OMA Ontario Medical Association

Ontario Medical Association Submission

CPSO Preliminary Policy Consultation – Planning for and Providing Quality End-of-Life Care

May 2021

The Ontario Medical Association (OMA) welcomes the opportunity to provide comments to the CPSO regarding its current policy, Planning for and Providing Quality End-of-Life Care. Below is the OMA's preliminary feedback on the existing policy. We look forward to providing additional feedback when the revised policy is available for consideration.

We have conducted a review of the draft policy and consulted with members. Members were asked to: (1) identify areas of the policy where additional clarification is needed, (2) identify ideas that were missing from the policy and (3) provide feedback regarding the application of potentially life-saving or life-sustaining measures and no-CPR orders (based on the CPSO's interest in this area). The feedback received is summarized below.

Areas Where Additional Clarity/Additional Information is Requested:

Definitions:
Participants noted that the policy mentions life-saving and life-sustaining treatments, but only CPR is specifically noted in the Definitions section. Other life-saving/sustaining treatments are also important and could be included in this section, or perhaps in an appendix or in the Advice to the Profession document. Measures to consider could include admission to an Intensive Care Unit, endotracheal intubation, mechanical ventilation, pharmacological hemodynamic support, initiation of renal replacement therapy, etc.

The OMA appreciates the CPSO's recognition that the medical standard of care is not always precise or clear in instances where it may be appropriate to withhold CPR or where no-CPR orders may be warranted. While physician judgment plays a role in these decisions, participants indicated that the medical standard of care needs to be clearly defined in relation to CPR, intubation, cardiac angiography, etc. Participants indicated that a clear statement by the CPSO describing circumstances for when measures like these can be withheld is important in a policy that regulates end-of-life care. Others suggested that a definition for "medically futile" should be included in the policy as a possible approach to this issue. The OMA recognizes that the CPSO is seeking information about the standard of care through its consultation process. This is a complex issue that likely requires more focussed, in-depth conversations with physicians than can be provided here.

Consent to Treatment
This section indicates that, "Physicians must obtain valid consent before a treatment is provided." Additional guidance regarding the documentation of consent is requested. As well, clarification regarding consent and documentation requirements in the event of a patient emergency is requested.

Managing Conflicts
Participants requested information concerning how to document a conflict with a patient or substitute decision maker, e.g., what information needs to be captured and where, and who should be notified (if anyone) regarding the dispute.

As well, information about how to manage unreasonable patient/substitute decision maker expectations would be helpful, for example, a script to assist with the communication with patients and their families/caregivers about how resuscitative efforts may differ from their expectations. Participants requested advice about what should be done when the physician believes the patient's/substitute decision maker's wishes would cause harm to the patient.

Suggestions were made to simplify the resolution process. For example, some participants indicated that consultation and agreement with another physician or nurse practitioner should be sufficient to support

the physician's decision-making. Consultation would need to be documented to verify agreement. Clarity in the policy is requested to confirm that should the conflict resolution process be unsuccessful, continuation of futile or inappropriate treatments, including CPR, are not required.

The policy states that physicians must, "take reasonable steps to transfer the care of the patient to another facility or health care provider as a last resort and only when all appropriate and available methods of resolving conflict have been exhausted." The phrase "as a last resort" may be considered redundant and can be removed.

This section of the policy states that, "Physicians are advised to apply to the Consent and Capacity Board when: a. conflicts arise between a physician and SDM over an interpretation of a wish or assessment of the applicability of a wish to a treatment decision, or b. a physician is of the view that the SDM is not acting in accordance with their legislative requirements." It would be helpful for the policy or Advice Document to provide examples of these types of conflicts as they seem to rise to a higher level of concern given the different route to dispute resolution.

Feedback Regarding Life-Saving or Life-Sustaining Measures

Through its consultation process, the CPSO expressed an interest in obtaining feedback about the application of potentially life-saving or life-sustaining measures and no-CPR orders. Responses from the survey of members are as follows:

- 87% of participants agreed that where there is disagreement between the medical standard of care and the patient's values with respect to providing life-saving or life- sustaining measures, it is important for physicians to try to accommodate those values.
- 27% agreed that physicians should write a no-CPR order even through there is disagreement with the patient or substitute decision maker.
- 40% agreed that physicians should be able to make a unilateral decision about a no-CPR order.
- 96% agreed that the physician should inform the patient or substitute decision maker about the no-CPR order and provide the reasons why.
- 83% agreed that the physicians should engage in conflict resolution if the patient or substitute decision maker does not agree.
- 74% agreed that if a patient experiences cardiac or respiratory arrest while conflict resolution is underway, the physician should provide resuscitative efforts required by the standard of care, including CPR.

Additional Comments

The OMA acknowledges the efforts the CPSO has made to reduce the length and complexity of its policies, and its efforts to clarify the required physician expectations (the must haves). The OMA received feedback that the current End-of-Life policy is still rather lengthy, and that it contains too much legal language that could be simplified into plain language. As well, there are areas of the policy where physicians are given advice, or strong advice, while in other areas, the expectation is clearly required. Where possible, it is recommended that advice be moved to the Advice to the Profession document.

The OMA appreciates the opportunity to provide feedback regarding the CPSO's policy, Planning for and Providing Quality End-of-Life Care. Please contact us if you have questions or require additional feedback while revising the policy.