MLST Submissions to CPSO

Re: Draft Policy on Decision-making for the End of Life

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.

MLST Comments on CPSO Draft EOL policy

The MLST wishes to congratulate the CPSO on the draft policy. The MLST approves of the Draft policy on EOL Decision-Making in that it adds clarity and transparency to the policy's previous version. The MLST believes the policy will promote the highest quality of end of life care and will promote trust and confidence in physicians in Ontario.

The MLST does however have four significant concerns with the current draft that we will discuss below:

1. Definitions of medical (clinical) benefit and medical standard of care:

   The MLST suggests that the CPSO define medical (clinical) benefit in the policy as those treatments and treatment plans that can potentially cure a reversible illness, stabilize a patient's state of health and/or alleviate pain and distress. These goals reflect the historical and current goals of medicine across cultural boundaries. The MLST further suggests that the medical standard of care be defined as any and all treatment options that could provide potential medical (clinical) benefit. The MLST strongly feels these definitions are required as physicians appear to confuse the medical standard of care with the definition of the legal standard of care. The provision of these definitions will add clarity and transparency to the CPSO policy.

   - In recognition of the increasing sub-specialization of medical and surgical practices, the MLST suggests that the CPSO recommend that CPR should only 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. The MLST further submits that it only through the involvement of such qualified and specialized physicians that the best quality of patient care will be achieved at the end of life. The MLST therefore suggests 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 submits that the CPSO should require physicians to obtain informed consent for a full code status, if CPR and life-sustaining treatments are being offered, in accordance with the principles outlined in the *Health Care Consent Act.*

2. Language that seems to contravene and confuse the purpose of healthcare:

In the current draft policy the CPSO states

Physicians are advised that patients and substitute decision- makers may assess the proposed treatment options differently than the physician as they may consider, for example, whether the treatment prolongs life even if there is no clinical benefit.

The MLST suggests to the CPSO that a further statement that if a treatment would not provide a clinical benefit (as defined above), such a treatment and/or treatment plan would fail to meet the purposes of medicine and fall outside the medical standard of care (e.g. if it just prolongs biological life). Such treatments and/or treatment plans should not be offered even if patients and/or substitute decision-makers assess the treatment options differently.

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.

3. Language that provides physicians with a mistaken understanding of the law.

In its current draft policy, at line 240 in subs. 5.2, it is stated that "*the College requires physicians to obtain consent for a "Do Not Resuscitate" order".*

a) The MLST respectfully submits the CPSO has erred with respect to the law in Ontario

The statement above is footnoted with a reference to the August 28, 2014 decision of the Health Professions Appeal and Review Board (HPARB) in *EGJW v. MGC* (2014 CanLII 49888), where two members of HPARB held that the decision of the Supreme Court of Canada in the *Cuthertson v. Rasouli* case (2013 SCC 53) stands for the proposition that physicians must obtain consent for a DNR order. HPARB interpreted the decision in the *Rasouli* case to "apply equally in the case of the withholding of treatment and a withdrawal of treatment", and expressed that the *Rasouli* case clarified the operation of the law.

In our respectful opinion, this is patently not correct. To the contrary, the Supreme Court of Canada clarified the operation of the law only as it applies to the withdrawal of treatment, specifically, mechanical ventilation, in situations similar to Mr. Rasouli's (which was very different than the patient who was the subject of *EGJC v. MGC)*. At no time did the SCC judges address the issue of withholding

(as opposed to withdrawing) treatment, or any end-of-life care other than mechanical ventilation in circumstances similar to Mr. Rasouli's.

The SCC did not decide that there is a *carte blanche* "right" to treatment at the end of life – only that an SDM has the right to determine whether mechanical life support can be withdrawn in the first instance, bound by certain rules, with the Consent and Capacity Board having the power to make the final decision on the issue (subject to appeal).

Why did the SCC consider the withdrawal of mechanical life support "treatment" under the *HCCA* (and therefore requires consent) in circumstances similar to Mr. Rasouli's? In broadly outlining their rationale, the SCC justices referred to eight factors; but in summarizing their thinking in paragraphs 67 and 68, they focused on four.

The withdrawal of life support:

1) Aims at the health-related purpose of preventing suffering and indignity at the end of life;
2) often entails physical interference with the patient's body (referring to extubation);
3) is closely associated with the provision of palliative care (as it will inevitably be administered as part of the process of withdrawal); and
4) impacts patient autonomy in the most fundamental way, by removing medical services that are keeping a patient alive.

Take the familiar example where a patient is near death, in such a condition where medical science tells us that should his or her heart stop, chest compressions, defibrillation and medications cannot physiologically meet the life-prolonging purpose of CPR. Such a patient will die with or without CPR; however, with CPR the death will potentially be prolonged and accompanied by greater pain, suffering and distress. In these circumstances, there is usually an interdisciplinary consensus that CPR interventions are inappropriate and, as such, they would not be offered as part of a treatment plan. Does the most responsible physician require consent to write the no CPR, or DNR, order?

The SCC in the *Rasouli* case determined nothing specifically in regard to this scenario. Applying, however, the same rationale used by the SCC justices:

1) Is a no-CPR route aimed at preventing suffering and indignity at the end of life? – yes
2) Does the no-CPR route entail physical interference with the patient's body? - No, quite the opposite
3) is the no-CPR route closely associated with the provision of palliative care? - Often, but not necessarily
4) Would CPR keep the patient alive? - certainly not.

Applying the SCC's rationale, therefore, it cannot reasonably be said that in the circumstances, the SCC has held that a no-CPR order would require consent. This helps explain why the SCC took pains to express that the *Rasouli* case "does not stand for the proposition that consent is required under the *HCCA* for withdrawals of other medical services or in other medical contexts" (para 70), and that "a more nuanced view that withdrawal of treatment may sometimes, although not always, constitute "treatment", better fits the provisions of the *HCCA* and the realities of medical care" (para 59).

It can be concluded that the SCC did not intend to change the law or the practice of medicine, insofar as which medical interventions should or should not be *offered.*

While HPARB may have jurisdiction to decide questions of law and to provided interpretation of statutes such as the *HCCA*, the decision has minimal precedential weight. HPARB cannot make declarations of general applicability. The decision is not even binding on HPARB itself in later proceedings. (See *Paul v. British Columbia (Forest Appeals Commission),* 2003 SCC 55 at para 31; *Alberta (A-G) v. United Food and Commercial Workers Union Local No 401*, 201 ABQB 777; *Transcanada Pipelines Ltd v Beardmore (Township),* [2000] OJ No 1066 (ONCA) at para 129, leave to appeal to SCC refused [2000] SCCA No 264.)

HPARB remitted the matter of *EGJW v. MGC* back to the CPSO's Inquiries, Complaints and Reports Committee for reconsideration. From there, it is fair to anticipate an eventual judicial review, in which a Court will undertake a rigorous analysis of the HPARB decision in order to reach the correct interpretation of the *HCCA*, and it is <u>that</u> review which will be a binding statement of the law, pending appeal.

The CPSO's draft policy also states, starting at line 221, that "physicians are not obliged to propose or provide life-saving treatments that are not within the standard of care". It is the acknowledged and prevailing view that interventions anticipated to be non-beneficial lie outside the standard of care. In the *EGJC v. MGC* case, HPARB simply sidestepped the question about whether or not resuscitation would have been of any benefit or even caused harm. With respect, the CPSO's policy should not sidestep such a fundamental issue.

b) *<u>The MLST respectfully submits that the CPSO has erred with respect to ethical standards of professionalism and this statement will promote a poor quality of medical care for the people of Ontario</u>*

Just as for any other treatment at the end of life, we submit physicians need to decide if CPR could offer any medical benefit (as we suggest it be defined above). If CPR would not offer any such medical benefit, it would fall outside the medical standard of care and should not be offered. However, where time permits, the non-offer should and must be disclosed to capable patients or their substitute decision-maker in the interest of clarity, transparency and the physician's fiduciary duty. Such disclosure are important and would allow the patient or substitute decision-maker to request and or obtain a second opinion regarding potential medical benefits. The MLST respectfully submits that wherever possible the physician obtain a second opinion and that this second opinion be documented in the medical record, again, if time permits.

We respectfully point out that if the CPSO accepts that life-saving and life-sustaining treatments do not need to be offered if they would provide no medical benefit, <u>no consent</u> for this non-offer needs to be obtained. Yet by stating that physicians must obtain consent for DNR orders, the CPSO places physicians in a clinical conundrum and an ethical and legal quandary. Conceivably, in such a situation, a physician who has already disclosed that life-saving and life-sustaining treatments will not be offered, who fails to obtain consent for a DNR order, would have to provide CPR and acute resuscitation in the event of a cardiac arrest. If the arrest team managed to obtain ROSC, the physicians would be in a clinical quandary as the patient would be-- in all likelihood--- intubated and would require life-sustaining treatments which are not being offered. What should then happen? Clinically therefore the need for consent to a DNR order does not make sense.

Ethically a physician should not offer nor provide medical treatments that are "bridges to nowhere". Moreover if the physician had previously determined that life-sustaining treatments would offer the patient no medical benefit prior to the patient deteriorating to the point of a cardiac arrest, the same physician will now be asked to provide life-sustaining treatments in a situation where the patient's clinical condition is significantly worse (once resuscitated post cardiac arrest). Such a situation would be the absolute opposite of the high quality end of life care that the CPSO policy aims at promoting.

In summary, the sentence in the draft policy that "the College requires physicians to obtain consent to a Do Not Resuscitate order" stands out as palpably contrary to so many of the other principles enunciated in the draft policy. It appears to be there solely in response to a decision of HPARB which we feel has been given undue weight by the College's policy-drafters, and which is not generally regarded to be accurately reflective of the law, much less good policy.

c) The MLST submits that the CPSO change the DNR wording to NO CPR

Finally the MLST submits that the CPSO depart from language such as DNR. The DNR terminology is confusing to frontline physicians: does it mean no CPR, no intubation, no life-sustaining treatment or all of the above? The MLST would suggest the CPSO clarify its language and use NO CPR instead.

4. Physician Assisted Death

In view of the recent Supreme Court of Canada ruling in *Carter v. Canada (Attorney General),* (2015 SCC 5), declaring the absolute prohibition against physician-assisted death to be unconstitutional, (but with that declaration of invalidity suspended for 12 months to permit Parliament to consider any legislative response), the MLST submits that the CPSO continue with the status quo, with a separate draft policy to follow.