TO: The College of Physicians and Surgeons of Ontario (CPSO)

RE: Policy Review: "Planning for and Providing Quality End-of-Life Care"

The following submission is on behalf of the Medico-Legal Society of Toronto ("MLST").

The Medico-Legal Society of Toronto (MLST) was founded in 1950 by a group of doctors and lawyers to promote medical, legal and scientific knowledge, cooperation and understanding between the professions in the interest of justice and in the best interests of patients and clients. The MLST's Submissions Committee is mandated to advocate on behalf of and in alignment with the MLST's mission, vision and objects, and to monitor and respond to government and stakeholder issues as well as calls for input. The CPSO has invited feedback from all stakeholders to assist the CPSO in updating its End of Life policy, currently being reviewed. Accordingly, the following submissions have been developed by the MLST and are hereby respectfully conveyed to the CPSO.

The MLST supports the addition of clarity and transparency to the MLST policy and advisory, to promote the highest quality of end of life care to patients, as well as trust and confidence in the providers of medical care in Ontario. To that end, we will focus on four significant suggestions for improvement discussed below:

1. Adopt language that provides physicians with a clear understanding of the law:

In February, 2015, the MLST made submissions on the CPSO's then draft policy circulated to stakeholders. Since then there have been further revisions to the policy to reflect certain legal developments which aligned with the 2015 MLST submission. In particular, our concern at that time was that there was a misinterpretation of the decision of the Supreme Court of Canada in the 2013 case of Cuthbertson v. Rasouli, as if the SCC had held that a no-CPR order always requires consent. This misperception was corrected in the decision of the Ontario Superior Court in the case of Wawrzyniak v. Livingstone (4900 CanLII 2019 ONSC), and the CPSO policy subsequently revised accordingly. This decision is referred to in footnote 14 in the Policy, stating:

*In **Wawrzyniak v. Livingstone, 2019 ONSC 4900** the Court concluded that the writing of a no-CPR order and withholding of CPR do not fall within the meaning of "treatment" in the Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A. As such, consent is not required prior to withholding CPR and physicians are only obliged to provide CPR in accordance with the standard of care.*

In the accompanying Advice document ("the Advisory"), it is stated that:

> *The Rasouli decision provided clarity regarding the consent requirements for withdrawing life-sustaining treatments. It did not, however, address whether the same requirements apply in the context of withholding CPR or writing a no-CPR order. In August 2019, the Ontario Superior Court released a significant decision specifically assessing whether the analysis and conclusions drawn in Rasouli apply in the context of withholding CPR and writing a no-CPR order. The decision was clear that the requirements are not the same – consent is not required prior to writing a no-CPR order and physicians are only obliged to provide CPR when doing so is within the standard of care.*

These summaries of the Wawryzniak decision seem to imply that the court decided that consent is never required for a no-CPR order, whereas what the Court actually decided was that consent is not required where CPR would almost certainly not benefit the patient and/or only cause harm. While the current Policy and Advisory make reference to the obligation to provide CPR only where it is "in accordance with the standard of care", it would be far more helpful to physicians if that standard of care was more clearly delineated in the Policy and Advisory. Afterall, it is the acknowledged and prevailing view that interventions anticipated to be non-beneficial lie outside the standard of care.

The MLST therefore proposes that the Policy and Advisory be clear that if any particular treatment, including CPR, almost certainly will not be of benefit, meaning it cannot potentially cure a reversible illness, stabilize the patient's state of health and/or alleviate pain and distress, that it does not fall within the medical standard of care to offer it. These goals reflect the historical and current goals of medicine across cultural boundaries.

2. Acknowledge that one physician's offer to provide CPR at one point in time does not preclude another physician from ordering no-CPR at another point in time

The *Wawryzniak* court decision also provided very helpful guidance in response to an argument that once a patient's plan of care is "full code", it cannot be changed ("withdrawn") without consent. To quote Justice Cavanagh:

> *Under the Health Care Consent Act, the only treatment a doctor would require consent to withhold or withdraw would be one proposed by the doctor or by another health practitioner. … I would add the refinement that is not necessary that a treatment that is not considered part of a plan of treatment be one that was "rejected from the onset" as being medically inappropriate.… A person's health condition during the course of medical care for a serious illness is likely to change over time and the physician must adjust the treatment options which are offered to a person during the course of care to reflect his or her clinical judgment. This may involve… deciding that a treatment that had been offered as part of a plan of treatment will almost certainly not benefit the patient and making the medical decision that this treatment will no longer be offered.*

Justice Cavanagh thereby held that the physicians were not required to obtain the consent of the patient's SDM for their medical decision to no longer offer CPR, in spite of the patient's previous "full code" status. Such guidance should be clearly incorporated into the CPSO policy and advisory.

The CPSO should also encourage physicians to reassess the benefits of CPR over time, and to ensure these assessments and rationale as to whether CPR is medically indicated are well documented.

3. Allow for a no-CPR order to be written although the conflict resolution process may not yet be complete

The MLST fully supports the expectation that notification, if not consent, be required for a no-CPR order, if time permits. As we previously submitted, physicians should be required to openly and transparently disclose that such life-saving and life-sustaining treatments will not be offered to promote discussion about end of life planning, the limitations of medical and surgical treatments to provide medical benefits as patients near the end of life, the provision of palliative care and the alleviation of pain and distress. Such discussions are ethically important to ensure patients and substitutes are well prepared for what will happen in the dying process and will understand that they will be accompanied and supported throughout this process by their physician and the healthcare team. Such clarity that life-saving and life-sustaining treatments will not be offered will allow patients and substitute decision-makers to request and obtain a second opinion if desired, and for the engagement of other conflict resolution processes if necessary and as time permits, as outlined in paragraph 25 of the current Policy.

The Policy currently requires, however, that as long as a patient or substitute decision-maker (SDM) insists that CPR be provided, that the physician must not write the no-CPR order, and that if the patient experiences cardiac or respiratory arrest while the conflict resolution process is still underway, that physicians must provide all resuscitative efforts "required by the standard of care, which may include CPR". In the Advisory, it is explained that "physicians are permitted to make a bedside determination about which resuscitative efforts, including CPR, to provide and are only required to provide those that are within the standard of care".

This is another example of why it is so important that the Policy be more definitive about what is meant by "required by the standard of care". Presumably, this statement is also intended to convey that physicians can give a verbal no-CPR order at the bedside where in their clinical judgment, CPR would almost certainly not benefit the patient and/or only cause harm.

In many academic centres, such a statement effectively places the decision-making burden of what constitutes the standard of care on a Junior physician in the actual moment of a cardiorespiratory arrest, to determine whether CPR falls within the standard of care. Such emergency decisions do not promote thoughtful considerations of potential benefits on the part of any physician, never mind a physician in training. Most trainees would provide CPR in these conflict circumstances and subject the patient to harm.

It bears noting that in the *Wawryzniak* case, the physicians had written the no-CPR order and had attempted but not yet succeeded in notifying the patient's daughter (his SDM) of this decision when his condition abruptly deteriorated. The patient's daughter arrived at the Hospital, witnessed this precipitous decline, and demanded that resuscitative measures be taken. One of the physicians who co-wrote the DNR order attended at the bedside and verbally confirmed the written order. Everyone at the bedside, including a respiratory therapist and nurses, were exposed to a terrible scene. No one would disagree that if it was at all possible, the harm experienced by the patient, his daughter, and all of the hospital staff should have been avoided. While the court acknowledged that the standard of care did call for physicians to attempt to have a discussion with a patient/SDM before writing a DNR order, expert evidence was accepted that the standard of care did not require this to occur before the order was written, particularly in light of the paramount duty not to cause harm to the patient. With the September 2019 amendment to its Policy, the CPSO seems to be acknowledging that the standard of care would preclude the provision of CPR in this scenario.

If that same fact scenario presented itself today, the physicians would still be found to have contravened CPSO policy in having written the DNR order before they made successful contact with the SDM to inform her. The bedside decision of the physician not to have CPR performed, however, would have complied with the policy. The outcome for the patient and his daughter would have been exactly the same. Without a written order, however, the stress caused to frontline staff at the bedside would have been even further intensified. It must be borne in mind that, as found by the Court in the *Wawryzniak* case, the writing of a no-CPR order is effectively a process requirement that is needed in order to respond to a hospital policy that CPR be provided as the default treatment option. That is, the writing of the order is simply a way for the Hospital team to understand what is expected of them in an arrest situation. The CPSO policy would provide stronger protections for patients if it defined the standard of care for CPR and non-offers of resuscitation and focussed on the content of discussions and disclosures. rather than on the writing of the no-CPR order.

It is not always the case in Ontario hospitals that a physician is available at the bedside of patient to make the clinical decision and to provide the verbal order that resuscitative measures are not to be provided. This is going to lead to frontline hospital staff having to perform CPR even in circumstances where there is no doubt that it lies outside the standard of care because of the lack of benefit and harm being caused to the patient. It makes no sense practically, ethically, professionally, or legally.

The MLST therefore submits that once it becomes clear on the evidence that CPR would be of no medical benefit and/or only cause harm, a physician ought to be able to write the no-CPR order even while discussions and conflict resolution processes are still underway, for the sake not only of the patient, but for the sake of the frontline staff who ought to be left with no doubt in any given case what they are to do in the event of an arrest situation.

4. Encourage early involvement of Critical Care physicians where possible

In our 2015 submissions, the MLST suggested that the CPSO recommend earlier involvement of Critical Care physicians in all acutely deteriorating patients who could be anticipated to require life-saving and life-sustaining treatment. The MLST proposed that in recognition of the increasing sub-specialization of medical and surgical practices, that the CPSO recommend that CPR be offered to and discussed with patients or their substitute decision-makers by those physicians who are best able to determine if these treatments (acute resuscitation, life-saving and life-sustaining treatments) have any potential medical benefits in the context of the individual patient's state of health. It was felt that through the involvement of such qualified and specialized physicians that the best quality of patient care will be achieved at the end of life.

This recommendation is not intended to rise to the level of an overarching standard of care. It is recognized that many hospitals have limited critical care trained physicians, and that most care on the wards may be provided by primary care physicians or a very limited contingent of physicians with more critical care training. Much care is fairly routine, and in many cases, the lack of benefit of CPR is obvious, not requiring sub-specialist training. But for those hospitals in Ontario that have ICU's, and where there is uncertainty as whether ICU care would be beneficial, ward physicians should be encouraged to seek consultation, just as they would of any expert in any other field. CPR is like surgery, insofar at it has its place – an even more limited one than surgery - and the analogy does not fall apart because someone is nearing the end-of-life. It is recognized that there is discomfort involved in having a non-offer conversation, and this can lead to physicians simply bending to whatever a SDM wants when it comes to ICU care and CPR, even though it won't help. CPR has no place at the end-of-life, as resuscitation will not be successful and CPR then becomes an instrument of harm to a patient. An explanation of what medicine can do to help (including palliative care), and why CPR will not be offered, needs a clear and empathetic explanation in the context of any given person's situation. ICU physicians are more used to having these tough conversations, and bringing this expertise to bear early can prevent bigger problems down the road and can be useful in preventing patient suffering.

Thank you for affording us the opportunity to provide submissions with respect to the CPSO's review of its policy and advisory on "Planning for and Providing Quality End-of-Life Care". We'd be please to provide any further clarification or answer questions upon request.