Withholding and Withdrawing Life Sustaining Treatments:

The Ethical and Legal Frameworks That Guide Us

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October 29th, 2025 | 0730-0900

THE UNIVERSITY OF BRITISH COLUMBIA
Continuing Professional Development
Faculty of Medicine

Land Acknowledgement

I am grateful to live, work and play on the traditional, ancestral and unceded territory of the Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Sə́lílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

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Disclosures

- No relationship or commercial interests to disclose.

- Research contributions from Pan-Canadian Palliative Care Research Collaborative Seed Fund

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Learning Objectives

- Review the concept of WWLST
- Describe relevant legal precedent in WWLST
- Discuss the ethical considerations of WWLST
- Examine these concepts as they apply to rural care

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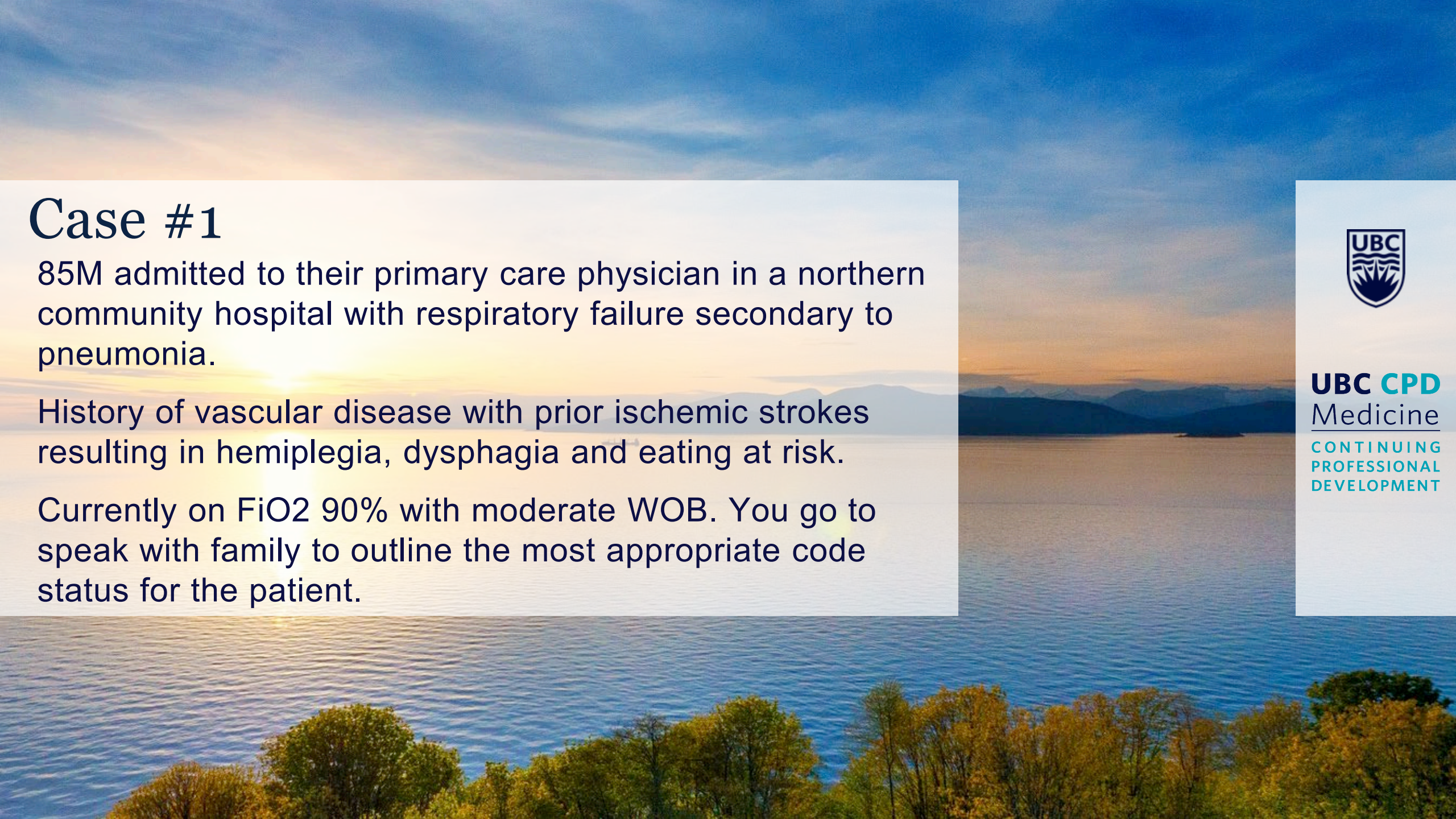
Case #1

85M admitted to their primary care physician in a northern community hospital with respiratory failure secondary to pneumonia.

History of vascular disease with prior ischemic strokes resulting in hemiplegia, dysphagia and eating at risk.

Currently on FiO2 90% with moderate WOB. You go to speak with family to outline the most appropriate code status for the patient.



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Case #1 Discussion

- Case of *withholding* interventions
- Importance of conversations in home communities with providers who know patients and their families
- What are patients wishes?

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Case #2

78M comorbid patient with CAD, COPD, advanced dementia, intubated in small community for respiratory failure and transferred to Kelowna for ongoing care.

On arrival found to be in multiorgan failure with respiratory failure, AKI, shock and delirium.

Ongoing conversations with family (still in home community) about goals of care.

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Case #2 Discussion

- Case of *withdrawing* interventions
- Importance of conversations in home communities with providers who know patients and their families
- What are patients wishes?

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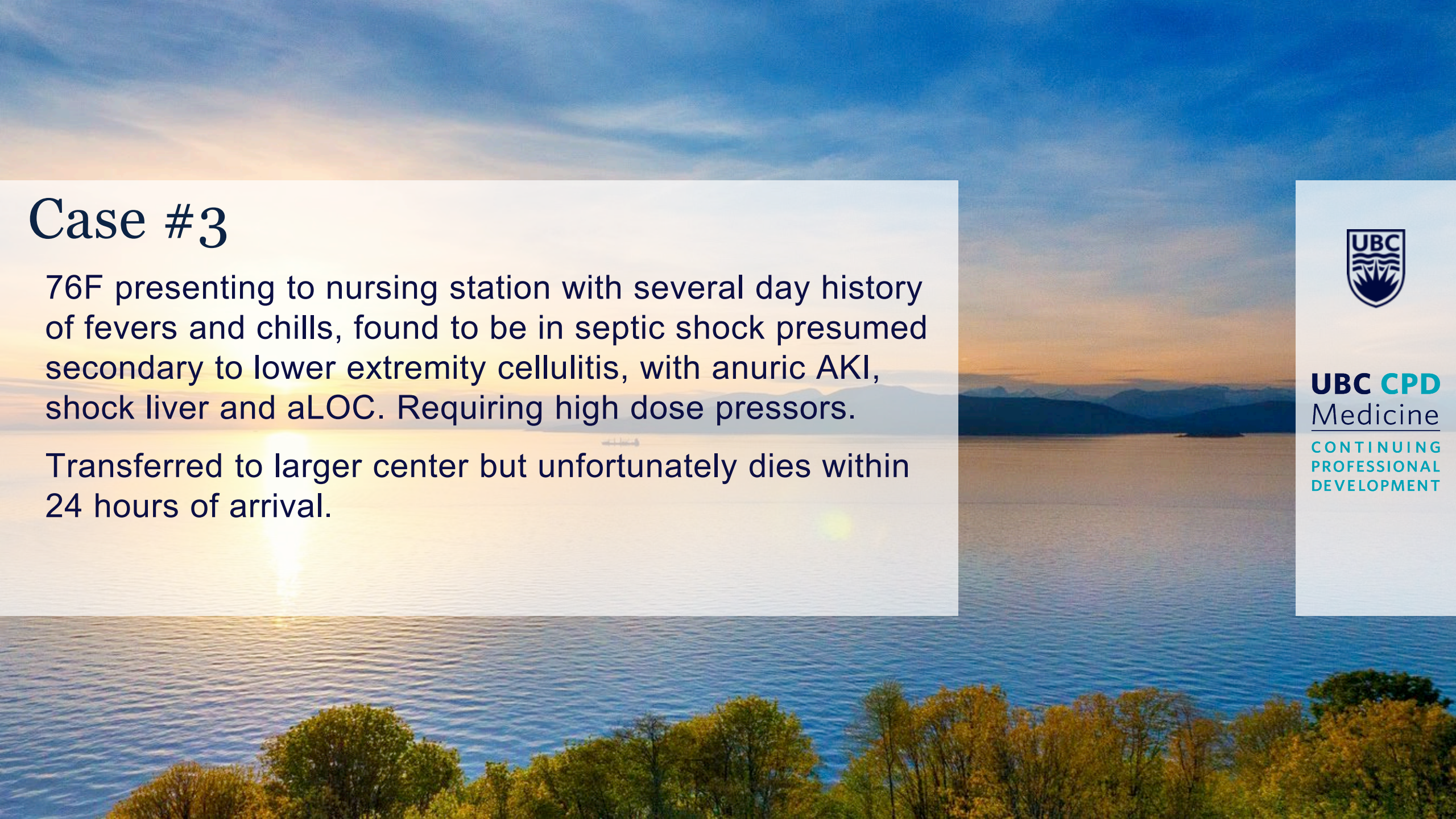
Case #3

76F presenting to nursing station with several day history of fevers and chills, found to be in septic shock presumed secondary to lower extremity cellulitis, with anuric AKI, shock liver and aLOC. Requiring high dose pressors.

Transferred to larger center but unfortunately dies within 24 hours of arrival.



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Case #3 Discussion

- Importance of conversations in home communities with providers who know patients and their families

- Patients wishes around end of life especially important when being transported out of home community and potentially far from family

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information preferences

goals

patient understanding

Serious Illness Conversation

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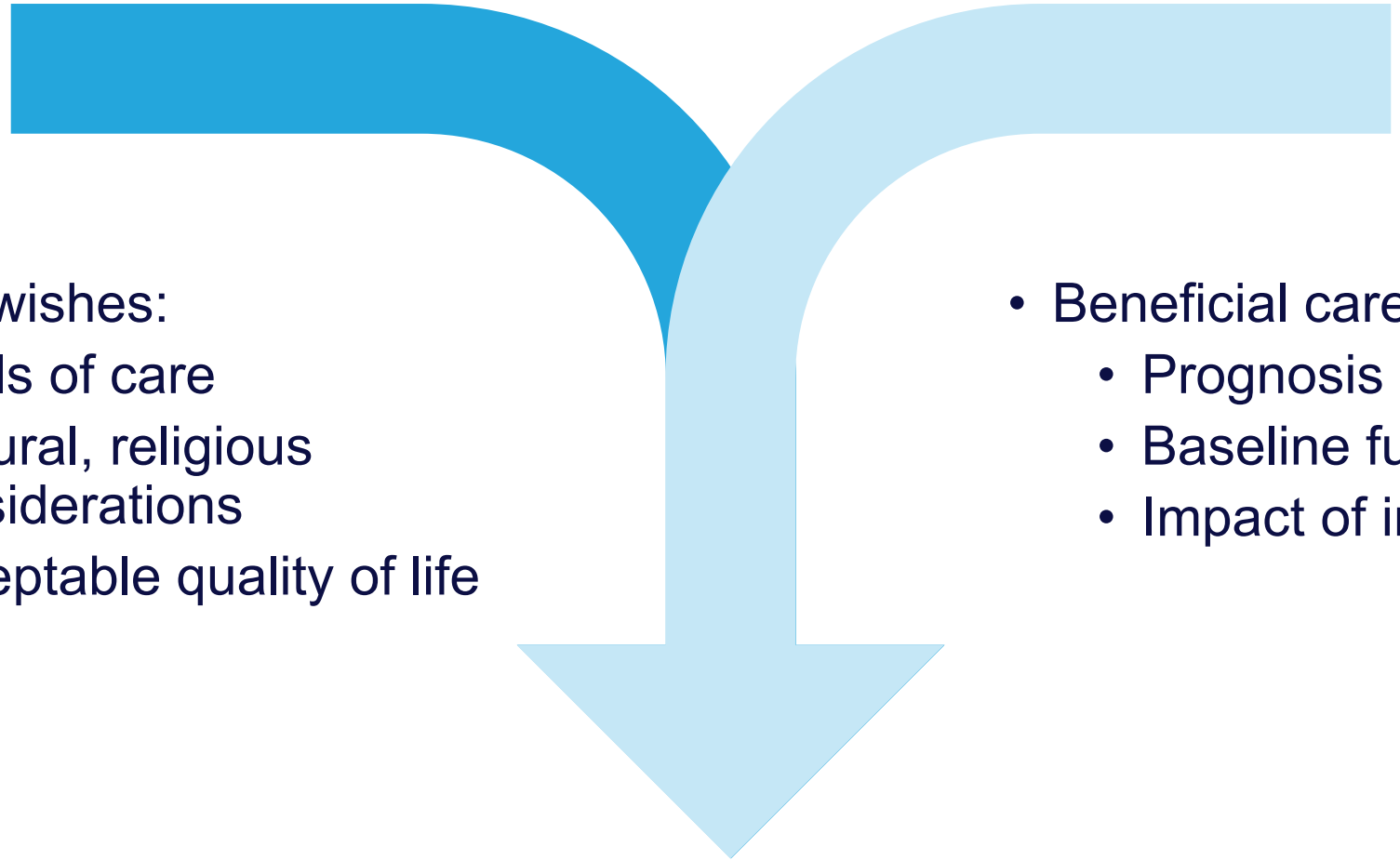
fears

trade-offs

prognosis

family understanding

Aligning Patient and Care Team



- Patient wishes:
  - Goals of care
  - Cultural, religious considerations
  - Acceptable quality of life

- Beneficial care:
  - Prognosis of disease
  - Baseline functioning
  - Impact of interventions

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The NEW ENGLAND JOURNAL of MEDICINE

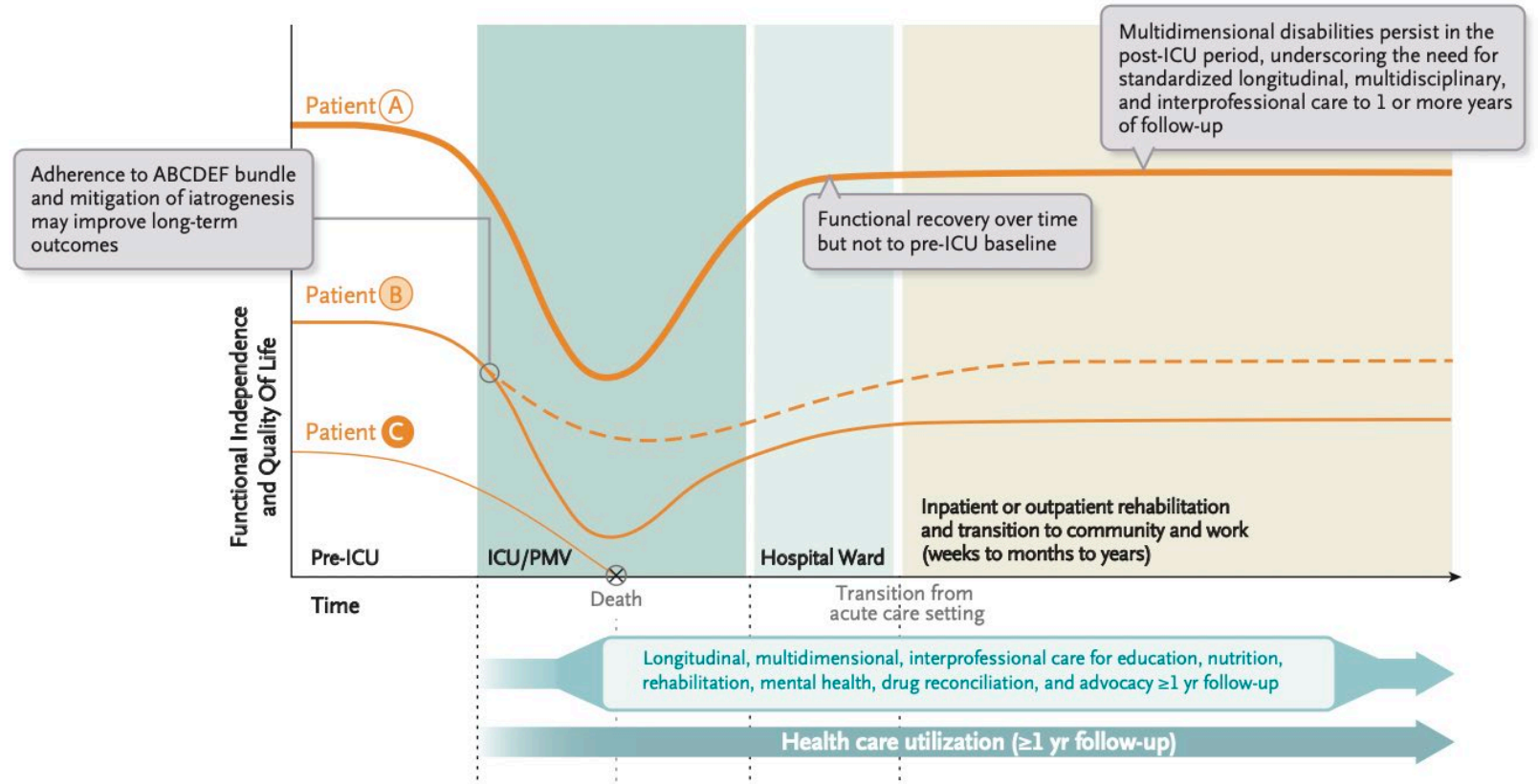
REVIEW ARTICLE

C. Corey Hardin, M.D., Ph.D., *Editor*

Outcomes after Critical Illness

Margaret S. Herridge, M.D., M.P.H., and Élie Azoulay, M.D., Ph.D.

A Patient Trajectory (risk stratified by frailty, age, burden of coexisting illness, pre-ICU function, and cognitive health trajectories)



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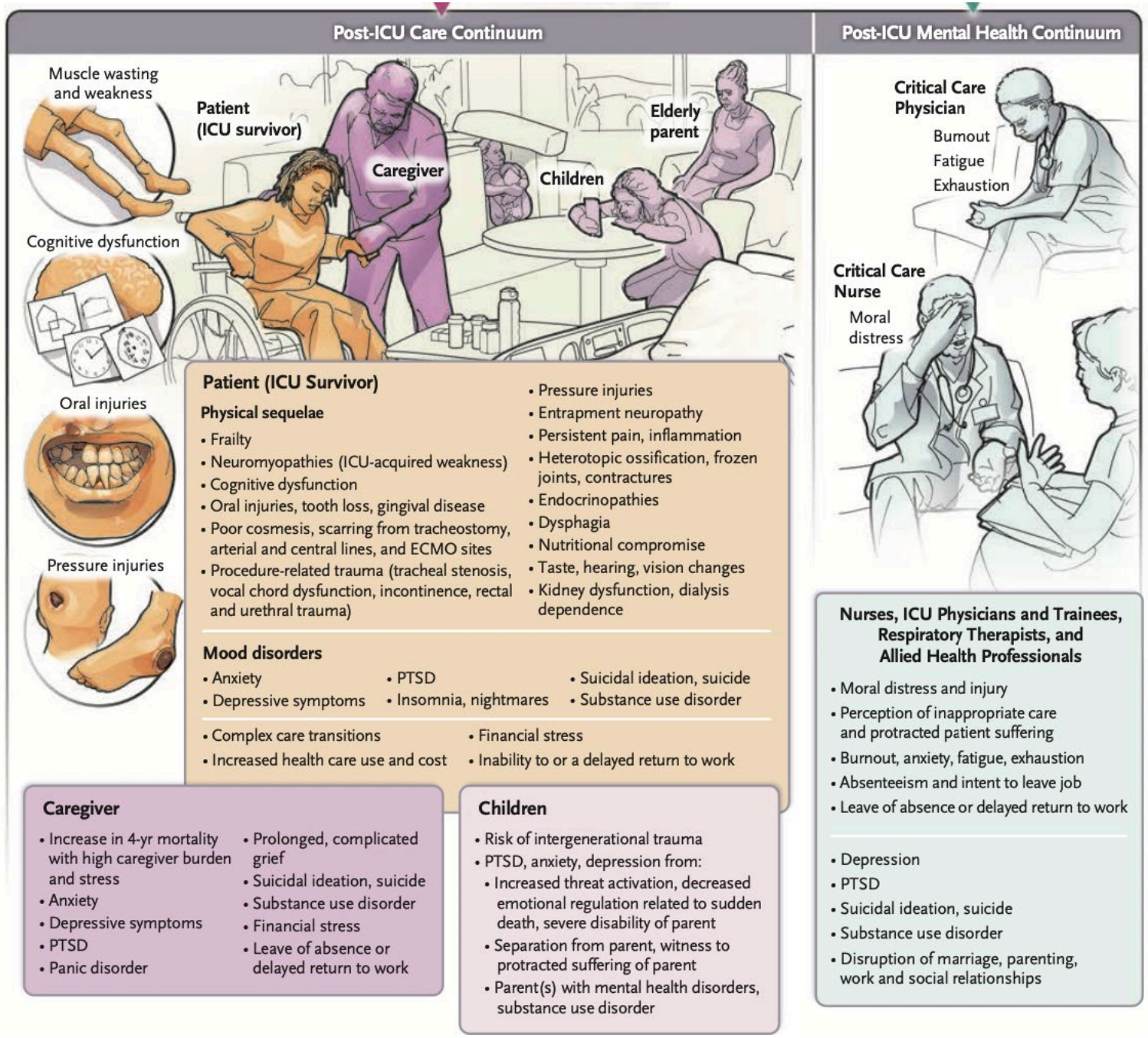

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Aligning Care Team

- Care team is large
    - family physicians, general internists, intensivists, consultants, nurses, respiratory therapists, social workers, spiritual care etc.
- Starts in community
- Clear communication and shared decision-making process

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Categories of Interventions

- Resuscitative interventions (CPR, defibrillation etc.)
- Life supporting interventions (mechanical ventilation, ECMO etc.)
- Life sustaining interventions (feeding, dialysis, IV therapies etc.)
- Other interventions (not at the end of life)

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Non-Beneficial Care

- Care that is no longer expected to achieve its intended outcomes or may harm the patient
- Common; 1 in 3 patients near the end of life receive non beneficial treatments
- Recognizing non-beneficial care increasingly important in resource limited settings

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Moral Distress

- Occurs when an individual feels unable to uphold or act on their values or core beliefs, because of external factors

- Repeated episodes of moral distress can have a lasting impact, even when the morally distressing event is over

- Strongly associated with burnout

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Burnout

- Psychological syndrome arising in response to chronic workplace stressors such as moral distress

- Characterized by:
  - emotional exhaustion
  - depersonalization
  - decreased sense of personal accomplishment

- Common; 1 in 4 providers in the ICU experience burnout

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Causes of Moral Distress

- Provision of non-beneficial care
  - Patient suffering
  - Poor alignment within care team
  - Poor alignment between care team and patient/family
  - Unclear or lack of communication
  - Resource limitations

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Withholding and Withdrawing Life Sustaining Treatments

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Withholding vs Withdrawing

- Clinically
- Ethically
- Legally

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Legal Precedent

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Legal precedent

- Statutory law
  - Ie. British Columbias Health Care (Consent) and Care Facility (Admissions) Act

- Common law
  - Cuthbertson v. Rasouli
  - Rotaru v. Vancouver General Hospital
  - De Châtillon v. Toma

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Summary

- Withholding care = prior to escalation of care
  - no consent required

- Withdrawing care = after escalation of care
  - consent required

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SUPREME COURT OF CANADA

CITATION: Cuthbertson *v.* Rasouli, 2013 SCC 53, [2013] 3 S.C.R. 341

DATE: 20131018
DOCKET: 34362

BETWEEN:

Brian Cuthbertson and Gordon Rubenfeld
Appellants
and
Hassan Rasouli, by his Litigation Guardian and Substitute Decision-Maker, Parichehr Salasel
Respondent
- and -
Consent and Capacity Board, Euthanasia Prevention Coalition, Canadian Critical Care Society, Canadian Association of Critical Care Nurses, Advocacy Centre for the Elderly, ARCH Disability Law Centre, Mental Health Legal Committee, HIV & AIDS Legal Clinic Ontario and Evangelical Fellowship of Canada
Interveners

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Cuthbertson v. Rasouli

- Ontario, 2010 – 2014
- Surgery for benign brain tumor, complicated by postoperative meningitis and left in minimally conscious state requiring life sustaining treatments (LST)
- Physicians concluded no reasonable hope for recovery, LST inappropriate, recommended withdrawal of LST and palliative care

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Cuthbertson v. Rasouli

- SDM applied to the Ontario Superior Court of Justice for injunction to prevent removal of LST
- Judge ruled consent required to withdraw LST as per the definition of ‘treatment’ under the Health Care Consent Act (HCCA)
- No injunction was required

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Cuthbertson v. Rasouli

- Physicians applied to Ontario Court of Appeal and eventually to Supreme Court of Canada stating:
    - Consent not required for withholding or withdrawing treatment outside the standard of care
    - Requiring physicians to provide non-beneficial treatment that may cause harm places them in breach of their professional duties

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Cuthbertson v. Rasouli

- Supreme Court dismissed physicians appeal in 5 – 2 decision based on statutory interpretation of the HCCA

- Consent is required to withdrawal life sustaining treatment:
  - As it serves a ‘health related purpose'
  - Requires physical contact with the patient
  - Implies provision of palliative care
  - Results in imminent death

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Cuthbertson v. Rasouli

- Consent is required for withdrawal of life sustaining treatment
- Supreme Court of Canada interpretation of Ontario statutory law

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IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: ***Rotaru v. Vancouver General Hospital Intensive Care Unit,*** 2008 BCSC 318

Date: 20080314
Docket: S081164
Registry: Vancouver

Between:

Georgeta Rotaru

Petitioner

And

Vancouver General Hospital Intensive Care Unit and Dean Chittock

Respondents

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Rotaru v. Vancouver General Hospital

- Patient with advanced vascular disease → ischemic leg, ischemic bowel requiring TPN, acute kidney injury deemed not a dialysis candidate by nephrology, recurrent ICU admissions

- Returned to ICU with respiratory arrest and worsening AKI from volume overload

- Medications, albumin and TPN stopped due to potential harm

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Rotaru v. Vancouver General Hospital

- Plaintiffs applied for an injunction to compel physician to resume these medications / albumin / TPN

- The court denied this request and stated that in the facts of this case, they cannot compel a physician to act contrary to their fundamental duty to the patient (ie do no harm)

- Physicians were not compelled to restart medications

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Rotaru v. Vancouver General Hospital

- Judge emphasizes the harms of requested treatment
- Judge states that given the facts of this case, the uncontradicted medical evidence, the court cannot order a physician to act against his or her clinical judgement
- Common law in BC on withholding life sustaining treatments

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IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *De Châtillon v. Toma,*
2023 BCSC 1356

Date: 20230803
Docket: S234079
Registry: Vancouver

Between:

Evangeline De Châtillon and Elise Bikus

Plaintiffs

And

Dr. Mustafa Toma, Dr. MacRedmond, Camille Ciarnello and Saint Paul's Hospital

Defendants

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De Châtillon v. Toma

- Patient had an out of hospital cardiac arrest and was admitted to CCU
- Physicians believed he would have a poor neurological prognosis and recommended withdrawal of life sustaining treatments and transition to comfort care
- SDM states patient would not want to live in vegetative state, but did not believe care team that he would not improve and therefore did not consent to withdrawing life sustaining treatment

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De Châtillon v. Toma

- Court Injunctions
  - Plaintiffs (SDM)
    - Sought injunction to remove DNR and request ongoing life sustaining treatment
  - Defendants (Providence Health Care Society)
    - Sought injunction to discontinue life sustaining treatment

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De Châtillon v. Toma

- There was no evidence of patients wishes and directions except the wishes communicated by SDMs; that he would not wish to live in a vegetative state
- Documented uncontradicted medical opinion was clear that ongoing care not within patient's best interest
- Courts ruled that the SDM opposition to withdrawal was not within the patient's best interest and therefore granted defendants order to withdraw life sustaining treatment

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De Châtillon v. Toma

- Case Specifics
  - Patients wishes (via SDM) well documented
  - Uncontradicted medical opinion documented
  - Health care team communicated harm of treatment
- Importance of early serious illness conversations
- Importance of following procedure and guidelines (SPH policy)

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Summary of Legal Precedent

- Withholding care = prior to escalation of care
  - no consent required

- Withdrawing care = after escalation of care
  - consent required

- Court judgements emphasized:
  - Unanimous, uncontradicted medical opinion documented
  - Harms of treatment communicated
  - Patients documented wishes
  - Following guidelines/policies

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Guidelines and Policies on WWLST

- American Thoracic Society (ATS) / American Association of Critical Care Nurses (AACN) / American College of Chest Physicians (ACCP) / European Society of Intensive Care Medicine (ESICM) / Society of Critical Care Medicine (SCCM)

- Canadian Critical Care Society (CCCS)
- Canadian Medical Association (CMA)

- Provincial colleges: ON, MB, SK

- Health authority or hospital policies

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Ethical Considerations

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Autonomy vs Justice

- Shift towards patient autonomy

- Does not oblige the physician to offer treatment outside the standard of care

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Beneficence vs Non-Maleficence

- ”Do no harm”
- Provide benefit to patient, act in their best interest

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What is Beneficial?

- Physiological
- Avoidance of death
- Quality of life
- Justice

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Quality of Life

- Value judgement
- Acceptable quality of life is subjective
- Culture and religion may play a role

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Best Interest

- Patient documented or expressed wishes
    - Serious Illness Conversations

- What is beneficial ?

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Rural Considerations

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Rural Considerations

- Resource limitations highlight importance of conversations with patients and families about goals of care before transfer
- Added complexity of patient transfer
- End of life wishes related to presence of family, community etc.
- Unique relationships in small communities allow for serious illness conversations

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Rural Resources

- RTVS
  - ROCCi
  - RUDi
  - MABAL
  - CHARLIE
- RACE line

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Summary

- Recognizing non-beneficial care important in resource limited environments
- Importance of early serious illness conversations with patients and families in home communities
- Withholding care = prior to escalation of care
    - no consent required
- Withdrawing care = after escalation of care
    - consent required

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Resources & References Mentioned

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Q&A

POST YOUR QUESTIONS IN THE CHATBOX

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