College of Physicians and Surgeons of Ontario
80 College Street,
Toronto, Ontario,
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Re: Feedback regarding CPSO draft policy statement: “Planning For and Providing Quality End-of-Life Care”

The Regional Bioethics Group (RBG) would like to commend the College of Physicians and Surgeons for recognizing the changing healthcare landscape and seeking external public consultation on “Planning For and Providing Quality End-of-Life Care” policy. The opinions expressed in this letter are those of the signatories and do not necessarily reflect the opinions of their respective organizations.

Physicians and their patients now have greater access to life-saving and life-sustaining treatments than ever before. These advances generate a greater responsibility on physicians to ensure that they are knowledgeable regarding the potential impact these advances will have on the overall care of their patients. However, these advances are not without their burdens and in some cases force us to ask ourselves the question: Are we saving a life or merely prolonging the dying process? Recent end-of-life cases have challenged the healthcare community as well as patients and families to further consider what treatment is appropriate at the end-of-life.

The RBG holds that the draft policy provides useful guidance regarding advance care planning, pain management, palliative sedation and the need for thorough ongoing communication.

In reviewing the policy, the RBG felt that it could be modified to better address the perceived conflict between line 221 and 240. From an ethics perspective, the RBG affirms line 221 that physicians should not be obliged to propose or provide life-saving or life-sustaining treatments that are not within the standard of care. However, line 221 seems inconsistent with line 240 and the proposed College requirement for physicians to obtain consent for a “Do Not Resuscitate” order. The requirement to obtain consent for a treatment that is outside the standard of care may require physicians to perform procedures and prescribe treatments that are inconsistent with the medical profession’s commitment to the principle of nonmaleficence. Moreover, we believe including line 240 in its current iteration runs the risk of harming patients in the following scenarios: (1) when a physician is unable to obtain consent for a “DNR Order” and the urgency of the clinical situation does not allow for a thorough engagement of a “Conflict Management” process, and (2) when a patient experiences a cardio-respiratory arrest and a substitute decision maker cannot be located in time to provide consent for a “DNR Order”. Line 240, in its current iteration, indicates that CPR would need to be initiated in both cases even if was considered outside the standard of care and harmful to the patient.

Furthermore, line 240 now makes it unclear whether requiring consent for a DNR order implies that consent must be obtained to stop performing CPR once CPR has been started. Line 240 also appears to be inconsistent with the Ministry of Health and Long Term Care’s DNR-C (Do Not

Resuscitate Confirmation) form which allows for DNR-C form to be completed when a physician believes CPR will not benefit the patient. Finally, line 240 raises further questions regarding the need to obtain consent for other treatments that lay outside the standard of care. It seems implausible that the Health Care Consent Act would require consent in all cases of withholding treatment, however the current iteration of the CPSO draft policy fails to adequately explain why consent would be required for a DNR order and not for all other instances where treatment is withheld because it is outside the standard of care.

It may be helpful to include in the draft policy other end-of-life related issues such as consent for apnea testing in the context of determining death by neurological criteria as well as the withdrawal of treatment following a declaration of death by neurological criteria. The draft policy could also further emphasize the need for good communication between physicians and patients/substitute decisions makers, as well as the need for strong communication amongst physicians and other members of the interprofessional team to ensure interprofessional consensus is obtained prior to the proposal of treatment.

We recognize that the College may find it necessary to include line 240 in light of the recent HPARB decision. If the College feels compelled to do so, the draft policy could be improved by distinguishing between patients/substitute decision makers (SDMs) to whom CPR has been proposed and consented to versus those patients/SDMs for whom CPR was never proposed nor requested. For patients/SDMs that have consented to CPR, the College may require consent for a change in the CPR status of the patient to DNR. If CPR has not been offered because it is outside the standard of care nor requested CPR, the College may reconsider line 240 and not require consent to be obtained prior to documenting a "DNR Order." For this latter scenario, physicians should still be required to inform the patient /SDM that CPR falls outside of the standard of care, and inform the patient/SDM of other treatment options as well as their rights to challenge this decision. This approach has the merit of honoring the spirit of the HBARB decision while placing equal emphasis on some of the important features arising in the provision of quality end-of-life care: open and honest communication, the weighing of benefit and burdens, honoring patient autonomy and previously expressed capable wishes in end-of-life decision making. We encourage you to revise the policy to include the following: *In situations where CPR is not the standard of care, consent for a "DNR Order" is not required*.

Thank you for the opportunity to review and provide feedback on the CPSO policy statement on "Planning For and Providing Quality End-of -Life Care." We hope you will consider our concerns when finalizing the policy.

Sincerely,

The Regional Bioethics Group