A Do Not Resucitate Order for an Infant Against Parental Wishes: A Comment on the *Case of Child and Family Services of Central Manitoba* v. *R.L. and S.L.H.*

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I. The Case Summary

On November 4, 1997, a three judge panel of the Manitoba Court of Appeal released its decision in a case called *Child and Family Services of Central Manitoba* v. *R.L. and S.L.H.*[1] The decision was written by Justice Twaddle, Chief Justice Scott and Justice Lyon concurring. In the result, the Court issued a ruling that has profound implications for the relationship between physicians and their patients and families.

The case arose as the tragic aftermath of an assault upon an infant and the question before the Court was whether his physician could enter a do-not-resuscitate (DNR) order on his chart over the objection of the parents. In granting the physician that authority, the Court chose to resolve fundamental questions on decision-making in so-called "right to die" cases. As will be noted, however, the Court failed to flesh out its judgment with the kind of jurisprudential analysis required by the weighty matters before it. The scanty nature of its judgment will be addressed in due course, but first, a review of the facts and the Court's holding.

The infant was apprehended by Child and Family Services (CFS) after being violently shaken at the age of three months. At the time of judgment he was eleven months old. According to the medical evidence at the trial:

> The injuries inflicted upon D [the patient] have reduced him to a "persistent vegetative state." His brain has, quite literally, shrunk over the intervening months. His doctor says D is moving from one intermittent illness to another. Sooner or later he will be struck by a serious illness that will require intrusive heroic measures which, if successful, will only bring him back to his persistent vegetative state.[2]

CFS agreed with the recommendation of the physician that the patient be subject to a DNR order. However, when the parents who were still his legal

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[1] (1997), 154 D.L.R. (4th) 409; 123 Man. R.(2d) 135 [hereinafter *L. and H.*].

[2] *Ibid.* at 136-7. Henceforth, the term persistent vegetative state will be abbreviated as PVS. A patient in such condition has no higher brain functioning—albeit there is brain stem (vegetative) activity—and consequently is without conscious awareness or the capacity to experience pain or suffering. It is also called a permanent vegetative state, and although the two terms—persistent and permanent—are used interchangeably they are technically distinguishable. The former is a diagnosis—that the patient is currently in a vegetative state. The latter is a prognosis – that the condition is permanent. Of course, to say that the condition is persistent is in itself a prediction of permanence. See Multi-Society Task Force on PVS. "Medical Aspects of the Persistent Vegetative State (Part 1)." (1994) 330 New Eng. J. Med. 1449.

guardians refused to consent, the agency sought judicial approval for the order. Its application was based upon section 25(3) of The *Child and Family Services Act*, which stipulates that an agency may seek a court order "authorizing medical...treatment for an apprehended child where the parents...refuse to consent to treatment."[3] The agency's petition was granted at trial and the parents appealed. Although the Court of Appeal overturned the ruling, its decision was no victory for the parents. That was because the Court found that section 25(3) dealt only with treatment; and that since a DNR order was in the realm of nontreatment, the authority to issue the order lay not with the judiciary but rather with the attending physician.[4] Twaddle J.A. concluded that, "[T]here is no legal obligation on a medical doctor to take heroic measures to maintain the life of a patient in an irreversible vegetative state."[5] In fact, he went so far as to comment that "(i)ndeed the opposite may be true." In his view:

> [P]hilosophical arguments apart, it is in no one's interest to artificially maintain the life of a...patient who is in an irreversible vegetative state. That is unless those responsible for the patient being in that state have an interest in prolonging life to avoid criminal responsibility for the death.[6]

Although he did not elaborate, he presumably had in mind the so-called "year-and-a-day rule," which stipulates that a person cannot be convicted of culpable homicide unless the victim dies within a year and a day from the time of the assault. (That centuries' old common law rule was found in section 227 of the Criminal Code; it was repealed in 1999.)[7] Although the police had yet to make an arrest for the assault against the infant, the case was still open. Since a suspect could be charged with unlawful act manslaughter (assault causing death) if the patient died within a year and a day of the incident, the judgment appears by implication to question the good faith of the parental objection to the DNR order. In any event, Twaddle J.A. ruled that:

> [N]either consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction where in his or her judgment the patient is in an irreversible vegetative state. Whether or not such a decision should be issued is a judgment call for the doctor to make having regard to the patient's history and condition and the doctor's evaluation of the hopelessness of the case. The wishes of the patient's family or guardian should be taken into account, but neither their consent nor the approval of a court is required.[8]

It may well be that the Court's decision was prompted by two factors: (1) its summary dismissal of the value of prolonging the life of a PVS patient; and (2) its assumption of the bad faith basis of the parental refusal to consent to the DNR order. Still, what precisely does the case establish as a legal precedent? A narrow reading of the *ratio decidendi*—the rule of law set by the Court—would restrict the

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[3] S.M. 1985-86, C. 8; C.C.S.M., C - 80.
[4] *L. and H., supra* note 1 at 138.
[5] *Ibid.*
[6] *Ibid.* at 137.
[7] R.S.C. 1985, c. C-46, s. 226. The repeal is by an *Act to Amend the Criminal Code*. It is found at S.C. 1999, c. 5, s. 9. The repeal was prompted by a Montréal case in which an assault victim was beaten into a vegetative state but lived beyond a year and a day before life-support measures were terminated.
[8] *L. and H., supra* note 1 at 138.

holding to the facts of the case: a DNR order for a PVS patient. This would follow from an exclusive focus upon the specific facts of the case: that the Court was asked to decide upon the permissibility of a DNR order for a PVS patient. Since the Court considered that life-sustaining treatment for a PVS patient is pointless, its judgment can be explained on that narrow ground. It therefore follows that the holding would not necessarily carry over to a patient with a different condition.

I suggest, however, that the Court did not intend to restrict its judgment to that particular fact scenario. It is true that Twaddle J.A. specifically ruled that it lies within the physician's discretion whether to issue a DNR order for a PVS patient.[9] And he elsewhere stated that a physician is not obliged to maintain the life of such a patient.[10] If he had simply said that these facts—a DNR order for a PVS patient—were sufficient in themselves to decide the case without looking at broader issues, then that would support a narrow-based decision. But that he did not do. Instead, he emphasized that the heart of the matter lay "in understand[ing] why authority for medical treatment is necessary."[11] As he explained, consent is required in non-emergency settings only when the provision of treatment without it would constitute assault. It therefore follows that "[t]here is no need for a consent from anyone for a doctor to refrain from intervening," subject to the rider that, "[t]he only fear a doctor need have in denying heroic measures is the fear of liability for negligence in circumstances where qualified practitioners would have thought intervention warranted."[12]

Since the legal basis of the ruling is grounded in the distinction between treatment and nontreatment, the ratio decidendi cannot be confined to the particular condition of the patient and the particular medical intervention at issue. As noted, the Court stressed that treatment involves physical contact with the patient. When there is non-emergency touching (i.e. treatment), then consent by patient or surrogate[13] is necessary to negate assault, whereas no such consent is required whenever the physician's action is not part of the treatment process, and that is the case when there is no physical contact with the body of the patient.

The focus is thus not upon the patient's medical condition nor upon the treatment to be withheld or withdrawn. Rather it is upon the crucial circumstance requiring consent – treatment that involves physical contact with the patient's body. It follows that if there is no such contact, the physician can act unilaterally even if the patient is not vegetative and the treatment refrained from is not cardiopulmonary resuscitation (CPR).

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[9] *Ibid.*
[10] *Ibid.*
[11] *Ibid.* at 137.
[12] *Ibid.* at 138.
[13] A surrogate is a substitute decision-maker, someone who decides for the patient when the patient is not mentally competent to decide for herself. The surrogate could be a proxy appointed by the patient in a health care directive, a legal guardian appointed by the court, or the next-of-kin. Strictly speaking, it is only a health care proxy or legal guardian who is legally empowered to make treatment decisions for an incompetent adult. Otherwise, the patient's spouse or other next-of-kin has no such authority. But when there is no guardian or proxy, the medical custom, which the law has never interfered with, is to consult with family members on treatment decisions. If the family asks that life-prolonging treatment be terminated the physician may well go along with that request, but the point is that the family has no legal standing to compel that decision. See B. Sneiderman, J.C. Irvine & P.H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses, and Other Health Care Professionals,* 2d ed. (Toronto: Carswell, 1995) at 482.

Moreover, it logically follows that if it is solely the physician's prerogative whether to refrain from a particular "treatment," it matters not whether the insistence upon it stems from the patient, let alone from a surrogate. If as the Court ruled in the instant case, the patient's legal guardians cannot dictate the provision of treatment, then it follows that no one else, including the patient, can do so. And that is because the only relevant concern is the reasonableness of the medical decision to forego life support measures, and that can be contested only after the fact.

A month after the Court's ruling, the office of the Manitoba Public Trustee sent a letter to Winnipeg hospitals enclosing a copy of the decision and advising that pursuant thereto, it "will not consider whether a do not resuscitate order should be placed on a client's chart."[14] (The office is empowered to consent to medical treatment for incompetent persons under an order of supervision.) Its view of the *L. and H.* decision prompted notification that, "[c]onsent of the Public Trustee should be sought only when the proposed course of treatment involves a touching of the patient's person in a non-emergency situation."[15]

Thus, although the case involved a patient whose condition was regarded by the Court as tantamount to a meaningless existence, the Public Trustee did not interpret the decision as restricted to PVS patients. It was in effect reading the holding in the case as setting the legal precedent that, whatever the patient's diagnosis/prognosis, a physician is not obliged to secure consent before making a nontreatment decision (subject to the proviso regarding liability for negligence). The same viewpoint was expressed by a Manitoba physician who lauded the *L. and H.* ruling as consistent with the position on futile therapy adopted by the Manitoba Medical Association (MMA). As he commented, "the gist of our [the MMA's] position is that patients have a legal right to refuse treatment, but they don't have a right to demand treatment.... It is unethical to waste resources on a futile case when the same resources may help to save the life of another patient."[16]

So much, then, for the summary of Twaddle J.A.'s ruling. It is my submission that whether or not he came to the right result, he regrettably failed to provide the intellectual grounding for his opinion. I turn now to a critique of his decision, beginning with: (1) his summary dismissal of any effort to maintain the life of a PVS patient; and (2) his grounding of unilateral medical decision-making in the distinction between the touching and non-touching of the patient. I shall then consider the policy implications of the case.

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[14]Letter (16 December 1997,) signed by the Public Trustee, Irene A. Hamilton.
[15]*Ibid.*
[16]"Court verdict 'splendid,' ethics professor says." (1998) 158 Can. Med. Ass. J. 59. See also Guideline No. 151 (March 1998) of the College of Physicians and Surgeons of Manitoba, titled: "Do Not Resuscitate (DNR) and Supportive Treatment Orders." The guideline states that regardless of the expressed opinions of patient and family, "physicians are not required to provide or continue interventions which would be considered futile." Futile is then defined as "treatment that offers no benefit and serves only to prolong the dying process." Of course, these definitions do not answer the questions: When can treatment be said to offer "no benefit" and what precisely does it mean "to prolong the dying process" – is treatment futile if it gives the patient a few days or weeks of life that the patient is able to enjoy, albeit in one sense it simply prolongs his dying?

2. The Patient in a Persistent (Permanent) Vegetative State

Although *L. and H.* is the first Canadian appellate court decision to consider the cessation of life-prolonging treatment for a PVS patient,[17] the matter has produced scores of opinions by high courts in other common law jurisdictions. The issue was first litigated in the New Jersey *Quinlan* case in 1975-6; and since then it has resulted in decisions by two dozen state supreme courts, the U.S. Supreme Court (the *Cruzan* case), and Commonwealth courts including the House of Lords (the *Bland* case).[18] With the exception of the debate over the proposed legalization of physician-assisted suicide and voluntary euthanasia, no topic in the bioethics literature has provoked more soul-searching and controversy than that of medical futility – and it is the plight of the PVS patient that has helped set that discussion in motion. An all too brief comment on that debate is in order.

If a treatment regimen is indeed futile, no one in her right mind would see the point of it. That is certainly true if it is physiological futility of which we speak. The Hastings Center Guidelines define "physiologic futility" by reference to treatment that is "clearly futile in achieving its physiological objective and so offers no physiologic benefit to the patient..."[19] If, for example, a patient insists upon an antibiotic for a viral infection or interferon to treat her stomach cancer, her demand is senseless and rightly resisted as an exercise in futility.

However, beyond that straightforward sense of the term, the futility of a particular treatment may be expressed in either quantitative or qualitative terms; and it is here that we enter the realm of the so-called futility debate. Quantitative futility refers to therapies that are highly unlikely to produce their intended effects, as shown, for example, by empirical data profiling the kinds of patients for whom CPR is not medically indicated. In that regard, the authors of a study published in a medical journal under the title, "Outcomes of Cardiopulmonary Resuscitation in the Elderly," concluded that CPR is "rarely effective for elderly patients with out-of-hospital arrests, unwitnessed arrests, or nonventricular arrhythmias (electromechanical dissociation, agonal rhythms, asystole)."[20]

The focus here is upon the high probability—rather than relative certainty—of a clinical conclusion. (If it were the latter, it would fit under the morally uncontested heading of physiological futility.) Hence, the prediction that a patient in a high risk category will not benefit from the treatment in question reflects a value judgment that fighting against the odds is not worth the effort. Simply put, if one must administer aggressive treatment to 100 patients in order to benefit but one of their number, is that benefit outweighed by the expenditure of ineffective and burdensome treatment upon the other 99? Moreover, does it represent a cost-effective application of scarce medical resources to devote so much time and effort

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[17] *L. and H.* was not the first Canadian case on point because one month before its ruling an Ontario trial judge heard a case involving the proposed termination of life-prolonging measures for a PVS patient. That case is discussed *infra* notes 31-33.

[18] *In re Quinlan*, 355 A.2d 647 (N.H.S.C.1976); *Cruzan* v. *Director,* 497 U.S. 261 (1990); *Airedale NHS Trust* v. *Bland*, [1993] 2 W.L.R. 316.

[19] The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Bloomington: Indiana University Press, 1989) at 19.

[20] D.J. Murphy *et al.*, "Outcomes of Cardiopulmonary Resuscitation in the Elderly" (1999) 111 Annals Int. Med. 199 at 204. Asystole is the faulty contraction of ventricles of the heart. Electromechanical dissociation is the failure of the heart muscle to contract in response to the heart's natural electrical impulse.

with so little result? Still, from the patient's or family's perspective, it is arguable that, even if the odds are heavily weighed against the success of a particular life-prolonging treatment, it is worth the effort because otherwise the outcome—death—is a virtual certainty.

In an article titled "Physician Authority For Unilateral DNR Orders," the authors note the two rationales offered to support a DNR order: (1) that the attempt will in all probability be unsuccessful; and (2) that even if resuscitated the patient's quality of life would be unacceptable.[21] They go on to endorse unilateral medical decision-making in the former but not the latter case. In their judgment, an assessment of probability implicates the physician's prognostic skills and thus falls within their professional judgment. However, a quality-of-life assessment is a value-laden judgment that falls outside the boundaries of the physician's expertise.[22]

When one turns to the latter category— qualitative futility—one confronts the dilemma of the patient in the *L. and H.* case. Twaddle J.A. did not say that CPR was contraindicated because it would most likely fail to accomplish its purpose (i.e. prove futile in the quantitative sense). His unstated premise was rather that life-extending treatment for a PVS patient is pointless because the patient is beyond both benefit and burden. In short, CPR cannot hurt such a patient who is beyond hurting but then neither can it help because the PVS patient is also beyond helping.

From that standpoint, ventilators (also called respirators) and feeding tubes for PVS patient are not medically futile in the strict physiological sense of the term because they clearly do what they are designed to do: breathe for and feed patients who cannot breathe and feed on their own. And if CPR can restart the patient's heart, it likewise is not contraindicated in the sense that antibiotics would be for a viral infection. Be that as it may, the PVS patient is a paradigmatic example of the kind of case in which treatment cancels itself out because it neither benefits nor burdens. It is said that in such cases life-support measures have an "effect" but that, given the prognosis, their use serves no rational end.

The meaning of the debate on qualitative futility is captured in the following comment by two physicians from the MacLean Center for Clinical Medical Ethics at the University of Chicago.

> A major source of controversy results from disagreements among different observers as to whether the predictable physiologic effect of a treatment is actually a benefit. For example, it is clear that, in general, tube feeding will predictably prolong the life of a permanently unconscious patient. However, whereas such a patient's family may believe that prolonging the life of their relative is beneficial, the patient's

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[21] F.H. Marsh & A. Staver, "Physician Authority for Unilateral DNR Orders" (1991) 12 J. Legal Med. 115.

[22] *Ibid.* at 118. I suggest that neither does the former call for a strictly medical decision. Deciding when the odds against a successful outcome are so overwhelming—albeit not certain—that continued treatment is not worth the effort surely calls for a value-laden response that implicates more than mere medical knowledge. In fact, if physicians did nothing more than make technical decisions, there would be no need for a field called medical ethics. As pioneer medical ethicist Paul Ramsey noted three decades ago in the introduction to his classic work, *The Patient as Person*, "[T]he problems of medical ethics...are by no means technical problems on which only the expert [in this case, the physician] can have an opinion. They are rather the problems of human beings in situations in which medical care is needed." P. Ramsey, *The Patient as Person* (New Haven: Yale University Press, 1970) at xi.

> physician may disagree. To assert that it is futile to provide tube feedings for a permanently unconscious patient is to assert that prolonging the patient's life is not a benefit. In such situations, claims of futility imply not that the therapy is ineffective, but rather that any effect is nonbeneficial. Thus the futility debate frequently reduces to: What effects count as benefits, and who decides which benefits are worth pursuing?[23]

That debate (albeit not directly expressed in terms of futility) has been at the centre of legal attention in the United States since the Quinlan family sought judicial approval to direct the removal of their daughter's respirator. Beginning with *Quinlan*, most of the American "right to die" cases have involved PVS patients whose health care facilities had contested the requests of family members to discontinue life-support measures. In most such cases, the institutions were not swayed by a commitment to maintaining life at all cost but rather by the absence of clear judicial authority to comply with family wishes.

In the result, there is a consensus in American case law that the termination of artificial life-support for PVS patients is supportable on both constitutional and common law grounds. It is pertinent to add, however, that in none of the cases was it suggested that the treating physician could act unilaterally to terminate life-support measures for a PVS patient on the grounds that such decision did not involve "treatment" of the patient.

I agree with that line of cases because to my mind it is pointless, dehumanizing, and a waste of resources to maintain the life of a PVS patient. I share the viewpoint of Dr. Lawrence J. Schneiderman who wrote in an article titled *Exile and PVS*:

> Although modern neurology dismisses the possibility of suffering in permanently unconscious patients, they exist in a worst possible, dehumanizing condition – enslaved to perpetual inertness, emotionless, helplessness, unlike any other form of human existence, isolated from every human connection and communication – an exile, whether perceived or not.... If physicians find this view persuasive, then withdrawing life-supporting treatment from a patient in PVS becomes not merely ethically permissible, but an obligatory act of beneficence.[24]

Still, one must concede that the decision that a patient—however dismal the prognosis—is better off dead is one that cannot be taken lightly. Given that the Court in *L. and H.* was asked to endorse a medical decision based upon quality of life grounds, it was surely incumbent upon Twaddle J.A. to address the profound ethical implications of the matter at hand. In the *Bland* case, the House of Lords devoted 46 pages to a painstaking analysis of the issues addressed by the proposed termination of artificial feeding for a PVS patient. In contrast, the Manitoba Court of Appeal disposed of the question of withholding life-prolonging treatment from such a patient in one sentence: "[P]hilosophical arguments apart, it is in no one's interest to artificially maintain the life of a...patient who is in an irreversible

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[23] R.M. Taylor & J.D. Lantos, "The Politics of Medical Futility" (1995) 11 Issues in L. & Med. 3 at 4.
[24] L.J. Schneiderman, "Exile and PVS" (1990) 20:3 Hastings Center Rep. 5 at 5.

vegetative state."[25] (Twaddle J.A.'s reasons for judgment take up a scant two pages in the law reports.)

Yet when one is dealing with so-called "right to die" cases, don't the issues at hand require the resolution of "philosophical arguments"? And if one decides, as did Twaddle J.A., that the "life" of a PVS patient is not worth living, isn't that a philosophical judgment? Surely the question warrants more than the cursory treatment afforded by the Manitoba court, whose rush to judgment stands in marked contrast to rulings by courts in the United States, Great Britain, and elsewhere which have given the attention that is deserved to life and death matters.

3. Touching Versus Nontouching

The *L. and H.* case is the only appellate court decision in a common law jurisdiction to rule that consent to the termination of life-prolonging measures is not required whenever the carrying out of the physician's decision does not entail hands-on treatment. According to Twaddle J.A., the only reason for the consent requirement to medical treatment is that, emergencies aside, non-consensual touching of the patient's body constitutes the crime of assault.[26] (It would of course likewise amount to the tort of battery.) He was thus led to conclude that, since not resuscitating is not touching, the physician could issue a DNR order for his PVS patient without securing consent from the legal guardians or the judiciary. Furthermore, consent is only required when there is physical contact with the patient, it follows that his ruling cannot be restricted to PVS patients and DNR orders. In sum, whatever the patient's medical situation, if treatment—whether CPR, artificial feeding, artificial respiration, dialysis, antibiotics, or whatever—is being foregone, then the physician can act unilaterally. And that is because, in Twaddle J.A.'s view, "[t]here is no need for a consent from anyone for a doctor to refrain from intervening."[27]

The Court thus restricts the decision-making authority of patient and surrogate to an active intervention. Simply put, treatment requires consent but nontreatment—refraining from intervening—does not. The Court's definition of treatment can be contrasted with that found in "Taber's Cyclopedic Medical Dictionary." The first entry under the heading of treatment defines it as "[m]edical, surgical or psychiatric management of a patient."[28] In that sense, a DNR order is seen as part of the treatment plan. This is clearly the position of the U.S. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. In its 1983 publication, *Deciding to Forego Life-Sustaining Treatment*,[29] the Commission emphatically rejected the claim that consent need not be obtained for a DNR order because it does not involve a course of treatment. "The Commission finds it necessary for the patient or surrogate to have given valid consent to any plan of treatment, whether involving omissions or actions, and rejects this claim."[30]

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[25] *Supra* note 1 at 137.
[26] *Ibid.*
[27] *Ibid.* at 138.
[28] C.W. Taber, *Taber's Cyclopedic Medical Dictionary*, 11th ed. (Philadelphia: Davis Compnay, 1970) at T-44.
[29] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment*, (Washington: U.S. Government Printing Office, 1983).
[30] *Ibid.* at 241, fn. 39.

That a DNR order is part of a treatment plan was also assumed by a judge of the Ontario Divisional Court in a case heard but one month before the decision in *L. and H.* In *London Health Sciences Centre et al.* v. *R.K. et al.*,[31] McDermid J. considered an application by the hospital and attending physician for a declaration of criminal and civil immunity if they withdrew life-support from an 83-year-old PVS patient. The application referred to the proposed discontinuation of "ventilation, nutrition and hydration by artificial means" and to non-resuscitation in the event that the patient suffered "a cardiac or respiratory arrest either before or after such discontinuance."[32] In the result, McDermid J. rejected the application, albeit he concluded that there were no legal obstacles to the proposed measures. He also concluded that "I have no hesitation in finding that the proposed plan of treatment, namely to withdraw artificial life support from R.K. and to refrain from resuscitating him in the event of another cardiac or pulmonary arrest, is in his best interests."[33]

In other words, a treatment plan for a patient encompasses measures that will be taken as well as measures that will not be taken. For how else can one determine the care—the treatment—of the patient? To say that a nontreatment option is not part of the patient's treatment is to ignore the fact that treatment is about caring – and that caring sometimes means hands-on and sometimes means hands-off. Either way, the patient is being treated as a person for whom not doing may be just as beneficial as doing.

Even if, however, one were to accept Twaddle J.A.'s treatment-versus-nontreatment dichotomy, it would require further refinement. Given his standpoint, it really becomes a question of treatment versus the withholding of treatment or the withdrawal of treatment when such does not involve bodily contact. Therefore, the import of his decision is that different legal implications may attach to withholding and withdrawing; that whereas consent is not required for withholding, there must be consent to withdrawal of treatment unless the procedure does not entail contact with the body of the patient.

In the *Bland* case, it was argued by the guardian *ad litem* for the patient that the proposed removal of his nasogastric tube and the discontinuance of artificial feeding were "positive acts of commission" and therefore tantamount to euthanasia (i.e. murder).[34] The Court responded that "the failure to continue to do what you have previously done is...by definition an omission to do what you have previously done."[35] Acknowledging that the "positive act of removing the nasogastric tube presents more difficulty," Lord Browne-Wilkinson offered some pertinent remarks about the artificiality of the distinction between life-ending acts of commission and omission.

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[31](1997), 152 D.L.R. (4th) 724 (Ont. Ct. (Gen. Div.).

[32]*Ibid.* at 726.

[33]*Ibid.* at 731. Regarding criminal immunity, McDermid J. held that a civil court could not impinge upon prosecutorial discretion, and that, in any event, counsel had not found any Canadian case in which a criminal charge was laid for terminating life-prolonging treatment. Regarding civil immunity, he concluded that such was already the effect of a written consent by the patient's wife and son in which they discharged the hospital and physician from liability for terminating life-prolonging treatment. He also expressed the view that the patient's condition was hopeless and that it was "futile to maintain him on the life support systems."

[34]Bland, *supra* note 18 at 383.

[35]*Ibid.*

> It is undoubtedly a positive act, similar to switching off a ventilator in the case of a patient whose life is being sustained by artificial ventilation. But...in neither case should the act be classified as positive, since to do so would be to introduce intolerably fine distinctions. If, instead of removing the nasogastric tube, it was left in place, but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission. Again...if the switching off of a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be reset every 12 hours; the failure to reset the machine could not be classified as a positive act. In my judgment, essentially what is being done is to omit to feed or to ventilate; the removal of the nasogastric tube or the switching off of a ventilator are merely incidents of that omission.[36]

Twaddle J.A.'s ruling would thus allow a physician to act without the consent of patient or surrogate when ventilator support is terminated by not resetting the time-clock. In other words, if there is no touching, then consent is not required. If however, a sedating dose of morphine were indicated because the patient might otherwise gasp for breath, then consent would be required.[37] It is true that if the physician did nothing and allowed the patient to suffer needlessly before dying of respiratory failure, then the family could sue for negligence. Still, this scenario surely illustrates the peculiar nature of a ruling that takes the overall treatment plan for a patient and bisects it into treatment, which requires consent, and refraining from treatment, which does not.

As their lordships in *Bland* correctly noted, the distinction between commission and omission does not hinge upon whether the physician makes contact with the patient's body in the course of discontinuing life-prolonging treatment. That conclusion is in accord with the overwhelming consensus by the courts (and by bioethicists) that there is no legal (or ethical) distinction between withholding and withdrawing life-prolonging treatment. In contrast, the import of the ruling in *L. and H.* is that the physician who withdraws artificial life-support without the consent of patient or surrogate commits the crime of assault (and the tort of battery) only if removal entails the touching of the patient. But should legal principles follow from such a nit-picking distinction? As Lord Browne-Wilkinson pointed out in *Bland*, the caregiver can adopt procedures to obviate the need to touch the patient in the process of discontinuing life-support measures. Thus, the touching versus nontouching dichotomy lacks any ethical or—the case of *L. and H.* aside—any legal relevance.

Surely, at the end of the day the question of patient (or surrogate) consent cannot be resolved on the narrow ground enunciated by Twaddle J.A. In a 1993 Supreme Court case, *Ciarlariello* v. *Schacter*,[38] the issue was whether the plaintiff had withdrawn consent to an angiogram that tragically resulted in rendering her a quadriplegic. In a unanimous ruling against the plaintiff, the Court held that although she had asked that the test be stopped, she then consented to its resumption. Speaking for the Court, Cory J. explained the core issue at stake.

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[36] *Ibid.* at 384.

[37] Of course, sedation would be unnecessary before removing life-support from a PVS patient who by definition is incapable of experiencing discomfort or suffering.

[38] (1993), 100 D.L.R. (4th) 609 (S.C.C.).

> It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done with one's own body.[39]

Admittedly, the Supreme Court was dealing with the question whether a patient had been treated without her consent and not whether the patient had the right to enforce treatment. Yet I suggest that in either case—"do not treat me!" and "you must treat me!"—questions of patient autonomy and bodily integrity cannot be ignored. It may come to pass that courts in other provinces will conclude that patients or families cannot enforce the demand for CPR. But if that happens, one hopes that the resultant limitation upon patient autonomy will not reduce itself to a touching-versus-nontouching equation.

4. The Right to Refuse Versus the Right to Demand

With due respect to the Manitoba court, I suggest that the fitting tension is not between nontouching and touching but rather between *negative* and *positive* rights. Case law in Canada and other common law jurisdictions has established the right of mentally competent patients (and when incompetent their surrogates) to refuse treatment. A patient's entitlement to freedom from unwarranted interference with her bodily integrity is a negative right – that she not receive hands-on treatment without consent.[40] That is why Twaddle, J.A. rightly emphasized that nonemergency treatment without the consent of the patient or surrogate is unlawful. In contrast, a patient's empowerment to compel particular medical treatment is a positive right.[41] As the authors of an article on medical futility put it:

> [T]he law underlying the right to refuse treatment does not easily transfer to the right to receive treatment. The difference between the demands "don't touch me" and "you must touch me" is dramatic. The law has almost uniformly conceded the former but has only hesitantly recognized the latter, and only in situations related to public health and safety.[42]

Surely there is more to the claimed right of a patient or surrogate to treatment—whether it be CPR, artificial ventilation, feeding tube, dialysis or whatever—than can be resolved by the simple invocation of a touching versus nontouching dichotomy. Profound public policy concerns are implicated by medical decisions to withhold and withdraw life-prolonging measures; and it is here that we confront that troublesome F word—futility—and its quantitative and qualitative aspects. The patient's right to refuse life-prolonging treatment flows from the recognition of patient autonomy as a core principle of medical law and ethics. The question here is whether the law's enshrinement of the patient's negative right to refuse treatment should be extended to include a positive right by the patient to demand treatment that is arguably futile, or for the patient's surrogate to demand

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[39] *Ibid.* at 618.
[40] A. Meisel, *The Right to Die*, 2d ed. (New York: Wiley Law , 1995) at 546.
[41] *Ibid.*
[42] W. Prip & A. Moretti, "Medical Futility: A Legal Perspective" in M.B. Zucker & H.D. Zucker, eds., *Medical Futility and the Evaluation of Life-Sustaining Treatment* (Cambridge: Cambridge University Press, 1997) 136 at 139.

such treatment on the grounds that this is what the patient would ask for if competent to speak for herself.

The only legal precedent cited by Twaddle J.A. is *In re Dinnerstein*,[43] a 1977 Massachusetts case in which an intermediate appellate court ruled that a DNR order was solely a medical decision. In that case there was no conflict between the physician and the adult children of the "essentially vegetative" patient. All agreed that the order was appropriate, and it was simply the uncertain state of the law at that time that led the physician and family to jointly petition for judicial approval. *Dinnerstein* is but one of a long line of American cases, beginning in 1976 with *Quinlan*, which have recognized the right of the family of a mentally incompetent patient to direct the cessation of life-prolonging treatment. To reiterate, the only case cited by Twaddle J.A. falls within that line of authority; it did not deal with the right of a physician to terminate treatment against the wishes of the patient or family.

Although *L. and H.* is the first Canadian case to deal with a claimed positive right to treatment, there is law on point from the United States.

Regarding unilateral DNR orders, there is a 1997 Nebraska case, *In Re Interest of Tabatha R.*,[44] that (as in *L. and H.*) involved an apprehended infant reduced to a vegetative state by violent shaking. The juvenile court had granted custody to the Department of Social Services (DSS), which decided after medical consultation to terminate ventilatory support. As required by statute, DSS petitioned the juvenile court to approve its decision. The Court ruled in favour of DSS over the strenuous objection of the parents. Although the Nebraska Supreme Court reversed, it did not thereby reject the power of the juvenile court to allow life-support to be terminated over parental objection. It overturned the ruling because the juvenile court had wrongfully allowed DSS to prove its case on a preponderance of the evidence standard whereas it should have required DSS to prove its case by "clear and convincing" evidence. (The latter is a more onerous burden of proof than the former.)[45] As the high court explained, the state constitution requires that parental rights be terminated only in accordance with the "clear and convincing" standard, and a proceeding to terminate life-support is "the functional equivalent of a proceeding to terminate parental rights."[46]

According to Professor Alan Meisel, author of the authoritative American text, *The Right to Die*, "This appears to be the first reported case in which a court has ordered the termination of treatment over family protests and has been upheld on appeal."[47] That is not quite true as the Nebraska Supreme Court did not uphold the lower court ruling. Still, it did not object in principle to such a decision provided that the lower court applied the correct burden of proof.

There is a 1997 opinion by the Nevada Attorney General involving the issuance of a DNR order for a terminally ill apprehended minor that invites comparison to the decision in *L. and H.* The opinion was in response to a question

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[43] 380 N.E. 2d 134 (Mass. Ct. App 1978).
[44] 564 N.W. 2d 598 (Neb. Sup. Ct. 1997) [hereinafter Tabatha R.].
[45] The "clear and convincing" standard of proof has been applied in a number of American cases to the question whether life-prolonging treatment can be terminated for a mentally incompetent patient.
[46] *Tabatha R., supra* note 44 at 605.
[47] *Supra* note 40, Volume 2, 1998 Cumulative Supplement at 180.

by the Division of Child and Family Services as to the circumstances under which the agency could place a DNR order on the chart of a terminally ill child in its custody when the parents were either unavailable to consent or refused to consent. In either event, the Attorney General directed that the Division could petition the Juvenile Court for authority to issue a DNR order as serving the best interests of the ward.[48]

According to the opinion, that power is derived from a state statute authorizing the Juvenile Court to order a minor ward "to undergo such medical...care or treatment as the court considers to be in the child's best interests." The Attorney General thus assumed (unlike Twaddle J.A.) that a DNR order fell under the heading of "care or treatment...." Although the opinion allows the entry of a DNR order without parental consent, it is only the juvenile court—not the physician acting unilaterally— that is endowed with that authority.

Aside from the scant case law on DNR orders, statutory guidelines for the withholding of CPR have been enacted in 30 American states.[49] Some of the statutes require the consent of either patient or surrogate to the issuance of a DNR order, and others allow the attending physician to issue the order without consent of patient or surrogate. Of course, the very existence of the statutes is an implicit rejection of the *L. and H.* position that, whatever the wishes of patient or surrogate, the physician can unilaterally withhold CPR because only treatment, and not its omission, requires consent. If it were as simple a matter as the touching-versus-nontouching equation, then why would a legislature deem it necessary to provide specific statutory authority for a physician to issue a DNR order without consent?

The same comment is applicable to health care directive statutes in the United States that specifically allow physicians to refuse to administer futile treatment. According to the Maine and New Mexico acts, "a health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care...."[50] The Louisiana act releases the physician from the obligation to provide "medically inappropriate" treatment, and, in Virginia, the operative phrase is "medically unnecessary."[51] Again, if it were simply a matter of touching-versus-nontouching, then such enactments would be superfluous because the physician would need no specific authority to refrain from intervention. (Needless to say, these provisions beg the question as to when such treatments would be "ineffective," "inappropriate," and "unnecessary," albeit their resolution is left to medical judgment.)

Although Twaddle J.A. cited the *Dinnerstein* case (presumably because it involved a DNR order), he did not mention two American cases that featured conflict between caregivers and patients' legal guardians and in which the rulings favoured the treatment demands of the latter. A 1991 Minnesota case, *In re Wanglie*,[52] involved an 86-year-old PVS patient on mechanical respiration whose husband insisted that she be kept alive. The position of the husband and the adult

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[48]*Nev. Op. Atty. Gen.* No. 8, 1997 WL 133532 (Nev. A.G.). The opinion is unreported.
[49]*Supra* note 40, Volume 1 at 556.
[50]*Maine Uniform Health-Care Decisons Act,* Me. Rev. Stat. Tit. 18-A, s. 5-807[f], *New Mexico Uniform Health-Care Decisions Act,* N.M. Stat. Ann. s. 24-7A-7[f].
[51]*Louisiana Life-Sustaining Procedures Act*, La. Rev. Stat. Ann. s. 40:1299.58.1, *Virginia Health Care Decisions Act*, Va. Code s. 54.1-2990.
[52]*In re Conservatorship of Wanglie*, No. PX-91-283 (Minn. Dist. Ct. Hennepin Co. July 1991). The case is discussed in *Meisel, supra* note 40 at 533-4.

children was that the patient would want to be kept alive as long as medically possible because she and the family shared the religious conviction that only God could take life. One of the treating physicians responded to the unresolvable conflict by petitioning the Probate Court to appoint him to replace Mr. Wanglie as the patient's legal guardian. If the petition were granted, his stated intention was to terminate life support. (The hospital was prepared to transfer the patient elsewhere but no placement could be found.)

The petitioner framed the issue in narrow terms—that he could better serve the patient's best interests than could her husband—and the probate judge responded in kind by denying the petition on the grounds that Mr. Wanglie was not remiss in his guardianship role. She came to that result because of compelling evidence that he was a devoted and loving husband who was passionately dedicated to promoting his wife's welfare. Although her ruling in effect amounted to a victory for the Wanglie family, the judge ducked the question of whether a physician has the unilateral authority to terminate life-prolonging treatment on the grounds of medical futility. In any event, Mrs. Wanglie died four days after the Court's ruling, still connected to the respirator.

There is also the 1993-4 Virginia case of *In the Matter of Baby K*,[53] in which the mother of a newborn anencephalic insisted upon aggressive treatment which the hospital strenuously opposed. As in *Wanglie*, the demand for treatment stemmed from the religious conviction that only God could take life. An anencephalic is born without higher brain functioning and is in a permanent vegetative state. Death usually occurs within days if not weeks of birth because of multiple complications which, given the underlying condition, are not treated. The hospital sought a court order allowing its staff to refrain from ventilating the infant if she had breathing difficulties—which in effect amounted to a request for a DNR order—but both the U.S. District Court and Circuit Court of Appeals ruled in favour of the mother. (If nontouching were so clearly the definitive key, then the hospital would not have sought judicial authority to refrain from treating. The same can be said about the *Wanglie* case.)

The District Court denied the petition by ruling that the withholding of treatment for respiratory failure would constitute child abuse in violation of a federal statute, the *Emergency Medical Treatment and Active Labor Act* (EMTALA), which prohibits discriminatory treatment against persons requiring emergency medical care. The hospital had contended that it was not in breach of the statute because emergency treatment for Baby K's respiratory distress could not cure her anencephaly. (The hospital did not argue that it could unilaterally refrain from ventilating the patient because nontreatment does not require consent. Its argument was rather that it was futile to aggressively treat an anencephalic.) At the time that the Court rendered its decision in July 1993, Baby K was nine-months-old and her periodic ventilator support necessitated frequent transfer from nursing home (her permanent placement) to hospital.

In the result, the District Court accepted the argument that the emergency condition for which treatment was sought was not anencephaly but rather respiratory distress; and that such treatment was not useless because it would resolve the patient's breathing crisis. In other words, the Court was implicitly

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[53] 832 F. Supp. 1022 (1993); 16 F.3d 590 (4th Cir., 1994); cert denied 115 S.Ct. 91 (1994).

rejecting an argument from qualitative futility. As it concluded: "in this case, where the choice essentially devolves to a subjective determination as to the quality of Baby K's life, it cannot be said that the continuation of Baby K's life is so unreasonably harmful as to constitute child abuse or neglect."[54]

The decision was affirmed by the U.S. Circuit Court of Appeals in February 1995. Two months later baby K died shortly after being rushed by ambulance to hospital for the sixth time.[55]

On the other hand, there is a 1995 Massachusetts case, *Gilgunn* v. *Massachusetts General Hospital,*[56] in which a civil jury dismissed a law suit claiming damages for emotional distress brought by the daughter of a mentally incompetent elderly patient who had died after the termination of artificial life-support. Although the daughter had insisted that it was her mother's wish to be kept alive for as long as possible, the attending physician removed the ventilator after he and medical colleagues were convinced that her mother would not recover from her comatose condition. (He had also written a DNR order over the daughter's objection.) In dismissing the action, the jury in effect found that the daughter was not entitled to recover damages for the unilateral action of the physician. There is no appellate decision because the jury verdict was not appealed, but in any event the case did not directly confront the question whether a family member has the right to insist upon life-prolonging treatment for an incompetent patient.

Although *L. and H.* is the only reported appellate court decision in Canada involving the withholding of CPR, the matter has been treated in the Joint Statement on Resuscitative Interventions issued in 1995 by the Canadian Medical Association, the Canadian Nurses Association, the Canadian Healthcare Association, and the Catholic Health Association of Canada.[57] According to the guidelines "there is no obligation to offer a person futile or nonbeneficial treatment."[58] Accordingly, CPR is not a reasonable option when "it offers no reasonable hope of recovery or improvement or because the person is permanently unable to experience any benefit."[59]

As pointed out by Professor Joan Gilmour, the guidelines are ambivalent as to whether physicians should be entitled to direct DNR orders over the objection of

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[54] *Ibid.* at 832 ; F. supp. at 1031.
[55] There is also a 1992 Georgia case, *In re Doe*, with similar facts and outcome to *Baby K*, although decided on purely statutory grounds. The 13-year-old patient was in a condition resembling PVS and the hospital sought judicial authorization for a DNR order. The parents protested and the trial court denied the petition. On appeal, the State Supreme Court affirmed, holding that the DNR order could not be imposed without parental consent. That was because the Georgia DNR statute provides that when a minor child is a proper candidate for nonresuscitation, the attending physician must obtain parental consent before issuing a DNR order. The case is found at 418 S.E.2d 3, and the statute is Ga. Code Ann ss. 31-39-1 to -9. According to Professor Meisel, the holding rests on a "narrow statutory basis"—the Georgia statute on DNR orders—and thus the decision is a "very thin precedent for anything other than the same fact situation in the same jurisdiction." See *Meisel*, *supra* note 40 at 560.
[56] No. 92-4820 (Mass. Super. Ct. Civ. Action Suffolk Co. April 22, 1995). The case is unreported. It is discussed in the article by Prip and Moretti, *supra* note 42 at 151-2. See also *Meisel, supra* note 40 1998 Cumulative Supplement at 181-3.
[57] CMA *et. al.,* "Joint Statement on Resuscitation Interventions" (1995) 153 Can. Med. Ass. J. 1652A.
[58] *Ibid.* at 1652B.
[59] *Ibid.*

patient or surrogate.[60] Although they provide that "[a]s a general rule a person should be involved in determining futility in his or her case," they go on to say that CPR should not be a treatment option when the patient will almost certainly not benefit from it.[61] This lack of clarity is no doubt a reflection of the complexities inherent in a conflict between the patient or family who insists upon saying yes and the physician saying no. That said, I turn to the question of whether the law has given a clear direction as to who wins that conflict.

5. The Physician's Authority to Withhold Life-Support Measures

In its 1982 working paper, *Euthanasia, Aiding Suicide and Cessation of Treatment*, the Law Reform Commission of Canada addressed the question: Who has the decision-making power to terminate life-prolonging treatment for incompetent patients?[62] The Commission indicated its firm opposition to mandatory judicial oversight of the decision-making process, concluding that court involvement was necessary only when there was unresolvable conflict within the patient's family or between family and physician.

> One would not wish to judicialize and hence to make adversarial a decision-making process which should be based more on consensus than confrontation. A judicial decision is necessary when there is some conflict. It may be superfluous when it is used merely to formalize a decision which has already been made and which no one has challenged and which involves no real dispute, controversy, or conflict.[63]

That position was affirmed in the Commission's follow-up report a year later, in which it suggested that the incompetent patient's physician should be the central figure in the decision-making process; that the physician consult with the family but that the ultimate responsibility must rest upon her shoulders.[64] Although it left open resort to the courts in cases of conflict, we have seen that the Manitoba Court of Appeal deems that route unnecessary when the medical decision involves the foregoing of treatment. Yet another court faced with the same essential facts might have used the occasion to develop common law guidelines for the resolution of such conflict (perhaps by prescribing resort to the courts or to a hospital review panel).

The import of the *L. and H.* case is that there is no civil liability (and by implication, no criminal liability) when caregivers act upon the reasonable medical judgment that life-prolonging treatment is no longer warranted in the particular case. As briefly noted in the introduction to section 4, there is already an abundance of case law in common law jurisdictions to that effect although the cases have not involved the foregoing of treatment over family dissent. Beginning with the 1976 decision by the New Jersey Supreme Court in the *Quinlan* case, the cases have rather involved families suing health care facilities for refusing to discontinue life-support measures.

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[60]Ontario Law Reform Commission, *Study Paper on Assisted Suicide, Euthanasia and Foregoing Treatment* (1996) at 232-3. Professor Gilmour's discussion of futility on pages 229-37 is an excellent introduction to the topic.
[61]*Supra* note 57 at 1652B.
[62]Working Paper 28, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1983) at 26.
[63]*Ibid.* at 64.
[64]Report 20, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1983) at 26.

There is, for example, a 1983 California case, *Barber and Nejdl* v. *Superior Court*,[65] in which the family of a comatose patient agreed with his physicians that it was time to call a halt to artificial life-support. When that happened, a prosecutor responded to the patient's death by charging the physicians with murder. (This is the only case in a common law jurisdiction in which the termination of life-prolonging treatment has led to a criminal charge.)

> A physician has no duty to continue treatment once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the immediate aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel. A physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless...without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery.[66]

If there is no medical duty to provide "futile" treatment, is the Court ruling that a physician can unilaterally terminate life-prolonging treatment? According to Professor Meisel, that interpretation does not follow because the ruling "must be understood in the context of the cases giving rise to it."[67] As he explained:

> In every such [American] case holding permissible the foregoing of life-sustaining treatment, there was legally valid consent from the patient either contemporaneously or through an advance directive or from a surrogate to do so. Indeed the earliest right-to-die cases—and possibly the current ones as well—are litigated precisely because there is a question about whether foregoing life-sustaining treatment is lawful if there is appropriate consent.... Thus...it is permissible to forego life-sustaining treatment deemed futile by a competent patient or the surrogate of an incompetent patient.[68]

As he adds (bearing in mind the earlier distinction between negative and positive rights), this line of authority does not address the question whether life-sustaining treatment "may be terminated *unilaterally* by an attending physician without the permission of someone authorized to give it or even in opposition to such a party."[69] Professor Meisel does not read the cases that establish the right of

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[65]195 Cal. Rptr. 484.
[66]*Ibid.* at 491.
[67]*Supra* note 40 at 538.
[68]*Ibid.*
[69]*Ibid. [*Emphasis original.] Notwithstanding the paucity of legal action by families against medical decisions to terminate treatment, there is evidence (at least in the United States) that physicians do act unilaterally in such circumstances. In 1988, a Boston physician reported that over the previous ten years, there were 20 cases at the Massachusetts General Hospital in which physicians had written DNR orders for terminally ill incompetent patients despite family objections - 16 of which occurred over the last three of the ten years. All the decisions were approved by the hospital's Optimum Care (Ethics) Committee on futility grounds. See T.A. Brennan "Incompetent Patients with Limited Care in the Absence of Family Consent" (1988) 109 Annals Int. Med. 819. A more recent study reported the results of a survey of physicians practicing in adult intensive care units across the United States. Of the 879 respondents, 726 acknowledged that they had withdrawn or withheld life-prolonging treatment on futility grounds. Of these 726, 219 (30%) had done so without the written or oral consent of patient or family, 120 (17%) without the knowledge of patient or family, and 28 (4%) despite objections from patient or family. See D. Asch, J. Hansen-Flaschen & P. Lanken, "Decisions to Limit or Continue Life-sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians'

patients and surrogates to refuse life-prolonging treatment as enshrining their right to demand such treatment. In his view, to contend that the former

> creates a claim on the part of patients to require that life-sustaining treatment be continued against the will of the physician—in effect, a right on the part of patients or families to dictate to physicians what treatment they will administer—is to read the common law precedents out of context and far too broadly.[70]

In sum, that the law allows for the termination of life-prolonging treatment at the demand of patient/surrogate does not necessarily translate into the legal mandate that life-prolonging treatment be continued at the demand of patient/surrogate. Notwithstanding *Wanglie* and *Baby K*, that issue remains unsettled. And however dealt with in the future, it is doubtful that judges in the United States (or elsewhere for that matter) will adopt the Manitoba Court of Appeal's touching-versus-nontouching dichotomy as a cut-and-dried solution to patient or surrogate demands for a positive right to treatment.[71]

6. The *Sawatsky* Case

Notwithstanding the ruling in the *L. and H.* case, a year later the wife of a mentally incompetent 79-year-old patient legally challenged the entry of a DNR order on his medical chart. In *Sawatsky* v. *Riverview Health Centre*,[72] Justice Beard of the Manitoba Court of Queen's Bench heard an application for an interlocutory injunction to put the DNR order on hold. In addition to Parkinson's disease, the patient had suffered multiple strokes. According to Riverview's medical director, "Mr. Sawatsky is able to convey his wishes only on a very inconsistent basis, and mostly through non-verbal signals, and only for very basic needs. He has difficulty swallowing, difficulty speaking, and the strokes have resulted in impairment of his mental abilities."[73]

The DNR order was based upon the medical judgment that in the event of a respiratory or cardiac arrest, CPR would most likely fail or otherwise would reduce the patient in a vegetative state. Justice Beard granted the injunction but was at pains to point out that her order did not address the merits of the case. Her stated intention was to clarify the situation, and she accordingly called for at least two

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Practices and Patients' Wishes" (1995) 151 Am. J. Respir. Crit. Care Med. 288. Although there are no comparable Canadian studies, I am familiar with a Winnipeg case in which life-support was terminated for a vegetative six-month-old patient over the objection of the father who kept insisting that God would perform a miracle.

[70] *Ibid.* at 540.

[71] In stark contrast to the United States, there are few Canadian cases that have litigated the claimed "negative" right of patients or surrogates to refuse life-prolonging treatment. Suffice it to cite two Quebec cases. Regarding patients, there is *Nancy B.* v. *Hôtel Dieu de Québec*, (1992) 69 C.C.C.(3d) 450, in which the Quebec Superior Court ruled that a mentally competent patient had the legal right to enforce the removal of her artificial life-support. Regarding surrogates, there is *Couture-Jacquet* v. *Montreal Children's Hospital* (1986), 28 D.L.R. (4th) 22, in which the mother and grandmother of a two-year-old with a deadly form of pelvic cancer refused to consent to a fourth series of chemotherapy treatments because of the dismal prognosis and the side effects of the previous treatments. The hospital sought to compel the treatments but the Quebec Court of Appeal rejected the petition on the grounds that the hospital had failed to prove that the family's decision was contrary to the child's best interests.

[72] *Sawatsky and Riverview Health Centre Inc.* Docket: CI 98-01-10245, [1998] M.J. No. 506. The case is unreported.

[73] *Ibid.* at 4.

independent medical opinions as to Mr. Sawatsky's condition and the advisability of the DNR order. Her expressed hope was that these additional reports would help resolve the conflict between Mrs. Sawatsky and her husband's caregivers.

Counsel for the Manitoba League of Persons With Disabilities, which was granted intervenor status in the *Sawatsky* case, raised the question whether a DNR order without the consent of patient or family breached the *Charter of Rights and Freedoms* – in particular section 7 (the right to life, liberty, and security of the person), section 12 (prohibiting cruel and unusual treatment or punishment), and section 15 (prohibiting discrimination based on mental or physical disability).[74] Justice Beard noted that Twaddle J.A.'s judgment did not consider the *Charter* and she left open the pursuit of *Charter* issues if the parties could not resolve their differences.[75]

The policy issue raised by the *Sawatsky* case is whether the law's recognition of the negative right to refuse treatment should be extended to include a positive right by patient or family to enforce a demand for treatment that the caregivers regards as medically unreasonable – that is, as futile in the quantitative or qualitative sense. What happens if the patient cannot be transferred to a physician prepared to accede to that demand? Should the law require the physician to act against her professional judgment that the proposed treatment will not benefit and may well harm the patient? The patient's nurses may feel the same way. The physician would say that a law that so commands clashes with the ethical commandment to physicians, "*Primum non nocere*" – above all, do not harm your patient.[76]

In 1992 the English Court of Appeal decided a case called *Re J (a Minor)*.[77] The l6-month-old patient, who was in foster care, was afflicted with severe microcephaly (an abnormally small head which is inevitably accompanied by brain damage), blindness, and severe forms of cerebral palsy and epilepsy. Since the consultant pediatrician was of the view that intensive therapeutic measures would not be medically appropriate if the infant were to suffer a life-threatening event, the local health authority sought a judicial declaration as to whether life-prolonging treatment could be withheld. In the result, the Court of Appeal held that it would amount to a judicial "abuse of power" to order a physician to act against her clinical judgment.[78] As it explained:

> If the court orders a doctor to treat a child in a manner contrary to his or her clinical judgment it would place the conscientious doctor in an

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[74] *Ibid.* at 8-9.
[75] As Justice Beard noted, the *Charter* may be relevant to the case because of the Supreme Court decision in *Eldridge* v. *Attorney General (British Columbia)* (1997), 151 D.L.R. 4th 577, in which the Court ruled that the Charter may apply to the actions and services of a hospital. The Court held that, although hospitals are not "government" for the purposes of section 32, they were carrying out a specific government objective in providing medically necessary services under the provincial *Hospital Insurance Act* and hence were subject to the *Charter* in the provision of those services. The case involved the failure to provide sign language interpretation (thus amounting to discrimination under s. 15), and as Justice Beard commented there are "significant differences" between the failure to provide translation services and the ethical issues implicated in *Sawatsky*. She thus left open the question of the applicability of the *Charter* to the case before her. See page 9 of her reasons for judgment.
[76] Admittedly, however, as the *Sawatsky* case illustrates, what the physician regards as harm to the patient may be viewed differently by the patient or family.
[77] 1992] 4 All E.R. 617.
[78] *Ibid.* at 622.

> impossible position. To perform the court's order could require a doctor to act in a manner which he or she genuinely believed not to be in the patient's best interests; to fail to treat the child as ordered would amount to a contempt of court. Any judge would be most reluctant to punish the doctor for such a contempt, which seems to me to be a very strong indication that such an order should not be made.[79]

In any event, the Court of Appeal's concern in *Re J* was not operative in the *Wanglie* and *Baby K* cases in which physicians were ordered to continue treatment that they considered medically unreasonable. Whatever one's view of these two American cases, it must be acknowledged that the physician's resolve to omit life-support measures for a mentally incompetent patient is not a purely medical decision. As indicated by my all too brief commentary on medical futility, such a decision reflects the value judgment that the patient's prognosis precludes aggressive measures to stave off death. Still, this kind of decision-making is standard procedure in hospital practice, and on any given day scores of patients across Canada die a quicker (and hopefully easier) death than they would if aggressive life-support measures were kept in place until the bitter end. That happens because it is senseless to keep patients alive for no other reason than that it can be done.

In its working paper, *Euthanasia, Aiding Suicide and Cessation of Treatment*, the Law Reform Commission of Canada repudiated the view that "it is the doctor's solemn duty to initiate and to continue treatment in all cases."[80]

> [T]he guiding principle for medical decision-making is not life in itself as an absolute value, but the patient's overall welfare. In most instances, this welfare imposes the maintenance of life, but this is not always the case. It is not the case when the prolonging of life has become purely artificial.... It is not the case when the maintenance of life results only in the affliction of additional suffering. In other words, it is not the case when treatment is diverted from its proper end and merely prolongs the dying process rather than life itself.[81]

Although the decision in *L. and H.* has provoked public concern that its import is to exclude families from the decision-making process, the reality of hospital practice is that the family of a mentally incompetent patient is not so much consulted as asked to accept the medical opinion that life-support measures be terminated. There will be discussion between physician and family, and the former may ask the latter for guidance, particularly for the known treatment wishes of the patient. (If the patient had the foresight to prepare a health care directive, that will help facilitate the discussion.) Physicians certainly consult with families, but not in the sense of an equal partnership. What rather happens is that physicians who are experienced with end-of-life matters invariably lead families to agree with their (the physicians') judgment calls, whether it be to continue or to stop treatment.[82]

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[79] *Ibid.* at 625. The media coverage of the case prompted an anonymous donor to fund the treatment, but not surprisingly it failed to save her life: H. McConnell, *Medical Post* (4 June 1996) 56.
[80] *Supra* note 62 at 58-9.
[81] *Ibid.* at 59.
[82] I say this because of innumerable discussions I have had over the years with physicians in Winnipeg and elsewhere about the reality of the decision-making process of terminating life-prolonging treatment for mentally incompetent patients. One can call this "anecdotal evidence," but it not only my experience that causes me to say this. I have heard much the same from a number of colleagues in the health law

(Sometimes the dialogue is initiated by the next-of-kin who question the need to prolong the patient's dying.) There are occasional cases of conflict between caregiver and family, and whatever the outcome *L. and H.* is the first Canadian case in which a medical decision to withhold treatment has been legally contested.

What has changed as a result of the *L. and H.* case is that physicians in Manitoba now have the clear authority to override family dissent. When the treatment withheld is life-prolonging, the family can succeed in an action for wrongful death if it can prove that the decision was medically unreasonable, albeit that remedy may be small consolation for the death of the patient. (Although it remains to be seen whether the controversy engendered by the *Sawatsky* case will inhibit physicians from unilaterally halting treatment.)

Be that as it may, the Manitoba ruling may affect the response of hospitals to cases that illustrate the so-called "daughter from California syndrome." Assume an elderly widowed patient and the acquiescence by her in-town adult children to the medical recommendation to forego her life-support measures. The daughter from California (or perhaps the son from a distant province), who has not seen the parent for years, appears on the scene, demands inappropriate aggressive care and disrupts the management of the case. The daughter's guilt feelings are reflected by acute denial as well as anger and resentment directed against the staff and her siblings, and she threatens the caregivers and hospital with a law suit unless her wishes are carried out. When the patient dies weeks or months later notwithstanding treatment, as often as not the daughter from California does not fly back for the funeral.[83]

There is anecdotal evidence that in such cases health care facilities will direct compliance with the demands of the sole dissenter, particularly when the insistence upon treatment is backed by a threatening letter from a lawyer. What often happens is that the hospital's legal counsel reacts to the spectre of a law suit by advising against the termination of life-support measures, notwithstanding the contrary views of the caregivers and other family members. Presumably, what explains the decision is uncertainty regarding hospital liability when life-prolonging measures are terminated over the objection of a family member.[84] However, that fear is likely unfounded as I am not aware of any Canadian case in which that kind of conflict has led to a law suit. (The first case in a common law jurisdiction in which a physician who terminated life-prolonging treatment was sued for wrongful death by a disgruntled next of kin was *Gilgunn*, in which as noted the jury ruled against the plaintiff.)[85]

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field reporting on their conversations with health care professionals. To the same effect is the experience reported by a sociologist who spent three years observing intensive care units in New York and Boston. See R. Zussman, *Intensive Care* (Chicago: University of Chicago Press, 1992) at Chapters 8 and 15.

[83]D.W. Molloy *et al.,* "Decision Making in the Incompetent Elderly: "The Daughter from California Syndrome." (1991) 39 J. Am. Geriatric Society 397.

[84]Twice in one recent year, I was consulted by Winnipeg hospitals in cases that illustrated the "daughter from California syndrome." I have also been consulted in a number of cases in which the dissenter is not from out of town, is close to the patient, and insists, against the views of other family members and caregivers, upon the continuation of life-prolonging measures. The reason usually given is that God will perform a miracle. In all these cases the legal advice received by the hospital was to continue treatment. From what I gathered, that advice was not based upon legal principles but rather upon the fear of media publicity of a law suit by an outraged plaintiff claiming that the hospital had killed her parent.

[85]Although *Gilgunn* was the first case of its kind on record, there is now another. In a 1995 Georgia case, *Velez* v. *Bethune*, 466 S.E.2d 627, an intermediate appellate court rejected the defendant-physician's motion for summary judgment in a wrongful death suit filed by the parents of his patient. The basis of the claim was that the physician had unilaterally terminated mechanical ventilation for their

The *Sawatsky* case highlights a public concern about undertreatment, and much of the media coverage portrayed it as a David and Goliath encounter – an elderly and devoted wife singlehandedly seeking to save her husband from the clutches of an impersonal medical system. (For example, one front page article in *The Globe and Mail* was headlined, "Doctors Won't Save Man Despite Wife's Plea".)[86] In letters to the press and comments on radio talk shows, concerned Manitobans expressed agreement with Mrs. Sawatsky when she said about her husband, "They have written him off. The older you get, the more vulnerable you become, the more expendable you get."[87] Her conflict with Riverview likewise prompted comments from the disabled community that unilateral DNR orders were an infringement of patients' entitlement to health care, which is why the Manitoba League of Persons With Disabilities sought intervenor status in the case.

What that concern reflects is the legitimate fear of undertreatment in a health care system that has the earmarks of an ailing underfunded patient. This is the converse side to the spectre of overtreatment— medical technology prolonging the dying process to no rational end—which has spawned the so-called "right to die" cases affirming the right of patients and their surrogates to refuse life-prolonging treatment.[88] Mrs. Sawatsky has in effect demanded that a positive right to treatment stand shoulder to shoulder with the negative right to refuse treatment. At least for now, the law in Manitoba says "No." Yet it may happen that in *Sawatsky* (or another case), the validity of a DNR order (or other nontreatment direction) will be contested on *Charter* grounds. If that comes to pass, then the judiciary will have to strike a balance between completing claims. On the one hand, there is the patient (or family) asserting the right to compel the reluctant physician to provide the contested treatment. On the other hand, there is the physician responding that there is no duty to do whatever the patient or family wants when clinical judgment dictates otherwise and that compelling treatment in such circumstances undercuts the physician's commitment to professional integrity.[89]

That the law has a stake in protecting the professional integrity of physicians is illustrated by American cases allowing mentally competent patients to refuse life-prolonging treatment. In the process, the courts have weighed the patient's right of

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nine-day-old daughter who was born prematurely at 24 weeks. Although acknowledging that the infant was dying and that the medical decision was in itself reasonable, the court ruled that the prognosis only affects the quantum of damages, because the defendant had no right to discontinue treatment without parental consent. Its decision thus followed that of the Georgia Supreme Court in the case of *In re Doe*, *supra* note 55, which likewise turned on the DNR statute requiring parental consent when the patient is a minor. (Yet it is questionable that the statute was controlling in *Bethune,* because the case did not involve a DNR order but rather the defendant's decision to stop drug therapy and mechanical ventilation.) The statute aside, a concurring judge concluded that the physician had no right to discontinue treatment unilaterally because the constitutional right of the parents to refuse treatment for their minor child carried over to the requirement of their consent before treatment could be stopped. But the analogy can be faulted because the negative right to refuse treatment does not necessarily carry over to a positive right to insist upon treatment.

[86]"Doctors Won't Save Man Despite Wife's Plea," *The [Toronto] Globe and Mail* (17 November 1998) A1.

[87]Letter to the Editor, *Winnipeg Sun* (10 November 1998) 3.

[88]It is that spectre which explains the development of the healthcare directive (popularly known as the living will), a document which allows for the anticipatory refusal of life-prolonging measures if there ever comes a time of mental incompetency when the patient is unable to express her wishes.

[89]Although I personally do not believe that unilateral DNR orders are vulnerable under sections 12 and 15 of the *Charter,* it may be that a case could be made under section 7 – i.e. that such decision-making lacks procedural fairness and thus breaches the principles of fundamental justice. However, the kind of review mechanism considered at note 99 would remedy that concern. In any event, a discussion of *Charter* issues is beyond the scope of this paper.

refusal against the state's interest in upholding the integrity of the medical profession. In finding that the patient's right of refusal is not trumped by such interest, the courts have ruled along the following lines, quoting from the judgment of the Nevada Supreme Court in a 1990 case, *McKay* v. *Bergstedt*:[90]

> Despite the medical profession's healing objectives, there are increasing numbers of people who fall in the category of those who may never be healed but whose lives may be extended by heroic measures. Unfortunately, there are times when such efforts will do little or nothing more than delay death in a bodily environment essentially bereft of quality. Under such conditions...the medical profession is not threatened by a competent adult's refusal of life-extending treatment.[91]

In short, even if the physician rues the patient's decision as medically unwise, her professional commitment to healing and caring is not compromised by the patient's overriding claim to bodily integrity. The *Sawatsky* case, of course, presents a different question: whether the profession is threatened by a demand for treatment that is opposed on futility grounds. Since Canadian, no less than American, law has a stake in the integrity of the medical profession, that question surely cannot be ignored if the *L. and H.* ruling is reopened by the claim that a rejection of the positive right to treatment is a denial of the patient's rights under the *Charter*.

Bear in mind, though, that, if the concept of futility were cut-and-dried, there would be nothing to debate. If a patient (or surrogate) asked for treatment that was physiologically futile—as for example antibiotics for a viral infection—the physician clearly would be bound to refuse compliance. Yet what if the physician can only say that the treatment is highly unlikely, but not certain, to be ineffective – as for example CPR for an elderly, debilitated patient such as Mr. Sawatsky? Or what if the physician insists that the treatment, although physiologically effective, cannot benefit the patient – as for example CPR for a PVS patient? These are, after all, not purely medical decisions, and that is because they implicate value judgments about when it is no longer worthwhile to keep a patient alive.[92] Moreover, there is a concern expressed by Professor Meisel about the economics of American health care that is surely applicable to Canada as well.

> There is a fear, not totally unwarranted, that physicians, on their own initiative or at the behest of health care administrators, will begin to make treatment recommendations and decisions based on the financial interests of the health care institution, rather than the best interests of the patient. The fact that this motivation may be unconscious does not make it any less pernicious; indeed, it may make it more dangerous because it is harder to detect.[93]

When Professor Meisel speaks of "financial interests," he is of course raising the spectre of rationing – a factor that was directly confronted by the English Court of Appeal in a 1995 case. *R.* v. *Cambridge Health Authority, ex B*.[94] This tragic case

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[90]801 P.2d 617 (Nev. Sup. Ct. 1990).
[91]*Ibid.* at 628.
[92]As previously noted, when a physician decides to forego life-extending treatment, what happens is not strictly a medical decision but rather a moral decision made in a medical context. See *supra* note 20.
[93]A. Meisel, *The Right to Die 1994 Cumulative Supplement No. 1* (New York: Wiley Law, 1994) at xxiv.
[94][1995] 2 All E.R. 129.

involved a 10-year-old girl afflicted with acute myeloid leukaemia, who had been treated with chemotherapy and a bone marrow transplant. When she suffered a relapse the health authority refused to authorize a second attempt because of its cost—equivalent to $170,000 Canadian dollars—as weighed against the slim odds of survival. The parents sought to compel the defendant to authorize the procedure, but the Court of Appeal turned them down, concluding that the health authority could not be faulted for considering other claims on its limited resources, particularly in light of the patient's unfavourable prognosis. In the result, it held that budgetary allocations lay not with the courts but rather with the health authorities.

The case certainly raised a futility issue: whether the treatment was contraindicated because the odds were heavily weighed against remission. (According to the medical witnesses, the odds of a complete remission with further treatment were in the range of 10 to 20%.) But it also raised the issue of rationing: the allocation of limited health care resources. Speaking for the Court, Sir Thomas Bingham MR reluctantly concluded:

> I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world.... Difficult and agonizing judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients.[95]

Questions of futility and rationing are not necessarily intertwined as a decision to halt life-prolonging treatment on futility grounds may be unaffected by economic factors. But the point is that the spectre of rationing already haunts our health care system, and disabled health consumers in particular are not paranoid when they express concerns about the interconnection between medical judgments of futility and the high costs of life-prolonging care. This concern is no reason to combat the dying process to the bitter end when there is a consensus by interested parties (caregivers and patients/families) that aggressive measures are no longer appropriate, but that spectre is not going away and it is better that we keep it in mind than bury it out of mind. (If it is arguable that futility decisions should not exclusively rest with physicians, an even stronger case can be made that decisions on rationing grounds can be made at the bedside only in accordance with policy directives hammered out by government.)

When the *Sawatsky* case hit the media, Mrs. Sawatsky was quoted as complaining that the Riverview physicians "were playing God" with her husband's life.[96] That may be true but the fact is that advances in medical technology have

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[95] *Ibid.* at 137. The extensive media coverage of the case prompted an anonymous donor to fund the patient's treatment but not surprisingly it failed to save her life. H. McConnell, "Girl at Centre of British Health Care Storm Dies of Leukemia" *Medical Post* (4 June 1996) 56.

[96] *Supra* note 86. As a metaphor, playing God has a more direct effect when a respirator is disconnected than when a DNR order is issued. When the patient has insufficient respiratory function to breathe on her own, the disconnecting of the respirator is in effect a death sentence that is quickly implemented. However, when a DNR order is put into effect it may not affect the result because the patient may never undergo a respiratory/cardiac arrest, or if that happens it may well be that CPR would in any event have been ineffective. In fact, a DNR order should really be called a DNAR order—do-not-attempt-resuscitation—because when issued the expectation is that CPR would be unlikely to work.

made that inevitable. A hundred years ago the medical profession could do little if anything to keep patients alive, but the technology is now there to prolong dying beyond the point at which nature should be allowed to take its course. But still, it is no simple matter to determine when that point of no return has come such that it is time to call a halt to life-support measures. According to section 19 of the code of conduct of the College of Physicians and Surgeons of Manitoba, "Treatment that offers no benefit and serves only to prolong the dying process should not be employed." None would disagree with that mission statement, but still it begs the question when in any particular case the treatment is in fact nonbeneficial and is only prolonging dying. Suffice it to say that if in *Sawatsky*—or a comparable case down the road—the *Charter* is invoked to contest a medical nontreatment decision, it will take judicial acumen of the highest order to sort out the issues and strike a balance between the interests at stake. Suffice it to conclude that whatever the end result of the *Sawatsky* case, we have not heard the last of the contentious issue of a patient's positive right to treatment.[97]

7. Conclusion

Although the law as it now stands in Manitoba is that physicians have the unilateral authority to make nontreatment decisions, that need not be the final word (even if the issue is not refought on *Charter* grounds). When a medical decision to stop life-prolonging measures is contested by a family member and consensus cannot be achieved, it would be appropriate to mandate a review panel to assess the case and work to resolve the conflict. That in a sense is what Justice Beard did in the *Sawatsky* case when she put the DNR order on hold and asked for at least two independent medical evaluations. Surely something along that line could be worked out by the Winnipeg Hospital Authority and the College of Physicians and Surgeons.[98]

Moreover, since such decisions are not purely medical, it would be advisable that a review panel contain nonmedical members, such as a hospital chaplain and a patient advocate. Committee involvement is regrettable but may be preferable to the unilateral decision of the attending physician. Furthermore, that kind of remedy might help to alleviate public anxiety that patients' interests are not at the forefront of medical decision-making at the end of life.[99]

What if, however, the nonresolvable conflict arises because it is the patient himself who insists upon CPR in the event of a respiratory/cardiac arrest? I can understand the reluctance of a physician who cannot gently persuade the patient otherwise to advise him that she cannot in good conscience comply with his wishes. According to Dr. Ken Brown, the Registrar of the College of Physicians and

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[97]Aside from the *Charter*, the question of unilateral DNR orders could be revisited from the common law standpoint. As I have argued in this paper, the touching-versus-nontouching dichotomy of the *L. and H.* case does not exhaust the matters at hand.

[98]The Winnipeg Hospital Authority is a regional board that administers and funds Winnipeg's nine hospitals.

[99]If the panel could not help to achieve consensus—and the patient could not be transferred to a facility prepared to do the family's bidding—then the *L. and H.* case would leave the physician's decision in place. That *L. and H.* case aside (and it is of course a binding precedent only in Manitoba), it is arguably the worst of two worlds to mandate that in the event of unresolvable conflict either the physician or the patient/family has the final word. At that point, the only forum for decision that remains is the judiciary. Such cases may tax the wisdom of Solomon but where else can such pressing matters of last resort be resolved?

Surgeons of Manitoba, the physician is not placed in that dilemma because when it comes to CPR, "the wishes of the patient always prevail."[100] Of course, if the patient's wishes prevail, then the same policy presumably would apply when a patient's health care directive stipulates that, "No matter what my condition, I want CPR if my heart stops." How far, then, does the principle take us; if the patient can insist upon CPR, where do we then draw the line? What do we do if confronted by a case such as that of the English leukaemia patient? If a child has a slim chance for survival, do we pass on a certain death sentence because her life is weighed against dollars and comes up wanting? Yet doesn't that in effect already happen when our health care budgets do not provide all the high-tech-at-high-cost marvels of modern medicine that we would otherwise have if funding were not limited? As we enter a new millennium, the case of *L. and H.* forces us to confront the kind of health care system that we want and that we can afford. And however we grapple with these questions, we can find precious little guidance in an equation that reduces itself to two variables: touching the patient and not touching the patient.

Finally, whatever one thinks of Mrs. Sawatsky's refusal to bow to medical judgment, we can all thank her for heightening public awareness of issues that affect us all as mortal beings. Her story has no villains, as those who disagreed with her refusal to abide by the DNR order were likewise motivated to do what was best for her husband.[101] In any case, who ever said that playing God was easy?[102]

8. Afterword

According to guidelines issued in June 1999 by the British Medical Association, physicians are entitled to overrule a family's wish to keep a patient alive if they (the physicians) believe that treatment is not benefitting the patient.[103] The guidelines acknowledge that if the family cannot be persuaded that life-prolonging treatment be terminated, then it may seek judicial resolution of the conflict. However, physicians are advised that they need not seek a court order for a unilateral decision to withdraw or withhold treatment because "(i)t is ultimately

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[100] *Winnipeg Free Press* (24 November 1998) A13.

[101] Six months after Justice Beard's ruling, the media reported that two independent medical assessments had concurred with the DNR order. According to one of the physicians, Mr. Sawatsky's Parkinson's disease has worsened and, "I believe that should Mr. Sawatsky suffer a cardiac arrest in his present state, death in hospital would be inevitable even if he was successfully resuscitated." *Winnipeg Free Press* (20 May 1999) A3. Months later, the Winnipeg Free Press reported that "as a result of her ongoing disagreement with the hospital, Helene Sawatzky has served notice she wants to move her husband to an apartment and arrange for home care." According to Riverview's director, Mr. Sawatsky's condition "is so poor that there are few in the community able to take on his care. I think it's going to be difficult for her to find an appropriate placement in the community, but we're not standing in the way of the plan" *Winnipeg Free Press* (9 October 1999) A8. Two weeks later Andrew Sawatsky died at the Victoria General Hospital in Winnipeg, *Winnipeg Free Press* (28 October 1999) at A2.

[102] In 1998, the media revealed another case involving a medical treatment refusal. In a front page story on July 14, the *Montreal Gazette* reported that a 76-year-old patient at the Jewish General Hospital had died that morning, 15 hours after his respirator was disconnected against the wishes of his wife and two adult sons, one of whom insisted that his father had repeatedly stated that although he knew he was dying he did not want the treatment terminated. According to a hospital spokesperson, the patient did not insist on the continuation of life-support and furthermore the decision was medically warranted because of "the unrelenting course of his disease." The article also noted that the Quebec coroner was investigating the case: *Montreal Gazette* (14 July 1998) A1. (An inquest was held the following spring but the findings have not yet been reported.)

[103] British Medical Association, *Withholding and Withdrawing Life Prolonging Medical Treatment* (London: BMJ Books, 1999).

the doctor's call."[104] But still, "the decision should be taken in a spirit of consensus and that will happen in the vast majority of cases."[105]

Yet it is bound to happen that an unresolvable conflict will lead a patient or family to seek judicial relief. In that event, the British courts can take their turn to confront the legal, medical, societal, and ethical complexities of a claimed positive right to treatment. I hope that whatever decision ultimately results will provide more enlightenment than did the Manitoba Court of Appeal when it decided the case of *Child and Family Services of Central Manitoba* v. *R.L. and S.L.H.*

[104]The quotation is taken from a summary of the report in *The London Times* (24 June 1999) 12.
[105]*Ibid.*