patient would or would not want to receive. A Directive cannot compel the health care team to provide treatments that lie outside the Standard of Care, nor may it direct a proxy to do so. Categorical statements (e.g. "I would *never* want to receive…", or "I want CPR *no matter what happens*…") should be given consideration but not be taken as literal instructions when made in the absence of clinical context.

Many different types of Directives are in use across Canada, for example, generic, disease specific, and institutional. Provincial legislation and institutional policies also vary and HCPs must be familiar with their local requirements (2).

(ii) When there is no written Directive, a competent and informed patient can verbally communicate their wishes and preferences, and these verbal directives should guide care in the same way as written instructions. However, this conversation should be documented in accordance with institutional policy such that it may inform future health care encounters.

In general, statements made by an acutely incapable patient (in relation to acute illness or medication, and therefore likely reversible) do not supersede the patient's own prior statements/Directives when they were competent. However, when discrepancies occur, physicians must consider the clinical context and the patient's presumed best interests. New information that the patient did not have access to when setting their Directive may influence and warrant a review of current and future goals.

B) Absence of Directive

(i) In emergency situations such as cardiac arrest, medical decisions may need to be made prior to knowledge or review of a Directive. In this situation, HCPs and SDMs should follow what they consider to be in the patient's best interests.

ii) When possible, a SDM should be identified in accordance with the appropriate provincial legislation and institutional policy, and this person should participate in the decision-making process on the patient's behalf.

(ii) The identified SDM is the recognized source of consent to treatment plans. The role of the SDM is to reproduce the choices the patient would make if he/she still had capacity. In this undertaking, the patient's own concept of wellbeing is respected, as is his/her interest in self-determination. In the absence of clear and relevant directives, the SDM should apply the "best interests" standard. This standard involves considering the patient's overall wellbeing, their general values and beliefs, and the potential burdens and benefits of the treatment options.

(iii) If there is concern that the SDM is not acting in the best interest of the patient, then the ICU team should explore the rationale behind the decisions made by the SDM. It may be necessary to involve local resources, including patient relations, the ethics consultation service or legal counsel, to clarify the role of the SDM and the best interests of the patient. In some jurisdictions, the ICU team can pursue legal means or a tribunal such as the Consent and Capacity Board (in Ontario, Yukon) for guidance or to allow the team to refer to a different SDM.

2.5 A Respectful and Dignified Death

(i) If decisions are made to withhold or withdraw LST, the goals of patient care in the ICU focus on comfort, and relief of suffering. The ICU team should provide a respectful, caring, and peaceful environment to best ensure a dignified death and a reverent family experience.

(ii) Palliative Care consultation services can provide additional expertise and support, and their use has been associated with a longer survival for patients (10). As such Palliative Care should be considered in the transition to comfort care.

(ii) It must be recognized that not all patients have an imminent death when LST is withheld or withdrawn. In fact, some may survive to be transferred out of the ICU. HCPs should prepare the family for this possibility and ensure that the patient's remaining time be as comfortable as possible.

(iii) Beneficence and compassion require the ICU team to support and facilitate the preparations of the patient and family for the impending death of the patient. This may include reasonable consideration for limited prolonging of life sustaining efforts until completion of social and spiritual goals.

(iv) When withholding or withdrawing LST, the ICU team may use opiates and/or other sedatives to relieve suffering. Although sedatives and opioids do not routinely hasten death when titrated to achieve comfort, it is possible that these medications may inadvertently hasten patient death. The Doctrine of *Double Effect* holds that it is acceptable for comfort medications to potentially hasten death, as long as that is not the intended effect of giving those medications (11). This is distinct from euthanasia and assisted suicide, in which medications are given for the deliberate purpose of hastening death.

Although Medical Assistance in Dying (MAID) has been decriminalized in Canada in specific circumstances (12), this is distinct from WWLST. Some patients/SDMs and family members may consider the withdrawal of LST to be equivalent to euthanasia, and object to it accordingly. The ICU team should explain the difference. In WWLST, the intent of the ICU team is to allow the patient to die naturally from the underlying disease or its complications, and provide comfort as required. Whereas, in medically assisted death, the intent is to provide comfort by deliberately and actively ending the patient's life. Furthermore, it is important to also note that the specific conditions and processes required for MAID, while possible, are rare in the ICU setting.

SECTION 3

3.1. Multi-Cultural Considerations

Patients, SDMs and HCPs reflect Canada's multicultural, multifaith, and multiethnic makeup. Due to the diversity both within and between the various faiths practiced in Canada, ICU team members may find themselves in circumstances where the beliefs held by their patients/families are not aligned with proposed changes to LST. The ICU team should be sensitive to the differing attitudes to WWLST. Furthermore, there can be discrepancies between personal practices and the common interpretations of the religious teachings, which require further discussion. Thus, there is a need to be conversant with the beliefs of patients and families when there is any consideration of WWLST. In these circumstances, early involvement of the relevant Spiritual Health service is recommended. Section 2 of the Canadian Charter of Rights and Freedoms protects Canadians in following the religion of their choice and not being discriminated against on the basis of that choice. However, this should not be extrapolated to protecting demands that are inconsistent with medical or secular standards.

3.2 Cardiopulmonary Resuscitation (CPR) and Do Not Attempt Resuscitation (DNAR) Orders

The most common decisions regarding WWLST involve restricting or limiting CPR. It is important to note that disagreements between the health care team and patient/SDM/family regarding CPR usually relate to misinformation/misunderstanding regarding the term "resuscitation". Moreover, disagreement

usually stems from the concern that a NO CPR or DNAR order results in neglect or very limited attention to otherwise treatable conditions unrelated to a cardiac arrest. Proper explanation regarding the appropriateness of a DNAR order is required and should be accompanied by specifically addressing which, if any, LST will still be provided. It must be recognized, and addressed that many members of the public (and some HCPs) are not fully informed about CPR or its sequelae (13). CPR is distinct from standard ICU interventions such as elective intubation and mechanical ventilation, hemodynamic support or vascular access procedures. Moreover, HCPs should explain that the likelihood of restoration of cerebral or corporeal health following CPR is variable but often poor, especially for frail patients, those who have failed to improve despite lengthy hospitalization, and those with advanced medical illness. (14,15).

There is no legal precedent in Canada for requiring the provision of CPR in situations where a physician determines that this lies outside the Standard of Care. The CCCS asserts the principle that CPR should not be provided outside the Standard of Care such as the scenario outlined in 2.2 (xiv); for this reason the CCCS disagrees with this aspect of the CPSO policy on Planning for and Providing Quality End-of-Life Care. The College of Physicians and Surgeons of Manitoba statement on WWLST also discusses the provision of CPR. Practitioners in these provinces must familiarize themselves with these policies. Ultimately, the duration and interventions performed during CPR should be consistent with the Standard of Care and clinical judgment, taking into account whether this aggressive intervention offers an opportunity to reverse premature death versus prolong an inevitable death or unnecessary patient suffering. When provided, there is no minimum duration for which CPR should be performed, nor are there mandatory interventions that are required during every episode of CPR (16,17).

3.3 Resources

When ICU demands exceed local resources, the ICU team is on the forefront of crisis management. This potentially places the treating team in the role of resource allocation. At no time - other than where pandemic or natural disaster legislation deems otherwise - should a decision to withhold or withdraw LST regarding an individual patient be influenced solely by perceived lack of resources. Preemptive health care policy and local mechanisms at various levels (individual ICU, hospital, regional, Provincial) should address delivery of ICU care when required. The ICU Community is responsible for informing stakeholders of the requirements/resources needed to deliver adequate, appropriate and timely ICU care.

3.4 Impasse

In clinical situations there are at least two autonomous agents: the patient/SDM and the health care provider(s), and each has their own responsibilities, values, and belief systems. Mutual respect for the autonomy of each agent is important. However, when the health care team determines that specific intervention(s) are without medical benefit and/or fall outside accepted standards of practice, respect for patient autonomy should not oblige the team to acquiesce to the request of the patient/SDM for that intervention (1).

Other critical care societies have addressed these issues and provide additional reflection and guidance (18,19)

The health care team should communicate these decisions at the earliest opportunity, and give patients/SDMs the opportunity to disagree or request alternate opinion(s). The team should make good faith attempts to communicate and reach an agreement with the patient/SDM about the plan of care. However, there are still situations where no consensus can be achieved despite appropriate communication and repeated medical assessment. When this occurs, further attempts at resolution should be pursued if there is not a significant time pressure. Efforts should include:

(i) Another effort at extended discussion with patient, family, other health care providers, and spiritual care providers (as outlined in Section 2.2).

(ii) Meeting of all parties with a mediator or impartial third party such as an institutional ethics consultant or equivalent.

(iii) Institutions/Regions should have a formal Conflict Resolution process that includes multiple representatives and stakeholders, that can be implemented when decision-making is required for both urgent and more protracted situations.(CMA Joint Statement on Preventing and Resolving Ethical Conflicts. 1999).

(iv) Consideration of transferring the patient to an alternative physician or institution. Where this is not achievable, it should be clearly explained to the patient/SDM/family.

(iv) Adjudication by the Consent and Capacity Board, where available, or the Courts. These should be available to all stakeholders, however, it should be recognized that these processes are not time sensitive and are resource intensive (20).

3.5 Conclusion

Discussions regarding WWLST must be collaborative and transparent. They should be centered on patient wishes that are informed and contextual and medical decisions that are supported by standards based consensus. When LST are no longer beneficial or wanted, an empathetic and supportive approach with patients and families will ensure that communications are shared in the best possible light despite the difficulty of the situation.

Acknowledgments:

Original Authors, Rocker, Dunbar / CCCS Board of Directors, etc,

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