IN REPLY

In reply: Reappraisal of the Canadian Critical Care Society's position on withholding and withdrawing life-sustaining treatment

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Committee

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To the Editor:

We appreciate the opportunity to address the issues raised by Yanke, Rady, and Verheijde.¹

A detailed interpretation of constitutional law is beyond the scope of both this response and the Canadian Critical Care Society's (CCCS) position paper on *Withholding and Withdrawing Life-Sustaining Treatment* (WWLST).² Nevertheless, rights and freedoms outlined in the Canadian Charter of Rights and Freedoms are not granted in an absolute fashion—they can be limited, according to Section 1, for purposes that are “demonstrably justified in a free and democratic society”.^A Canadians are guaranteed freedom of thought, belief, and expression and to follow the religion of their choice, but one should not conclude that the Charter permits Canadians to dictate all aspects of their medical care based on such beliefs. Ironically, a recent Ontario Superior Court decision³ recognized that *physicians'* freedoms might be limited by mandating them to provide effective referrals for treatments against their beliefs to ensure equitable access for patients to such treatments.

A Supreme Court of Canada decision⁴ failed to completely clarify the role of consent in WWLST as it

deferred to the interpretation by the lower courts in Ontario of the Health Care Consent Act, for which there is no equivalent in the rest of Canada.⁵ The wish to remain alive, or for a loved one to remain alive, is a fully understandable sentiment. But in the face of terminal or irreversible illness, those wishes cannot be the sole basis driving specific medical decisions. Cardiopulmonary resuscitation (CPR) may sometimes be a means of respecting a wish to remain alive, but CPR itself is not a wish *per se*. Physicians routinely refuse to perform futile surgery or provide ineffective antibiotics and should also be the decision-makers as to when to stop CPR. These decisions are not violations of religious freedom or personal autonomy; they are unavoidable granular decisions that occur whenever someone attempts to translate patient wishes and medical realities into a plan of care.

Medical decisions always involve values—religious or secular. The CCCS fully recognizes and supports the importance of accommodating a patient's and family's belief system in both the active treatment and WWLST phases of care. Nevertheless, we recognize that there is a clear distinction between respecting values and acceding to demands about specific clinical decisions.

There are two court cases^B pending in Ontario regarding additional non-beneficial support and treatment for those declared dead by neurologic criteria. It is our

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^A *Canadian Heritage*. The Canadian Charter of Rights and Freedoms. Available from URL: <http://publications.gc.ca/collections/Collection/CH37-4-3-2002E.pdf> (accessed February 2018).

^B *CBC News*. Opinion – Science must be the guiding factor when diagnosing brain death. Posted November 16th, 2017. Available from URL: <http://www.cbc.ca/news/opinion/science-brain-death-1.4403210> (accessed February 2018).

hope that the appropriate determinants will be considered in these decisions so that healthcare practitioners can be confident that they can continue to provide similarly appropriate and equitable care to all Canadians.

Conflicts of interest None declared.

Editorial responsibility This submission was handled by Dr. Hilary P. Grocott, Editor-in-Chief, *Canadian Journal of Anesthesia*.

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