Decision-Making for End-of-Life Care

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Advance care planning discussions: Conversations that take place between health-care providers and capable patients, and where possible, substitute decision-makers, which enable patients to reflect on and communicate their personal, cultural, and religious/spiritual values and beliefs, as well as their wishes, including which treatment(s) they may want at the end of life. The aim of these discussions is to prepare patients and/or substitute decision-makers for future decision-making.

Do Not Resuscitate (DNR) order: A written order in a patient's medical record that provides instructions to the health-care team regarding which resuscitative measures should not be performed if the patient experiences a cardiac or respiratory arrest. DNR orders can be all-encompassing, i.e., "no resuscitative measures," and may be referred to by other names, such as "do not attempt resuscitation" (DNAR) orders, "no-cardiopulmonary resuscitation" (no-CPR) orders, and "do not intubate" orders.[1]

Goals of care discussions: Conversations that take place between health-care providers, patients and/or substitute decision-makers, in the context of a serious illness when there are treatment or care decisions that need to be made in the foreseeable future. The aim of these discussions is to educate patients and/or substitute decision-makers about available treatment options; help define obtainable goals of care by identifying the patient's personal, cultural, and religious/spiritual values and beliefs, as well as their wishes, if they can be ascertained; and align treatment options accordingly through the process of shared decision-making.

[1] Although DNR orders may also include limiting what life-sustaining measures are offered, for the purposes of this policy, DNR orders pertain to resuscitative measures only.

Life-sustaining treatment: Any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or replace a vital function essential to the life of the patient (e.g., mechanical ventilation, medically assisted nutrition and hydration, vasopressors and inotropes, etc.).

Medical futility: A term used to describe treatment that would not achieve its physiologic goal (e.g., with respect to resuscitative measures, treatment that would not provide oxygenated blood flow to the heart and brain).

Resuscitative measures: A suite of medical interventions, including chest compressions, artificial ventilation, intubation and/or defibrillation, that may be provided following cardiac or respiratory arrest in an attempt to restore or maintain cardiac, pulmonary, and circulatory function. Not all interventions in the suite will necessarily be provided or required in all cases.

Substitute decision-maker (SDM): A person, or persons, who may give or refuse consent to a treatment on behalf of an incapable person.[2]

Policy

Advance Care Planning and Goals of Care Discussions

1. Physicians who provide care as part of a sustained physician-patient relationship **must** determine whether, based on the patient's illness or medical condition, it is appropriate to initiate an advance care planning discussion, and if so:
    a. raise end-of-life care issues with the patient; and
    b. encourage the patient to discuss those issues with their SDM.

2. Physicians who provide care to patients who are palliative, receiving non-curative treatment, or at risk of clinical deterioration in the foreseeable future **must**, where possible:
    a. initiate a timely goals of care discussion (particularly when the risk of a cardiac or respiratory arrest is foreseeable), which involves:
        i. describing the underlying illness or medical condition and prognosis;
        ii. educating the patient and/or SDM about the available treatment options, which may include resuscitative measures, and explaining the outcomes that can and cannot be achieved; and
        iii. defining the patient's goals of care by helping the patient and/or SDM identify the patient's wishes, values and beliefs, or if they cannot be ascertained, identifying what would be in the patient's best interests;

[2] For more information on substitute decision-makers, please see the College's *Consent to Treatment* policy.

b. facilitate the goals of care discussion to help build consensus about what treatment decision(s) need to be made; and
c. review the goals of care discussion with the patient and/or SDM whenever it is appropriate to do so (e.g., when there is a significant change in the patient's medical condition or when the patient and/or SDM indicate that the patient's wishes, values, and/or beliefs have changed).

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3. Physicians **must** seek to balance medical expertise and patient wishes, values, and beliefs when making decisions about end-of-life care.

Withdrawing Potentially Life-Sustaining Treatment

4. Physicians **must** obtain consent from patients and/or SDMs before withdrawing life-sustaining treatment.[3]
    a. As part of the consent process, physicians **must**:
        i. explain why they are proposing to withdraw life-sustaining treatment; and
        ii. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

Managing Disagreements

5. Where consent cannot be obtained and the physician is of the view that life-sustaining treatment should be withdrawn, the physician **must** try to resolve the disagreement with the patient and/or SDM in a timely manner by:
    a. communicating information regarding the patient's diagnosis and/or prognosis, treatment options, and assessments of those options;
    b. identifying the basis for the disagreement, taking reasonable steps to clarify any misunderstandings, and answering questions;
    c. reassuring the patient and/or SDM that the patient will continue to receive all other clinically appropriate care or treatment(s);
    d. making reasonable efforts to support the patient's physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering supportive services (e.g., social work, spiritual care, etc.) and consultation with the patient's family physician, where appropriate and available;
    e. offering to make a referral to another health-care provider and facilitating obtaining a second opinion, where appropriate and available;

[3] The Supreme Court of Canada determined in *Cuthbertson v. Rasouli, 2013 SCC 53* (hereinafter *Rasouli*) that consent must be obtained prior to withdrawing life-sustaining treatment.

f. offering consultation with an ethicist or ethics committee, where appropriate and available; and
g. taking reasonable steps to transfer care of the patient to another facility or health-care provider, if possible, and only when all appropriate and available methods of resolving disagreements have been exhausted.[4]

6. Physicians **must** determine whether to apply to the Consent and Capacity Board when:[5]
   a. in relation to treatment decisions, disagreements arise with an SDM over an interpretation of a wish, or assessment of the applicability of a wish, or if no wish can be ascertained, what is in the best interests of the patient; or
   b. they are of the view that an SDM is not acting in accordance with their legislative requirements.[6]

Withholding Resuscitative Measures

A physician's decision to withhold resuscitative measures is not "treatment" and therefore does not require the patient or SDM's consent.[7]

A physician may decide that providing resuscitative measures is not appropriate for a patient in situations where they determine that:

- providing resuscitative measures would be medically futile (i.e., no intervention can successfully resuscitate the patient)[8]; or
- the risks of providing resuscitative measures outweigh the potential benefits (i.e., even if the patient could be resuscitated in the immediate term, it would cause them more harm than good).[9]

7. When a physician determines that providing resuscitative measures to a patient would be medically futile, the physician can write a DNR order in the patient's

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[4] In following such a course, physicians must comply with the College's *Ending the Physician-Patient Relationship* policy.
[5] In *Rasouli,* the Supreme Court of Canada determined that when SDMs refuse to provide consent to withdraw life-support that, in the physician's opinion, is not in the patient's best interests, physicians must apply to the Consent and Capacity Board for a determination of whether the SDM has met the substitute decision-making requirements of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (hereinafter *HCCA*) and whether the refused consent is valid. See in particular paragraph 119 of *Rasouli.*
[6] Please see footnote 2.
[7] In *Wawrzyniak v. Livingstone*, 2019 ONSC 4900, the Court concluded that the writing of a DNR order and withholding of cardiopulmonary resuscitation (CPR) do not fall within the meaning of "treatment" in the *HCCA*. Accordingly, consent is not required prior to writing a DNR order and withholding resuscitative measures, such as CPR, and physicians are only required to provide resuscitative measures in accordance with the standard of care.
[8] The concept of medical futility is as close as possible to a value free, "objective," view of futility.
[9] This risk-benefit calculation involves subjective value judgments.

medical record but **must**, at the earliest opportunity (and, if possible, before the DNR order is written):

a. inform the patient and/or SDM that an order will be or has been written;
b. explain to the patient and/or SDM why resuscitative measures are not appropriate; and
c. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

8. Before determining that resuscitative measures will not be provided because the risks of providing those interventions would outweigh the potential benefits, the physician **must** consider the patient's wishes, as well as their personal, cultural, and religious/spiritual values and beliefs, if they can be ascertained and/or the physician is aware of them.

9. When a physician determines that the risks of providing resuscitative measures would outweigh the potential benefits, the physician can write a DNR order in the patient's medical record but **must**, before writing the order:
    a. inform the patient and/or SDM that the order will be written;
    b. explain to the patient and/or SDM why resuscitative measures are not appropriate, including the risks of providing those interventions and the likely clinical outcomes if the patient is resuscitated; and
    c. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

10. When a patient's condition is deteriorating rapidly and there is an imminent need for an order to be written (e.g., actual or impending cardiac or respiratory arrest), the physician can write a DNR order in the patient's record but **must** comply with the expectations set out in provision 9 at the earliest opportunity.

11. When a physician is not able to determine whether the risks of providing resuscitative measures would outweigh the potential benefits, the physician **must not** write a DNR order in the patient's medical record unless the patient and/or SDM requests or agrees to it.

Providing Support if Disagreements Arise

12. If the patient and/or SDM disagree with the writing of a DNR order, the physician can write the order, but **must**, at the earliest opportunity after learning of the disagreement, make reasonable efforts to provide support to the patient and/or SDM by:
    a. identifying the basis for the disagreement, taking reasonable steps to clarify any misunderstandings, and answering questions;
    b. reassuring the patient and/or SDM that the patient will continue to receive all other clinically appropriate care or treatment(s);

c. making reasonable efforts to support the patient's physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering supportive services (e.g., social work, spiritual care, etc.), where appropriate and available; and
d. taking reasonable steps to transfer care of the patient to another facility or health-care provider, if possible and requested by the patient and/or SDM.[10]

[10] Please see footnote 4.