

CPSO Decision-Making for End-of-Life Care

<https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Decision-Making-for-End-of-Life-Care>

Reviewed and updated 2023

This is a much anticipated revision which incorporates, in particular, the ruling in [Wawrzyniak v. Livingstone, 2019 ONSC 4900](#), where the court determined that not offering CPR (and consequently writing a DNR or no CPR Order was not a treatment under the HCCA and therefore did not need consent.

Key features of the Policy

Summary and *commentary*

Definitions

Advance care planning: concerns the capable patient's wishes for treatment they may, or may not want at the end of life. The objective is to guide future patient and substitute decision-maker decision-making.

Goals of care discussions: occur in the context of a significant illness or disease when there are treatment decisions to be made in the foreseeable future. Intention is to "educate.. about *available* treatment options and help define *obtainable goals* of care by identifying the patient's personal, cultural, and religious/spiritual values and beliefs as well as their wishes..." (Emphasis added.)

So, advance care planning can occur in the absence of any significant illness, and should guide goals of care discussions.

1. When "appropriate" physicians in a sustained physician patient relationship **must** initiate a discussion about advance care planning. (Emphasis in original.)

*When is "appropriate?" One often-used marker is the question: "Would you be surprised to learn that this patient had died in the next 12 months?" If "No" then the physician **must** initiate ACP discussions.*

How is that done/supported in the hospital context?

How are those discussions recorded?

How do they follow the patient?

If those discussions are initiated in another health care setting, how do they follow the patient into hospital?

What impact do discussions with physician A have on physician B?

2. When patients have a significant illness... and are at risk of clinical deterioration in the foreseeable future, physicians **must** initiate a timely goals of care discussion. (Emphasis in original.)

- a. (ii) which includes: “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...” (Emphasis added.)

What is hospital policy on this topic?

What are the hospital documentation processes?

How do resuscitative interventions get discussed?

How does the “goals of care” discussion get recorded?

How does the “goals of care” discussion get incorporated into treatment plans, or course of treatment?

How do “goals of care” follow the patient?

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

What does “balance” mean?

4. Physicians **must** obtain consent from patients and/or SDMs before withdrawing life-sustaining treatment.

No change (Rasouli case)

5. Managing disagreements: 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..
 - a. ... e, f, g: offering referral, second opinion, consult with ethicist/ethics committee where appropriate and available.
6. Physicians **must** determine whether to apply to the Consent and Capacity Board...

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.

WvL noted above. This is far more clearly explained in the “Advice to the profession.” This policy is best read in conjunction with the “Advice.” <https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Decision-Making-for-End-of-Life-Care/Advice-to-the-Profession-End-of-Life-Care>

Where the risk of harm associated with resuscitation outweighs the potential benefits, physicians may decide it is appropriate to withhold resuscitative measures and write an order to this effect in the patient’s medical record.

In WvL the discussion concerns where an attempted resuscitation would be outside of the standard of care. If a resuscitation attempt was “almost certain not to bring a benefit” it was outside the standard of care and so ought not be offered and no consent was required not to offer.

The Policy then uses the phrase “risk of harm associated with resuscitation outweighs the potential benefits” and then the word: “may.”

What does “risk of harm” mean? And what does it mean in the context of :

7. 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 or the physician is aware of them.

Clearly (maybe clearly) if the patient has identified that they would not wish to be resuscitated under certain conditions those conditions constitute the patient’s determination that the risks of harm of resuscitation outweigh any potential benefits. But the physician is only permitted (may write an order) not required.

There are two (or more) ideas running together here.

A capable patient is entitled to tell anyone – including a care provider or physician – do not touch me – or do not attempt to resuscitate me. The patient does not need the physician’s agreement to make such a demand, that is simply an individual’s right to control their own person. The patient (person) has the authority to make this decision.

The question for health care organizations is how they recognize, record, and honour that basic right.

A second question concerns when a physician should determine that a resuscitation attempt should not be made because it is outside the standard of care, almost certainly will not benefit, or is “futile.”

This is a medical decision, made under the authority of the physician. If the medical decision is that a resuscitation attempt is almost certainly not going to benefit the patient a DNR order can (should?) be written by the physician and this does not need consent.

*The third possibility is that a conversation between physician and patient (sdm) determines that a resuscitation attempt is not appropriate in **this** case. This decision can (should) be initiated by the physician (under a goals of care discussion) and includes the likely outcome of a resuscitation attempt and the patient’s wishes and values.*

The CPSO policy does not clearly identify a patient’s right to refuse or “pre-refuse” a resuscitation attempt. Nor does it clearly distinguish between a physician decision that a resuscitation attempt would be outside of the standard of care and therefore should not be offered and a situation where a resuscitation attempt would not bring a greater balance of benefit over harm given the patients values and wishes.

8. Physician **must**, before writing DNR order inform, communicate, provide details of proposed care.
9. 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 an order to withhold resuscitative measures in the patient’s medical record but **must** comply with

the expectations set out in provision 8 at the earliest opportunity (rather than before writing the order).

10. Providing support if disagreements arise.

Similar to note at 5 above.

Summary

The policy:

Emphasizes the physician obligation to engage in early advance care planning discussions and to have timely goals of care discussions.

Reiterates that physicians do not need patient consent to not offer resuscitation attempts that are outside the standard of care.

Provides some guidance on conversations with patients and sdms when “the risk of harm associated with resuscitation outweighs the potential benefits.”

Gaps and unanswered questions

The policy:

Does not clearly articulate a patient’s right to refuse (or pre-refuse) a resuscitation attempt.

Does not speak to how discussions/decisions by one physician move with the patient to guide later care providers.

Does not speak to hospital polices to support these conversations and decisions.

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