

Initiative: Feedback on College of Physicians and Surgeons of Ontario's (CPSO) Draft End-of-Life Policy
Date: Feb. 20, 2015

This brief outlines feedback from Sunnybrook Health Sciences Centre on the CPSO's draft End-of-Life Policy. The brief provides responses to the feedback questions posed by the CPSO.

CPSO Questions:

1) Does the draft policy provide useful guidance?

- Yes, the draft generally provides useful guidance but currently includes a major discrepancy between lines 221-224 and line 240 that undermines the clarity of the draft. It is inconsistent to say that, "physicians are not obliged to propose or provide life-saving or life-sustaining treatments that are not within the standard of care" but then later state that consent is required to obtain a Do Not Resuscitate order.
- Further to the above noted discrepancy, requiring consent for a No CPR order is problematic for the following reasons:

i) Violates Established Ethical Principles

It is a well-established principle in medical ethics that physicians should not harm their patients, commonly referred to as the ethical principle of non-maleficence. While some treatments, such as chemotherapy, may have significant harmful side effects, it is provided on the basis that the treatment has a positive benefit to harm ratio, such that the benefit outweighs the harm. Requiring physicians to potentially provide CPR to patients for whom it almost certainly offers no benefit (i.e. falls outside the standard of care to provide) puts physicians in the ethically indefensible position of causing harm to a patient without an overriding benefit.

ii) Legal Interpretation Errors in HPARB decision:

a) the HPARB decision rests upon a broad reading of the definition of "treatment" contained in the *Health Care Consent Act* (HCCA) which was explicitly rejected in the Court of Appeal's decision in *Rasouli*, where it was found that neither the withholding nor the withdrawal of treatment requires consent but that consent is required only for treatments that a physician offers (*Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482, at 54-57). This was also implicitly rejected in the Supreme Court's decision. The ONCA stands for the proposition that you cannot create a situation in which physicians are required to provide "medically valueless" treatment (*Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482, at 54).

b) The Supreme Court stated that its decision “does not stand for the proposition that consent is required under the HCCA for withdrawals of other medical services or in other medical contexts” (*Cuthbertson & Rubinfeld v. Rasouli* 2013 SCC 53, at 70)

c) There is no decided case in which a court has held that the HCCA requires consent for not offering treatments. The HPARB decision errs in holding that the Supreme Court’s decision in *Rasouli* has this effect.

d) HPARB appears to have interpreted the Substitute Decision-Maker’s request for a full code and documentation to this effect in the medical chart to constitute an offer to provide CPR when per the HCCA; only a health care practitioner can propose a treatment.”...[F]ull code instructions are apparent at numerous points in the patient’s chart...The progress notes made on that date...states clearly: “CODE STATUS: Daughter wants FULL CODE: (EGJW v MGC, 2014 CanLII 49888 (ON HPARB), at 37). However, the HCCA is clear that the obligation belongs to the health care practitioner to propose a treatment (HCCA s2.1 & s10.1). While a patient or SDM can request a treatment; this request does not fall under the HCCA until it is proposed by a health care practitioner that is offering the treatment.

iii) The HCCA’s Definition of “Plan of Treatment” is Permissive with Respect to Withholding or Withdrawing treatment

a) The s2.1 definition of plan of treatment from the HCCA states the following: “plan of treatment” means a plan that,

- (a) is developed by one or more health practitioners,
- (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person’s current health condition, and
- (c) provides for the administration to the person of various treatments or courses of treatment and *may* [emphasis added], in addition, provide for the withholding or withdrawal of treatment in light of the person’s current health condition; (“plan de traitement”)

- The permissive word “may” means that all instances of withholding or withdrawal of treatment do not fall under the definition of plan of treatment and therefore, consent is not always required. The *Rasouli* ruling is narrowly tailored to address only the withdrawal of life-sustaining treatments. This was largely on the basis that the withdrawal of life support entails physical interference with the patient’s body, whereas this is not relevant in the case of withholding CPR.
- Where the plan of treatment that previously included CPR changes due to the patient’s condition; and it falls within in the standard of care to not offer CPR; and the treatment has not yet been initiated, a new plan of treatment offered by the physician that includes withholding treatment does not require consent.

Suggested policy language: Where the plan of treatment changes due to the patient’s clinical deterioration such that it would no longer fall within the standard of care to provide a particular treatment; and the treatment has not yet been initiated, a new plan of treatment offered by the physician that includes withholding treatment, such as CPR, does not require consent. Where time permits, changes to a plan of treatment that include withholding a treatment, should be discussed with the patient or SDM. If there is disagreement, conflict resolution procedures should be followed. If consensus cannot be reached, the physician is not obligated to offer or provide a treatment that does not fall within the standard of care.

2) Are there any issues not included in the draft policy that should be addressed? If so, what are they?

- In the Communication section, make explicit reference to the use of trained interpreters to facilitate communication with patients and SDMs for whom English is not their preferred language of communication. Also, specify that healthcare providers or use of other *ad hoc* interpreters, such as family members, is not appropriate. Alternatively, this could be addressed in the CPSO’s Consent to Treatment Policy that is currently being revised.

3) Are there other ways in which the draft policy should be improved?

- Clarify either in definition of Advance Care Planning or within the Advance Care Planning section that Advance Care Planning can only be completed by a capable patient and that Substitute Decision Makers or family members cannot complete Advance Care Planning on behalf of an incapable patient, i.e. if the patient is incapable, then discussions only occur in the consent to treatment context.
- Under section 4.1 No Treatment without Consent, include reference to the emergency consent exception in the *Health Care Consent Act*.
- Instead of simply using DNR language, consider an e.g. to identify other common terminology that is used in acute care hospitals (e.g. Do Not Attempt Resuscitation (DNAR), No CPR, Allow Natural Death (AND), etc.)