

MANITOBA LAW REFORM COMMISSION

**WITHHOLDING OR WITHDRAWING LIFE SUSTAINING
MEDICAL TREATMENT**

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APPENDIX C

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA SAMPLE POLICY WITHHOLDING AND/OR WITHDRAWING LIFE-SUSTAINING TREATMENT

BACKGROUND

The relationship between physician and patient is based on the ethical principles of justice, beneficence, non-maleficence and respect for patient autonomy. The primary goal of medical treatment is to restore or maintain patient health as much as possible, maximizing benefit and minimizing harm.

Patients, their families, substitute decision makers and health care providers require a supportive environment in which to address issues relating to end of life care. The term family as it is used throughout this Policy includes those who are closely linked to a patient in knowledge, care and affection and may include not only biological family and those linked to a patient by marriage, but may also include a patient's family by choice.

Physicians have a responsibility to consult with their patients or substitute decision makers, and where appropriate, their patients' families, regarding either withholding or withdrawing life-sustaining treatment and to attempt to facilitate a consensus on how to proceed.¹ Approaches towards reaching a consensus and/or managing conflict need to be tailored to the particular concerns and circumstances of each patient and will require physicians to use their best clinical and ethical judgment. Physicians should recognize that decisions concerning life-sustaining treatment may need to be revisited as patient circumstances change.

This Policy sets out a process-based approach to making these decisions and sets the parameters within which these decisions should be made. It focuses on conflict resolution when life-sustaining treatment is sought and a physician believes that it is medically inappropriate for the patient.

¹ Article 17, Code of Conduct.

The approach recognizes:

1. the right of patients or substitute decision makers and, where appropriate, patients' families to participate in decisions regarding life-sustaining treatment; and
2. physicians' integrity and autonomy by providing a basis for physicians to refuse to provide life-sustaining treatment when they determine that it would be medically inappropriate to do so.

The spectrum of clinical scenarios raising consideration of withholding and/or withdrawing life-sustaining treatment ranges from abstract discussions about potential end of life circumstances² to unforeseen medical emergencies³. There will be varying degrees of possible patient or substitute decision maker participation and/or the involvement of families across the spectrum; however, the principles outlined herein apply to all decisions to withdraw or withhold life-sustaining treatment. While the manner in which the requirements will be met may vary as necessary to accommodate unique circumstances, the process followed must adhere to the requirements as closely as possible in each case.

SCOPE

This Policy applies to all physicians.

POLICY

A. The *Most Responsible Physician*

The identity of "*most responsible physician*" must be clearly communicated to all members of the health care team, the patient or substitute decision maker and, where appropriate, the patient's family, and must be documented in the patient's medical record.

The *most responsible physician*:

1. is the coordinator of the patient's clinical care;
2. is the person to whom the patient or substitute decision maker and/or family members and other health care providers look for direction and dialogue;
3. serves as a consistent clinical presence, even when consultants or other health care providers may be variably involved; and
4. is not necessarily the clinician with the most expertise, but rather the one with the most meaningful ongoing relationship with the patient, by virtue of history, circumstance, relationship, or request.

² e.g. . consulting with a patient in the course of preparing a Health Care Directive or regarding an advanced care plan to address anticipated end of life situations in the course of treatment of a chronic condition.

³ e.g. ceasing resuscitative efforts following a cardiac or respiratory arrest resulting from an unforeseen event such as an accident or the sudden onset of an acute condition.

For a patient admitted to a health care facility such as a hospital or personal care home, it is the responsibility of the physician identified on the chart addressograph or database to either act as the *most responsible physician*, or to clearly designate another willing physician as the *most responsible physician*. For a patient in an emergency department or intensive care unit, the *most responsible physician* may be the emergency room physician or intensive care physician in urgent situations, but may often be the family physician or a specialist who has assumed care of the patient. Ultimately, it is the responsibility of the emergency department or intensive care unit staff to be aware of the identity of the *most responsible physician* for a given patient under their care. For patients in the community, the *most responsible physician* is either the patient's family physician, or the specialist who has taken primary responsibility for ongoing medical care due to the complexity of the case.

When a physician is confronted with a clinical scenario in which withholding or withdrawing a life-sustaining medical intervention may be appropriate, where that physician is not the patient's *most responsible physician*, the physician should consult with the *most responsible physician*, if possible. Otherwise, that physician should assume the role of the *most responsible physician* or find someone who will.

B. Prognosis and Treatment Options

The *most responsible physician*, in consultation with other members of the health care team, should consider the range of medically appropriate treatments for the patient, including those that are life-sustaining interventions that may be withheld or withdrawn. In assessing the patient's prognosis and the treatment options, the *most responsible physician* must rely on the best available clinical evidence, including, where appropriate, consultation with a specialist⁴.

Where the *most responsible physician* is uncertain and/or is ambivalent about any aspect of the range of medically appropriate life-sustaining treatment for the patient, prior to reaching a conclusion as to what form of treatment is most medically appropriate for the patient, the *most responsible physician* must seek additional clinical input:

1. where possible, from other health care team members, such as another physician involved in the patient's care, and/or
2. by consulting with at least one other physician, preferably inside the same institution, or if not available;
3. by consulting with a physician outside the institution by telephone.

C. Consultation with the Patient or Substitute Decision Maker and/or Family

⁴ Recognize your limitations and the competence of others and when indicated, recommend that additional opinions and services be sought. Article 6, Code of Conduct.

Patient

Where the range of medically appropriate treatments involve the possibility of withholding or withdrawing life-sustaining treatment, the *most responsible physician* must, as early as possible and where possible, while the patient is competent and capable of participating in the discussion, consult with the patient regarding the patient's prognosis and wishes for treatment. In the case of many chronic diseases likely to result in eventual deterioration of health and death, timing of initiation and the extent of such discussions will depend on many factors, including the personal circumstances of the patient, and will involve the exercise of clinical judgment by the physician.

Substitute Decision Maker

Where the patient is not competent to make decisions regarding care, the *most responsible physician* must, as early as possible and in consultation with others where appropriate, identify the patient's substitute decision maker.

If the patient has a health care directive appointing a health care proxy, the *most responsible physician* must accept the appointment as expressed in the directive. Where the directive identifies a health care proxy, the proxy will be the patient's substitute decision maker.

Where there is no health care directive and/or proxy, the *most responsible physician* must ascertain the identity of the person with legal authority to make decisions on behalf of the patient and that person will be the patient's substitute decision maker. Depending on the circumstances, the substitute decision maker may be a family member, legal guardian, court appointed committee or other party such as the Public Trustee. The physician must consult with the substitute decision maker in the same way as the physician would otherwise consult with the patient.

Consultations

In consultation with the patient or the substitute decision maker, the *most responsible physician* must attempt to reach a consensus on how to proceed. The consultations with the patient and/or substitute decision maker should include:

- with the assistance of patient or substitute decision maker, identification of others who should be involved in the discussion, and, where possible, accommodating the participation of anyone identified in the discussion;
- an inquiry as to the patient's personal, cultural and family issues that may impact on the decision, such as their existing knowledge, awareness and understanding of the patient's condition and treatment options and their interest in pursuing treatment options;
- a description of the nature of the underlying condition or ailment;
- the options for treatment and their expected outcome;
- the prognosis with or without medical intervention in the form of life-sustaining

treatment;

- the reason why the physician feels that initiating or continuing life-sustaining treatment may be medically inappropriate;
- options including palliative care and hospice care where applicable;
- assurances that the patient will not be abandoned in the event that medical intervention is either withheld or withdrawn;
- confirmation that other forms of medical treatment such as palliative care measures which emphasize patient comfort and dignity will be provided;
- where the *most responsible physician* recommends either withholding or withdrawing life-sustaining treatment and the recommendation is not accepted, an exploration of the reasons why the patient or substitute decision maker wishes treatment to be continued and address these issues directly with a view to resolving them, including, where appropriate:
 1. a description of the decision making process, including the information that the physician has the responsibility to recommend and provide only those treatments that the physician determines are medically appropriate for the patient;
 2. exploring feelings of guilt that may exist and addressing fears that those involved in the decision are causing the patient's death by agreeing with a recommendation that life-sustaining treatment be withheld or withdrawn;
 3. among the solutions offered, offering a time-limited trial of therapy with clear predefined outcome goals to accommodate either medical issues or satisfy personal concerns of patient, substitute decision maker, the patient's family or others;
 4. mutually agreeing to take any additional or alternative steps to facilitate a consensus, including, but not limited to, involving institutional resources such as a patient advocate, mediator, ethics committee or institutional review process;
 5. an offer of institutional resources such as social work, chaplaincy, or bioethics to assist the patient or substitute decision maker or family with their psychosocial, cultural, spiritual, and informational needs;
- documentation of the pertinent details of this communication in the patient's health record.

If a consensus results from the consultation with either the patient or the substitute decision maker, the decision can be implemented without the consent of the patient's family or others, but if a medical intervention is to be withheld or withdrawn, the *most responsible physician* should, with the consent of the patient or substitute decision maker, attempt to communicate with the family members and fully explain the reasons for the decision.

D. Additional Clinical Input

If consensus cannot be reached as a result of the consultations referred to above, the *most responsible physician* must address with the patient or substitute decision maker the option

of the patient or substitute decision maker's obtaining an independent medical opinion concerning the medical appropriateness of the intervention in question and facilitating a request for an independent medical opinion by providing all relevant medical information to the consultant chosen by the patient or substitute decision maker.

E. The Most Responsible Physician's Onus to Decide

Where the patient is not competent and it is not reasonably possible to consult with the substitute decision maker, the onus is on the *most responsible physician* to decide whether or not life-sustaining treatment should be withheld or withdrawn. When a physician is confronted with making such a decision without the input of the patient or someone to whom the authority to represent the interests of the patient has been delegated, the onus is on the *most responsible physician* to make the decision based on his/her determination of what is in the best interests of the patient⁵. In such circumstances, the *most responsible physician* should consider consulting with other members of the health care team, including another physician in reaching a decision. The *most responsible physician* should communicate the decision to other members of the health care team as soon as possible after the decision has been made.

F. Transfer of Care

The *most responsible physician* must, where possible, provide the patient or substitute decision maker with an opportunity to identify another physician willing to assume care of the patient and facilitate the transfer at any time when the patient or substitute decision maker requests that the patient's care be transferred to another physician who is willing to assume care of the patient.

G. Impasse – Notice of Decision

If, despite all reasonable efforts, a consensus cannot be reached, the *most responsible physician* must, where possible, provide at least 72 hours notice to the patient or substitute decision maker, preferably in writing, prior to withholding or withdrawing life-sustaining treatment.

H. Withholding or Withdrawal of Life-sustaining Treatment

The *most responsible physician* may withhold or withdraw life-sustaining treatment, or

⁵ What is in the best interests of the patient will depend on each individual patient. Decisions should be justifiable in terms of providing an overall health benefit to the patient. In determining what is in the patient's best interests, the *most responsible physician* should take into account relevant information that may impact on the decision, such as what is medically appropriate and what was the patient's understanding of the condition and treatment options and desire to pursue treatment, as well as any social, cultural, and/or spiritual issues of which the *most responsible physician* is aware.

authorize other members of the health care team to withhold or withdraw life-sustaining treatment, including intensive care:

1. with the consent of the patient or substitute decision maker at any time;
2. without the consent of the patient or substitute decision maker:
 - i) where the *most responsible physician* has otherwise complied with all of the requirements of this policy **and**
 - a) the *most responsible physician* believes that it is medically appropriate for the patient, **and**
 - b) the *most responsible physician* is unable to obtain consent because the patient is not competent, **and**
 - c) it is not possible to consult with the substitute decision maker;

OR

- ii) where consultation with the patient or substitute decision maker has not resulted in consensus:
 - a) **after** the notice period has elapsed, **and**
 - b) in the absence of a transfer of the patient's care to another physician **or** the initiation of legal steps to prevent the treatment from being withdrawn or withheld at any time during the notice period.

**EXECUTIVE SUMMARY
OF
REPORT ON
WITHHOLDING OR WITHDRAWING
LIFE SUSTAINING MEDICAL TREATMENT**

A. INTRODUCTION

In June 2002, the Manitoba Law Reform Commission released a discussion paper entitled *Withholding or Withdrawing Life Sustaining Treatment*, which is appended to the Report. It explores a range of issues relating to end of life medical decision-making including: the power of modern technology to prolong life beyond its natural end; the propriety of providing life sustaining medical treatment which offers no therapeutic benefit and may threaten additional harm; the competing interests of patients, physicians and other stakeholders; the allocation of ultimate authority for making decisions to withhold or withdraw life sustaining medical treatment; and the principles and procedures that should guide the decision making process.

The Report outlines the policies and procedures that should guide end of life decision making and contains our recommendations on how best to implement that protocol.

B. PRINCIPLES AND POLICIES

The Commission believes that there are certain fundamental principles and policies that should be reflected in the rules or framework controlling the withholding or withdrawal of life sustaining medical treatment.

1. There must be a uniform approach and process to withholding or withdrawing life sustaining medical treatment across the province and in all health care institutions.
2. The uniform approach must apply to all decisions to withhold or withdraw life sustaining medical treatment whether in the form of Do-Not-Resuscitate (DNR) orders or other decisions.
3. The uniform approach must treat all citizens fairly and equitably and provide equal access to medically appropriate medical care to all without bias or favour. In particular equal treatment must extend to the elderly and persons with disabilities. Neither of those circumstances is a sign of terminal illness or impending death.
4. The decision making process must be clear and transparent and must be communicated clearly not only to the patient and his or her family but also to the public in order to

facilitate a broad understanding of how these decisions are made.

5. Emphasis must be placed on the *process* for decision making rather than the formulation of specific rules which would purport to dictate the decision. The process must be designed to facilitate an *agreement* between the physician and the patient or his or her substitute decision maker. It should have the following features:
 - the process should be instigated by the attending physician;
 - the process should begin at the earliest appropriate time to provide an opportunity for considered and informed discussion and decision-making;
 - full and complete information must be provided by the attending physician to the patient/substitute decision maker about the nature of the patient's condition, prognosis, treatment options (including those that the physician may not favour) and the expected benefit or harm of those options;
 - a full and complete explanation by the attending physician why he or she believes that withholding or withdrawal of life sustaining medical treatment is medically appropriate;
 - a full and complete discussion between the attending physician and the patient of his or her personal, cultural circumstances and spiritual beliefs and concerns insofar as they are relevant to the decision at hand and welcomed by the patient;
 - a full and complete discussion between the attending physician and the patient of his or her wishes, concerns, expectations and preferred treatment options including consideration of a time limited trial of therapy;
 - a full consultation with the family of the patient unless such communication is prevented for some documented reason such as impracticality, breach of privacy or confidence;
 - full information and assurances to the patient that a withdrawing of withholding of life sustaining medical treatment does not amount to an abandonment of care and compassion and that palliative treatment will be provided.
6. Where a consensus cannot be reached between the physician and the patient or substitute decision maker about withholding or withdrawing life sustaining medical treatment resort should be had to other available informal dispute resolution procedures. Institutional facilitators and mediators such as ethicists, pastoral care workers and other qualified persons can assist in finding a consensus between the physician and the patient or substitute decision maker. In some circumstances, independent external mediators may be helpful. Every reasonable effort should be used to secure agreement in as informal and sensitive a process as possible.
7. Where there is disagreement between the physician and the patient or substitute decision maker on the appropriate course of action, the patient must be given an opportunity to secure an independent second opinion from a physician who is not a member of the patient's health care team and/or request that his or her care be transferred to another willing physician.
8. Where all preceding measures have failed to produce an agreement, the physician may,

after an appropriate notice period, withhold or withdraw life sustaining medical treatment where such treatment would be medically inappropriate.

9. We do not favour a right to indefinite life sustaining medical treatment. The appeal of autonomous decision making and personal control of all end of life medical decision making is initially attractive but an unfettered right to life sustaining treatment may result in unreasonable demands being made for indefinite inappropriate medical treatment.
10. Final resort to the courts will remain available where the procedures designed to achieve consensus have irretrievably broken down.

C. IMPLEMENTATION

The Commission does not favour a legislative implementation of these principles. Its preference is to see them embodied in a statement or by-law of the College of Physicians and Surgeons of Manitoba. It has, indeed, been drawn to our attention that the College is developing a new protocol for end of life decision making and we have studied its sample *Proposed Policy on Withholding or Withdrawing Life-sustaining Treatment*. The policy reflects many of the principles for end of life decision making that we have described. We have therefore devoted much time and attention to that sample policy and have recommended changes that would further emphasize and promote our views. We also recommend that other health care institutions, agencies, associations and bodies involved in delivering health care in Manitoba should adopt the Policy of the College once amended to reflect our advice. We urge them to use the Policy as a template for their own protocols and procedures.

We envisage a cohesive and integrated approach to maximize consensus decision making without imposing an obligation on physicians to provide inappropriate medical care. Such an approach, coupled with an extensive program of public education and awareness of the end of life decision making process, will serve the citizens of Manitoba well.

RAPPORT SUR LA RESTRICTION OU LE RETRAIT DE TRAITEMENTS MÉDICAUX DE SURVIE

RÉSUMÉ

A. INTRODUCTION

En juin 2002, la Commission de réforme du droit du Manitoba a publié un document de travail sur la restriction ou le retrait de traitements médicaux de survie (*Withholding or Withdrawing Life Sustaining Treatment*), que nous avons joint au rapport. Ce document examine toute une série de questions ayant trait aux décisions médicales concernant la mort, notamment : la capacité de prolonger la vie au-delà de ses limites habituelles, grâce à la technologie moderne; la légitimité de prodiguer des soins médicaux afin de maintenir une personne en vie quand ces soins n'ont aucun avantage thérapeutique et pourraient même présenter plus de dangers; les intérêts opposés des patients, des médecins et des autres parties concernées; la délégation d'autorité pour prendre la décision finale relativement à la restriction ou au retrait d'un traitement médical de survie; et les principes et procédures qui devraient guider tout processus décisionnel.

Le rapport donne un aperçu des politiques et procédures qui devraient guider les décisions médicales concernant la mort et présente nos recommandations sur la meilleure façon de mettre celles-ci en œuvre.

B. PRINCIPES ET POLITIQUES

La Commission croit qu'il existe certains principes et politiques fondamentaux qui devraient être reflétés dans les règles ou dans le cadre autorisant la restriction ou le retrait de traitements médicaux de survie.

1. Il faudrait adopter une approche et un processus uniformes en ce qui concerne la restriction ou le retrait de traitements médicaux de survie, à l'échelle de la province et dans tous les établissements de soins de santé.
2. Cette approche doit s'appliquer à toutes les décisions prises relativement à la restriction ou au retrait de traitements médicaux de survie, qu'il s'agisse d'ordonnances de ne pas réanimer (DNR) ou d'autres décisions.
3. Cette approche doit permettre de traiter tous les Manitobains et Manitobaines raisonnablement et équitablement et d'offrir à chacun et à chacune le même accès aux soins médicaux appropriés, sans discrimination ni favoritisme. Ce traitement équitable doit

s'appliquer tout particulièrement aux aînés et aux personnes handicapées, ces deux groupes de personnes n'étant pas dans une situation synonyme de maladie terminale ou de mort imminente.

4. Le processus décisionnel doit être clair et transparent et doit de plus être expliqué clairement non seulement au patient et à sa famille, mais aussi au public afin que le plus grand nombre de personnes possibles comprenne la manière dont ces décisions sont prises.
5. Il faut mettre l'accent sur le *processus décisionnel* plutôt que sur la formulation de règles particulières qui permettraient d'arrêter la décision. Le processus doit être conçu de manière à favoriser une *entente* entre le médecin et le patient ou son subrogé. Pour ce faire, le processus décisionnel devrait :
 - être amorcé par le médecin traitant;
 - être déclenché le plus tôt possible et à un moment approprié afin de laisser aux personnes concernées le temps de mûrement réfléchir, d'avoir des discussions éclairées et de prendre les décisions qui s'imposent;
 - obliger le médecin traitant à fournir au patient ou à son subrogé des renseignements complets sur l'état de santé du patient, son pronostic, les options en matière de traitement (y compris les interventions qui vont à l'encontre de l'avis du médecin), ainsi que les résultats escomptés ou les répercussions négatives des différents traitements (le cas échéant);
 - inclure une explication complète de la part du médecin traitant indiquant pourquoi il croit approprié de refuser ou d'interrompre le traitement médical de survie;
 - comprendre une discussion détaillée et complète entre le médecin traitant et le patient relativement aux circonstances personnelles et culturelles, aux croyances religieuses et aux préoccupations de ce dernier, et ce, dans la mesure où celles-ci influeraient sur la décision à prendre et seraient bien accueillies par le patient;
 - comprendre une discussion détaillée et complète entre le médecin traitant et le patient afin de connaître les désirs, préoccupations, attentes et choix de traitement préférés de ce dernier, y compris la possibilité de suivre une thérapie pendant une période déterminée;
 - inclure un entretien approfondi avec la famille du patient sauf si cela est interdit en raison d'une exigence documentée (p. ex. un tel entretien ne serait pas pratique ou constituerait un abus de confiance ou une atteinte à la vie privée du patient);
 - permettre au patient d'avoir accès à des renseignements complets et de recevoir l'assurance que même si le traitement médical de survie est refusé ou interrompu, il recevra toujours des soins prodigués avec compassion et le traitement palliatif nécessaire.
6. Lorsque le médecin traitant et le patient ou son subrogé ne sont pas d'accord pour refuser ou interrompre un traitement médical de survie, ils devraient recourir à un autre type de procédure informelle afin de régler leurs différends. Un facilitateur ou un médiateur de l'établissement de soins, comme un service de pastorale, un comité de bioéthique ou d'autres personnes qualifiées pourraient aider les parties concernées à trouver un

consensus. Dans certaines situations, il pourrait s'avérer utile de recourir à un service de médiation externe. Il faut tout mettre en œuvre pour que les parties concernées arrivent à s'entendre, et ce, de la manière la plus simple et sensible possible.

7. Lorsqu'il y a un différend entre le médecin traitant et le patient ou son subrogé sur le plan d'action à suivre, il faut donner au patient la possibilité de demander conseil auprès d'un autre médecin ne faisant pas partie de l'équipe soignante ou de demander à ce qu'un autre médecin consentant s'occupe de son cas.
8. Lorsque toutes les procédures précédentes ont échoué, le médecin traitant pourrait, après une période de préavis appropriée, refuser ou interrompre le traitement médical de survie, s'il juge celui-ci inapproprié sur le plan médical.
9. Nous ne voulons pas reconnaître le droit de faire appel à des traitements médicaux de survie pour une durée illimitée. Au premier abord, il pourrait sembler attrayant de disposer d'un processus décisionnel autonome et de laisser aux gens le soin de prendre leurs propres décisions en matière de traitements en fin de vie, mais la possibilité d'avoir un recours illimité aux soins médicaux de survie pourrait créer des demandes déraisonnables de traitements médicaux inappropriés et à durée illimitée.
10. Il restera la possibilité de recourir aux tribunaux quand tous les moyens mis en œuvre pour atteindre un consensus ont abouti à un échec total.

C. MISE EN ŒUVRE

Les membres de la Commission ne tiennent pas à ce que ces principes soient mis en œuvre grâce à des mesures législatives. Ils préféreraient qu'ils soient incorporés dans un énoncé ou dans un règlement formulé par le Collège des médecins et chirurgiens du Manitoba. Nous savons que le Collège élabore actuellement un nouveau protocole relativement à la prise de décisions en fin de vie et avons étudié l'ébauche intitulée *Proposed Policy on Withholding or Withdrawing Life-sustaining Treatment* (politique proposée sur la restriction ou le retrait des traitements médicaux de survie). Cette politique comprend bon nombre de principes relatifs à la prise de décisions en fin de vie qui sont similaires à ceux que nous avons décrits plus haut. Nous avons donc consacré beaucoup de temps et de soins à étudier cette ébauche et avons suggéré des changements qui permettraient de souligner et de promouvoir davantage nos points de vue. Nous recommandons aussi que les autres établissements, organismes, associations ou organisations offrant des soins de santé au Manitoba adoptent les politiques du Collège une fois que celles-ci auront été modifiées en fonction de nos recommandations. Nous demandons avec instance qu'ils utilisent ces politiques comme guide pour l'élaboration de leurs propres protocoles et procédures.

Nous envisageons une approche cohésive et intégrée qui favorisera une prise de décisions par consensus, de manière que les médecins ne soient pas obligés de fournir des soins médicaux

inappropriés. Une telle approche, combinée à un vaste programme d'éducation et de sensibilisation du public relativement au processus décisionnel en fin de vie, sera dans l'intérêt de tous les Manitobains et Manitobaines.