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College of Physicians and Surgeons of Ontario
Decision-making for the End of Life Policy Working Group
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RE: Feedback – Decision-making for the End of Life policy

We applaud the update to the CPSO’s policy on End-of-Life care. We believe that this important revision will improve the quality of death and dying for many Ontarians.

The revised policy has also addressed a key legal development in a contentious area of end-of-life decision-making, the Supreme Court of Canada’s (SCC) ruling on Rasouli v. Cuthbertson. This ruling stated that the withdrawal of life-sustaining therapies constitutes a ‘treatment,’ and therefore requires consent under the terms of Ontario’s Health Care Consent Act (HCCA).

However, we believe that section 5.2 of the new CPSO policy inappropriately applies similar reasoning to another common treatment at the end of life—the provision of cardiopulmonary resuscitation (CPR), a ‘treatment package’ which can include interventions such as chest compressions, electrical shocks, intravenous medications, and invasive mechanical ventilation.

Firstly, it is important to note that CPR is distinct from the withdrawal of life support. As described by the SCC in Rasouli v. Cuthbertson, the definition of “treatment” includes anything performed for a health-related purpose, including the act of withdrawing life-sustaining therapy. However, withholding CPR does not involve any action towards the patient, and no treatments are withdrawn. The absence of CPR cannot reasonably be said to constitute an act, and therefore does not meet the definition of “treatment” under the HCCA.

As the SCC ruling on Rasouli therefore does not apply to withholding CPR, the CPSO’s policy on CPR should thus be based upon the best interests of patients; local standards of care; and other legal rulings which apply in Ontario. As the policy is currently worded, we have concerns that it will result in the inappropriate use of CPR.

Lines 221-224 of the policy state, very reasonably, that physicians are not obliged to propose life-saving or life-sustaining treatments that are not within the standard of care. However, line 240 states that the College requires physicians to obtain consent for a “Do Not Resuscitate” (DNR) order. If consent is required for all DNR orders, this would imply that physicians by default must offer CPR to all patients, even when it is not the standard of care.

3 Ontario Health Care Consent Act: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm
The 'standard of care' is based on what a reasonable physician would do under given circumstances. We agree that clinical judgments about the 'standard of care' should not be made solely on the likelihood of 'clinical benefit' or presuppositions about the quality of life following CPR. Such judgments may open the door to physicians determining which patients receive CPR based solely on a patient’s age, disability, or perceived quality of life, which would be an unethical form of discrimination. As is stated in lines 229-230, there may well be disagreement between the physician and patient/SDM about what is truly in the patient’s best interests. The ‘standard of care’ for deciding to offer CPR must therefore be based on the likelihood of whether or not CPR will improve survival.

However, a patient’s age, comorbidities, or underlying disease do affect the likelihood of any treatment, including CPR, providing them with prolonged survival. Recent Canadian data suggests that that survival following CPR in the ICU is often less than 2%6. Although there is no set number for survival below which a treatment is no longer the ‘standard of care,’ there is clearly a minimal level below which offering a treatment falls outside of that standard. These decisions are routinely made by physicians when deciding which treatments to offer to patients.

Within the context of CPR, there are many treatment options available to physicians which are not offered— for example, pericardiocentesis, open chest cardiac massage, or extra-corporeal membrane oxygenation— because the probability of clinical benefit or improved survival is considered too small to justify the treatment. They are considered to fall outside of the ‘standard of care,’ though they may be pursued if a patient/SDM provides consent and the physician judges it to have a reasonable chance of prolonging life.

For a patient who has suffered cardiac arrest due to a disease for which there are no remaining treatment options (e.g. no further treatments likely to improve the patient’s condition or wellbeing, or reduce the extent or rate of the patient’s deterioration), no reasonable physician would propose or enact CPR, as it has such an small chance of prolonging survival. Examples include advanced cancers with no further surgical or medical treatments, or progressive organ failure despite optimal medical therapy.

Thus CPR does not always fall within the standard of care. Physicians may judge the likelihood of success (defined as prolonged survival) to be too small, given the clinical situation at hand. As per policy lines 221-224, under these circumstances, physicians should not offer CPR7. Consent cannot be required to withhold a treatment that has not been proposed in the first place, even if such a treatment it is the expectation of the patient/SDM. Thus, we suggest the wording of the policy be amended to reflect this (see suggestion #1, below).

If, on the other hand, the policy means to say that the offering of CPR should be the standard of care in all cases, irrespective of whether the administration of CPR provides clinical benefits or prolongation of survival, we would still argue that consent is not required for a “no CPR” order.

As noted above, CPR is a ‘treatment package.’ If a patient or family consents to CPR (or, likewise, has refused to consent to a DNR order), the individual elements of CPR which are to be used, if any, are up to physician discretion based on the probability of prolonged survival and availability of those treatment options. The judge in the recent Ontario Court of Appeals case, Ceferelli v. Hamilton Health Sciences agreed, stating that even if a family does not consent to a

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1 Kutsogiannis DJ, Bagshaw SM, Laing B, Brindley PG. Predictors of survival after cardiac or respiratory arrest in critical care units. CMAJ. 2011 Oct 4;183(14):1589-95
DNR order, that a medical order for "no CPR, no defibrillation" can still be written, as the treatment plan for CPR

"...gives the responsible physician discretion regarding which components of [CPR] are to be used and which are not. ...the contested order [of 'no CPR'] was simply one available to the doctor within that plan. It cannot be said to be a withdrawal of treatment from that treatment plan. No question therefore arises of the need for consent."\(^5\)

Thus, if the CPSO is suggesting that the offering of CPR is what should be considered the "standard of care" in all cases, in the event of arrest, physicians may still justifiably decide not to proceed with any of the interventions contained within that treatment package. As above, the elements of CPR which are provided or withheld must of course fall within the 'standard of care'.

In the Health Professions Appeal and Review Board review of EGJW v MGC, another case of physicians withholding CPR, which preceded Cefereilli v. Hamilton Health Sciences, a 2009 report by lawyer Mark Handelman states: "The argument that withholding or withdrawing a treatment is not "treatment" has never been successfully made in the Courts or tribunals of Ontario, at least since the HCCA was enacted over a decade ago. I am not aware of any cases in which that argument was even made."\(^6\)

The ruling on Cefereilli vs. HHS is the first such case, and clearly ruled that not offering CPR, even when a patient/SDM has agreed to a "full code" status, does not obligate the physician to enact all elements of that treatment plan, including CPR. Not performing elements of that treatment plan, including CPR and electrical shocks, as long as it is in keeping with the standard of care, is not a withdrawal or change of the treatment plan.

Consent should not mandate a clinician to perform a treatment if circumstances change and it no longer provides a reasonable chance of prolonged survival. Nor should a patient or SDM’s refusal to provide consent to not have a treatment performed oblige enactment of that treatment. Otherwise, patients and SDMs could arguably compel physicians to provide any treatment, by simply denying consent to have it withheld.

In summary, withholding CPR in the event of cardiac arrest does not constitute a 'treatment' underneath the HCCA, and therefore the SCC ruling on Rasouli does not imply that consent is required to withhold CPR. Secondly: consent is not required to withhold a treatment which has not been proposed, and in circumstances where CPR is not the standard of care, it should not be proposed. Therefore, consent is not always required to obtain a DNR order. Thirdly: even if offering of CPR was mandatory, and family does not consent to a DNR order, the individual elements of CPR remain at physician discretion. Therefore, physicians can and should withhold any or all elements of the treatment package of CPR which do not offer a reasonable hope of prolonging life, or otherwise do not fall within the standard of care.

We suggest two changes to the policy which will clarify these issues:


\(^6\) EGJW v MGC, 2014 CanLII 49888 (ON HPRB): [http://canlii.ca/t/g8s9m](http://canlii.ca/t/g8s9m) retrieved on 2015-01-11
1) Change line 240 to read “The College requires physicians to obtain consent for a ‘Do Not Resuscitate’ order, under circumstances where the provision of CPR would be considered the standard of care.”

Additionally,

2) Add after line 240: “For patients who have consented to the provision of CPR, the interventions to be offered, if any, during the resuscitation are at the discretion of the treating physician, and must be within the standard of care.”

Thank you for the opportunity to provide feedback on this important policy document.