

"We Are Not Asking for the Right to Die". *Can Med Assoc J* 1991; 144: 770-7.

- 6 Discussion Paper on Advance Directives and Durable Powers of Attorney for Health Care. Manitoba Law Reform Commission. Winnipeg, Manitoba. July, 1990.

REPLY

Dr. Craig raises excellent issues. He points out that even if a patient had a dated, signed and witnessed form stating he did not wish medical treatment there would be no guarantee that the patient was "informed" about the choice he had made - a choice that very well might cost him his life. In Dr. Craig's example a patient had not been "informed" about the consequences of her decision to refuse blood. When informed that blood refusal meant she was prepared to die rather than receiving someone else's blood, she stated she "did not like the idea of receiving someone else's blood" but would accept blood to save her life. A life-threatening decision not to accept blood was changed when the clear meaning of that decision was spelled out.

Dr. Craig raises the problem of "informed refusal." If physicians cannot perform medical procedures without "informed consent" it would appear reasonable that patients should be "informed" about the consequences of their decision before they refuse treatment. None of these issues was adequately considered in the case of Malette vs Shulman. My proposal (that at the very least, and in order to be legally binding, a patient must be required to have a signed, witnessed and recently dated form stating his wish not to accept medical treatment) only gives us assurance that the patient has thought about the problem recently. This form will not protect patients from incorrect information. This would be a bare minimum standard that does not exist today. But as Dr. Craig points out even that standard would not have helped his patient.

To improve on the signed, witnessed and recently dated form Dr. Craig suggests an "informed refusal" form might help. For those of us who believe that "informed consent" is not possible, scepticism about the value of "informed refusal" comes easily. In fact Dr. Craig's patient illustrates the problem of "informed refusal." His patient was "informed" by medical personnel about the "refusal" and yet did not understand the meaning of the "informed refusal." If medical personnel can't obtain a correct "informed refusal" how well will laymen fare and who else is there to obtain this "informed refusal"?

Living Wills represent the next attempt to inform physicians of the incompetent patient's wishes for medical treatment. Unfortunately, they are tainted with the same brush as "informed consent" and "informed refusal." Has the patient who creates a living will really been "informed" about the choices that a physician may have to make on his behalf when the patient is incompetent? I suggest the chances that the patient has been informed about the particular choices to be made are small. If that is true, these documents should not be legally binding but only considered as guidelines to help the physician make difficult choices.

Anaesthetists and Intensivists frequently must make decisions about what medical care a patient would want if he were competent to make the decision. I am not satisfied (and probably never will be) with the decision-making process. The objective should be to provide the medical care that the patient wishes to

receive or not to receive, with full knowledge of the probable consequences. How can that be best achieved? In an ideal world "informed refusal" and "living wills" would provide a helpful solution. But Dr. Craig's case illustrates how "informed refusal" (if legally binding) also fails to provide the patient with the medical care he desires.

What is the best solution? I would be interested in physicians' opinions on whether (a) the current status, (b) a signed, recently dated, witnessed card, (c) informed refusal and/or (d) other proposals would best help the physician in our dilemma of how to provide the care the patient wants even when he is incompetent.

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