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REVIEW ARTICLE/BRIEF REVIEW

The future of decision-making in critical care after *Cuthbertson v. Rasouli*

L'avenir de la prise de décision dans les soins critiques après l'affaire *Cuthbertson contre Rasouli*

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Abstract

Purpose *The Supreme Court of Canada (SCC) ruling on Cuthbertson v. Rasouli has implications for all acute healthcare providers. This well-publicized case involved a disagreement between healthcare providers and a patient's family regarding the principles surrounding withdrawal of life support, which the physicians involved considered no longer of medical benefit and outside the standard of care, and whether consent was required for such withdrawals. Our objective in writing this article is to clarify the implications of this ruling on the care of critically ill patients.*

Source *SCC ruling Cuthbertson v. Rasouli.*

Principal findings *The SCC ruled that consent must be obtained for all treatments that serve a "health-related purpose", including withdrawal of such treatments. The SCC did not fully consider what the standard of care should be. Health-related purpose is not sufficient in and of itself to mandate treatment, and clinicians must still ensure that their patients or decision-makers are aware of the possible medical benefits, risks, and expected outcomes of treatments. The provision of treatments that have no potential to provide medical benefit and carry only risks would still fall outside the standard of care. Nevertheless, due to their health-related purpose, physicians must seek consent for the discontinuation of these treatments.*

Conclusion *The SCC ruled that due to the legal definition of "health-related purpose", which is distinct from medical benefit, consent is required to withdraw life-support and outlined the steps to be taken should conflict arise. The SCC decision did not directly address the role of medical standard of care in these situations. In order to ensure optimal decision-making and communication with patients and their families, it is critical for healthcare providers to have a clear understanding of the implications of this legal ruling on medical practice.*

Résumé

Objectif *Le jugement de la Cour suprême du Canada (CSC) dans l'affaire Cuthbertson contre Rasouli a des implications pour tout personnel de la santé donnant des soins aigus. Ce cas dont il a été largement fait état impliquait un désaccord entre des professionnels de la santé et la famille d'un patient concernant les principes entourant le retrait du système de maintien des fonctions vitales, que les médecins concernés estimaient ne plus apporter de bénéfice médical et dépasser les normes de soin, et la nécessité d'un consentement pour un tel retrait.*

This article is accompanied by two editorials. Please see Can J Anesth 2014; 61: this issue.

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En rédigeant cet article, notre objectif est de clarifier les implications que ce jugement a sur les soins de patients dans un état critique.

Source *Jugement de la CSC dans l'affaire Cuthbertson contre Rasouli.*

Constatations principales *La CSC a jugé qu'un consentement doit être obtenu pour tous les traitements qui servent un « objectif lié à la santé », y compris le retrait de tels traitements. La CSC n'a pas pleinement pris en compte ce que devaient être les normes de soins. Un objectif lié à la santé n'est pas en soi suffisant pour exiger un traitement et les cliniciens doivent encore s'assurer que leurs patients ou ceux qui prennent les décisions sont informés des avantages et risques éventuels ainsi que des résultats escomptés des traitements. La fourniture de traitements qui n'apporteraient pas d'avantages médicaux et qui comporteraient uniquement des risques serait toujours exclue des normes de soins. Néanmoins, en raison de leur objectif lié à la santé, les médecins doivent obtenir un consentement pour l'interruption de ces traitements.*

Conclusion *La CSC a jugé que, compte tenu de la définition légale d'un « objectif lié à la santé » qui est distinct d'un bénéfice médical, un consentement est requis pour le retrait du système de maintien des fonctions vitales et a détaillé les étapes en suivre dans le cas d'un conflit. La décision de la CSC n'a pas directement abordé le rôle de la norme médicale des soins dans ces situations. Afin d'assurer une prise de décision optimale et une communication avec les patients et leurs familles, il est essentiel que le personnel de la santé comprenne clairement les implications de ce jugement sur la pratique médicale.*

On October 18th, 2013, the Supreme Court of Canada (SCC) released its long-awaited ruling in *Cuthbertson v. Rasouli* - it generated considerable media and public attention.[1] It is important that the legal principles of this ruling and the implications for healthcare teams be clearly communicated and understood by both healthcare professionals and the public as they are vulnerable to oversimplification and to a wide range of interpretations. For physicians, the case revolved around the role of medical benefit and standard of care - principles that must be understood as they form the basis of medical decision-making in daily practice. The SCC ruling, however, turned on the statutory interpretation of the Ontario Health Care Consent Act and whether consent was required for withdrawal of life-sustaining treatments that, according to the healthcare team, could no longer provide any medical benefit in view of the patient's subsequent course in hospital or within the intensive care unit (ICU).

The promotion of patient- and family-centred care, the legitimate empowerment of patients and substitute decision-makers in personalizing treatment plans, and the ready availability of healthcare information in the public domain have raised the stakes for the quality of communication by healthcare teams. That is to say, the challenges for healthcare professionals regarding the quality of communication not only include the translation of relevant health information, experience, and recommended choices for discussion with patients and their families, but also include communication around the nature of the relationship between autonomous decision-making, the proper roles of substitute decision-makers, and the impact of publicly available health-related information. Such information arises from a range of sources that span unrealistic fictional entertainment, over-reaching inspiring fundraising slogans, and often inaccurate or, at the very least, out of context information on the internet. The stakes for successfully navigating these challenges to communication include the avoidance of conflict and, in particular, the avoidance of the very real harm and inappropriate treatment of vulnerable patients.

Ideally, this case could have stimulated reflection, discussion, and engagement of an informed public as well as enhanced confidence and trust between patients, families, and their healthcare providers. Unfortunately, there are multiple examples where the media have misportrayed the issues and interpreted this case and the SCC ruling in ways that are counterproductive to this outcome.[2-4] Accordingly, we clearly lay out the particulars of the Supreme Court ruling and present our interpretation of its implications for clinical practice (Table 1).

Review of the case

The published facts of the case are as follows: Mr. Rasouli underwent resection of a meningioma and unfortunately suffered infectious complications that left him in a minimally conscious state and unable to breathe effectively without mechanical ventilation.[1-4] Mr. Rasouli suffered from an irreversible illness, and the physicians' opinion was that ongoing provision of mechanical ventilation and critical care would not cure him, stabilize his state of health by slowing the rate and/or extent of its deterioration, or alleviate his pain, suffering, and indignity – that is, it would not provide any *medical benefit*. In the opinion of the physicians, a point had been reached where continuing life-sustaining treatments would result only in ongoing harms, namely, the complications and side effects of life-sustaining treatments may themselves be causes of

Table 1 Key points

1. *The Supreme* Court of Canada (SCC) decision was a legal ruling – that the statute applies and consent must be obtained for treatments that serve a "health-related purpose"
2. The SCC ruling neither considered nor set aside the role of the standard of care
3. "Health-related purpose" is not sufficient in and of itself to be an indication for treatment
4. Clinicians must still ensure that all of their patients (or substitute decision-makers [SDMs]) are aware of the possible benefits, risks, and expected and possible outcomes of the treatments provided
5. Clinicians must not withhold a trial of potentially beneficial therapies for fear that they will not be able to obtain consent to withdraw these therapies if they prove not to provide any medical benefit.
6. The ongoing provision of therapies that have no potential benefit and carry only risks fall outside the standard of care, and physicians, as directed by the SCC, should seek consent from informed patients and SDMs to discontinue these therapies.

significant morbidity, pain, and mortality. As such, the physicians considered that continuing these treatments would now fall outside the standard of care.

The physicians communicated their position to the family; however, the family held the view that life support provided ongoing value to the patient and should be continued. As a result, an intractable conflict arose. The physicians therefore asked the courts to clarify whether consent was required for withdrawal of treatment in circumstances where the standard of care did not require continuation of treatment. The case was first heard in the Ontario Superior Court in 2011[5] and was ultimately appealed to the SCC.[1,6]

In Ontario Superior Court, Justice Himel ruled that the definition of plan of treatment in the Ontario Health Care Consent Act (HCCA) included the words "withholding and withdrawal of treatment", and therefore consent was required to discontinue life supporting treatments. Even though physicians argued that such treatments fell outside of the standard of care, in the absence of consent, the Court ruled that physicians should apply to the Ontario Consent and Capacity Board (CCB). The Court neither addressed the question of whether or not these treatments fell within the standard of care nor the issue regarding the role of standard of care in conflict situations. When the case was appealed to the Ontario Court of Appeal,[6] the justices again ruled that physicians required consent to withdraw life support. Nevertheless, the basis for their ruling was different, i.e., withdrawal of life support required initiation of palliative care as death was imminent, and the two were therefore "integrally linked" as a "treatment package".[7] The Court ruled that since consent is required to institute palliative care, consent is also required for withdrawal of life support. The Court of Appeal did not restrict the right of physicians to withhold treatments that were determined to be "of no medical value" without the need to obtain consent.[8] Again, issues of standard of care were not addressed.

The physicians subsequently appealed to the Supreme Court alleging that the Court of Appeal erred both in fact and in law. They argued that the Court erred since (1) palliative care is care that is initiated not only at the time of withdrawal but from the beginning of life-sustaining treatments; (2) the Court's condition of imminence of death is vague and difficult to apply in clinical practice; (3) the Court failed to address the role of standard of care; and (4) the construct of "treatment package" was unknown to medicine and an inaccurate concept on which to found the legal principles in the case.

What the Supreme Court decision said

In its *Cuthbertson v. Rasouli* decision, the SCC ruled – in a five to two majority decision against the physicians – that consent is required to withdraw life-sustaining treatments.[1] The four main reasons for this were: (1) Life-sustaining treatments and withdrawal of life-sustaining treatments serve a "health-related purpose", as does the provision of palliative care, which is "closely associated" with such withdrawals; thus, all require consent under the HCCA; (2) the "critical interests" at stake in withdrawing life-sustaining treatments go to the "heart of patient autonomy"; (3) requiring consent reflects the meaningful role of substitute decision-makers in the consent process; and (4) withdrawal may involve physical interference with a patient's body, which requires consent.

Medical benefit and health-related purpose

Many healthcare workers will not be familiar with the term "health-related purpose" as used in the *Cuthbertson v. Rasouli* decision or the important distinction between "medical benefit" and "health-related purpose".[1] The SCC defined "health-related purpose" as a legal concept separate from that of medical benefit as determined by the healthcare team:

> *[36] The concept of "medical benefit" is a clinical term used by physicians to determine whether a given procedure should be offered to a patient. This clinical term has legal implications for the physician's standard of care. If a treatment would be of medical benefit to the patient in this sense, the physician may be required to offer that treatment in order to comply with his standard of care. Whether a given treatment offers a medical benefit requires a*

contextual assessment of the patient's circumstances, including the patient's condition and prognosis, the expected result of treatment for that patient, and any risks of treatment for that patient: A.F., at para. 44. [37] The concept of "health-related purpose", by contrast, is a legal term used in the HCCA to set limits on when actions taken by health practitioners will require consent under the statute. Treatment is "anything that is done" for one of the enumerated purposes (therapeutic, preventive, palliative, diagnostic and cosmetic) or "other health-related purpose". Under the HCCA, only acts undertaken for a health-related purpose constitute treatment, and therefore require consent. The concept of health-related purpose in the HCCA does not interfere with a physician's professional assessment of whether a procedure offers a medical benefit. Its only function is to determine when the actions of health care practitioners require patient consent.

Thus health-related purpose encompasses many of the enumerated purposes for which medical treatment is administered, but it does not necessarily imply or indicate that such treatments provide medical benefit. It is very important to point out that the SCC went to lengths to distinguish the concept of *health-related purpose* from that of *medical benefit*.

The SCC ruling clarifies the term "health-related purpose" as a part of the legal definition of treatment. For the first time, the SCC has identified that health-related purpose may diverge from the medical standard of care in circumstances of life support. This divergence means an additional legal standard is imposed on the usual medical standard, an additional formal legal review as it were of medical decision-making in situations of intractable conflict regarding the continuation or withdrawal of life-sustaining treatments. Any treatments that serve a health-related purpose require consent for either their institution or discontinuation under the HCCA.

The SCC decision did not address the standard of care

It is important for healthcare providers to be aware that the Supreme Court's ruling does not change the concepts of either medical benefit or medical standard of care. The medical standard of care encompasses a range of treatments that have the potential to provide medical benefits at varying amounts of risk. The assessment of whether potential treatments may offer medical benefit is based on scientific knowledge, experience, and a careful and systematic analysis of a patient's state of health. Such methodical and objective analysis is required to avoid subjective assessments that may be vulnerable to the personal values and biases of the treating healthcare provider. Consultation with multi-professional team members and other consulting healthcare teams are key components of the care of such complex patients and also serve to protect patients from individual physicians' biases. Careful consideration of the potential for medical benefit based on evidence-based practice, clinical experience, and consensus guidelines, along with the extent and level of risks that lead a physician to recommend one treatment over another should not be confused with bias. Indeed, the courts will look to physicians' methodical application of specialized knowledge in assessing the medical standard of care. The legal definition of medical standard of care is the degree of prudence and caution that a reasonable physician with the same training would have exercised in the same circumstances. Particularly in cases in which there is disagreement among physicians as to the standard of care, courts may question whether the medical standard reflects an appropriate level of prudence and whether it reflects values important to society as a whole. Therefore, court rulings themselves may on occasion influence the medical standard of care.

In summary, the medical standard of care requires some reversibility to the illness and some ability of the treatment to cure, stabilize, and/or alleviate pain and symptoms. If treatment options exist that can achieve such goals, then the values of *both* physicians and patients will shape decisions and choices made among these treatment options. Physicians may modify original recommendations based purely on science and the medical realities that take into consideration the patient's values and their own benefit:risk assessment of treatment options. Once again, physicians must clearly communicate the values supporting their changed recommendation to promote dialogue and decrease bias. It is here that effectiveness as opposed to worthwhileness comes into play.

Though the physicians had argued that the medical standard of care was engaged in the case of Mr. Rasouli, given that continuation of life-sustaining treatments could offer no medical benefit and fell outside the medical standard of care within critical care, the SCC explicitly stated that their ruling did not seek to change the medical standard of care nor address the role of standard of care in such situations:

[110] There has been no trial on the standard of care in this case, so we can only speculate as to its content in situations like Mr. Rasouli's. Whatever its content, the standard of care does not hold physicians to a standard of perfection but, rather, only to one of reasonable care.

Nevertheless, the SCC went to considerable lengths to reinforce the importance of medical benefit and standard of care in any consideration of similar cases in future:

> *[74] … In each of these types of proceedings, the physician's submissions on the patient's condition, the nature of the proposal to withdraw life support, and what will medically benefit the patient will be highly relevant …*
> *[96] As I see it, this review of s. 21(2) reveals that although a patient's beliefs and prior expressed wishes are mandatory considerations, there is no doubt that the medical implications of a proposed treatment will bear significant weight in the analysis.*

The SCC's ruling did not state that continuing life-sustaining treatments always falls within the medical standard of care regardless of the patient's circumstances. Nevertheless, in view of the "critical interests at stake" and the Court's perception that such decisions go to the "heart of patient autonomy", the Court used the concept of "health-related purpose" to establish a legal duty to obtain consent for withdrawal of life support in Ontario and to obtain a review of this duty by the Consent and Capacity Board in cases of conflict between healthcare teams and substitute decision-makers. Though the SCC ruling turned on a statutory interpretation of the Ontario HCCA, because the ruling originates from the SCC, the ruling's principles will influence cases on similar conflicts across Canada.

Conflicts between healthcare teams and substitute decision-makers

Fortunately, intractable conflicts between healthcare teams and substitute decision-makers (SDMs) are rare. Nevertheless, when conflicts do arise, the Court has outlined practical steps to follow:

> *[116] I conclude that the following steps apply under the HCCA in a case such as this, where the substitute decision-maker and the medical health care providers disagree on whether life support should be discontinued.*
>
> *1. The health practitioner determines whether in his view continuance of life support is medically indicated for the patient*
> *2. If the health practitioner determines that continuance of life support is no longer medically indicated for the patient, he advises the patient's substitute decision-maker and seeks her consent to withdraw the treatment;*
> *3. The substitute decision-maker gives or refuses consent in accordance with the applicable prior wishes of the incapable person, or in the absence of such wishes on the basis of the best interests of the patient, having regard to the specified factors in s. 21(2) of the HCCA;*
> *4. If the substitute decision-maker consents, the health practitioner withdraws life support*
> *5. If the substitute decision-maker refuses consent to withdrawal of life support, the health practitioner may challenge the substitute decision-maker's refusal by applying to the Consent and Capacity Board: s. 37;*
> *6. If the Board finds that the refusal to provide consent to the withdrawal of life support was not in accordance with the requirements of the HCCA, it may substitute its own decision for that of the substitute decision-maker, and permit withdrawal of life support.*

Current limitations of the Ontario Consent and Capacity Board in resolving conflicts

Contrary to the media's frequent portrayal of the issue as doctor *vs.* patient,[4,9] the physicians aim before the SCC was to clarify the principles that should be considered by lower courts in cases of disagreement between treating physicians and SDMs in such situations. In cases of intractable conflict, the physicians asked that decisions regarding the withdrawal of life support be reviewed by the Ontario Superior Court instead of the CCB. This was based on the belief that such cases engaged standard of care considerations and that the CCB did not have the legal mandate to adjudicate such conflicts. The CCB has never had the legal mandate under the HCCA to adjudicate on the standard of care. Nothing has changed following *Cuthbertson v. Rasouli*. The function of the CCB is to evaluate whether the SDM's decision-making for an incompetent patient is in line with their legal mandate under s. 21 (according to previous expressed capable wishes or best interests). The CCB does not decide what treatments meet the standard of care – it considers only whether the SDM is appropriately exercising the patient's freedom of choice among the available treatment options. The physicians argued that since they were no longer willing to offer to provide life support to Rasouli, the treatment was no longer one of the options from which the patient (and thus the SDM) could freely choose. Instead, where conflicts regarding the withdrawal of life support arose between the SDM and the physician, the only question was whether the physician should be required by the medical standard of care to continue to provide the treatment. Only the Court was in a position to decide this question.

The SCC rejected these arguments, holding that the medical standard of care is too blunt an instrument to be the only standard on which the withdrawal of life support could be decided. In cases such as *Cuthbertson v. Rasouli* at least, the SCC found that life support was still "treatment" under the HCCA even if it served no medical benefit as it had a "health-related purpose" and that the patient should have the right to determine when it should be withdrawn. Since the SCC made the withdrawal of life support subject to patient consent, the CCB was the appropriate forum in which to adjudicate these conflicts.

The physicians also argued that adjudications by the courts would provide greater depth in the legal deliberative process and improve fairness, transparency, and ultimately protection for critically ill patients. For SDMs facing the loss of a loved one, having so lost trust in the decision-making of the healthcare team as to end in an intractable conflict situation, it is important that the legal process be as robust as possible in an effort to help SDMs cope subsequently with grief and bereavement should the ruling side with the physicians.

The CCB is an independent provincial tribunal created under the Ontario Mental Health Act. Originally created to hear applications for involuntary psychiatric admission and consent for treatment, the Board's role evolved under the HCCA in 1995 to adjudicate whether the process of substitute decision-making had complied with the required legal standards. In the absence of previously expressed applicable wishes that are not impossible to comply with, SDMs in Ontario are required by the HCCA to act according to the patient's best interests, integrating individual patient values as well as criteria of medical benefit (Table 2).

The constituent CCB membership, however, still reflects its original purpose and is currently composed of lawyers, psychiatrists, and members of the public.[10] The CCB currently has no specialty critical care representation among its members and does not seek to develop expertise by having the same members hear critical care cases. These drawbacks mean that deliberations of the CCB may lack specific expertise of content and sufficient context and breadth of opinion to adjudicate whether a SDM is acting in the "best interests" of a critically ill patient (HCCA s 21(2)), especially with respect to any medical benefits and risks of the proposed or ongoing life-sustaining treatments in question. The CCB does not have the mandate or means to deliberate questions regarding the standard of care and where a treatment falls outside of the standard of care. Physicians must prove to the panel that withdrawing the treatment is in the "best interests" of the patient.

The timeliness of the CCB process is also problematic. In contrast to what has been reported in the media, the physician authors' personal experiences in such adjudications maintain that such hearings are often inefficient and prone to delays and month-long adjournments. Rulings may be appealed to the Superior Court, which could take months to schedule a hearing.[11-14] Superior Court rulings may then be appealed to the Court of Appeal, which again could take months with no statutory limit on the time frame to render a decision. The impact of these delays can be substantial on critically ill patients. Significant deterioration in overall health, physical condition, cognitive function, and physiologic reserve can occur over such months in the ICU despite the best efforts of ICU teams. The process by which end-of-life decisions are made in Canada varies by province. While in Ontario, the SCC has made clear that conflicts regarding the withdrawal of life support will be considered by the CCB, in some provinces, physicians may still have recourse to the courts to argue that the medical standard of care does not require them to continue (and may indeed require them to discontinue) life supporting treatments. Although the SCC ruling is persuasive in all jurisdictions, it is binding only in Ontario since the decision turned on an interpretation of "health-related purpose" in the HCCA. The larger question of whether a patient has a right to consent to the withdrawal of life support under common

Table 2 Table of definitions

Medical benefit: In situations of some reversibility of medical illness, medical benefit is the ability to cure, stabilize state of health, and/or alleviate pain and symptoms. There may be a range of treatment options that would achieve these goals. All such treatments would fall under the medical standard of care
Harms: side effects, complications, and adverse events related to treatments or to progressive irreversible end-stage illnesses
Medical definition of standard of care: a range of treatments that have the potential to provide some medical benefits (even if small) at varying amounts of risk. The assessment of whether potential treatments may offer medical benefit is based on scientific knowledge, experience, as well as a careful and systematic analysis of a patient's state of health. Patients can choose among these treatment options according to their values/beliefs.
Legal definition of medical standard of care: the degree of prudence and caution that a reasonable physician with the same training would have exercised in the same circumstances.
Health-related purpose: is a legal term used in the HCCA to set limits on when actions taken by health practitioners will require consent under the statute. Treatment is "anything that is done" for one of the enumerated purposes (therapeutic, preventive, palliative, diagnostic, and cosmetic) or "other health-related purpose". Under the HCCA, only acts undertaken for a health-related purpose constitute treatment, and therefore require consent to administer or withdraw. The concept of health-related purpose in the HCCA does not interfere with a physician's professional assessment of whether a procedure offers a medical benefit. Its only function is to determine when the actions of healthcare practitioners require patient consent.

HCCA = Ontario Health Care Consent Act

law or under different legislative regimes is still unclear. As a result, there are still inconsistent standards for end-of-life decision-making across Canada.

The future of decision-making in critical care

The purpose of medicine has never been to prolong life indefinitely but rather to prevent, diagnose, and treat illnesses and alleviate symptoms to the extent possible and desired by patients. The *Cuthbertson v. Rasouli* decision is best read as a call to the critical care field to reflect on and define clearly its role in the care of patients. Most importantly, we must explain to patients and SDMs the circumstances when we may be able to help and when we cannot, no matter how much we as healthcare providers may yearn to do so.

All life-sustaining treatments are trials of treatment as no medical treatment can be guaranteed to succeed. Such trials of treatment will need to be re-evaluated as the illness evolves, and recommendations to continue or withdraw therapies must be based on the context of the individual patient. This must be clear to patients and SDMs right from the start of life-sustaining treatments. Quality care, especially in the context of critical care medicine, means understanding when life-sustaining treatments should be offered and what patients are asked to undergo. It involves explaining to SDMs what treatments entail and that all such treatments are trials of treatment - unfortunately without any guarantee of a successful outcome. It also involves educating SDMs up front regarding how they must legally make decisions for incapable patients, not just in times of conflict. Crucial to our professional duty to critically ill patients and to the provision of the highest quality of care is ensuring that critical care physicians are explicitly clear and consistent with patients and SDMs that they will not offer life-sustaining treatments and resuscitation when it cannot provide any medical benefit. To do so causes only harm, and that is the poorest quality of care possible.

The decision in *Cuthbertson v. Rasouli* raises another important conundrum for physicians, that is, whether to start a course of treatment that may not be lawfully withdrawn where medically appropriate. In our view, a physician must not be guided by the fear that consent to the withdrawal of life supporting treatments cannot be obtained once it has begun. Critical care physicians must continue to offer trials of therapy in which medical benefit is uncertain or improbable, because a given patient may "beat the odds" and this outcome is to be celebrated. Any fears that an SDM may refuse future consent to the withdrawal of life-sustaining treatments, if these should no longer be of any medical benefit, should not prevent such treatments from being offered (and provided, if consent is given). Furthermore, physicians should not shy away from continuing to advocate for their patients by bringing conflicts with substitute decision-makers forth to the CCB. In our opinion, the time has come for clinicians to be more proactive and explicit with respect to our roles and responsibilities in caring for the critically ill and thus avoid any potential errors of omission that may contribute to harm or inappropriate treatment of vulnerable patients. We consider failure to offer treatments appropriately, and acceding to SDM's insistence to continue treatments that no longer offer any medical benefit, as representing poor quality of care, and risks weakening our ability to protect the most vulnerable among us, in addition to devaluing our profession.

In our view, critical care will also be devalued if we cease to advocate for a fairer, expert, and timely adjudication process in the event of intractable conflicts. The SCC's ruling in *Cuthbertson v. Rasouli* refers intractable conflicts in Ontario to the CCB. Based on the physician authors' personal experiences and respective published research, the CCB must improve its adjudication of such cases. The adjudication process, including appeals, must be more expert, streamlined, and timely to ensure faster resolutions, avoid needless delays, and ultimately provide better protection for the critically ill.

Healthcare providers should see the *Cuthbertson v. Rasouli* case as an opportunity to build on the strengths, knowledge, and skills they bring to the care of critically ill patients and to recognize the value of their moral, ethical, and professional role in advocating for clear and consistent treatment plans that offer some medical benefit and fall within the medical standard of care. Such an approach will enhance therapeutic relationships with patients and families, include an informed, client-centred, and respectful approach to education regarding the role and principles of substitute decision-making, and ensure patients' preferences and values are respected in the context of medical realities. A methodical, deliberate, and explicit approach is needed - one that supports the SDM, and where the timing and pace considers their capacity to make decisions in the context of challenging and emotionally charged situations.

When critical care teams advocate withdrawing life-sustaining treatments in cases such as *Cuthbertson v. Rasouli*, the intent is not to achieve social justice or address resource constraints; rather, it reflects the pursuit of a balance between the real benefits to humanity of increasing advances in medical technology and the unacceptable infringement that medical technology can have on a person's inherent dignity. The goal is to ensure that we don't overlook suffering as part of the human experience of disease and prolong pain and harm where there is no expectation that our interventions will improve the

patient's condition, much less to the degree that restores the patient's decisional autonomy which forms the foundation for the SCC ruling.

Conclusion

The SCC ruled that consent is required for withdrawal of life-sustaining therapies due to the legal definition of "health-related purpose", which is distinct from *medical benefit*. The SCC explicitly stated that their ruling did not seek to change the medical standard of care nor did it address the role of standard of care in such situations of intractable conflict. In fact, the SCC emphasized the importance of the notions of medical benefit and standard of care in medical decision-making. A clear understanding of the implications of this legal ruling on practice is critical for healthcare providers to ensure optimal decision-making and communication with patients and families.

Conflicts of interest None declared.

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