

Ethics and the Law

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Abstract Health care providers' interpretation of law can have intended and unintended effects on health care delivery in Canada. At times, health care providers encounter situations where they perceive the law to conflict with their sense of what is most ethically justified. In many cases, these health care providers feel especially torn because they assume that the legal requirements must dictate the decision, and cannot be explored or questioned. We challenge this assumption: the law is not as cut-and-dried as some assume; therefore, its significance to health care decisions should be carefully considered. Within a systematic ethics process, legal considerations can be a source of values and information and can create opportunities for further dialogue. This approach is justified because it appropriately reflects the relationship of the law to ethics. This way of thinking about the law and ethics also avoids potentially harmful consequences of legalistic approaches to decision-making, such as breakdowns in communication, adversarial relationships, and a reduction of ethically complex decisions to simple rule following.

Keywords Ethics · Law · Healthcare ethics · Legal considerations · Values-based decision-making

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Introduction

Using an illustrative case, this paper examines the connection between ethics and the law within the practice of health care. We explore ethics and the law's distinct roles and points of connection to argue that:

1. Legal considerations should not unquestioningly be seen as determinative in a complex health care decision.
2. Relevant statutes and legislation are an important source of societal norms and values that ought to be considered within a systematic values-based decision-making process.
3. Legal considerations ought to be incorporated into a values-based process because this leads to more justified decisions while avoiding breakdowns in communication, the development of adversarial relationships, and a reduction of complex decision-making to overly simplified rule-following.

Vignette: Mr. James

Mr. James is a 90-year-old man with a history of chronic obstructive pulmonary disease. He was admitted to a community hospital ICU 50 days ago with aspiration pneumonia requiring mechanical ventilation. Dr. Sarjit is looking after Mr. James. Mr. James' hospital course has been complicated by ventilator-associated pneumonia, a *Clostridium difficile* infection and cardiac arrest requiring cardiopulmonary resuscitation (CPR) that resulted in numerous broken ribs. He is currently medically stable on mechanical ventilation, but when his sedation is lifted he appears extremely uncomfortable and fights the ventilator, requiring restraints.

The care team largely agrees that Mr. James' care plan should focus on palliative care as he has little, if any, chance of recovery. The system is also currently experiencing pressures on intensive care resources. However, Mr. James' daughter has consistently said that the family wishes to pursue aggressive treatment for Mr. James, insisting they believe this is what he would choose. Mr. James does not have an Advance Directive, nor has he named a substitute decision-maker. Mr. James' daughter is acting as his Temporary Substitute Decision-Maker (TSDM).

Dr. Sarjit also looked after Mrs. James two years earlier, when she was admitted for a stroke. Mr. James decided, on his wife's behalf, that she be removed from life support. His children grieved that Mr. James's decision contravened their mother's faith, which they believed would not support a decision to withdraw treatment. The children appear to share Mrs. James' views about life and death, and not their father's.

Dr. Sarjit is distressed because she and several members of the care team had gotten to know Mr. James while his wife was in their care. Mr. James told them that he "wouldn't want to be kept alive by machines" and that he was upset by how long his wife spent on "the machines." Given these views, the team feels confident that continued ventilation is not what Mr. James would choose. Dr. Sarjit has met several times with Mr. James' children to discuss the care plan. After several

upsetting meetings, Dr. Sarjit called the Canadian Medical Protective Association (CMPA) for advice. She was told that if she wanted to avoid a lawsuit she should “find common ground with the family.” Dr. Sarjit infers that she must do whatever the family wishes.

Dr. Sarjit believes she knows what Mr. James likely would want done. There is little to no possibility that he will recover. However, advance care planning legislation¹ indicates that without written documentation of his wishes, first his wife (now deceased), and then his children have the authority to make health care decisions for him. Dr. Sarjit could disregard Mr. James’ children’s wishes on the grounds that they are not making decisions in line with what she believes to be Mr. James’ values, but she fears this would expose her to legal liability. The law seems clear and opposed to what she believes is right.

The Formal Role of Law in Health Care

Statutes within the criminal code, court rulings, and federal and provincial legislation (known as statutory law) affect how health care is organized and delivered in Canada’s various health care jurisdictions (Pozgar 2014). Federal laws such as the Canada Health Act describe roles, expectations and processes for health care delivery (*Bentley v. Maplewood Seniors Care Society* (2014)). For example, the Canada Health Act’s emphasis on medically necessary health care shapes the public health system’s focus on physician-driven health care services. Provinces have legislation governing hospitals, consent to health care, the health care professions, and the provision of mental health services. Court rulings can dictate the limits of health care (see the recent Supreme Court of Canada ruling on physician-assisted death, *Carter v. Canada (Attorney General)* (2015)), and can further refine and specify the nuances of partnership and decision-making in health care (for example, see the Rasouli ruling, *Rasouli v. Sunnybrook Health Sciences Centre* (2011)). The Criminal Code of Canada also dictates limitations of behaviours that affect health care, particularly around behaviours at the end of life. The British Columbia Supreme Court Ruling regarding Margot Bentley shows how legal interpretations of the Criminal Code can narrow what can legitimately be requested through an advance directive (*Bentley v. Maplewood Seniors Care Society* (2014) BCSC 165).²

Informal Influences of the Law in Health Care

The less formal influence of law in health care can have a number of unintended and sometimes harmful effects. These are important to recognize because they have implications for thinking about how the law should be situated in the health care interaction.

¹ In British Columbia, this would be the Health Care (Consent) and Care Facility (Admission) Act (2015).

² Justice Greyell ruled that Ms. Bentley could not request that her care providers discontinue feeding her as long as her body continued to show receptivity to the safe delivery of food by mouth.

Mistaken Beliefs About the Law are Common

Mistaken beliefs about the law can be a source of unintended legal influence on health care. For example, employees of a health care organization (e.g., a regional health authority or a Local Health Integration Network (LHIN)) sometimes fear being sued. In fact, they would not individually be subject to a suit. Rather, the organization would be held responsible in court.

There is also widespread misinterpretation of the law, either because people are unfamiliar with what the legal directives actually say or where people draw inappropriate inferences about the application of the law to their situation from court rulings made in a materially different context. The Rasoulli decision, for instance, has had a palpable effect on physicians' perceptions of their role and their willingness to advocate strongly for patients in cases where families and the health care team disagree. This effect has been noted outside of the ruling's jurisdiction, where it is not clear that the same decision would be made. Ultimately, rulings have led physicians to believe that disagreements between physicians and families about goals of care would not likely be resolved in the physician's favour.

Another mistaken belief is that the direction provided by law ought to be followed without question. The law ought not to be thought of as the only and final word in health care decisions. There should be openness to considering options that do not appear to align with the law. A related error comes when individuals overestimate the intended rigidity of a rule. Mason and Laurie note, "one of the most cogent arguments against introducing legal rules into human affairs [is] that once rules acquire a specific meaning, they allow little room for manoeuvre and can turn out to be more restrictive than was originally intended by the framer of the rule" (Mason and Laurie 2011, p. 27).

Interpreting the law as the only source of direction can lead to mistrust between and adversarial attitudes amongst those who must collaborate for successful health care. For example, physicians working within regional health authorities (and similar organizations) report feeling unsupported by these organizations, in part, due to the separate legal protections for each. The Canadian Medical Protective Association (CMPA) individually covers physicians for liability, whereas separate insurers cover health organizations. Many physicians believe that if legal issues arose in the case of a particular patient, they would not be supported by the contracting organization, and worse, if necessary the organization would "throw [the physician] under the bus"³ to protect its own interests. Among health care teams even a mention of possible legal recourse can disrupt a trusting and open therapeutic relationship, replacing it with a relationship characterized by guarded communication and avoidance. Mason and Laurie observe, "Trust and respect are more likely to flourish in [a relationship] which is governed by morality rather than by legal rules and the injection of formality and excessive caution between doctor and patient cannot be in the patient's interests if it means that each sees the other as a potential adversary" (Mason and Laurie 2011, p. 28).

³ Personal communication between practicing hospitalist and K.Duthie, November 2014.

Legal Uncertainty Can Cause Inaccurate and Harmful Speculation

Even with a clear understanding of the facts of a ruling, including its jurisdiction and context, one is often left to speculate how the courts would rule in any other situation. However, if speculation is wrong, health care decisions may be handled inappropriately. While legal experts can develop a formal opinion about the implications of an existing ruling, these predictions cannot be certain.

Practitioners can be Motivated to Avoid Legal Hassles

The nature of legal process can also influence health care. This process can be enormously time consuming and painful, even if the court rules in favour of the health care provider. This creates a motivation to avoid conflict with the law, not because it represents right action, but rather to avoid hassle and headache. In Dr. Sarjit's circumstance, it may be that motivation to avoid a legal action altogether is enough not to engage with the family, even if she could be assured that a suit is unlikely to be successful. Although other health care providers express a similar desire to avoid process, this motivation is seen most in physicians who perceive themselves as likely to be sued.

These ways that the law influences the practice of health care are cause for concern because they can lead to a medical practice where the primary concern shifts from doing what one judges to be most ethically justified, toward doing what one feels is legally safe (Mason and Laurie 2011).

Limits of the Law for Health Care Decisions

While finely detailed and well intentioned in many respects, the law is limited in its utility as the determining factor in health care decisions.

As discussed above, contrary to many peoples' beliefs, the law is not black and white. In many cases the law requires interpretation, both by non-legal experts to provide the contextual understanding required to make concepts meaningful, as well as by legal experts—lawyers and judges who formally apply the law in cases being disputed. This requirement for interpretation creates significant uncertainty about how to move forward, particularly if aligning with legal requirements is the primary driver of a decision.

The law is also incomplete. For example, there is often a lack of legislation to regulate new health care technologies and their consequences. Case law may not yet have generated relevant precedents. There are decisions, technologies, and questions that the law is not yet equipped to answer (Mason and Laurie 2011).

A final limitation of the law in health care arises from its imperfect reflection of social norms and values. As discussed below, the law is, in part, an indication and codification of what society values (Wacks 2014). In a diverse society where individuals or groups sometimes hold conflicting norms and values, the law cannot

reflect what is important to all. As such, some may perceive certain laws as unethical and therefore inappropriate drivers of decisions in particular circumstances. For example, some may see the recent Supreme Court decision to lift the prohibition on physician-assisted death as unethical (*Carter v. Canada (Attorney General)* 2015). Ultimately, while information about the content, process, and consequences of the law are immensely important to health care decision-making, the law alone cannot tell us what we ought to do.

Ethics

Ethics as a discipline examines questions about goodness and rightness, such as “How ought we to be in this world?” and “What do we owe each other?” The task of applied ethics is to work out ethical questions within the contexts of real and specific challenges. Health care is an ethically laden enterprise because it regularly raises questions about how we ought to behave, what qualifies as the good or right thing, and how we ought to pursue this notion of goodness. Clinical ethics is a type of applied ethics where moral theory and process are brought to bear on specific questions within health care contexts with a view to arriving at a way forward. The work of clinical ethics is often led by a clinical ethicist and, when done well, involves collaborative and deliberative discussion among the patients, family members and loved ones, and health care providers involved in a particular scenario.

In our practice, we discuss ethics in terms of values, which simply refers to what is important to those involved. An ethically challenging situation in health care is one where the values of those affected are either unclear or in conflict (Jiwani 2017). This conflict can be either among internally held values, or with others’ values.⁴

Ethics and the Law

People often mistakenly assume that decisions that comply with the law are necessarily ethical or ethically justified. Ethics and the law are conceptually and procedurally distinct. The easiest way to demonstrate the distinction between ethics and the law is to recognize that reasonable people reasonably see many laws as unethical. Examples of laws whose ethical justification can be reasonably questioned include laws that prohibit food sharing in public or giving rides to others in need. Picketing funerals, euthanizing healthy animals, and smoking around children are examples of actions that are legal but whose ethical justification is

⁴ There is no predetermined way to “objectively” resolve specific disagreements until the facts and values (and interpretation of facts and values) are sorted out. The only thing one can hold on to prior to deliberation are the values of respect for each other, trying to understand different perspectives, and integrity, which orients and motivates the deliberation towards producing a decision that lives up to the values of all stakeholders. Disagreements are resolved depending on how participants live up to the values of respect and integrity, i.e., to what extent they can compromise some of their views (if compromise is needed in making a decision). This is of course after they have resolved mere misunderstandings and are caught in real substantive disagreements that are difficult to resolve.

questionable. These examples show that the moral content of a law is distinct from the law itself, and must be unpacked and explored.

Given this conceptual distinction, when considering how to arrive at an ethically sound health care decision, the law can be most usefully understood as a codification of social values and norms. The Canadian legal system, though derived from the British System of Common Law, is meant to be a reflection of the values of Canadian citizens. Some of these laws respond to acts that we consider a direct affront to human dignity and respect for life; others have arisen in response to our ever-changing society and advances in technology. Regardless of their origin, laws are a reflection of what is important to citizens and to the moral sensibility of the collection of communities and subpublics within a certain social, political, historical context.

Additionally, laws tend to be sufficiently vague so as to allow for interpretation and adaptation to reflect the time and place in which they are being applied. Given its ontological character, the law can be integrated into a process to arrive at an ethically sound decision, but it cannot respond to morally laden questions on its own. If this were the case, enacting the law would provide us with a clear and comprehensive direction for how to respond to cases around which there is moral uncertainty. In reality, even in cases where we know what the law means, this does not in and of itself give us a direction for how to move forward.

Ethics-Based Decision-Making as Process

Clinical cases are complex in that they bring together the life stories of multiple people with varying history and in relationships with different power distributions. In Mr. James' case, those involved include: Mr. James, his children, Dr. Sarjit, other attending health care providers (nurses, respiratory therapists, social workers, etc.), and the institution. Despite differences in power, experience, degree of self-reflection and wisdom, each of those involved have their integrity on the line in decisions that are made. That is, they all have deep and abiding interests in ensuring that the decisions made and actions taken in the care of Mr. James align with their individual perspectives of what matters.

In most cases, the individuals involved do not necessarily know what values are most important and how these values should be manifest in the care plan. Despite outward appearances of confidence and conviction, each individual comes to the situation with a perspective limited by their experiences. Each must work out what should matter most in this particular situation and how these value considerations should illuminate the various alternative actions.

Working out what should matter is best achieved through intentional processes where participants are enabled and supported to treat each other with respect. Through such processes, those affected by the decision can be supported to understand others' perspectives on the scenario, to better understand and deepen

their own perspectives,⁵ to understand the value constraints of social norms (for example, as embodied in the law and the literature) and to identify common values with which to make decisions.⁶

Reconsidering the Role of Law in Health Care Decision-making

Legal considerations alone are insufficient for making good health care decisions. We propose that good ethics process should incorporate legal considerations, ensuring they get their due attention while also addressing the limitations that a legalistic approach entails.

⁵ Authenticity requires that values are actually valued by people and not merely “philosophically legislated” as ideal for people to value (i.e., people should value this whether they actually value this or not). We find it dangerous if not contrary to basic liberty and integrity to have people live up to values they do not consider important. On the contrary, we believe that it is important to be clear why stakeholders value things in the first place. It is because people need to justify why they consider what they value important that they need to carefully clarify these values. Values clarification is crucial but preliminary to values justification (which most moral philosophers are normatively concerned about). Which values to prioritize over others is collectively decided through deliberation and exchanging reasons and justifications of such values. It is because of the deliberative rigours required in values clarification and values justification central to our framework that we argue that it is not mere subjective preference/values clarification that we wish to propose. On the contrary, we wish to involve all stakeholders in moral deliberation as opposed to relying merely on experts who may be well-versed in moral theory but are unaware of the intricacies of actual values and reasons that stakeholders hold that will enable them to support clinical decisions as ethical as opposed to merely bowing to the powerful dictates of the “ethics expert.” For related discussion on the role of ethics experts see Verkerk and Lindemann (2012). The ethics framework we propose embodies our commitment to the same rigorous moral deliberation that moral philosophers are committed to but adds the serious work of involving stakeholders in such deliberation. After all, our ethical theoretical rigour is meant to serve the process of making legitimate ethical decisions that all stakeholders should participate in.

⁶ Values are not necessarily subjective (as opposed to being intersubjectively determined through deliberation). Contrary to the belief that preferences are preformed before engaging in conversations Schenker and Arnold (2017) argue against an assumption made by Kamm (2017) by reminding that “...preferences are discovered in conversation, a process in which patients reflect on priorities, evaluate their importance and consider their implications.” What may be considered by some ethicists to be objective values that “should” be valued by people (even if these values are not actually valued by these same people) are themselves produced through deliberation. These apparently “objective” values are actually generalized products of deliberating on what people in society actually value. Take for example the case of the prominent principles of bioethics that emerged from the Belmont Report of 1978. The Belmont Report identified the three basic ethical principles of (a) Respect for persons, (b) Beneficence and (c) Justice and three requirements that apply those three principles. The three requirements are (a) Informed Consent, (b) Assessment of Risks and Benefits and (c) the requirement that there be fair procedures and outcomes in the selection of research subjects. The Commission used the expression “basic ethical principles” to mean “general judgments that serve as a basic justification for the many particular ethical prescriptions and evaluations of human actions” (p. 4). The source of these basic principles is the cultural tradition of the members of the Commission and these are only three of those other principles “generally accepted” in the said cultural tradition that “are particularly relevant to the ethics of research involving human subjects” (p. 4). Albert Jonsen, who was a member of the Commission, recounts that there were 8 principles originally identified (Jonsen 2005, p. 4) but because the commissioners felt that the list should not include too many principles and that whichever included should be universal, they reduced them to three. Two of the three principles were suggested by H. Tristram Engelhardt, Jr. (respect for persons as free agents and concern to support the best interests of human subjects in research) and one other by Tom Beauchamp (distributive justice) (Jonsen 2005, p. 4).

With this understanding of ethics as a values-based process and the law as a codification of social values and moral norms, we propose the following way to integrate the law into ethics-based decision making in health care.

The Laws Relevant to a Particular Health Care Decision Should be Seen as a Legitimate Source of Values

As indicated above, laws are a reflection of broad social norms. Whether or not decision-makers ultimately decide to align a decision with a particular law, they should actively explore the law's content to uncover embedded values. For example, Section 19 of the BC Health Care (Consent) and Care Facility (Admission) Act (2015) requires that TSDMs consult with the patient they are deciding for prior to making decisions. There are a number of relevant values packed into this law: (1) the importance of including patients in decisions, even when their capacity to participate is limited; (2) the importance of respect for patients' values regarding care; and (3) the importance of minimizing the patient's suffering.

By exploring a law's underlying values, decision-makers can consider the law's moral content among the other relevant values that the team will identify through their ethics process. This allows the team to consider the broadest roster of values to arrive at their decision. Conceptualized in this way, the law can be understood as another way into the ethics conversation; not a conversation closer, but a starter.

The Law Should be Seen as Source of Input About the Possible Consequences of Various Options

Knowing what the law says and how it might apply in a particular decision-making context can help a decision-making team understand the possible consequences (including legal ramifications) of the various options they are considering. For example, knowing how the Criminal Code might apply (i.e., whether care providers might be vulnerable to criminal charges) in contexts where a family is requesting that feeding be discontinued, as was the case for Margot Bentley, would likely be important for a team considering whether or not to comply with the request (*Bentley v. Maplewood Seniors Care Society* (2014)). Again, this should not be the only consideration, but information about the significance of the law would be of key importance.

Motivation to Align with the Law Should be Seen as a Value Itself

A good ethics decision-making process requires that we understand what is important from the multiple perspectives involved. Common values in clinical decision-making include the importance of minimizing a patient's exposure to harm, respecting a patient's competently made decisions, and so on. For practical reasons, teams often indicate that it is important that whatever their decision is, it align with relevant legislation or statutes. When we understand the importance of aligning with the law as one of several values under consideration in an ethics process, we shed the assumption that aligning with the law is always the most

important thing. We allow ourselves to consider the law in relation to other things that may be important.

If we assume that the most important thing when it comes to decision-making is that we do what the law says, and if we accept that the law is not always reflective of what is ethically justified, we risk finding ourselves enacting that which is legally but not ethically justified.

Returning to the Vignette

Dr. Sarjit feels conflicted because she believes she knows what her patient would choose, and yet feels legally bound to follow the decisions of Mr. James' decision-makers, which she feels do not align with his wishes. The options, as she sees it, are to ignore the law and provide the care that she believes Mr. James would consent to, taking relational and legal risks as she does so, or to disregard what she believes are her patient's wishes.

Framed in this way, Dr. Sarjit has set herself up to construe the issue to be who ought to have the power to make the decisions for this patient. Thinking about the problem in this way risks having those involved be overly concerned with what consent legislation has to say about decision-making authority, and overlook the spirit of the law,⁷ which is meant to ensure that decisions about Mr. James' care align with his values and beliefs.

We suggest that Dr. Sarjit could most effectively support her patient (and his family) in this situation by seeing the legislation as a source of values that should guide decision-making, rather than an unreflective mechanism for distributing power. In essence, we recommend shifting the focus from the law to ethics. At core, Dr. Sarjit, Mr. James' family, and the law are (or at least should be) centrally concerned about proceeding in a way that Mr. James would want if he were in a position to say so. From here, each can recognize that the other comes to the table with a different perspective. A shared process would enable Mr. James' decision makers to understand and evaluate evidence about Mr. James beliefs, values and wishes, with the collective goal of serving him best. All involved who

⁷ In referring to "spirit of the law" we mean the overall logic and motivation behind healthcare legislation in general, i.e., codifying the values of society in certain points of its history, thus, ensuring that decisions about patients align with their values and beliefs as members of that specific society. Understood this way, no one person decides what the spirit of the law is. It is a general enabling principle of fairness that is supportive of the integrity of all stakeholders. Contrary to the concern that the interpretation of the "spirit of the law" might "wind up devolving into an epistemic backdoor for the powerful to assert their interests over those who lack power," our explicit interpretation of the "spirit of the law" is meant to ensure that decisions about patients' care align with their values and beliefs. Ensuring this requires a deliberative process that carefully considers the subjectivities of everyone, not just the powerful. We doubt that the letter of the law can offer the objectivity we need in making good decisions for two reasons: (1) The "letter of the law" requires competent interpretation delegated to the judgment of courts and the legal system. Thus, this "judgment" is not more objective or less subjective than its counterpart (e.g., intent of the law or spirit of the law). (2) The letter of the law may eventually become obsolete when a new situation (not anticipated by the drafters of the law) presents a counter-intuitive case where it appears that not following the letter of the law is the moral (or even constitutional) thing to do. See related discussion on intent of law in Easterbrook (1988), Koh (2002), and Nunez (1972).

have had a relationship with the patient can bring their evidence of his wishes, with the acknowledgement that the evidence that the care team brings is equally relevant to that offered by the family.⁸

Those participating in this conversation should not assume that they have all the answers or that they necessarily understand Mr. James' wishes in a deep way. The conversation should allow those at the table to work out more deeply what Mr. James believes and values' are likely to be, and how these would influence the decision. Questions about what Mr. James believes will happen when he dies, and what he thinks a good life, or death, looks like, could all assist decision-makers to uncover deeper values.

This conversation could proceed in different directions. If it comes to light that Mr. James' family understands that his wishes would be to discontinue aggressive health care interventions but that they do not feel compelled to align their substitute decision with his wishes, the law could serve as a reminder to the family that Mr. James' wishes must be respected and should ultimately drive his care.

If Mr. James' children wish to align their decisions with his values, but have a sincere disagreement with the care team about what his values may be, it would be appropriate for the team to gently ask how the family makes sense of their perspective, especially in light of Mr. James' expressions of his wishes to the team and Mr. James' decisions about his wife's care in the past. The intention would not be to prove the family wrong, but to try to deepen and triangulate everyone's perspectives towards a point of shared understanding. A trust that all are sincerely committed to arriving at this shared understanding without judgment would be crucial to the success of the share decision.

In an increasingly law-driven health care field, it can be extremely difficult to resist a legalistic framing of complex decisions, however we believe it crucially important to do so. Looking at conflict through the lens of ethics maintains a focus on what should matter most in the decision, and avoids deterioration into adversarial approaches and rule following, which can result in core health care values (respect, benefit, patient-centredness) being overlooked.

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References

- Bentley v. Maplewood Seniors Care Society. (2014) BCSC 165 Canada Health Act R.S.C., 1985, c. c-6. British Columbia Act Ministry. Health Care (Consent) and Care Facility (Admission) Act, [RSBC 1996] Chapter 181. http://www.bclaws.ca/civix/document/id/complete/statreg/96181_01#section16. Accessed on 13 July 2015.
- Carter v. Canada (Attorney General). (2015) SCC 5, 1 S.C.R. 331.
- Easterbrook, F. H. (1988). Role of original intent in statutory construction. *Harvard Journal of Law and Public Policy*, 11, 59–66.
- Jiwani, B. (2017). *Clinical ethics consultation toolkit: Helping people live with greater integrity*. Springer.

⁸ This is not to say that the care team has had the same type of relationship with Mr. James (either in intensity or duration) but that the care team's story of Mr. James is a crucial part of the deliberation.

- Jonsen, A. R. (2005). On the origins and future of the Belmont Report. In J. F. Childress, E. M. Meslin, & H. T. Shapiro (Eds.), *Belmont revisited: Ethical principles for research with human subjects* (pp. 3–11). Washington, DC: Georgetown University Press.
- Kamm, F. M. (2017). Advanced and end of life care: Cautionary suggestions. *Journal of Medical Ethics*. doi:10.1136/medethics-2016-103980.
- Koh, H. H. (2002). The spirit of the laws. *Harvard International Law Journal*, 43, 23–40.
- Mason, J. K., & Laurie, G. T. (2011). *Mason & McCall Smith's law and medical ethics* (8th ed.). New York: Oxford University Press.
- Nunez, R. I. (1972). The nature of legislative intent and the use of legislative documents as extrinsic aids to statutory interpretation: A reexamination. *California Western Law Review*, 9, 128–135.
- Pozgar, G. D. (2014). *Legal and ethical essentials of health care administration* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.
- Rasouli v. Sunnybrook Health Sciences Centre, 2011 ONSC 1500 (CanLII). (2011). Ontario Superior Court of Justice. <http://canlii.ca/t/fkhw4>. Accessed on 11 July 2015.
- Schenker, Y., & Arnold, R. (2017). Problems with precision and neutrality in EOL preference elicitation. *Journal of Medical Ethics*. doi:10.1136/medethics-2017-104143.
- Verkerk, M., & Lindemann, H. (2012). Toward a naturalized clinical ethics. *Kennedy Institute of Ethics Journal*, 22(4), 289–306.
- Wacks, R. (2014). *Philosophy of law, a very short introduction* (2nd ed.). Oxford: Oxford University Press.