



WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENTS

ETHICS ISSUE QUICK REFERENCE GUIDE

Updated 2019

The Issue

Quick summary

- Withholding and withdrawing life-sustaining care is an emotional and occasionally controversial decision.
- Each case requires careful consideration of the values, ethical principles, and ethical theories by the care team.

Withdrawing or withholding life sustaining therapy is a difficult ethical decision. Life sustaining therapy is defined as any treatment with the intent to prolong a patient's life rather than treat or reverse the underlying medical condition.

Generally speaking, most ethicists considered it ethically permissible to withdraw a treatment if it would have been permissible to withhold the same treatment (Vincent, 2005). See page 2 for more information.

Part of the reason these are considered morally equivalent is that the act (withdrawing treatment) or omission (not starting treatment) has the same end result. Ultimately, if the patient dies, it is a result of their underlying condition, not the act, the omission, or any element of the care provided (including comfort measures such as pain medication).

In practice, this is not always easy. Clinical care providers do not view withdrawing or withholding life sustaining treatment as equivalent (Levin, 2005). Withdrawing treatment is often more emotionally difficult in practice (Vincent, 2005). Each case requires careful consideration of the values, ethical principles, and ethical theories by the clinical care team.

Ethical Considerations: Values

Dignity: The patient's conception of quality of life, choice, and a dignified death should be understood by all involved.

Professional Integrity: The health care providers involved need to ensure that all involved understand the intervention and that a fully informed consent is obtained.

Respect for autonomy: Ultimately, the patient (directly or represented by their substitute decision-maker) will determine whether life-sustaining interventions should be continued. This can cause conflict when the health care team believes that the patient's best interests will be served in a different way.

Fidelity: This is the understanding that members of the health care team are trustworthy and will act faithfully on the patient's wishes.

Comfort: Irrespective of whether treatment is being withdrawn, withheld, or maintained, the ultimate goal is to ensure the patient suffers as little as possible.



For more information,
see the reference list
on page 4.



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Ethical Principles

Patient Autonomy: Competent, fully informed patients have the right to forego or withdraw life sustaining therapy. This is well established in practice and in law. When a patient is not able to make health care decisions, their substitute decision-maker has the right to provide or refuse consent on behalf of the patient. What does/would the patient want?

Competent, fully informed patients have the right to forego or withdraw life sustaining therapy. This right does not make the decision any easier.

Beneficence: Consider what is the benefit to beginning or continuing life sustaining therapy. Will the therapy ultimately provide the benefit they want?

Non-Maleficence: Consider the harms, pain and discomfort associated with the treatment. Will suffering ensue if treatment is withheld or withdrawn? Will the patient suffer if the treatment is not initiated or withdrawn?

Justice: The Supreme Court of Canada has also ruled that health care providers cannot withdraw life-sustaining therapy without consent of the patient or substitute decision-maker (Cuthbertson v. Rasouli, 2013).

However, patients have the right to withdraw their consent to treatment at any time, if they fully understand the implications of the refusal, even if the withdrawal would result in death (Nancy B. v. Hôtel-Dieu de Québec, 1992). A substitute decision-maker (such as a Public Guardian or a family member) can speak for and consent to or decline treatment on behalf of a patient who is incapable of expressing their own wishes, including to the withdrawal of life sustaining therapy if they feel it would be consistent with the patient's wishes.

Distributive Justice: Beginning or continuing life sustaining therapy that will not achieve the patient's goals of care may cause health care staff moral distress. It can feel like a judgment is being made about whether a particular person deserves the intervention. Especially when it concerns a choice about who should receive a scarce resource (like an ICU bed) when there is greater demand than capacity, it can help to have policies and guidelines that support clinical decision-making, so that decisions about whether to provide or stop treatment are made on the basis of the patient's wishes and whether the patient will benefit.



For more information, see the reference list on page 4.

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Ethical Theories

Virtue Ethics: Kindness, honesty, and empathy are important virtues to consider when discussing with the patient and family members the possibility of withdrawing or withholding life sustaining therapy. Questions to consider: What would a good person do? What would a good health care provider do? How can those morally admirable qualities be embodied during the difficult conversations?

Consequences: Consider the implications of withdrawing or withholding life sustaining therapy for the patient and the patient's family. What are the actions that the healthcare team can take to emphasize the good? What will result in the least harm?

Duties, obligations, and rules: What are the professional duties of the physician and the healthcare team? What guidance do professional codes of ethics provide? Are there relevant laws or policies that need to be considered?

Relationships: Good communication and reduction of uncertainty can help to make a decision to withhold or withdraw treatment easier (Levin 2005). How do the relationships between and among the health care team, the patient and the family affect communication and the decision-making process? What solution will best preserve the relationships involved in the situation? How can we best demonstrate caring and respect? How can we acknowledge and account for power differentials that exist? Are culture, faith, (dis)advantage or privilege affecting the options being considered?

Questions for discussion and consideration

1. What are the patient's wishes? If they are not capable of providing information, what does their substitute decision-maker say?
2. Who is the ultimate decision-maker? Are they fully informed? Do they have a good understanding of the implications?
3. What is consistent with good quality care? Is this at odds with the patient's wishes?
4. What values are at play? Consider the patient, family and providers, as well as the personal, professional and organizational values.
5. What guidance do professional codes of ethics offer in conflict situations?
6. Are there resources in place to support family and staff such as spiritual health services, ethics consultation, social work, or Employee Assistance Programs?
7. Use of an ethical decision-making framework may be helpful. Consider your organization's ethics resources, or work through the WRHA Ethics Decision Making Guide, which can be found at <http://www.wrha.mb.ca/about/ethics/patient-care.php> .

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For more information on any of the points in this document, please contact us, or talk with your library about the resources on this list.

This Quick Reference was originally developed by Ellie Einarson in 2014.

WRHA ETHICS SERVICES

Phone: 204-926-7124
E-mail: ethics@wrha.mb.ca
<http://www.wrha.mb.ca/about/ethics/index.php>



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