February 18, 2015

RE: Response from the Canadian Critical Care Society, the Canadian Society of Palliative Care Physicians, and the Canadian Hospice and Palliative Care Association to the CPSO’s draft “Planning for and Providing Quality End-of-Life Care” Policy.

Dear

We are writing on behalf of the Canadian Critical Care Society, the Canadian Society of Palliative Care Physicians, and the Canadian Hospice and Palliative Care Association to express our concern about the CPSO’s recently drafted “Planning for and Providing Quality End-of-Life Care” Policy. As a whole, we applaud the emphasis that the policy places on good communication, and the importance of quality end-of-life care. But we are concerned that some of the requirements set out in this policy are inconsistent with current Ontario law and sound medical practice. The draft policy, as it is currently written, should not go to council for approval. This draft policy should be revised, and the CPSO should include representatives from Ontario’s Critical Care community in the revision process.

Overall, we have three main concerns about this draft policy:

1. It requires physicians to obtain consent for a DNR order even when CPR would not be within the standard of care. We feel that there is no legal justification for this requirement, and it is problematic because it could lead to inappropriate treatment or place physicians in an untenable ethical position. We have suggested new language that should resolve these issues.

2. The conflict resolution process laid out the draft policy does not distinguish between disputes about consent and disputes about the standard of care. These are distinct questions and should have distinct conflict resolution processes.

3. The policy does not provide adequate guidance for physicians who are providing “aggressive” symptom management for dying patients in the face of objections from the substitute decision-maker. We have suggested new language that should support appropriate symptom management while respecting the Healthcare Consent Act.

This letter contains 3 parts: the first is a summary of specific concerns; the second contains suggested changes to the draft policy; the third contains references and more detailed medico-legal explanations of our concerns and rationale. We appreciate that this letter is lengthy, but the issues we address go to the core of our practice. We hope that you will recognize the fact that this letter
represents the position of the three national physician organizations that focus on critical and end-of-life care, and that our concerns are significant.

**PART I: SUMMARY OF CONCERNS AND SUGGESTED CHANGES:**

1. **Section 5.2:** Physicians should not require consent to write a DNR order, and the policy should better distinguish between what needs to be proposed vs. what needs to be communicated to the patient/SDM.

   - **The CPSO should treat CPR the same as every other medical treatment.** When CPR is not within the standard of care, it should not be offered. Physicians should not require consent to stop offering CPR, even if CPR was offered by another physician. If a physician feels that CPR is not within the standard of care, they must make reasonable efforts to communicate this to the patient/SDM. But breakdowns in communication are inevitable, and requiring universal consent is unlikely to improve communication in most cases, and is very likely to lead to patient harm in the form of inappropriate CPR. This requirement for consent to withhold CPR is unprecedented and inconsistent with national policies in Canada and many other countries.

   - **There is no legal justification to require consent for a DNR order when CPR is outside the standard of care.** The only rationale provided for requiring consent for a DNR order is a recent Health Professions Appeal and Review Board (HPARB) ruling. We feel that the HPARB misinterpreted the Rasouli decision from the Supreme Court of Canada (and the Ontario Court of Appeal). The courts specifically warned against interpreting their decision as the HPARB has done. The Supreme Court explained their rationale for requiring consent for withdrawing life support in Rasouli, and none of it applies to a DNR order. Furthermore, the Ontario Court of Appeal has recently ruled that physicians do not require consent to withhold CPR.

   - **Requiring consent for a DNR order can place physicians in a dilemma.** If a physician feels that CPR is nonbeneficial, but is unable to obtain consent for a DNR order, then he/she must either leave a “full code” order in place (knowing that he/she has no intention of providing CPR), or he/she must provide treatments outside the standard of care. Physicians should be allowed to write orders that reflect the care that they intend to provide.

Minor concerns:

- **The Rasouli decision did establish that physicians cannot withdraw life-sustaining treatment without consent, even if that treatment falls outside the standard of care.** Thus, contrary to Line 221, physicians may be obliged to provide (but not necessarily initiate) life-sustaining treatment that is not within the standard of care. The policy should also emphasize that this may also apply to a “trial” of life-sustaining treatment.

- **The policy should encourage the use of more detailed treatment orders.** The “Full Code” and “DNR” paradigm does not capture the complexity of most treatment plans. Other jurisdictions use at least 3 categories of plan (e.g. “RMC”):
  - Resuscitation: Including life-sustaining therapy and CPR if appropriate
  - Medical Treatment: Including fluids, antibiotics, blood transfusions as appropriate but not CPR or other life-sustaining therapies
  - Comfort: Including comfort medications but no non-comfort medications, life-sustaining therapies or CPR

- **The policy should avoid the term “life-saving treatment”,** since therapies such as CPR are often not life saving, and the term is misleading.
• Section 5.2 does not include a provision for emergency scenarios.

2. Sections 8.1 and 8.2: The conflict resolution mechanism needs to distinguish between the process used to clarify values and wishes, and the process used to clarify the standard of care. The policy should better explain the limited role of the CCB.

• The Consent and Capacity Board (CCB) is not the appropriate venue to resolve questions about the appropriateness of CPR (Line 355, 362). The CCB can only decide on the appropriateness of CPR in a very narrow set of circumstances, and Ontario clinicians do not feel that the CCB should be used for resolving disputes about the appropriateness of care in general.

• The option of transferring a patient to another facility (Line 356-8) is not a realistic option in our experience, since none of the undersigned physicians have ever seen a patient accepted by another facility in this circumstance. This option may be considered by attending physicians faced with an intractable dispute, but it is disingenuous to propose this option to a patient or family member when there is no realistic chance of success. The CPSO should indicate what is required for a physician to meet their obligation to seek a transfer of care (e.g. How many appropriate facilities must be contacted?).

3. Section 5.3: The policy should provide more guidance about the need for consent when using “Aggressive Pain Management and Palliative Sedation” to treat symptomatic patients at end-of-life in the face of SDM opposition.

• Physicians should not usually require consent to provide comfort measures for an incapable patient who is obviously symptomatic, since every reasonable plan of care includes appropriate symptom management. Withholding appropriate comfort medications from a symptomatic, dying patient is inappropriate and outside the standard of care. Physicians should only withhold such treatment with the consent of a capable patient, or if there is CLEAR evidence of a Prior Applicable Capable Wish to this effect.

PART 2: SUGGESTED CHANGES
Suggested Changes to Section 5.2 (New text underlined):

• Line 216-240 should read:

“As with all treatment, physicians must obtain consent from the patient if the patient is capable or the incapable patient’s SDM to provide CPR and life-sustaining treatment. In case of an emergency (i.e. when the patient is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm [HCCA s25]), the physician may provide treatments (including CPR and life support) for an incapable patient without consent provided that the treatment lies within the standard of care and the physician has no reasonable grounds to believe that the patient would not have wanted the treatment [HCCA s. 26]. Physicians are advised that if a patient or substitute decision-maker does not consent to CPR or life-sustaining treatment, it is still appropriate to provide palliative care.

Physicians are not obliged to propose or initiate CPR or life-sustaining treatments that are not within the standard of care. If a physician feels that CPR or life-sustaining treatment lies outside the standard of care, the physician should write an order that these therapies should not be initiated. The physician must make reasonable efforts to communicate this decision and the rationale behind it to the patient or SDM at the earliest opportunity, to allow for
discussion of the rationale and the alternative plans of treatment, and to give the patient or SDM the chance to request a second opinion. However, physicians should write orders that reflect the care that they intend to provide, and physicians do not require consent to write a DNR order. If a patient is already receiving life-sustaining treatment(s) that are not within the standard of care, the physician must obtain consent to withdraw these treatment(s).

[DELETE: However, when a life-saving or life-sustaining treatment falls within the standard of care, physicians must identify this treatment option for the patient and/or substitute decision-maker even if it is not the physicians' preferred treatment option.]

If CPR or life-sustaining treatment is within the standard of care, but not recommended by the treating physician, then the physician must involve the patient and/or substitute decision-maker in the assessment of all treatment options that fall within the standard of care and be prepared to provide CPR or life-sustaining treatment if the patient or substitute decision-maker chooses this option and provides consent. [DELETE: Physicians are advised that patients and substitute decision-makers may assess the proposed treatment options differently than the physician as they may consider, for example, whether the treatment prolongs life even if there is no clinical benefit.]

Physicians may wish to propose life-sustaining treatment on a trial basis while being clear regarding the outcomes that would need to be achieved to warrant the continuation of treatment and outcomes that would warrant the discontinuation of treatment. This allows for the exploration of a potentially positive outcome while building consensus regarding the circumstances in which life-sustaining treatment will be withdrawn. If a trial of life-sustaining treatment does not achieve the pre-established outcomes, the physician is advised to reconfirm consent to withdraw life-sustaining measures before proceeding [Rasouli].

Suggested Changes to Sections 8.1 and 8.2:

- Line 249-51 should be changed to read: “If the physician and the patient or substitute decision-maker do not achieve consensus about the treatment that will be provided, then the physician must engage in a dispute-resolution process that is appropriate to the situation. The physician must distinguish between a dispute about a treatment that falls outside the standard of care, and a dispute about a treatment that falls within the standard of care. Either way, the physician should follow the appropriate dispute resolution mechanism outlined in section 8.1.”

- Section 8.1 should be changed. Lines 341-58 should read: “Physicians must distinguish between a dispute about a treatment that falls outside the standard of care, and a dispute about a treatment that falls within the standard of care.

The standard of care is defined on the basis of Crics v. Sylvester [1956] S.C.R. 991, which found that a physician is “...bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing...” This means that a physician would be expected to propose or provide any therapy that a physician with similar training and experience would propose or provide. This does not mean that a physician is expected to propose or provide therapies that would be offered by only a small number of similarly-trained physicians, or by physicians who are not experts in the field of practice with greatest relevance to the therapy in question. However, physicians are expected to consider what a similarly trained and experienced physician
would propose or provide, and should be prepared to propose and provide such therapies, even if they do not recommend them.

If a patient or SDM is requesting the initiation of therapy that falls outside the standard of care, the physician must take appropriate steps to clarify patient/SDM concerns, and ensure that their assessment of the standard of care is reasonable. These steps include:

- Clear, patient and timely communication regarding:
  - The patient’s diagnosis and/or prognosis;
  - Treatment options and assessments of those options;
  - Availability of supportive services (e.g. social work, spiritual care, etc.); and
  - Availability of palliative care resources.

- Identifying misinformation and/or misunderstandings that might be causing the conflict and take reasonable steps to ensure that these are corrected and that questions are answered;

- Offering referral to another professional with expertise in the relevant area and facilitate obtaining a second opinion, as appropriate.

If the patient or SDM is requesting initiation of therapy that falls within the standard of care, but that the physician feels is inappropriate or inadvisable for other reasons, the physician must take appropriate steps to clarify patient/SDM concerns and ensure that valid consent is obtained for the requested treatment. These steps include:

- Clear, patient and timely communication regarding:
  - The patient’s diagnosis and/or prognosis;
  - Treatment options and assessments of those options;
  - Availability of supportive services (e.g. social work, spiritual care, etc.); and
  - Availability of palliative care resources.

- Identifying misinformation and/or misunderstandings that might be causing the conflict and take reasonable steps to ensure that these are corrected and that questions are answered;

- Offer consultation with an ethicist or ethics committee, as appropriate and available;

- Where appropriate, seek legal advice regarding mediation, adjudication or arbitration processes that are available (in some cases, this may involve an application to the Consent and Capacity Board - see section 8.2);

If the above processes do not achieve consensus, the physician may inquire about the possibility of transferring care of the patient to another facility or health provider as a last resort. Given the low likelihood that the patient will be accepted in this circumstance, the physician should refrain from leading patients or families to believe that this is a realistic prospect.”

- Section 8.2: the title should read: “8.2 Clarifying the Role of the Consent and Capacity Board”. The text should be changed to: “If an SDM is requesting that a specific treatment (e.g. CPR) be initiated for an incapable patient, and the treating physician feels that the
treatment falls within a reasonable standard of care but is not in the best interests of an incapable patient (as defined by the HCCA s.21(2)), the physician is advised to apply to the Consent and Capacity Board for direction. If an incapable patient is receiving life-sustaining therapy that the physician believes to be outside the standard of care, but the SDM does not consent to withdraw this therapy, the physician should likewise apply to the Consent and Capacity Board for direction. The Consent and Capacity Board has no role in resolving disputes involving capable patients or patients who have a Prior Applicable Capable Wish (as defined by the HCCA s.21(1)), although the Board may be convened to decide whether a PACW exists.”

Suggested Changes to Section 5.3: The following sentence should be added to the end of section 5.3:

- “Physicians should generally provide comfort measures for an incapable patient who is obviously symptomatic. Comfort measures should only be withheld if a capable patient requests that they be withheld, or if there is clear evidence of a specific Prior Applicable Capable Wish that these medications be withheld.”

PART 3: DETAILED MEDICO-LEGAL EXPLANATION OF CONCERNS AND RATIONALE:

A. There should not be a universal requirement for consent to write a DNR order.

We are most concerned with the requirement for physicians to obtain consent before writing a “DNR” order (section 5.2). This is a significant departure from the previous policy, and is contrary to the relevant policies of the Canadian Medical Association (updated 2013)\(^1\), the British Medical Association (updated October 2014)\(^2\), and the Australian Medical Association (updated 2014)\(^3\). Ideally, physicians, patients and family members should participate in a process of shared decision-making. All parties would communicate about end-of-life care in a timely fashion, and come to a common understanding about the medical facts of the situation, the values that should inform decision-making, the potential treatment options, and the likely outcome of each option. This common understanding is achieved in the majority of cases, to the benefit of all concerned. But even in cases of intractable dispute, professional policies in Canada and elsewhere have never before required consent to withhold nonbeneficial CPR. There is a difference between requiring communication and requiring consent.

1. The CPSO should not treat CPR differently from other medical treatments.

The CPSO needs to acknowledge that CPR is a medical treatment and not a wish or a value. Physicians should always aim to respect patient wishes and values, but an unwavering demand for CPR from a patient or SDM should be treated the same way as an unwavering demand for chemotherapy or surgery. It should be respected when the medical situation warrants it, but not followed in all circumstances.

CPR is a “default” treatment for cardiac arrest, but only in the sense that surgery and chemotherapy are “default” options for cancer. If a patient presents with cancer, they would usually be offered surgery and chemotherapy. But nobody would suggest that surgery or chemotherapy should be universally offered without considering clinical circumstances, and

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\(^1\) Available at [http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD14-01.pdf](http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD14-01.pdf)

\(^2\) Available at [https://www.resus.org.uk/pages/DecisionsRelatingToCPR.pdf](https://www.resus.org.uk/pages/DecisionsRelatingToCPR.pdf)

continued until the patient agrees to stop. There are times when chemotherapy and surgery are not appropriate, and although there is a requirement to communicate this to patients and SDMs, physicians do not require consent to take these options off the table. CPR should be no different.

From a medico-legal perspective in Ontario, CPR is a treatment. The Healthcare Consent Act does not specify that any treatments should be provided by “default,” but the HCCA does allow for treatments such as CPR to be provided under the “Emergency Treatment” provision of the Healthcare Consent Act [s.25]. A treatment can be provided without consent in situations where a patient “is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm”. Presumably, s.25 would only apply to therapies that are expected to alleviate the suffering or preventing the serious bodily harm. In addition, a health practitioner cannot invoke s.25 if there are reasonable grounds to believe that the patient expressed a capable wish that he/she did not want the treatment in question [s.26]. Thus, a DNR order (effectively pre-empting the use of the emergency treatment provision of the HCCA to perform CPR) could be justified on the grounds of either futility or patient wishes.

Some argue that CPR is actually part of a plan of treatment that would exist by “default” or as the result of a conversation that occurred previously (e.g. on admission). This would mean that CPR would have to be provided in the event of a cardiac arrest, and that this plan of treatment could not be changed without consent. This is a flawed argument on many levels. First, as stated above, treatments cannot be provided by “default” in any situation. Second, most resuscitation conversations are brief and rarely achieve the standards of informed consent indicated in the HCCA, resulting in a very poor understanding of CPR and its risks, benefits and alternatives. Third, a physician should not be bound to follow treatment plans offered by another physician, or plans offered previously by the same physician under different circumstances. Even if the patient initially provided informed consent for CPR, the second physician might have more expertise and experience with CPR and life-sustaining treatments, or the clinical situation may have changed. A primary care physician could refer a patient to a surgeon or oncologist with the plan to treat a newly-diagnosed cancer with chemotherapy or surgery, but the surgeon and the oncologist are not bound to provide those therapies if they are inappropriate, even if the primary care physician obtained informed consent for that plan of treatment. CPR should be no different.

2. The Health Professions Appeal and Review Board (HPARB) misinterpreted the Rasouli decision from the Supreme Court of Canada. The Ontario Court of Appeal has found that consent is not required to withhold CPR.

In section 5.2 the policy states that “The College requires physicians to obtain consent for a “Do Not Resuscitate” order”, and cites a recent Health Professions Appeal and Review Board (HPARB) ruling (EGJW v. MGC, 2014 CanLII 49888) as justification. We feel that the HPARB ruling is based on an incorrect interpretation of the Rasouli decision, and is therefore not a sufficient justification for changing CPSO policy to require physicians to obtain consent for a DNR order. In fact, the case reviewed in the HPARB ruling illustrates some of the key problems that can arise when requiring consent for a DNR order (e.g. standard of care was established through 2nd and 3rd opinions; unable to contact family members in a timely fashion; patient deterioration before conflict resolution mechanisms could be initiated).

The CPSO Discipline Committee reviewed the case twice, each time finding that the physicians had acted appropriately in the circumstances. The HPARB instructed the CPSO to review the case a third time, in light of the recent Rasouli decision by the Supreme Court of Canada (SCC). Similar to the SCC, the HPARB focused on the wording of section 2(1) paragraph (c) of the Healthcare Consent Act (HCCA), which indicates that a plan of treatment “...may... provide for the withholding or withdrawal of treatment in light of the person’s current health condition...”
The word “may” is important here, and the HPARB has interpreted this word more broadly than the SCC did in Rasouli. While the Rasouli decision did establish that consent was required to withdraw life support from someone in Mr. Rasouli’s condition, the SCC was at great pains to limit the scope of the decision to cases like those of Mr. Rasouli. In their decision, the majority stated:

“These considerations lead me to conclude that “treatment” in the HCCA should be understood as extending to withdrawal of life support in the situation at issue here and as that process is described in these proceedings. This case does not stand for the proposition that consent is required under the HCCA for withdrawals of other medical services or in other medical contexts.” [p70; italics mine]

This statement is very meaningful, because it indicates that consent is not required for every change in treatment plan, even those that might involve withdrawal (and presumably withholding) of medical treatments. The SCC did not establish a clear “test” to determine what factors would indicate the need for consent, but their reasoning in Rasouli centred on 3 elements:

- The need to administer an new treatment (Comfort measures in Rasouli)
- Need for physical contact (to disconnect or deactivate life support in Rasouli)
- Likelihood of death shortly after withdrawal (a reasonable expectation for someone like Mr. Rasouli who was dependent of life-sustaining treatments)

None of these three considerations apply to a DNR order. They can (and usually are) written without any other orders; there is no need for physical contact; and death is not the immediate consequence of a DNR order.

In the Ontario Court of Appeal’s decision for the same case [2011 ONCA], Justices Moldaver and Simmons wrote that the HCCA “does not require doctors to obtain consent from a patient or substitute decision-maker to withhold or withdraw ‘treatment’ that they view as medically ineffective or inappropriate.” While the SCC ruled that this isn’t the case with respect to withdrawal of LST, they declined to speak to withholding, which leaves the Court of Appeals language unchallenged.

Furthermore, the SCC stated in Rasouli that the legislature “could not have intended” the HCCA to allow patients “...to compel the continuation of any treatment, regardless of its medical implications.” (para 58). A Full Code order does not specify what treatments will be applied, and a ‘Code’ situation may include many different medical scenarios; the physician is left to decide which treatments (e.g. intubation, chest compressions, central line insertion, epinephrine) would be appropriate in each case. Physicians are also left to decide how long they ought to continue their attempt at resuscitation- presumably until they feel that there is no longer a reasonable chance of recovery. So if physicians are allowed to decide whether to provide each individual element of a resuscitation, and how long to continue resuscitative efforts, then presumably they should be allowed to decide that no elements of resuscitation would be appropriate, and that no amount of resuscitative efforts would lead to a recovery. This was precisely the rationale used by the Ontario Court of Appeal in Ceferele vs. Hamilton Health Sciences (2013, ONCA 413), a case that specifically addressed the issue of consent for withholding CPR.

The CPSO should recognize the Ontario Court of Appeal and the SCC’s efforts to limit the scope of their decisions in Rasouli, and to make it clear that consent may NOT be required to withhold or withdraw life support in situations that are different from Rasouli. We feel that the HPARB’s ruling, with its questionable interpretation of the Rasouli decision, is not a sufficient basis
for the CPSO to change their policy in this regard. The CPSO should follow the judgment of the Ontario Court of Appeal in Ceferelli, a case which specifically addressed this issue.

3. The current draft policy can make it impossible for physicians to reconcile the need for consent with the need to meet the standard of care.

   We support the policy’s statement that “Physicians are not obliged to propose or provide life-saving or life-sustaining treatments that are not within the standard of care” (Section 5.2). There must be a role for medical judgment, and CPR is simply not effective in many situations, or would serve only to prolong the dying process for a terminally ill patient. But this statement creates two problems for practicing physicians:

i. There is no written standard of care for providing/withholding CPR in Canada.

   There is no universally-accepted definition of “futility”, and no published guidelines to indicate when CPR should not be performed. Previous authors have attempted to define futility without success; and although previous Canadian studies have shown that futility is a widely-accepted concept, they did not establish a precise definition that could be used at the bedside for a specific patient. We should not expect that an explicit, written, universal standard of care will ever be developed for the non-provision of CPR. A standard of care can still be established using other expert opinions, and the CPSO could serve an important role in establishing a more robust means of ensuring that the standard of care is provided consistently and appropriately for seriously ill patients.

ii. If a physician establishes that the standard of care would not include CPR, but the patient/SDM refuses to consent to a DNR order, how should the physician proceed?

   The wording of section 5.2 could create a difficult dilemma for physicians. On the one hand, a physician should not provide CPR that he/she believes to be nonbeneficial. On the other hand, the physician cannot write a DNR order without consent. There is no ethical solution to this dilemma. If the physician provides inappropriate CPR, he/she could face professional sanction; and if the physician had previously documented his/her belief that CPR would be ineffective and serve only to cause suffering and prolong the dying process, the physician may not have a defense against a charge of malpractice.

   On the other hand, if the physician decides not to provide inappropriate CPR but leave the default “Full Code” order in place, then the physician is being intentionally duplicitous. He/she is violating two of the core values of professionalism identified in the CPSO’s Practice Guide—namely altruism and trustworthiness. This situation is no different from the “slow codes” that preceded shared decision-making and undermined public trust in the medical profession.

   Some have suggested that a physician could leave a “Full Code” order in place, initiate a Code Blue when the patient suffers a cardiac arrest, and then decide at the time whether or not to initiate CPR. This would also be a duplicitous approach, since the futility of CPR would have been evident long before the arrest in most cases. It would also place other physicians in a difficult position, since the cardiac arrest would likely occur outside of normal working hours, when the patient is being covered by an on-call physician who may not be familiar with their case. When a “code blue” is called, the responding physician would be expected to address immediate issues (Airway, Breathing and Circulation) before reading the medical record to determine the appropriateness of CPR.

   The only ethical solution to this dilemma is to require physicians to write a medical order that corresponds to the plan that they intend to implement.
4. If the main goal of the policy is to improve communication, then requiring consent for a DNR order is unlikely to achieve that goal, and it will likely harm many patients and family members.

i. It is not always possible or practical to obtain consent to withhold inappropriate CPR

In reality, we routinely see cases where communication does not take place, or it takes place only once a crisis has arisen. Physicians may be unable to speak with patients or contact their substitute decision-makers (SDMs) in time, despite multiple efforts. Patients, family members and physicians sometimes do not have a common understanding that an illness is terminal, or a therapy is ineffective, even when the evidence is overwhelming. And patients or substitute decision-makers may accept a terminal prognosis but continue to hope for a “miracle”, and insist that “everything” be done regardless of futility or side-effects. Canadian physicians strongly prefer to resolve disagreements about care through communication and consensus-building. But breakdowns in shared decision-making are inevitable, and are not necessarily due to a lack of effort or understanding on either side.

Ultimately, it is not always possible to obtain consent to withhold nonbeneficial CPR before a patient deteriorates. The process of obtaining consent for a DNR order is easily derailed by a variety of factors beyond anyone’s control. It is problematic to create an end-of-life decision-making policy that depends on multiple processes taking place in a timely fashion, flawless communication and logical decision-making. This policy is especially problematic if the consequence of any breakdown in shared decision-making is potentially open-ended life support, subject only to the limitations set by a patient or family member.

ii. The harms of inappropriate CPR cannot be justified by the failure of shared decision-making.

A breakdown in communication and decision-making is harmful. Performing inappropriate CPR because of a breakdown in communication does not mitigate that harm; rather, it compounds it. CPR (and the life-support that follows successful CPR) causes pain and suffering to the patient, and is associated with significant psychological morbidity in family members. CPR can only be justified when there is a realistic prospect of success. If CPR and life support are not going to succeed, then they cannot be justified solely on the basis of a request from the patient/SDM.

We strongly support the requirement to communicate, and to respect patient wishes and values when possible. But requiring communication and requiring consent are two different matters. Requiring physicians to obtain consent for all DNR orders is unlikely to improve communication, and it is very likely to lead to more inappropriate CPR and life support.

B. The conflict resolution mechanism needs to distinguish between the process used to clarify values and wishes, and the process used to clarify the standard of care.

The conflict resolution process established in section 8.1 is well-described and would be appropriate for a capable adult patient who is not expected to deteriorate in the timeframe required to pursue all of the steps indicated. However, the patient is not always capable, or they may be deteriorating over a matter of minutes to hours. This can make it difficult to use the process outlined in 8.1 to clarify patient wishes. Moreover, the process outlined in 8.1 is oriented towards determining whether the patient would or would not want CPR. It is not appropriate for determining whether CPR is appropriate in the medical circumstances.

The Consent and Capacity Board (CCB) should not be used to resolve conflicts about the appropriateness of CPR (Sections 8.1 and 8.2).

We feel that the CCB is not the appropriate venue to resolve questions of medical appropriateness. If a physician feels that an SDM is not acting in the “Best Interests” of the patient,
he/she can ask for a Form G hearing, and the CCB can consider questions of medical benefit. However, only 27 physicians have done so in the past decade7. Notably, even though the CCB ruled in favour of the physician in 21 (78%) of those cases, 9 were appealed by the SDM and the delays involved in the appeals process were generally felt to negate the perceived benefits of the CCB overall8.

The CCB does not have the authority to review decisions made by a capable patient or on the basis of a Prior Applicable Capable Wish (PACW). The CCB would have no role for capable patients, rapidly-deteriorating patients or those with a clear and specific PACW and an SDM who is unwilling to depart from the PACW. In such a case, the patient would need to be initiated or maintained on life-sustaining measures indefinitely, regardless of the best interests of the patient, the standard of care, or the lack of medical benefit7.

Ultimately, very few questions of medical benefit are ever referred to the CCB. Even though the CCB can be convened in a matter of days, and they try to resolve the question from the perspective of a neutral third party, it remains a time-consuming and emotionally-taxing process for most physicians to initiate. It also places the onus on the physician to initiate the process and assume an adversarial role by asking whether family members are acting in the interests of the patient rather than the more pertinent and less adversarial question of whether or not a therapy will offer any benefit. We should also note that a recent national survey of Canadian nurses and physicians working in ICUs and on medical wards found that Ontario respondents were significantly more dissatisfied with the current means of resolving cases of nonbeneficial treatment than respondents from other parts of the country (87% vs. 73%, p<0.0005)7. Clearly, the Ontario medical community does not feel that the CCB is the proper way to resolve cases of nonbeneficial treatment, even if the CCB routinely rules in their favour. The CPSO should recognize the importance of the perspective of its frontline members.

C. The policy does not indicate whether consent is required to provide comfort care for a symptomatic dying patient.

The section addressing aggressive pain management (5.3) should provide clear guidance on this issue, as family members sometimes refuse to allow comfort medications to be provided in the belief that these are harmful and could shorten life. Some have previously expressed the opinion that a dying patient who is “experiencing severe suffering” is in an emergency situation according to the HCCA (5.25), and that treatment can be provided without consent if the delay involved in obtaining consent would prolong their suffering and the physician feels that the SDM is not making their decision based on the best interests of the patient (5.27)7. However, s.26 indicates that the emergency provision cannot be invoked if there are reasonable grounds to believe that the patient had a PACW and would not have wanted to receive comfort medications. Physicians need guidance from the CPSO about whether they can provide comfort medications to an incapable dying patient who is apparently suffering, even when the SDM is refusing them on the patient’s behalf.

In summary, we feel that the draft policy, as it is currently written, should not go to council for approval. This draft policy should be revised, and the CPSO should include representatives from Ontario’s Critical Care community in the revision process. We hope that you will recognize the fact that this letter represents the position of the three national physician organizations that focus on critical and end-of-life care, and that our concerns are significant.
On behalf of the Canadian Critical Care Society, the Canadian Society of Palliative Care Physicians, and the Canadian Hospice and Palliative Care Association (Letters of Support Attached).

References.


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As President of the Canadian Critical Care Society, I would like to express on behalf of our members that we have substantial concerns with the draft policy “Planning and Providing Quality End of Life Care”.

Our members are practicing critical care physicians and associated health care professionals with an interest in critical care. A member of our Clinical and Ethical Affairs Committee has worked with our Board of Directors, Society members and other organizations to produce a detailed critique and recommendations for this policy. This document is being submitted separately with the full support of our Board.

We welcome an updated policy on this important matter, and the leadership of the CPSO to tackle this difficult and delicate issue. We agree that improved communication and quality care at the end of life should be priorities. However, we hope that our suggestions for improvement will be incorporated for the reasons provided in our response.
January 12, 2015

Dear

Thank you for sending a copy of your excellent response regarding the draft CPSO policy on Planning for and Providing Quality End-of-Life Care.

Many of your concerns outlined in your document, reflect the mission, vision and goals of the Canadian Society of Palliative Care Physicians.

We support your efforts to improve palliative care.

Yours truly,

President, Canadian Society of Palliative Care Physicians
February 5, 2015

Dear

We recently had the pleasure of reading your response regarding the draft College of Physicians and Surgeons of Ontario policy on Planning for and Providing Quality End-of-Life Care.

As you know, the Canadian Hospice Palliative Care Association (CHPCA) is the national association, which provides leadership in hospice palliative care in Canada. The CHPCA offers leadership in the pursuit of excellence in care for persons approaching death so that the burdens of suffering, loneliness and grief are lessened.

The concerns detailed in your response align with the values of the CHPCA and for this reason we fully support your document.

We genuinely appreciate your dedication to better issues pertaining to palliative care.