

An Interprofessional Interpretation of Ontario's CPSO End-of-Life Policy

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Volume 7, Number 4, 2024

URI: <https://id.erudit.org/iderudit/1114964ar>

DOI: <https://doi.org/10.7202/1114964ar>

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Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

[Explore this journal](#)

Cite this article

Sklar, M. C., Walker, Q., Lewis, E., Born, K. & Sas, C. (2024). An Interprofessional Interpretation of Ontario's CPSO End-of-Life Policy. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, 7(4), 102–105.
<https://doi.org/10.7202/1114964ar>

Article abstract

In the acute care setting, we often ask families to make challenging decisions regarding their loved ones' preferences and choices for end-of-life care when these individuals can no longer make those decisions themselves. This already stressful situation can be exacerbated by medical jargon and conflicting messaging from various well-meaning health care practitioners. Some of this ambiguity likely stems from medical providers' lack of familiarity with end-of-life policies and their obligations as providers. Further, there can be discomfort for many families and clinicians about speaking about end of life, alongside varying cultural norms and expectations around death and dying. In this analysis, we aim to outline fundamental concepts and misconceptions surrounding cardiopulmonary resuscitation, the administration and withdrawal of life-sustaining therapies, and the framework provided by regulatory bodies for medical professionals to approach these situations. As legal and ethical principles may vary nationally between jurisdictions, our discussion will be based on Ontario policy and law. However, we believe that a similar approach would help hospitals and health care bodies provide clarity to clinicians, patients and families alike, and could be easily adapted into medical education materials.

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COMMENTAIRE CRITIQUE / CRITICAL COMMENTARY (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

An Interprofessional Interpretation of Ontario's CPSO End-of-Life Policy

Michael C. Sklar^{a,b}, Quinn Walker^c, Ellen Lewis^d, Karen Born^e, Courtney Sas^f

Résumé

Dans le cadre des soins aigus, nous demandons souvent aux familles de prendre des décisions difficiles concernant les préférences et les choix de leurs proches en matière de soins de fin de vie, lorsque ces personnes ne peuvent plus prendre ces décisions elles-mêmes. Cette situation déjà stressante peut être exacerbée par le jargon médical et les messages contradictoires de divers professionnels de la santé bien intentionnés. Une partie de cette ambiguïté provient probablement du manque de familiarité des prestataires médicaux avec les politiques de fin de vie et leurs obligations en tant que prestataires. En outre, de nombreuses familles et de nombreux cliniciens peuvent se sentir mal à l'aise à l'idée de parler de la fin de vie, en plus de normes et d'attentes culturelles différentes concernant la mort et le décès. Dans cette analyse, nous visons à souligner les concepts fondamentaux et les idées fausses entourant la réanimation cardio-pulmonaire, l'administration et le retrait des thérapies de maintien en vie, et le cadre fourni par les organismes de réglementation pour que les professionnels de la santé abordent ces situations. Étant donné que les principes juridiques et éthiques peuvent varier d'une juridiction à l'autre, notre discussion sera basée sur la politique et le droit de l'Ontario. Cependant, nous pensons qu'une approche similaire aiderait les hôpitaux et les organismes de soins de santé à clarifier la situation pour les cliniciens, les patients et les familles, et qu'elle pourrait être facilement adaptée au matériel de formation médicale.

Mots-clés

fin de vie, statut du code, interprofessionnel, futilité médicale, thérapie de maintien en vie, arrêt des soins

Abstract

In the acute care setting, we often ask families to make challenging decisions regarding their loved ones' preferences and choices for end-of-life care when these individuals can no longer make those decisions themselves. This already stressful situation can be exacerbated by medical jargon and conflicting messaging from various well-meaning health care practitioners. Some of this ambiguity likely stems from medical providers' lack of familiarity with end-of-life policies and their obligations as providers. Further, there can be discomfort for many families and clinicians about speaking about end of life, alongside varying cultural norms and expectations around death and dying. In this analysis, we aim to outline fundamental concepts and misconceptions surrounding cardiopulmonary resuscitation, the administration and withdrawal of life-sustaining therapies, and the framework provided by regulatory bodies for medical professionals to approach these situations. As legal and ethical principles may vary nationally between jurisdictions, our discussion will be based on Ontario policy and law. However, we believe that a similar approach would help hospitals and health care bodies provide clarity to clinicians, patients and families alike, and could be easily adapted into medical education materials.

Keywords

end of life, code status, interprofessional, medical futility, life sustaining therapy, withdrawal of care

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INTRODUCTION

Technological advances in medicine have made it increasingly possible for clinicians to prolong life; however, with this capability comes ongoing debates regarding what constitutes high quality end-of-life care and resuscitation. Uncertainty regarding treatment choices and trajectories at the end of life continues to be a source of considerable confusion and moral distress for clinicians, patients and families. In the acute care setting, we often ask families to make challenging decisions regarding their loved ones' preferences and choices for end-of-life care when these individuals can no longer make those decisions themselves. This already stressful situation can be exacerbated by medical jargon and conflicting messaging from various well-meaning health care practitioners. Some of this ambiguity likely stems from medical providers' lack of familiarity with end-of-life policies and their obligations as providers. Further, there can be discomfort for many families and clinicians about speaking about end of life, alongside varying cultural norms and expectations around death and dying.

In this analysis, we outline fundamental concepts and misconceptions surrounding cardiopulmonary resuscitation (CPR), the administration and withdrawal of life-sustaining therapies, and the framework provided by regulatory bodies for medical professionals to approach these situations. As legal and ethical principles may vary nationally between jurisdictions, our discussion will be based on Ontario policy and law. However, we believe that a similar approach would help hospitals and health care bodies provide clarity to clinicians, patients and families alike, and could be easily adapted into medical education materials.

WHAT IS A “FULL CODE” ORDER?

Colloquially, a “full code” refers to a series of interventions that a patient or substitute decision maker (SDM) has requested the medical team to undertake in the event of an acute, life-threatening event. This often includes significant procedures such as CPR, defibrillation, vasopressor support, and mechanical ventilation. However, there is no consensus definition on what “full code” really means. While clinicians often understand it to mean all available measures that have a reasonable chance of succeeding, there is no comprehensive list of procedures, in part because what may have a reasonable chance of succeeding in one patient won’t in another – or what one clinician may determine to be a reasonable chance may be considered futile by another clinician. In addition, there is often very little discussion about the results of full code: the type of life a patient can expect after cardiac arrest and what degree of “normality” they can expect. It might be more appropriate to consider using the term “resuscitative measures” when discussing therapies with patients and families, because depending on the situation, resuscitation of the cardio-pulmonary circuit may include vasopressor support and artificial ventilation in addition to chest compressions (1). This would allow the family or substitute decision makers to contextualize what efforts will be attempted.

In explaining what efforts are to be attempted, it will be valuable to elucidate both what and why a particular measure would not be attempted. Decision makers – either patients or SDMs – may believe that CPR will be attempted for an interminable amount of time, or that patients experiencing brain death will receive mechanical ventilation. Simply saying that a patient is “full code” implies *all* measures should be attempted, when it is possible that some (if not all) of these interventions are futile and possibly harmful, and decision makers will not understand why those measures are not then attempted. Especially in a situation where it is a matter of professional judgment, and where different professionals may make contrary judgments, it is important to outline what to expect. Even in the case of “standard” CPR, patients may suffer cracked ribs or experience other significant injury as part of the interventions (2). Referring to a specific procedure not only clarifies the intervention for the decision maker, it guides clinicians to explain the implications of the procedure and when it may not be attempted.

IS CPR ALWAYS MANDATED FOR PATIENTS WITH A “FULL CODE” ORDER?

Reasonable policies and organizations differ as to whether CPR is always required with a full code order. In Ontario, the College of Physicians and Surgeons of Ontario (CPSO) have end-of-life policies in place that include recommendations for CPR (3). The policy follows the ruling in the *Wawrzyniak v. Livingstone* case (4). An SDM had requested a “full code” order on the patient at issue, and specifically, that physicians attempt resuscitation; the physicians withheld CPR on the basis of futility, because the patient was elderly, suffering from several illnesses, and was near death. After the patient died, the SDM sued on the grounds of medical malpractice, failure to treat, and failure to obtain her consent for the treatment plan. The trial judge found that the physicians could reasonably withhold CPR as a treatment option because they had determined that the patient “almost certainly would not benefit” from CPR and it would increase suffering: potentially breaking bones, puncturing organs, and causing internal bleeding (4). The court found that the physicians were not guilty of acting below the standard of care, and that they had refused to provide treatment that would not be of “medical benefit.” Even though the SDM had previously requested a full code order, the physicians did not need her consent to refuse to provide CPR. However, the physicians were obligated to communicate this change in the treatment plan to the patient and/or SDM when practical. The physicians in the *Wawrzyniak* case had met this standard, and as such, were not negligent in their actions.

This case is important beyond its holding because it solidifies two ideas articulated above: that physicians have variable ideas about what is the appropriate standard of care under a “full code” order and that patients or SDMs may not understand what full code or medical futility entails. If healthcare professionals explain these principles – and that they may not perform certain procedures in a situation where these will not offer medical benefits – then decision makers can be better prepared for the eventuality that physicians may not use “all available measures” with respect to a given patient. This is not a question as to who has the legal right to control patient care. Where a patient is no longer able to participate in decision making, that role falls to the SDM, and they have the legal right to control care under the Health Care Consent Act (HCCA) (5). Instead, it is a question of what is within the scope of a clinician’s discretion and what is described to the SDM, whoever they may be.

The CPSO policy on planning and providing quality end-of-life care was updated in March 2023 (3), and is in-line with the court’s ruling. Broadly, the policy states that physicians can issue a no-CPR or “Do Not Resuscitate” (DNR) order and must inform the patient and/or SDM of the order. If there is a disagreement, the physician and decision maker should try to resolve this conflict. To mitigate conflict, the policy recommends physicians and decision makers identify bases of disagreement, reassuring the decision makers that clinically appropriate care will continue to be given, supporting physical and emotional comfort; further, physicians should facilitate obtaining second opinions and consultations with a hospital ethicist, as needed. If the patient experiences cardiac or respiratory arrest while conflict resolution is underway regarding the writing of a no-CPR order, physicians must provide all resuscitative efforts required by the standard of care. This does not mean that physicians must provide CPR. Instead, they must make an individualized patient assessment and provide appropriate care, which may or may not include CPR or other life support. In short, physicians are not obliged to perform CPR at the time of a cardiac arrest, regardless of the patient’s resuscitation order, if it is not considered medically beneficial.

MUST A PHYSICIAN PROVIDE LIFE SUPPORT IN THE PERCEIVED FACE OF FUTILITY?

A commonly encountered belief is that a patient with organ failure and a “full code” order must be admitted to an intensive care unit (ICU) and provided with ongoing life support. This is in fact not the case. Patients with little chance of survival need not receive all available measures. Part of this confusion, however, may arise from the nebulous concept of “medical futility” and its inherent subjectivity. As indicated by the case above in which the SDM introduced expert testimony that CPR would not be futile, healthcare professionals may vary widely in their opinions of certain procedures. This does not indicate that those opinions do not have a factual, medically-defensible basis. Instead, it means that even in situations with the same facts, professionals may have different beliefs or perspectives on what has, say, a 1% chance of succeeding versus a 5% chance of succeeding, and whether this is a meaningful difference in pursuing a course of action (especially if the procedure carries inherent risks). In 1990, Schneiderman and colleagues attempted to develop a definition for medical futility, which covered interventions and drug therapy imparting a <1% chance of survival (6). However, this in itself carries subjectivity: what does “survival” mean, and how does it differ from normality? Would a procedure that would leave a person in an indefinite vegetative state qualify as a non-futile procedure? Or a procedure that has a 1% chance of full recovery and a 99% chance of a vegetative state? These are the discussions to include with decision makers: What qualifies to the clinician and the decision maker as futile? What kind of life would the patient want? And where do they draw the line?

Under the Ontario Health Care Consent Act, physicians are not required to offer patients and their families every potential treatment option (5). Further support comes from *Wawrzyniak*, where the court stated that “the physician’s professional assessment of whether the treatment offers a medical benefit... [requires] a contextual assessment of the patient’s circumstances, including the patient’s condition and prognosis, the expected result of treatment for that patient, and any risks of treatment for that patient” (4,7).

This is consistent with standard methods of treatment. For instance, a surgeon can refuse to perform a surgery with an extremely high mortality rate, based on factors such as the surgeon’s skill level and the patient’s condition. Critical care clinicians have the same clinical discretion. The coronavirus pandemic resulted in thousands of patients, mainly older adults, developing severe respiratory failure across Canada in a compressed period of time. The majority of these patients were not offered extracorporeal life support, an intervention with high risk of morbidity and complications, especially in frail, elderly patients (8,9). This was appropriate clinical decision making, and in line with the standard of care. We should feel confident to apply our expertise to the provision of life-support similarly in intensive care units.

Physicians, however, need to be meticulous when trying to understand how the vulnerability of their patients affects their mortality. When discussing medical futility, physicians need to be cautious when understanding the systemic barriers their patient may have experienced in accessing health care and how that could have exacerbated their critical health diagnosis. To illustrate, black Americans are less likely to have such advance care planning conversations, more likely to receive invasive and harmful treatment at the end of life, including CPR and mechanical ventilation, and are less likely to have access to high quality palliative care in a hospice setting. Similar trends are seen with other ethnic minority groups and non-majority cultural groups in Canada and Australia (10). When physicians improve their communication about goals and preferences with patients and families, they can improve equity. Physicians can empower families by involving them in the entire process of care decision making, interacting with them frequently and giving them a voice in care planning. When marginalized people are included and empowered, physicians help narrow health disparities (10).

IS CONSENT REQUIRED FOR THE WITHDRAWAL OF LIFE-SUSTAINING THERAPIES?

In Ontario, the requirements for withdrawal of life-sustaining therapies are clear in both policy and law. These were laid out in *Cuthbertson v. Rasouli*, where the Supreme Court of Canada held that physicians must have consent to withdraw futile life-sustaining therapies, because it “entails physical interference with the patient’s body and is closely associated with the provision of palliative care” (11). The CPSO policy affirms the same principle (3). The Ontario Court of Appeal ruled in *McKitty v. Hayani* that once a patient is determined deceased, the HCCA no longer applies and physicians do not need consent to stop mechanical ventilation or vasopressor support (5).

We believe that explaining futility and normality as part of discussions surrounding a full code order will help smooth later conversations with families, decision makers or SDMs surrounding withdrawal. For one thing, the transparency about what procedures will be attempted will help SDMs understand that those measures have been attempted with respect to a particular patient, that physicians have attempted all they can. Second, it will build trust between families or SDMs and the physicians, who know that they have all reasonable options available to them. Thirdly, physicians will have a better understanding of the patient’s pre-expressed values and preferences and may shed light on what kind of life a patient would expect and accept if they require life supportive interventions.

CONCLUSION

Discrepancies between medical futility and patient or family wishes will always exist, which is why communication is essential. Physicians empathize with families who want more time with their loved one, regardless of the outcome. Saying goodbye is never an easy process and it is understandable that families struggle with this process. It is important that physicians communicate that continuing to keep someone alive could cause harm such as increased pain, loss of dignity and

discomfort (10). This issue is particularly poignant, highlighted by the challenges in communication that occurred during the COVID-19 pandemic. These challenges were multifactorial, and included a high-volume workload, reduced frontline healthcare personnel and restricted visitation policies. It is important to explain to families or SDMs that they should be making decisions based on their loved one's previously expressed capable wishes and not based on their personal current emotional state. During this fragile time, it is essential to build a safe and trusting rapport with families and offer emotional support from social work and or spiritual care providers. Advance care planning to elicit patient goals, preferences and values towards care at the end of life is the most effective way to prevent such situations from occurring in the first place. As educators of medical trainees of various disciplines we assert that more formal training on advanced directives and communication be incorporated into curriculum development to help mitigate conflict and enable the next generation of clinicians to engage meaningfully and compassionately with families.

Physicians have a duty to provide high-quality, compassionate, and family-centred care. It is the physician's role to communicate with patients and families so that goal-concordant care can be provided, or, if the care team cannot reach agreement with the family, that the treatment plan and alternative options can be explained. Sometimes families will request life-support when it is not safe or warranted to provide. Clinicians must navigate this complex terrain and hold two goals at the same time. The first is to make every effort to engage with families and SDMs to provide high quality care concordant with the patient's goals, values and wishes, but also uphold legal and ethical standards to not use therapies when they may cause harm to patients.

Reçu/Received: 9/7/2024

Conflits d'intérêts
Aucun à déclarer

Publié/Published: 2/12/2024

Conflicts of Interest
None to declare

Édition/Editors: Nico Nortjé & Aliya Affdal

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