MLST Submissions to CPSO re 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 EOL Policy

Discussion of "benefit" in Section 3.2 – CPR and Other Potentially Life-Saving Treatments

The MLST recommends that the CPSO End of Life policy keep the existing guidance regarding the decision to offer life-sustaining treatments such as CPR and life support. While the Supreme Court's decision in *Cuthbertson v Rasouli* may require that physicians *maintain* treatment that is of no medical benefit where the patient does not consent to the treatment's withdrawal, it does not require physicians to *offer* such treatment. A physician's decision to *offer* treatment is still well informed by the CPSO End of Life policy.

While we suggest that this section remain largely intact, a few changes are required to clarify the distinction between *not offering* and *ceasing to provide* treatment.

First, the MLST suggests that the first sentence of the section that now reads "Physicians are not obliged to provide treatments that will almost certainly not be of benefit to the patient" be changed to "Physicians are not obliged to offer treatments that will almost certainly not be of benefit to the patient".

Second, the first sentence of the eighth paragraph should be amended to make the same distinction. The first sentence now reads:

> When it is clear from available evidence that treatment will almost certainly not be of benefit or may be harmful to the patient, physicians should refrain from beginning or maintaining such treatment.

The MLST recommends that the current language be revised as follows:

> When it is clear from available evidence that treatment will almost certainly not be of benefit or may be harmful to the patient, <u>physicians should not offer such treatment, or should seek the patient's or SDM's consent to discontinue it</u>.

The text should distinguish between the decision to "begin" and the decision to "maintain" treatment. The decision to refrain from "beginning" treatment may in fact be a decision to *not offer* treatment, which should be clear. If a physician has decided the treatment is not indicated in the circumstances, and has therefore not offered it to a patient, the patient's consent is not required. However, following *Rasouli*, if a physician has decided that a life-supporting treatment should no longer be "maintained" because it is no longer indicated, consent is required from the patient or substitute decision-maker for its withdrawal.

<u>Third</u>, the second sentence of the eighth paragraph of the policy also requires clarification. The sentence is currently written as follows:

> Any recommendation not to initiate life support, or to withdraw life support, should be discussed with the patient or substitute decision-maker, and the family if there is consent.

The MLST suggests that this sentence be amended as follows:

> A physician should seek consent for any decision to withdraw life support as early as possible from the patient or substitute decision-maker, and the family if there is consent.
>
> Where a physician has decided not to offer life support to a patient, the physician should, where appropriate, discuss this with the patient or substitute decision-maker, and the family if there is consent.

The decision not to initiate life support may not be a "recommendation" as the policy now provides. Here, the distinction between *withholding* and *not offering* must be clarified. A treatment may be indicated but not recommended, e.g. in cases in which a benefit is possible but with a high risk of complications. In such cases, the physician *offers* the treatment, but

recommends that it be *withheld* in the circumstances. Such an approach clearly requires patient (or SDM) consent.

Contrast this with *not offering* treatment, as with cases in which treatment is not indicated. While many treatments exist to treat life-threatening illness, such as heart transplants, dialysis, heart and lung interventions, etc., these will only be offered where they are available and may possibly provide a benefit. It is, in the view of the MLST, improper to suggest that a physician must discuss every decision not to initiate life-supporting treatments, particularly when an unavailable or non-indicated treatment is not an option raised by the patient, the substitute-decision maker, or the family. While a physician should give a family the opportunity to seek a second opinion, discretion should be left to the physician to discuss his or her decisions to not offer treatment as every end of life scenario will require a different approach.

Conclusions

The MLST sincerely hopes that the CPSO will find our submissions helpful. We recognize that the nature of our submissions, if adopted, is such that much of the current content of the policy will be retained, but with a significant change in format and some additional content, much of which has not yet been developed in precise detail nor provided by us. That being the case, we expect that the CPSO will benefit from inviting another round of submissions once it is in a position to circulate a new draft of the Policy. The MLST would be pleased to part of such a process.

Further suggested changes in light of the decision in *Cuthbertson et. al. v Rasouli et. al.*

The Supreme Court of Canada's decision in *Rasouli* has clarified that, according to the *Health Care Consent Act*, patient consent is required prior to the withdrawal of life support. The CPSO policy should ensure that physicians understand the legal scope of the decision.

First, it should be clarified in the policy that the decision in *Rasouli* does not change the physician's standard of care regarding both the decision to offer or propose treatment, and in the decision to recommend that it be discontinued. Physicians should continue to advocate in the best interests of their patients, and attempt—as much as is legally possible—to conform to the standard of care. This may require, in some cases, that the physician seek direction from the Consent and Capacity Board where he or she believes that a SDM is not acting in the patient's best interests. Physicians should be encouraged to advocate for their patients before the CCB where necessary.

Second, physicians should be advised to continue to offer end of life treatment that is of uncertain benefit, without regard to concerns that they may not be legally permitted to withdraw treatment without patient consent. The appropriate means of addressing such potential conflict is described in the Conflict Resolution section of the End of Life policy, and may require, if all attempts at resolution fail, that the matter be resolved by the Consent and Capacity Board.

Third, although the Conflict Resolution section can assist physicians engaged in conflicts in end of life treatment scenarios, this section is applicable to conflicts arising in any area of medicine. In the view of the MLST, this section should be incorporated into the policy entitled "Consent to Medical Treatment" last published in January/February 2006.

Suggested changes to the Home Palliative Care section

The MLST would suggest that this section of the policy be removed and a separate policy developed. The EOL decision making policy is already long and we respectfully submit that the inclusion of a section on home palliative care detracts from its main focus.

Suggested changes to the Advance Care Planning section

The MLST also respectfully submits that advance care planning should become a separate policy. Advance care planning generally encompasses a broad range of decisions pertaining to personal care and healthcare and is not solely confined to end of life decisions, nor those regarding resuscitation and life support. Advance care planning is an important aspect of healthcare and requires a separate policy in order to do justice to the key principles, duties and processes that are engaged.