Professional Standards on Withholding / Withdrawing

Year	Source	Statement	Justification
2012	**American College of Physicians Ethics Manual;Ann Intern Med. 2012;156:73-104**	_"In the circumstance that no evidence shows that a specific treatment desired by the patient will provide any medical benefit – the physician is not ethically obliged to provide such treatment (although the physician should be aware of any relevant state law). The physician need not provide an effort at resuscitation that cannot conceivably restore circulation and breathing – but he or she should help the family to understand and accept this reality. The more common and much more difficult circumstance occurs when treatment offers some small prospect of benefit at a great burden of suffering (or financial cost—see "Resource Allocation" within in the Physician and Society section) but the patient or family nevertheless desires it."	Medical benefit
2011	**Rasouli v. Sunnybrook Health Sciences Centre – 2011 ONCA 482**	_"…we are prepared to accept that the [HCCA] does not require doctors to obtain consent from a patient or substitute decision-maker to withhold or withdraw "treatment" that they view as medically ineffective or inappropriate."	Medically ineffective – Inappropriate
2011	**Schneiderman – Wrong Medicine: Doctors – Patients – and Futile Treatment by Lawrence J. Schneiderman and Nancy S. Jecker – k . 2011 John Hopkins University Press**	1. Treatment is inappropriate when the patient is permanently unconscious or otherwise unable to appreciate the effects of medical treatment. (must treat the person not just the body) 2. Treatment is inappropriate when it can only sustain the patient in the intensive care unit or acute hospital setting. (preoccupation with their illness precludes meaningful participation in the human community) 3. Treatment should not be offered when it has not worked in the last 100 cases	Futile
2008	**Rotaru v. Vancouver General Hospital Intensive Care Unit - 2008 BCSC 318**	Rather – the Petition raises the issue of whether – after certain treatment has ceased – the Court is in a position to order that the treatment resume where the medical advisors state that it is in their bona" fide clinical judgment that the former treatment is contra-indicated. [16] When faced with a similar situation – the Lord Justices in Re J – supra – were of the view that they could not conceive of any circumstances in which it would be other than an abuse of power to require a medical practitioner to act contrary to the fundamental duty which that practitioner owed to his or her patient. The statements to that effect set out in clear and strong language the position taken in Re J – supra. I agree with that view."	Contra-indicated - Duty to patient
2008	**Children's Aid Society of Ottawa-Carleton v. M.C. – [2008] O.J. No.3795 – 301 D.L.R. (4th) 194 – (Ont. Sup.Ct.)**	The decision to withdraw or withhold life-sustaining treatment is inherently a medical one – with the sole purview of a patient's treating doctors. Consent is not needed for the doctors to make use of their professional judgment and discretion to cease treatment or give only palliative care."	Medical judgment
2007	**Legal Liability of Doctors and Hospital in Canada (4th ed.) (Thomson-Carswell)**	Once a doctor-patient relationship is formed – the doctor's obligation is to treat the patient. However – this does not mean that the doctor has a duty to provide (and the patient a correlative right to receive) whatever treatment the patient may request. If a patient requests treatment which the doctor considers to be inappropriate and potentially harmful – the doctor's overriding duty to act in the patient's best interests dictates that the treatment be withheld. Likewise – there is no legal duty to perform treatment which the doctor reasonably believes to be medically futile – that is – treatment which offers no prospect of therapeutic benefit for the patient."	Inappropriate - Best interests – Medically futile - Therapeutic benefit
2006	**College of Physicians and Surgeons of Ontario Policy Statement # 1-06 – Decision Making at the End of Life**	Physicians are under no obligation to provide treatment that will almost certainly not be of benefit to the patient Patient almost certainly will not benefit: There is almost certainly no chance that the person will benefit from CPR and other life support – either because the underlying illness or disease makes recovery or improvement virtually unprecedented – or because the person will be unable to experience any permanent benefit."	Benefit - Recovery unprecedented

2002	**American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science**	Patients or families may ask for care that is highly unlikely to improve health outcomes. Healthcare providers – however – are not obliged to provide such care when there is scientific and social consensus that the treatment is ineffective. If the purpose of a medical treatment cannot be achieved – the treatment can be considered futile. An objective criterion for medical futility was defined in 1990 for interventions and drug therapy as imparting a <1% chance of survival. Although this criterion may be controversial – it remains a basis for current futility research. Without objective signs of irreversible death (eg – decapitation – rigor mortis – or decomposition) and in the absence of known advance directives declining resuscitative attempts – full resuscitation should be offered." Highly unlikely to improve health outcomes.	Ineffective - *<1% chance of survival* *- Objective signs of irreversible death*
2000	**Canadian Critical Care Society Position: Withholding or withdrawal of life support. Journal of Palliative Care 16 Supp. – 2000; s53-62**	When it is clear treatment will not be effective and is not in accord with the standard medical practice or norms – the physician is not obligated to begin – continue – or maintain the treatment"	Effective - Standard medical practice
1999	**American Medical Association Council on Ethical and Judicial Affairs: Medical Futility in End-of-Life Care Report**	"[i]f transfer is not possible because no physician and no institution can be found to follow the patient's and/or proxy's wishes it may be because the request is considered offensive to medical ethics and professional standards in the eyes of a majority of the health care profession. In such a case – by ethics standards – the intervention in question need not be provided – although the legal ramifications of this course of action are uncertain."	Ethics standards
1997	**Consensus statement of the Society of Critical Care Medicine's Ethics Committee regarding futile and other possibly inadvisable treatments**.	[t]reatments should be defined as futile only when they will not accomplish their intended goal." Treatments that are extremely unlikely to be beneficial – are extremely costly – or are of uncertain benefit may be considered inappropriate and hence inadvisable – but should not be labeled futile.	Futility
1997	**Child & Family Services of Central Manitoba v. L. (R.) [1997] – 154 D.L.R (4th) 409 Man. R. (2d) 135 (C.A.)**	There is no legal obligation on a medical doctor to take heroic measures to maintain the life of a patient in an irreversible vegetative state. *[N]either a consent nor a court order in lieu is required for a medical doctors to issue a non-resuscitation direction where – in his or her judgment – the patient is in an irreversible vegetative state."*	Vegetative state
1995	**CMA – Canadian Hospital Association – and the Catholic Health Association Joint Statement on Resuscitative Interventions**	There is no obligation to offer a person futile or non-beneficial treatment. *Treatment is considered futile when the treatment "offers no reasonable hope of recovery or improvement – or because the patient is permanently unable to experience any benefit" People who almost certainly won't benefit from CPR are not candidates for CPR – and it should not be presented as a treatment option. Whether this is discussed with the person is a matter of judgment"*	Non-beneficial – No r*easonable hope of recovery* *- Unable to experience benefit*
1995	**The Special Senate Committee on Euthanasia and Assisted Suicide: Of Life and Death – Final Report**	Futility must be understood very narrowly as treatment that will – in the opinion of the health care team – be completely ineffective."	Completely ineffective
1992	**The Appleton International Conference: Developing Guidelines for Decisions to Forgo Life-Prolonging Medical Treatment**	(a) Doctors are not obliged to provide physiologically futile treatments (ie treatments that cannot produce the desired physiological change). Where a doctor considers a life-prolonging treatment not to be physiologically futile – but nonetheless 'futile' in another sense of the word because of the low probability of success or because of the low quality of life that would remain – then decisions about the withholding or withdrawal of such treatments should be made in the context of full and open discussion of the nature and extent of the 'futility' of the treatment with the patient or the patient's representative; (b) If a requested treatment entails – according to the norms of medical practice (10) – loss of function – mutilation – or pain disproportionate to benefit – the doctor is not obliged to provide it; (c) If a doctor has a conscientious objection to a requested treatment (11) – that doctor is not obliged to provide it. The doctor should explain all treatment options and his or her position regarding them. If the patient wishes – the doctor should arrange an orderly transition to another doctor of the patient's choice; (d) Scarcity of resources may sometimes require overriding a patient's request for a life-prolonging treatment (see Part IV) (12).	Medically futile - Physiologically futile - Disproportionate to benefit - Conscientious objection

About HQCQ

The Healthcare Consent Quality Collaborative is a group of professionals, academics, and clinicians who are interested in improving healthcare quality by starting with our basic ethical and legal obligations to patients in the consent process. #72B626

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