

February 20, 2015

Dear Policy Committee College of Physicians and Surgeons of Ontario,

Thank you for the opportunity to comment on your draft end-of-life policy. We are based in a Catholic hospital and formed a multidisciplinary working group to critique the draft CPSO policy. Physicians, social workers, and ethicists participated in the working group.

There was unanimity in the criticism of the statement in line 240: “the College requires physicians to obtain consent for a “Do Not Resuscitate” order”. Below we discuss criticisms of the proposed requirement of consent for a “Do Not Resuscitate” order.

Requiring consent may lead to situations where physicians would be forced to harm their patients. Physicians are required to propose treatments that would benefit their patients. According to the Joint Statement on Resuscitative Interventions<sup>1</sup> there are four general categories of patients: 1) Patients who are likely to benefit from CPR; 2) Patients for whom the benefits of CPR are uncertain; 3) Patients for whom the benefits of CPR are unlikely; and 4) Patients who almost certainly will not benefit from CPR. We agree that for the first three categories of patients a “Do Not Resuscitate” decision should require the agreement of the patient or SDM; however, for the final category of patient, performing CPR would not be beneficial and would constitute harm to the patient. By requiring consent, physicians would no longer have the discretion to not offer a non-beneficial treatment to their patients. Physician could only withhold a non-beneficial treatment if the patient or SDM agrees. Requiring consent for a “Do Not Resuscitate” order would contravene the longstanding medical ethics principle of non-maleficence.

Offering CPR to patients who are unlikely to benefit from CPR is not consistent with the Health Ethics Guide. As a Catholic hospital we are required to follow the Health Ethics Guide, which articulates the moral obligations of Catholic institutions and those working in Catholic institutions. The Health Ethics Guide states “Health care professionals are under no obligation to provide treatment that will not accomplish the goal for which it was intended<sup>2</sup>”. Furthermore, the guide states that for CPR decisions “it is not ordinarily indicated for use on persons who have reached the end

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<sup>1</sup> Catholic Health Association of Canada , Canadian Medical Association , Canadian Healthcare Association and Canadian Nurses Association .1995. Joint Statement on Resuscitative Interventions. Catholic Health Association of Canada (CHAC), Canadian Medical Association (CMA), Canadian Healthcare Association (CHA) and Canadian Nurses Association (CNA). Ottawa.

<sup>2</sup> Catholic Health Alliance of Canada. (2012). *Health Ethics Guide*, 3<sup>rd</sup> edition, Ottawa, Canada: Catholic Health Alliance of Canada. Article 81 pg 63.

stages of a progressive fatal condition”<sup>3</sup>. By offering CPR to patients who would not benefit from the treatment we risk contravening an important guiding document that we are all supposed to comply with.

The requirement of consent for a “Do Not Resuscitate” decision is not internally consistent with other statements in the draft policy and with our understanding of the recent Supreme Court ruling *Cuthbertson v. Rasouli*. In the draft CPSO policy line 211 it is stated: “Physicians are not obliged to propose or provide life-saving or life-sustaining treatments that are not within the standard of care.” For patients who will almost certainly not benefit from CPR (category 4), by requiring consent, physicians would be forced to offer treatment that falls outside of the standard of care. Furthermore, our understanding of the recent *Cuthbertson v. Rasouli* ruling is that while consent is required to withdraw ventilator support, physicians are not obliged to offer life-sustaining treatment that would not benefit the patient. Once again, by requiring consent for a “Do Not Resuscitate” order, physicians would be required to offer CPR to patients that would not benefit from the treatment.

Finally, by requiring consent for a “Do Not Resuscitate” order, there may be unintended consequences. For example, if consent is required not to resuscitate a patient then should we require consent to stop CPR once initiated. Currently, a physician can stop CPR if it is felt not to be beneficial. Under the proposed scheme physicians would be required to offer CPR to all patients, even those who would not benefit from CPR. As such, it is logically consistent that the benefit standard might be insufficient to determine when CPR in progress can be discontinued. Another unintended consequence is that, if approved, this policy would set a precedent. If physicians are required to get consent to *not* offer a treatment then would physicians be required to get consent to *not* offer other treatments. Such a scenario would not be tenable. Finally, under the proposed scheme, physicians will be required to get consent for a “Do Not Resuscitate” order from the public guardian and trustee in cases where no other SDM on the hierarchy of SDMs can be found. Such a situation is problematic since the PG&T currently does not consent to a “Do Not Resuscitate” order by itself. Furthermore, the PG&T often does not respond immediately and there is often no after hours coverage. As such, there will likely be situations where we provide CPR to patients in category 4 simply because we could not reach an SDM in time to consent for a “Do Not Resuscitate” order.

For the reasons outlined above we respectfully recommend that the requirement for consent for a “Do Not Resuscitate” order be removed from the draft policy. We believe that requiring consent for a “Do Not Resuscitate” order may harm patients since it requires physicians to offer treatments they feel are not in the best interests of their patients in some circumstances. At our institution we require physicians to discuss code status with all patients at a significant risk of cardio or respiratory

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<sup>3</sup> Catholic Health Alliance of Canada. (2012). *Health Ethics Guide*, 3<sup>rd</sup> edition, Ottawa, Canada: Catholic Health Alliance of Canada. Article 86, pg 66.

arrest. Physicians are required to offer CPR to all patients who may benefit from CPR (category 1-3); however, we do not require physicians to offer CPR to patients who almost certainly would not benefit from CPR (category 4). Instead, we require physicians to inform such patients or their SDMs that they will not be offered CPR. If the patient or SDM disagrees with the decision, we initiate a mediation process which includes offering a second opinion. It is our opinion that our current policy promotes constructive dialogue and balances the autonomy of patients with the principle of non-maleficence.

Sincerely,