PRIVATE AND CONFIDENTIAL

c/o Ms. Mercedes Perez
Swadron Associates
115 Berkeley Street
Toronto, ON M5A 2W8

THE
COLLEGE
OF
PHYSICIANS
AND
SURGEONS
OF
ONTARIO

In reply please quote: 95903

PRIVATE AND CONFIDENTIAL

June 10, 2015

Ms. Elizabeth J. Wawrzyniak
c/o Ms. Mercedes Perez
Swadron Associates
115 Berkeley Street
Toronto, ON M5A 2W8

Dear Ms. Wawrzyniak:

Re: Complaint Regarding Drs. Chapman and Livingstone

I am writing to advise you that the Inquiries, Complaints and Reports Committee (the "Committee") of the College of Physicians and Surgeons of Ontario has now considered your complaint. The Committee made its decision after a careful review of all relevant information gathered during the investigation. A copy of the Committee's decision is enclosed.

If you believe the Committee's investigation was inadequate or its decision was unreasonable, you can request that it be reviewed by the Health Professions Appeal and Review Board (HPARB). HPARB, a body created by the government of Ontario, is entirely independent and separate from the College. **Your request for a review must be made directly to HPARB, and not to the College.** It should be addressed as follows:

Attention: Ms. Sara van der Vliet, Registrar
The Health Professions Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 2T5
Tel: (416) 327-8512 or Fax: (416) 327-8524

Please note that your right to ask for a review expires 30 days after the date you receive this letter.

Should this matter be appealed by either party to the decision, HPARB will contact the College to confirm your address. We will advise them that you may be contacted at the address noted above, unless you notify us of a different address.

Yours truly,

Ciarán Buggle
Manager, Committee Support
Investigations and Resolutions

CB/ss
encl.

THE
COLLEGE
OF
PHYSICIANS
AND
SURGEONS
OF
ONTARIO

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE
(the "Committee")

DECISION AND REASONS

COMPLAINANT: Ms. Elizabeth G. Joy Wawrzyniak

PATIENT: Mr. Douglas DeGuerre

RESPONDENTS: Dr. Martin Giles Chapman (CPSO #71701)
Dr. Donald James Livingstone (CPSO# 32346)

CPSO FILE #: 95903

INTRODUCTION

Ms. Wawrzyniak's initial letter of complaint was received at the College on January 13, 2009. She expressed concern about the care her late father, Mr. DeGuerre, received from Dr. Chapman, an anaesthetist, and Dr. Livingstone, an internal medicine specialist, during an admission to Sunnybrook Health Sciences Centre (SHSC) in September 2008 due to progression of ischemia in his legs. Mr. DeGuerre underwent bilateral above knee amputations on September 17. His condition deteriorated post-operatively, and a "Do Not Resuscitate" (DNR) order was instituted on September 22. Sadly, Mr. DeGuerre passed away later that same day from complications of congestive heart failure and renal failure.

In January 2010, the Committee considered Ms. Wawrzyniak's complaint about Drs. Chapman and Livingstone (along with her complaints about two other physicians) and decided that the appropriate disposition was to take no further action. The Committee concluded that Drs. Chapman and Livingstone used good clinical judgment and acted in Mr. DeGuerre's best interest.

Ms. Wawrzyniak requested a review of the Committee's decision by the Health Professions Appeal and Review Board ("HPARB" or the "Board"). HPARB is an organization independent of the College, whose mandate includes reviewing decisions of health professions colleges upon request of either the person who complained or the health professional complained about. Unless HPARB has specifically directed a disposition (which is not the case in the present matter), the Committee is free to come to any determination it feels is reasonable, after reconsideration of the matter.

In a decision dated January 2012, HPARB decided that the Committee's investigation was adequate, but its decision relating to Drs. Chapman and Livingstone was unreasonable. Specifically, the Board noted that:

- The Committee did not address whether it was appropriate for Dr. Chapman to place a DNR order on the patient's chart and execute it in light of the fact that the substitute decision maker (SDM) did not consent to it.

- The question before the Committee was not whether the patient's death was inevitable and whether the resuscitative measure would have been beneficial. Rather, the question was whether it was within the standard of practice of the profession for such an order to be made without consent from the SDM.

- The Committee has an obligation to justify its decision more fully, and to consider and address the statutory framework in Ontario (*Health Care Consent Act* – the HCCA), the relevant sections of the College policy titled *Decision-making for the End of Life* (the College policy), and the pertinent SHSC policies.

HPARB directed the Committee to reconsider its assessment of the complaints respecting Dr. Chapman and Dr. Livingstone.

The Committee reconsidered Ms. Wawrzyniak's complaint about Drs. Chapman and Livingstone in September 2012, and confirmed the previous panel's decision that the appropriate disposition was to take no further action. The Committee stated that it was satisfied that Drs. Chapman and Livingstone at all times complied with the provisions of the relevant SHSC policy, and that they acted reasonably and appropriately in the circumstances of this case in placing the DNR order on Mr. DeGuerre's chart.

Ms. Wawrzyniak requested that HPARB review the Committee's September 2012 decision. In a decision dated August 28, 2014, HPARB stated that the Committee's investigation was adequate, but that its decision was unreasonable. Specifically, the Board noted that:

- In taking the view that the doctors acted in compliance with hospital policy, and arguably with College policy, the Committee gave scant consideration to the HCCA and the consent to treatment requirements it establishes. The HCCA extends specifically to cases involving the withholding of treatment.

- The complaint in this case was not simply that the doctors declined to provide treatment to the patient, but that a plan of treatment calling for "Full Code" was changed unilaterally by the doctors. The Board is of the opinion that the doctors were required to obtain consent from the SDM before replacing the "Full Code" order with the DNR order regardless of their view as to the futility of treatment, and in the absence of consent, were required to invoke the dispute resolution procedure under the HCCA.

- The Committee must consider whether this is a proper case for referral to the Discipline Committee or whether in the circumstances of the matter, some form of remediation is required.

- It is incumbent on the College to ensure that doctors understand their legal obligations under the HCCA, and that College policies conform to the requirements of the HCCA and ensure the primacy of the HCCA. College policy should be shared with hospitals in order that they can review and revise their policies as required.

HPARB directed the Committee to reconsider its second decision to take no action against Drs. Chapman and Livingstone, in terms of their implementation of a DNR order in the circumstances of this case; and recommended that the College review and revise its policies to ensure that they are in compliance with the requirements of the HCCA.

The Committee considered this matter at its meeting on May 21, 2015.

The Committee wishes to take this opportunity to express our deepest condolences to Ms. Wawrzyniak for the sad loss of her father, and to also express our sympathies for the extreme distress that she experienced as a result of the truly unfortunate events leading up to her father's death.

We recognize how important these concerns are to Ms. Wawrzyniak, and we acknowledge the significance of the issues that have been raised in this complaint. There are multiple challenges that arise in situations where physicians are providing care to patients who face life-threatening illnesses and end of life decisions. These are often emotionally charged situations, which have the potential to give rise to misunderstandings and conflict. It is fundamentally important for physicians to ensure that they approach these situations with respect and compassion, and that they engage in clear, effective communication with the patient and his/her family members, in an attempt to minimize tension and discord and to provide care that is in the best interest of the patient.

The Committee would point out that the College is currently in the process of reviewing and amending its policy on *Decision-making for the End of Life*, to provide the best guidance possible to physicians in these difficult situations. As part of this process, there has been wide consultation with members of the profession, various organizations (including the Ontario Hospital Association) and the public. Consultation on the revised/draft policy, *Planning for and Providing Quality End of Life Care*, closed on February 20, 2015 and the College is currently reviewing the feedback received. The draft policy is posted on the College's website.

ROLE OF THE COMMITTEE

The College's complaints process provides a route for members of the public to raise concerns about a doctor's practice or conduct. The *Regulated Health Professions Act* requires the Committee to consider every complaint submitted to the College. The Committee, with the assistance of staff, conducts an investigation, then meets to review the written record of investigation and to reach a decision.

The Committee cannot award financial compensation of any kind. Its process is not focussed on determining liability, or on punishing doctors. The Committee evaluates the investigative information available. It then determines what action, if any, is warranted, taking into account the seriousness and context of the concerns raised, the physician's insight into his or her practice, capacity for remediation, and relevant College history, if any.

The Committee's role, broadly, is to protect the public by determining whether remedial action is necessary and, if so, what action would best enhance the quality of medical care of the particular physician, and the general quality of medical care in Ontario, by reinforcing the standards of practice.

The range of dispositions available to the Committee includes taking no further action, providing advice, cautioning a physician in writing or in person, or requiring a physician to complete a specified continuing education or remediation program.

In a small number of very serious cases, the Committee may refer a specified allegation of professional misconduct or incompetence to the College's Discipline Committee. The Committee will do this where it believes that referral to the Discipline Committee is in the public interest, and that the available information has a reasonable chance of supporting a successful prosecution.

The Committee appreciates Ms. Wawrzyniak's bringing these concerns to the College's attention. Public engagement aids the College in protecting the public interest and improving the quality of physicians' care throughout the province. The Committee also acknowledges Drs. Chapman and Livingstone for demonstrating professional accountability by providing a response to the complaint.

INFORMATION BEFORE THE COMMITTEE

The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the

College's website at www.cpso.on.ca, under the heading "Policies & Publications." The Committee will provide a copy of any policy it refers to in this decision. In this case we enclose a copy of Policy Statement #1-06, *Decision-making for the End of Life.*

The Committee always has before it the physician's history with the College, if any.

The Committee carefully reviewed all the information gathered during the investigation, including the information that was before the Committee in September 2012, the Committee's decision of 2012, HPARB's decision of August 2014, the Supreme Court of Canada's decision in *Cuthbertson v. Rasouli,* [2013] 3 SCR 341, 2013 SCC 53 ("*Rasouli*"), and additional information submitted by Ms. Wawrzyniak (and her counsel) and Drs. Chapman and Livingstone (via their counsel).

Issue before the Committee

HPARB directed the Committee to consider its decision to take no action against Dr. Chapman and Dr. Livingstone in light of the requirements of the HCCA.

Information from Ms. Wawrzyniak

Ms. Wawrzyniak provided additional information to the College following release of HPARB's decision, including the following:

Regarding Dr. Livingstone

- Dr. Livingstone knew that her father was transferred to SHSC because he was seeking active care, including consideration of a limb amputation.

- Dr. Livingstone knew that she held a power of attorney (POA) for her father, and he was aware of the HCCA.

- She only spoke with Dr. Livingstone three times - on the telephone on September 10, 2008, and in person on September 10 and September 12. She left notes for him in her father's chart and on the "whiteboard" outside of his hospital room, but he made no attempt to contact her.

- Following her father's surgery, she discussed her father's treatment plan, including his resuscitation status, with two physicians, Dr. Bellini and Dr. Aoun (whom Dr. Livingstone supervised).

- Dr. Livingstone was on-call when her father was transferred from the ICU back to the medical floor on September 21. Dr. Livingstone made no attempt to contact her. She did have a lengthy discussion with Dr. Aoun, however, and he confirmed again that her father was "Full Code".

- Dr. Livingstone had a discussion with Dr. Chapman on September 22, 2008. Dr. Chapman showed Dr. Livingstone a copy of her father's nursing home directive (dated August 28, 2009), which stated that he did not wish to have CPR. Dr. Livingstone should have known that the nursing home directive was not relevant, as her father had been transferred to the hospital for treatment.

Regarding Dr. Chapman

- Dr. Chapman had no direct knowledge of any discussions that took place with Dr. Livingstone, Dr. Bellini or Dr. Aoun, and she never spoke with Dr. Chapman. He signed off on a DNR order without any attempt to contact her before signing the order.

- Both Dr. Bellini and Dr. Aoun wrote notes confirming that her father's resuscitation status was "Full Code". She had a lengthy discussion with Dr. Bellini on September 18, during which they fully discussed the rationale for "Full Code".

- Dr. Chapman was aware of the "Full Code" order, but he appeared to place his opinions above the opinions of his colleagues. He could have contacted Dr. Bellini if he had a concern about the "Full Code" status. However, he did not contact either Dr. Bellini or Dr. Aoun. It appears that Dr. Chapman placed himself in the role of the CCB (Consent and Capacity Board).

- Her father's nursing home Treatment Plan and his 2007 POA were not relevant. His circumstances had changed and she was following his latest capable expressed wishes.

- The existence of a POA does not override provisions in the HCCA. Just because her father completed a POA and had a nursing home advance directive did not mean he lost decision-making authority for treatment.

- It seems that Dr. Chapman believes that as a member of the Rapid Response Team, he is permitted to determine patient's best interests, and change an approved treatment plan by writing a DNR order without consent, ignoring healthcare legislation, and blocking patient transfers to the ICU.

- Dr. Chapman said that when he first met her father he "decided that it was essential to reinstate the DNAR order". However, there was no DNR order to reinstate. Her father's resuscitation status in the hospital had always been "Full Code" except for the limited instructions given to Dr. Livingstone that applied only in the operating room (OR).

- Dr. Chapman stated that he spoke with Dr. Taz Sinuff, (the attending in charge of the ICU at the time) and she agreed with his opinion, but there is nothing charted by Dr. Sinuff to indicate she did a consultation. Dr. Chapman did not document his telephone conversation with Dr. Sinuff.

- When Dr. Chapman entered the room, her father was breathing spontaneously on his own and did not require resuscitation, but he required breathing support. Dr. Chapman ordered the respiratory therapist (RT) to stop treatment. (She provided the College with a copy of the RT's statement to the College of Respiratory Therapists.)

- She identified herself and begged Dr. Chapman to help her father, but he refused. She tried to help her father, and tried phoning for help. Dr. Chapman just stood at the bottom of the bed and watched. It was only after her father was refused medical treatment that he went into respiratory arrest followed by cardiac arrest.

- Dr. Chapman's actions were deliberate - he wrote the DNR order and then refused her father care.

Regarding both physicians

- All College and hospital policies must conform to Ontario's consent and capacity legislation (the HCCA), which is clearly written. The onus is on the physician to know and understand the law. It is not unusual for a physician to work at more than one hospital or institution. A primary purpose of the HCCA is to provide rules with respect to consent to treatment that apply consistently in all settings.

- Her father's death on September 22, 2008 was preventable. She feels this matter should be forwarded to the Discipline Committee for a proper, fact-finding hearing.

Response from counsel for Dr. Chapman and Dr. Livingstone

Following HPARB's decision, and in response to the additional information provided by Ms. Wawrzyniak to the College, counsel for Drs. Chapman and Livingstone provided the following information:

- Dr. Chapman and Dr. Livingstone did not act unlawfully in writing a DNR order for Mr. DeGuerre. The case law suggests that a withholding of medically non-indicated therapy is not a "treatment" under the HCCA.

- The decision in *Rasouli* makes it clear that an SDM is not entitled to compel a physician to administer a treatment that the physician is not prepared to offer.

- In *Rasouli* the issue was whether physicians required consent to withdraw life support which was actively being provided and which would require physical interference with the patient's body to withdraw. In this case, the decision is to not offer treatment, which does not require consent because it does not involve any positive act, nor does it involve any physical interference with the patient's body.

- The definition of "treatment" in the HCCA contemplates some positive act. The DNR order in this case was not a positive act. Although the definition of "treatment" is broad, it is not so broad that a patient's SDM may compel a doctor to administer a particular treatment by refusing to consent to the withholding of that treatment.

- Even if HPARB is correct and the writing of the DNR order was a change to Mr. DeGuerre's plan of treatment, by September 22, 2008, Mr. DeGuerre's condition had changed such that his plan of treatment permitted the writing of the DNR order without further consent.

- In *Rasouli*, the SCC stated that a plan of treatment may change in response to changes in the patient's condition. Implicit in every plan of treatment is that treatment will only continue to be offered and/or provided so long as the patient's condition has not changed, rendering the treatment inappropriate. The requisite change occurred in Mr. DeGuerre's case.

- As the Committee found in its 2012 decision, "Mr. DeGuerre's situation on September 22, 2008 was very different from previously, and he may well have not wanted extreme measures given his condition and prognosis at that time." When Dr. Chapman assessed Mr. DeGuerre on September 22, his overall status was extremely poor, and Dr. Chapman was of the view that he was in the final phase of his life and further aggressive therapy such as CPR or readmission to the ICU would almost certainly have provided no lasting benefit to his health, only increased suffering.

- Dr. Chapman and Dr. Livingstone were not obliged to offer resuscitation to Mr. DeGuerre because they were not involved in his care when that treatment was proposed. A plan of treatment is only binding on those health practitioners who are involved in the patient's plan of treatment. Dr. Chapman and Dr. Livingstone were not involved in Mr. DeGuerre's plan of treatment (nor part of the closed ICU team caring for him) when the September 18, 2008 "Full Code" order was written, nor were they consulted before the order was written.

- Doctors are expected to exercise their own judgment and to determine what treatments they will and will not offer based on the condition of the patient at the time the doctor is involved.

- Even if the Board is correct that the withholding of resuscitative measures was a "treatment", the emergency provisions of the HCCA (section 25) authorized such a withholding. Mr. DeGuerre had signed an advance directive indicating that he did not want to receive resuscitative measures in the event of a terminal illness, and there was insufficient time to convene a hearing of the CCB. In the circumstances, the emergency provisions of the HCCA authorized the withholding of resuscitative measures from Mr. DeGuerre.

- Section 27 of the HCCA states that a doctor may administer treatment over the objections of the patient's SDM if there is an emergency and the SDM has not complied with the principles governing substitute decision-making.

- Dr. Wright prepared a report on behalf of Dr. Chapman and Dr. Livingstone, in which he opined that the DNR order was "entirely appropriate". Dr. Wright commented that Mr. DeGuerre was clearly in a dreadful situation, and was at the terminal stage of his multiple morbidities even 12 days before his death. He expressed the opinion that the DNR order was entirely appropriate, in light of Mr. DeGuerre's clearly stated wishes in his POA and the fact that he was at the terminal stage of a combination of multiple acute and chronic irremediable diseases and CPR was futile and would have caused even further distress and physical trauma to Mr. DeGuerre.

- The Division of General Internal Medicine and the hospital ethicist reviewed this case, and both reviews determined that the DNR order was clinically and ethically appropriate in the circumstances. The ICRC agreed, finding that Dr. Chapman used good clinical judgment and acted in Mr. DeGuerre's best interests in making the DNR order.

- If the writing of the DNR did not comply with the HCCA, this was because of a good-faith misunderstanding of the requirements of the HCCA, which were, at best, unclear in 2008.

- Dr. Chapman made good-faith efforts to communicate the DNR order to Ms. Wawrzyniak by leaving messages for her at her work and home.

- This is not an appropriate case for referral to the Discipline Committee.

Comments from Ms. Wawrzyniak

After having an opportunity to read the additional response from counsel for Drs. Chapman and Livingstone, Ms. Wawrzyniak wrote to the College stating in part:

- Ontario law provides that decisions concerning medical treatment for patients unable to make decisions for themselves be made by a SDM appointed pursuant to the HCCA. The CCB is responsible for resolving any disputes that arise between doctors and SDMs.

- Dr. Livingstone and Dr. Chapman admit to changing an approved treatment plan from "Full Code/CPR" to DNR without obtaining consent or informing her.

- She wishes to have her complaint forwarded to the Discipline Committee for a full and complete hearing to determine the facts of what took place on September 22, 2008.

- Her father had been transferred to the hospital for active care. He wanted to live and he wanted everything done. She was following his wishes.

- She had a lengthy in-person conversation with Dr. Aoun (who reported to Dr. Livingstone) on September 21, 2008. Dr. Aoun wrote orders and documented: "daughter wants full code". Approximately 12 hours later Dr. Chapman and Dr. Livingstone changed her father's approved treatment plan. Neither physician knew her father. Dr. Chapman then left her a misleading telephone message and did not provide her with his telephone number so that she could return his call.

- When she arrived at the hospital after dinnertime on September 22, she found her father alone without anyone paying attention to his needs. It was clear that he was "air hungry" and she called for an RT "stat". When the RT arrived, he began treating her father. When Dr. Chapman arrived, over her objections, he ordered the RT to withdraw and withhold the treatment he was providing. She took the ambu bag and tried to help her father breathe. Dr. Chapman refused to help. He just stood there while her father suffered respiratory arrest, cardiac arrest, and death.

- If Dr. Chapman had provided respiratory support, her father would not have needed resuscitating.

- HPARB confirmed that the withholding of resuscitative measures from her father was "treatment" for which consent was required.

Comments from counsel for Ms. Wawrzyniak

After reviewing the further response from counsel for Drs. Chapman and Livingstone Ms. Wawrzyniak's counsel also provided comments including the following:

- Drs. Chapman and Livingstone acted unlawfully in unilaterally placing a DNR order in Mr. DeGuerre's chart and ensuring that it was executed contrary to Ms. Wawrzyniak's clear instructions.

- Informed consent to the withdrawal of treatment has always been mandated by the HCCA. Physicians cannot act unilaterally in this respect. This applies in the context of both the withholding and withdrawal of end of life treatments. If physicians disagree with the decision of the SDM, the dispute must be resolved by the CCB.

- The SCC in *Rasouli* found that consent is required for the withdrawal of life support that a physician believes will be of no medical benefit to the patient.

- HPARB rejected the physicians' attempt to distinguish the withdrawal of treatment from the withholding of treatment. They stated that the HCCA is clear that withdrawing or withholding a treatment is also a treatment; and that even if consent is not required for the withholding of a procedure, once consent is sought for the procedure or withholding, the treatment team is bound by the consent or refusal of consent obtained, subject only to the right to challenge it by application to the CCB.

- The evidence in the record amply proves that the plan of treatment that had been proposed to Ms. Wawrzyniak, and to which she had consented, included CPR as part of a "Full Code" status. This plan of treatment was unilaterally withdrawn and changed to "do not attempt resuscitation in event of cardiac arrest" by Drs. Chapman and Livingstone without Ms. Wawrzyniak's consent on September 22, 2008.

- In keeping with Sunnybrook's "No CPR Policy", there is a default code status in the plan of treatment of every patient at Sunnybrook which includes CPR.

- Dr. Chapman's order for the RT to remove the resuscitation bag/mask from Mr. DeGuerre and to place him on a non-rebreather oxygen mask involved touching and interfering with Mr. DeGuerre's body. There was a withdrawal of treatment already initiated. Under the HCCA and the common law, physical interference requires consent.

- Dr. Chapman and Dr. Livingstone do not provide any authority, either statutory or case law, to support their argument that a plan of treatment is only binding on those health practitioners who are involved in the patient's plan of treatment.

- Mr. DeGuerre's plan of treatment at SHSC was provided by a multidisciplinary team. His daughter was entitled to assume that, having provided informed consent to a proposed plan of treatment that included "Full Code", her instructions would be documented in her father's chart, which would then be available to every member of the multidisciplinary team. If the plan of treatment was to be changed, the onus was on the physician who proposed to change the plan to obtain informed consent from Ms. Wawrzyniak.

- When Dr. Chapman and Dr. Livingstone entered the DNR order on the record, there was no medical emergency. Mr. DeGuerre's condition was described as stable. There is no clear evidence that either physician knew of the existence or contents of the November 2007 POA for personal care at the time that they wrote the DNR order on the chart.

- Even if they were aware of the POA, they were not in a position legally or otherwise to interpret the meaning and scope of the advanced care directive contained in the POA. Prior capable wishes are to be interpreted by the SDM. The fact that Ms. Wawrzyniak had on numerous occasions requested "Full Code" status for her father was sufficient to signal a conflict or uncertainty respecting any prior capable wish.

- Dr. Wright's opinion, offered by counsel for Drs. Chapman and Livingstone, is completely irrelevant. He does not canvas the law of consent, treatment and substitute decision making in Ontario. He cannot be qualified as an expert on law or the HCCA. He simply provides a subjective and at times personal perspective on end-of-life care.

- Dr. Chapman and Dr. Livingstone acted deliberately, willfully and unilaterally in this case, and contrary to the standard practice of their profession. They engaged in professional misconduct of a serious nature, causing Mr. DeGuerre's death on September 22, 2008, and great personal suffering and shock to his daughter. The ICRC should refer this matter to the Discipline Committee.

Additional Comments from counsel for Dr. Chapman and Dr. Livingstone

After reviewing the comments of Ms. Wawrzyniak and her counsel, counsel for Drs. Chapman and Livingstone provided the following additional information:

- Consent is not obtained before the standing "Full Code" order is put into effect. Under SHSC's policy, CPR is attempted in the event of an arrest on an emergency basis. The policy impliedly relies on the emergency provisions of the HCCA to justify the administration of CPR without consent.

- It is not always permissible to administer CPR under the emergency provisions of the HCCA because, as in this case, CPR would not have been effective and would only have exacerbated the patient's suffering.

- There was no interference with Mr. DeGuerre's body when the DNR order was written, and the order itself is therefore not a "treatment" as defined in the HCCA.

- Neither Dr. Chapman nor Dr. Livingstone interfered with Mr. DeGuerre at the time that Dr. Chapman instructed the RT. The administration of oxygen was already clearly part of Mr. DeGuerre's plan of treatment. Therefore Dr. Chapman's instruction to the RT was not a "treatment" for which further consent was required.

- Ms. Wawrzyniak is asserting that it was her right to demand that the RT continue his efforts (and engage in others) until she gave permission for those efforts to stop.

- Under the interpretation advanced by Ms. Wawrzyniak, both CPR and a DNR order are "treatment" such that consent is required. This places doctors in an impossible situation. The only solution is to recognize that it is CPR, and not a DNR order, that is treatment as defined in the HCCA.

- *Rasouli* contemplates that a plan of treatment may be capable of flexible alteration in response to a change in a patient's condition. There had been a change in Mr. DeGuerre's clinical status such that resuscitation was no longer an appropriate treatment for him.

- The "Full Code" order that Ms. Wawrzyniak relies on was written by a junior resident. No reasonable interpretation of the HCCA permits a junior resident to bind every doctor who is, or may become, involved in a patient's plan of care.

- The Committee has, on two prior occasions, found that Dr. Chapman and Dr. Livingstone acted appropriately. Dr. Wright's opinion is simply one further opinion in that regard, for the Committee's consideration. Ms. Wawrzyniak has not provided any opinion to the contrary.

Additional Comments from counsel for Ms. Wawrzyniak

After reviewing the further response from counsel for Drs. Chapman and Livingstone Ms. Wawrzyniak's counsel provided further comments including the following:

- SHSC's No CPR policy clearly states that "a specific instruction is necessary if CPR is not to be initiated". Consent to change a patient's code status from the default status is required. This is in keeping with the consent requirements set out in the HCCA. A patient's code status cannot be changed, even in an emergency, by a physician based on his or her own subjective or ethical preferences.

- The standing "Full Code" status must be part of every patient's "plan of treatment". It is equivalent to a physician's order in that it prescribes a "treatment" or "plan of treatment" that may be required in future if an emergency arises.

- The emergency provisions of the HCCA do not encourage or prescribe or otherwise delineate any specific type of treatment for emergency situations. Therefore, SHSC's No CPR policy does not impliedly rely on the HCCA emergency provisions because these provisions say nothing about a patient's code status.

- The emergency provisions of the HCCA do not support the characterization of SHSC's default "Full Code" status that the doctors are advancing. Section 25 of the HCCA provides that in an emergency, treatment must be administered in keeping with substitute consent unless the delay in obtaining the substitute consent will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.

- In this case, the doctors already had the substitute consent of Ms. Wawrzyniak: she had on numerous occasions consented to a "Full Code" status for her father in the event of a medical emergency

- The DNR order is a positive act: it is the written expression of a "plan of treatment". As such, consent is required for the order itself. Once the order is documented, it will mandate that the treatment team do or not do certain things that will directly affect the bodily security and personal autonomy of a patient. A DNR order requires consent because when it is implemented it will require interference with a patient's body.

- *Rasouli* squarely addressed whether a withdrawal of life support constitutes "treatment". The SCC found that the withdrawal of life support need not always involve physically touching the patient's body, and constitutes "treatment" which requires consent.

- Even if the physicians were not bound by the "Full Code" status documented by the junior resident, they were required to obtain Ms. Wawrzyniak's consent for their proposed plan of treatment.

- While it is true that the Committee has on two occasions concluded that the doctors acted appropriately, HPARB has on two occasions disagreed with the Committee's conclusions and has required the Committee to reconsider its decisions.

- Ms. Wawrzyniak has provided ample evidence and legal argument demonstrating that Drs. Chapman and Livingstone did not comply with the law of consent in Ontario. As she has established a prima face case that the doctors engaged in professional misconduct or acted incompetently, the case should be referred to the Discipline Committee.

- The procedural process of this Committee is severely circumscribed relative to that of the Discipline Committee, other administrative tribunals, and the courts. It can only screen complaints, and cannot make "actual" or "unequivocal" findings of professional misconduct or incompetence. It is not suited to determining questions of law; and it is clear that questions of law lie at the heart of Ms. Wawrzyniak's complaint.

- The mandate, process and jurisdiction of the Discipline Committee is much broader than that of this Committee and is better suited to making final decisions on the questions of fact and law in this case. If the Discipline Committee finds that a physician has committed an act of professional misconduct or that he or she is incompetent, it can take appropriate remedial action. These actions are sanctions and can be recorded in the public registry.

- Ontario Reg. 856/93, Professional Misconduct, specifically defines acts of professional misconduct for the purpose of the HCCA, and several are applicable to the conduct of Drs. Chapman and Livingstone (as detailed in the submission).

Additional Comments from counsel for Dr. Chapman and Dr. Livingstone

After reviewing the additional comments of Ms. Wawrzyniak's counsel, counsel for Drs. Chapman and Livingstone provided the following final comments:

- Under SHSC's policy, consent is not obtained before CPR is administered. The only legal justification for allowing CPR to be administered in such cases is the emergency provisions of the HCCA. The policy cannot create a plan of treatment because it is not incorporated into each patient's plan of treatment by a health practitioner and does not deal with each patient's current health condition.

- The definition of "plan of treatment" states that it is a plan that "is developed by one or more health practitioners", "deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition", and "provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition".

- The policy is a blanket policy rather than a plan that has been developed by a health practitioner involved in the patient's care, and it directs that CPR be performed regardless of the person's health condition.

- Ms. Wawrzyniak refused to consent to a DNR order by insisting that her father be made "Full Code". Accordingly, Section 27 of the HCCA applies.

- The passage from *Rasouli* that Ms. Wawrzyniak relies on does not apply to this case because it only applies to the withdrawal of medical services that are actively prolonging the patient's life. Implicit in Ms. Wawrzyniak's submission was the assumption that resuscitation would have prolonged her father's life.

- In *Rasouli,* the SCC held that the withdrawal of mechanical ventilation required consent, in part, because it was keeping the patient alive. Resuscitation would not have prolonged Mr. DeGuerre's life. It would have caused him great suffering without any reasonable prospect of prolonging his life. Accordingly, the DNR order was not a treatment as defined in the HCCA for which consent was required.

- Referral to the Discipline Committee is not an appropriate outcome in this case. Referral to Discipline is reserved for the most serious of cases.

- The Committee is obliged to consider whether it is appropriate to employ other remedial action in order to adequately protect the public's interest. In *Matheson v. College of Nurses of Ontario,* the Divisional Court said that "the power to refer should be used only sparingly, where it feels a serious case is involved..."

- In *Reyhanian v. Health Professions Appeal and Review Board,* the Divisional Court stated, "...the ICRC is entitled to take a critical look at the facts underlying the complaint and the evidence that does and does not support it, along with a myriad of other issues (such as the record of the respondent, special circumstances surrounding the incident, policy concerns, the capacity of the discipline committee, among others)."

- The Committee is required to consider whether any action is required, and if so, whether some action short of a referral to the Discipline Committee is warranted.

- This is not an appropriate case for a referral to the Discipline Committee, and they request that the Committee take no action with respect to the complaint.

ANALYSIS AND CONCLUSIONS

The Committee considered the following points in reaching its decision:

- Mr. DeGuerre was admitted to SHSC on September 10, 2008 with a very poor prognosis and chance for survival. Dr. Livingstone discussed this with Ms. Wawrzyniak pre-operatively, and she expressed the wish not to administer respiratory resuscitation but to provide other measures during the surgery.

- Post-operatively, Ms. Wawrzyniak visited the ICU and asked the resident to make her father's status "Full Code", and the resident noted this in the chart. On September 22, after discussing the situation with the hospital ethicist and other members of the team, Dr. Chapman made the decision to place a DNR order on Mr. DeGuerre's chart given the futility of the situation. Dr. Livingstone co-signed the order.

- Dr. Chapman then left a message with Ms. Wawrzyniak asking her to call him back, so that he could discuss the DNR order with her. His message did not give any details of what was to be discussed and did not indicate any urgency. He also attempted, unsuccessfully, to reach Ms. Wawrzyniak at work.

- Unfortunately, Mr. DeGuerre's condition deteriorated rapidly that day, and Ms. Wawrzyniak arrived at her father's bedside at a difficult point, having not yet had an opportunity to speak with Dr. Chapman about the situation. Dr. Chapman was present in the room. Despite Ms. Wawrzyniak asking for full CPR for her father, it was not administered.

- SHSC's ethicist and the Division of General Internal Medicine reviewed the decision to place the DNR order on Mr. DeGuerre's chart without Ms. Wawrzyniak's consent; both concurred with the decision. The original panel of the Committee reviewing this complaint agreed that the decision was appropriate, and they concluded that Drs. Chapman and Livingstone acted properly, with Mr. DeGuerre's best interests in mind.

- The original panel of the Committee reviewing this matter in January 2010 noted that Mr. DeGuerre had a prior advance directive in his POA signed November 2007 which stated that he gave authority to the treating physician to not administer resuscitative measures if the physician felt it would only prolong his dying. However, the panel of the Committee that reviewed the matter in September 2012 acknowledged that an advance directive is to be interpreted by an individual's SDM, and that it is not to be treated by the physician as consent or refusal to consent to treatment: as is clearly set out in the College's current policy regarding end of life decisions.

- In September 2012, the Committee noted that Ms. Wawrzyniak is of the view that her father's advance directive should not be given any weight in the circumstances, as his later expressed wishes were different from those set out in the advance directive. She advises that it is on this basis that she requested full resuscitative measures.

- This panel of the Committee concurs with the conclusions expressed by both previous panels, that Dr. Chapman demonstrated good clinical judgment in determining that extreme measures to preserve life would be futile and would only further exacerbate Mr. DeGuerre's suffering.

- It is clear from the medical record that Mr. DeGuerre's death was inevitable, and the Committee feels that it is important to clearly state that the actions of Dr. Chapman and Dr. Livingstone in making and enforcing the DNR order that day (whether inappropriate for other reasons) did not decrease Mr. DeGuerre's life span in any meaningful way. While Ms. Wawrzyniak takes the position that her father's death was preventable, this, sadly, was not true.

- The panel of the Committee that reconsidered this matter in September 2012 determined that Drs. Chapman and Livingstone acted in compliance with the relevant policies of SHSC in refusing to offer care that they deemed to be futile and in taking reasonable steps to try to communicate their decision in this regard in a timely manner to Ms. Wawrzyniak.

- This panel respectfully disagrees. In our view, Drs. Chapman and Livingstone failed to properly communicate with Ms. Wawrzyniak in this case when they made the decision that it was appropriate in the circumstances to change her father's status from "Full Code" to DNR.

- The College's policy on *Decision-making for the End of Life* states in part, "To help avoid conflict, physicians should communicate in a timely manner with the patient or substitute decision-maker…concerning treatment options, any assessment of those options made by the health care team, available supportive services…and palliative care resources."

- As was noted by the Committee in September 2012, the College's current policy does not clearly state whether a physician must obtain a patient or his/her SDM's consent (pursuant to the provisions of the HCCA) prior to making a DNR order, or whether the physician is required to provide CPR until a dispute/disagreement about a DNR order is resolved (which the panel noted would seem to be contrary to the principle that physicians are not obliged to provide treatments that will almost certainly not be of benefit to the patient).

- As noted above, the College is in the process of reviewing and making changes to its policy in this area, to provide clearer guidance to physicians. The Committee, of course, can only expect physicians to have complied with the policy that was in place at the time which, we note, was relatively new at the time of the events in this case (having been issued in 2007).

- While the Committee acknowledges that there is a lack of clarity in the current version of the College's policy in certain respects, the policy does clearly state that when a patient is not capable, a SDM makes treatment decisions for the patient; and that communication is of fundamental importance in end of life situations. Specifically, it states:

  PRINCIPLES

  The College believes that:

  …

  2. *Ongoing communication with the patient or substitute decision-maker, and family if there is consent, and with other care providers is crucial to good end-of-life decision-making and care.*

  3. *The patient or substitute decision-maker, and family if there is consent, should have the opportunity to participate in informed discussions about the care options that may optimize the quality of the patient's life while he or she is living with a life-threatening illness, and when dying. These individuals should participate in choosing the best available options, based on those informed discussion and the patient's goals, values and beliefs.*

  The Role of the Physician

  …

  Physicians should strive to ensure that there is communication with patients or substitute decision-makers, and families if there is consent, when treatment can no longer prevent death, and help them to reassess and revise priorities.

  PART 3: INTERVENTIONS AND CARE MANAGEMENT

  3.2 CPR and Other Potentially Life-Sustaining Treatments

  …

  Physicians should initiate timely discussions about treatment choices and likely outcomes with patients or substitute decision-makers…and in general, these persons should be involved in the assessment of benefit. Physicians should ensure that information about a

> *patient's and, where appropriate, family's preferences is elicited....Physicians should recognize that decisions concerning resuscitation and other life-sustaining treatments might change over time. These decisions should be reassessed whenever it is appropriate to do so; in particular, when the condition of the patient changes and when the patient or substitute decision-maker indicates that he or she has changed the decision about such treatment.*

- In terms of Dr. Chapman and Dr. Livingstone's actions in placing the DNR order on Mr. DeGuerre's chart, counsel for the parties have provided very detailed legal arguments on the state of the law, and the Committee has carefully reviewed all of these submissions.

- In our opinion, the state of the law in this area does not appear to be as clear as either side has put forward. Counsel have presented "black and white" positions on the issue in this case, when, in our view, it was a grey area in 2008 when the facts in this case took place, and remains a grey area at this time.

- While we now have the Supreme Court of Canada's decision in *Rasouli*, this decision does not specifically answer the question about the legality of the DNR order in the present case, as *Rasouli* dealt with a withdrawal of care rather than the placement/implementation of a DNR order.

- What is clear to the Committee, is that once Drs. Chapman and Livingstone decided that there should be a change in Mr. DeGuerre's status from "Full Code" to DNR (after reasonably exercising their medical judgment, and with the best of intentions), they did not take adequate steps to discuss the proposed change with Ms. Wawrzyniak.

- There was a "Full Code" status clearly documented in the record, ongoing communication between a very involved daughter (Ms. Wawrzyniak, the acknowledged SDM) and other health care professionals, and a documented discussion between a resident and Ms. Wawrzyniak the day before the DNR order was made. Dr. Chapman and Dr. Livingstone proceeded to place the DNR order on the record, when it was not an "emergency situation", without making reasonable or sufficient efforts to have a proper discussion with Ms. Wawrzyniak about the change, culminating in a terrible scene at her father's bedside.

- The Committee notes that Dr. Chapman and Dr. Livingstone's counsel takes the position that the physicians were not bound by the "Full Code" status recorded in Mr. DeGuerre's chart, as they were not involved in forming the plan that included this status; and that it would be an "absurd" result if the treatment decisions made/arrived at by one doctor would become binding on all subsequent doctors involved in a patient's care.

- If true, this would indicate to a patient's loved one that if they agree to a plan of treatment/care with a physician, they cannot rely on the plan if a new physician joins the team, and that they need to have a discussion every day with every health care provider to ensure that nobody is changing the agreed upon plan of treatment/care.

- In the Committee's view, there has to be a reasonable expectation on the part of the patient/SDM and his/her family that a physician will follow the plan of care documented in the chart, and that no meaningful or material change will be made to the plan developed through previous discussions, unless there is some conversation as to why it needs to be changed (except in emergency situations).

- Physicians must be aware that the HCCA is the legal framework in which discussions and decisions about a patient's care are taking place, and that there has to be clear communication between the patient's SDM and the health care team about the patient's care.

- The events in this case were truly unfortunate, and they could have been avoided if there had been proper communication. If Dr. Chapman and/or Dr. Livingstone had taken adequate steps to communicate and discuss the decision to change from "Full Code" to DNR with Ms. Wawrzyniak, it would have allowed the physicians or Ms. Wawrzyniak to avail themselves of the dispute resolution process options available, which may include obtaining legal advice or the involvement of a hospital board, or application to the CCB. There are mechanisms and options in place to be followed in the case of disagreement (as is noted in both the hospital and College policies), but because Drs. Chapman and Livingstone did not follow the proper process in the facts of this case (i.e. in discussing the matter with Ms. Wawrzyniak before changing her father's status), there was no opportunity to try to resolve any disagreement on this issue.

- In the Committee's view, not enough had been done prior to the moment of distress in this case, leading to a situation that should never have unfolded. What occurred was an unfortunate outcome of a flawed process.

- Drs. Chapman and Livingstone should not have changed Mr. DeGuerre's "Full Code" status without a conversation with Ms. Wawrzyniak, at a minimum. If this discussion could not take place before Mr. DeGuerre's condition deteriorated, by implication, he should have received "Full Code" treatment until such time as the physicians had the opportunity to have a full and meaningful conversation with Ms. Wawrzyniak.

- In the Committee's opinion, in all of the circumstances in this case, Dr. Chapman and Dr. Livingstone's conduct was not completely appropriate, and some action is necessary.

- However, the Committee is of the opinion that this is not a matter which warrants referral to the Discipline Committee. We have reached this conclusion for the following reasons:
    - The essential facts in this case are undisputed, and are very well documented in the extensive hospital chart (and in the extensive submissions of the parties). While this Committee is not generally able to make determinations of credibility, it is not required to do so to adequately consider and dispose of the issues in this case.
    - As is noted by Drs. Chapman and Livingstone's counsel, before referring a specified allegation to the Discipline Committee, this Committee is to consider whether it is appropriate to employ other remedial action in relation to concerns raised in order to adequately protect the public's interest
    - In *Reyhanian v. Health Professions Appeal and Review Board* [2013] O.J. No. 1292, the Divisional Court stated that the Committee is entitled to take a critical look at the evidence before it, to determine whether a referral to the Discipline Committee is warranted. The Committee is not required to refer a matter simply because it raises serious or important issues. In *Re Matheson and College of Nurses of Ontario* 27 O.R. (2D) 632, the Court of Appeal stated that the Committee's power to refer an individual to the Discipline Committee should be used sparingly.
    - We recognize that the issues being addressed in this case are very serious, and we are by no means trivializing them by concluding that a referral to the Discipline Committee is not warranted on the facts of this case.
    - While HPARB has indicated that the Committee should consider whether a referral to the Discipline Committee is warranted here, HPARB has not directed that such a referral be made. The Committee has fully considered (but rejected) referral.
    - In our view it would not be reasonable to apply a present day lens to decisions that Drs. Chapman and Livingstone made in good faith, in 2008, interpreting policy that was in place at that time.
    - Counsel for Drs. Chapman and Livingstone has indicated that if the physicians were non-compliant with the HCCA (and College policy) in writing the DNR order on Mr. DeGuerre's chart, this was because of a good-faith misunderstanding of the requirements of the HCCA, which were, at best, unclear in 2008.
    - HPARB acknowledged that a good-faith misunderstanding as to the nature of a legal duty is an important factor to consider in determining the appropriate action to take in this matter.
    - Drs. Chapman and Livingstone have no relevant history with the College.
    - In our view, while this case raises a very important issue with a compelling public interest, it is not appropriate to address this issue (as it arises in the particular fact situation of this case) through a discipline proceeding.

  - In our opinion, the important issues raised in this case are best addressed through a thorough review and update of the College's policy on end of life issues, to clarify expectations and to offer guidance and education to the profession as a whole.
  - As noted above, the College has consulted broadly with many organizations (including the Ontario Hospital Association) on the proposed new policy in this area, which, when finalized, will be communicated to the profession in an issue of the College's publication, Dialogue, and to the public via the College's website.

- In the Committee's view, a remedial response is most appropriate in the present case. It is clear that Drs. Chapman and Livingstone have reflected deeply about the issues raised; and that this complaint has focused their attention on the need to educate themselves and to consider how they might handle a similar situation differently in the future.

Based on all of the above, the Committee has determined that the appropriate disposition is to issue a written caution to Dr. Chapman and Dr. Livingstone on failing to ensure proper communication with the patient's SDM when a "Full Code" status was being changed to a DNR order, in the particular circumstances of this case (i.e. where there had been numerous discussions between the SDM and her father's health care providers, a "Full Code" status was clearly documented on the chart, a conversation had taken place the day before where the SDM confirmed her desire for "Full Code" and she understood that this status was continuing, there had been no satisfactory attempt to discuss the change from "Full Code" to DNR with the SDM, which resulted in her attending her father's bedside and witnessing his difficult final moments as they unfolded.)

A written caution arises when the Committee is concerned about an aspect of a physician's practice, and believes that the physician would benefit from some written direction as to future conduct.

On occasion, the Committee requires physicians to review the medical literature relevant to a particular issue, and to submit to the Committee a written summary of what they have learned. In the present case, the Committee requests Dr. Chapman and Dr. Livingstone to each carefully and fully review the HCCA and provide the Committee with a written report, approximately two-four pages in length, including statements about what they have learned, whether/how the relevant policies at SHSC have been reviewed in light of this case, and reflecting on how their own practices will change in the future. The Committee expects to receive Dr. Chapman and Dr. Livingstone's reports within three months of their receipt of this Decision and Reasons. They may submit their reports to the attention of "Committee Support" at the College, where a Medical Advisor will review them.

DISPOSITION

For the reasons set out above, the Committee cautions Dr. Chapman and Dr. Livingstone about their failure to ensure proper communication with the patient's SDM when a "Full Code" status was being changed to a DNR order, in the particular circumstances of this case; and requests that they submit written homework as set out above.

David Rouselle

PANEL MEMBERS: May 21, 2015

D. ROUSELLE, MD – Chair, ICR Committee
W. SPOTSWOOD, MD
P. ZULIANI, MD
L. THURLING, MD
R. PRATT – Public Member

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT #1-06

Decision-making for the End of Life

APPROVED BY COUNCIL:	September 2002
REVIEWED AND UPDATED:	February 2006
PUBLICATION DATE:	May/June/July 2006
TO BE REVIEWED BY:	February 2011
KEY WORDS:	Advance directive; CPR; DNR order; Life support; Palliative care; Power of attorney for personal care; Substitute decision-maker; Organ and tissue donation.
RELATED TOPICS:	Consent to Medical Treatment; Mandatory Reporting; Ending the Physician-Patient Relationship.
LEGISLATIVE REFERENCES:	*Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A; *Substitute Decisions Act, 1992*, S.O. 1992, c. 30; Ontario Regulation 865/93, as amended (made under the *Medicine Act, 1991*); *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H. 20; *Child and Family Services Act*, R.S.O. 1990 c. C.11, as amended; *Vital Statistics Act*, R.S.O. 1990 c. V.4; *Criminal Code*, R.S.C. 1985, c. C-46, as amended.
COLLEGE CONTACT:	Physician Advisory Service

Decision-making for the End of Life

PURPOSE

The purpose of this policy is to assist physicians in providing medically and ethically appropriate care to patients at the end of life; specifically, care that aims to reduce suffering, respects the wishes and needs of patients and their families, and lessens conflict and distress.

PRINCIPLES

The College believes that:

1. End-of-life care must strive to address the physical, psychological, social, and spiritual needs of patients, and where appropriate their families, with sensitivity to their personal, cultural and religious values, goals, beliefs and practices.
2. Ongoing communication with the patient or substitute decision-maker, and family if there is consent, and with other care providers is crucial to good end-of-life decision-making and care.
3. The patient or substitute decision-maker, and family if there is consent, should have the opportunity to participate in informed discussions about the care options that may optimize the quality of the patient's life while he or she is living with a life-threatening illness, and when dying. These individuals should participate in choosing the best available options, based on those informed discussions and the patient's goals, values and beliefs.

BACKGROUND: ETHICAL CARE FOR THE END OF LIFE

Definitions

For the purpose of reading this document, the following definitions of "family" and "substitute decision-maker" should be taken into consideration.

By law, when a patient is mentally capable, he or she must provide consent for the treatment decisions involved in his or her care. When the patient is not capable, a substitute decision-maker makes these decisions for the patient (see the College's Consent to Medical Treatment policy). Family members can be involved, with the consent of the patient or the substitute decision-maker, as the case may be. For practical purposes, this document uses the phrase "patient or substitute decision-maker, and family if there is consent" to represent the authority for, and participation in, making decisions.

The word "family" as it is used throughout this document refers to those closest to the patient in knowledge, care and affection. Family may include the biological family, the family of acquisition (related by marriage/contract), and the family of choice and friends. The patient determines who will be involved in his or her care and/or present at the bedside.[1]

Further definitions can be found in Appendix 1.

Quality Care at the End of Life

Many factors influence decision-making for people who face life-threatening illnesses, including type of disease, prognosis, intensity of treatment and potential adverse effects, family issues, social factors, goals, values and beliefs, and personal priorities. Patient choices can change as the disease progresses and as the end of life approaches.

Research and experience show that patient goals for quality end-of-life care generally include the following:

Medical care:

- Management of pain and other distressing symptoms;
- Avoidance of unnecessary prolongation of dying;
- Facilitation of clear decision-making and communication.

Personal issues:

- Treatment with respect and compassion;
- Preservation of dignity;
- Affirmation of the whole person;
- Opportunity to address personal concerns;
- Achievement of a sense of preparedness, control and meaning;
- Preparation for death;
- Achievement of closure.

Relationships:

- Strengthening of relationships with loved ones;
- Relief of unnecessary burdens on others;
- Contribution to others and continued participation and active involvement in social interactions, to the extent possible.

---

[1] Adapted from the definition used by the Canadian Hospice Palliative Care Association.

The Role of the Physician

It is important that physicians understand and personally acknowledge that death is an acceptable outcome of care in certain circumstances, and that in many situations treatment cannot prevent death.

Physicians should aim to provide their patients with care that fulfills the goals identified previously, is compassionate and respectful, and allows patients to experience as dignified a death as possible.

Dying patients may have last wishes relating to many issues other than treatment. Physicians should endeavour to honour the last wishes of patients wherever it is possible to do so, as respect for the autonomy of the patient must continue, to the extent clinically, physically, and legally possible, to the end of life.

Physicians should ask about and seek to incorporate patient, and where appropriate, family choices, values, beliefs and goals in decisions for the end of life. In so doing, physicians should strive to understand the impact of culture and religion on the patient's personal choices.

Physicians should advocate for meaningful and/or realistic goals of care. Where appropriate for the patient or substitute decision-maker, and family if there is consent, this will involve an early discussion of diagnoses and prognosis, and of the potential benefits, burdens, and risks associated with various therapies and with the refusal of therapy.

Physicians should facilitate access to interdisciplinary pain and symptom management, palliative and supportive care, where available, even while the major focus of care is on treating the patient's disease effectively. The care should aim to help patients and, where appropriate, families cope with physical, psychological, social and spiritual needs, and to relieve unnecessary suffering.

Physicians should strive to ensure that there is communication with patients or substitute decision-makers, and families if there is consent, when treatment can no longer prevent death, and help them to reassess and revise priorities. It may be the physician or other members of the health care team who do this.

COLLEGE POLICY

PART 1: CONSENT

1.1 Capacity and Informed Consent

The requirements of informed consent at the end of life are the same as the requirements in other situations (see the Consent to Medical Treatment policy).

When the patient is mentally capable, he or she makes treatment decisions and must provide consent for the many decisions involved in his or her care, including the participation of family members. When the patient is not capable, a substitute decision-maker makes these decisions for the patient.

Informed decision-making requires that the patient or substitute decision-maker be given the information and support necessary for assessing the available options for care. In the context of decision-making for the end of life, this includes information about the potential benefits, risks and consequences of the proposed courses of action, including palliative care.

PART 2: PLANNING

2.1 Advance Care Planning

Advance care planning has been defined as the "process of communication among patients, their health care providers, their families, and important others regarding the kind of care that will be considered appropriate when the patient cannot make decisions."[2]

As part of routine care in an ongoing physician-patient relationship, physicians are encouraged to discuss the importance of advance care planning with their patients, and to help their patients engage in such planning by providing necessary medical information and opportunity for discussion.

When patients become ill and as illness progresses, physicians should ensure that the patients' advance care instructions and wishes are reassessed with the patients or substitute decision-makers, and family if there is consent, on an ongoing basis. This may be done by the physician or by other members of the health care team.

---

[2] Teno et al. *Hastings Center Report*, 1994.

Decision-making for the End of Life

Advance Directives

Physicians should be aware that the *Health Care Consent Act* allows a capable person to create an advance directive. Through an advance directive, a person can indicate the kinds of treatment that he or she would accept or reject should he or she become incapable. Advance care wishes need not be written and can be changed at any time. These wishes are to be interpreted by the person's substitute decision-maker; they are not directions to a health care practitioner and do not constitute a consent or refusal of consent to treatment.[3]

One form of written advance directive is a Power of Attorney for Personal Care ("power of attorney"). A "power of attorney" is a document which, in order to be legally valid, must meet the requirements of the *Substitute Decisions Act (SDA)*.[4] The "power of attorney" must appoint an individual to make personal care decisions on behalf of the grantor in the event of his or her incapacity. The person appointed by the "power of attorney" is called the attorney for personal care. The "power of attorney" may or may not give the attorney special instructions about the particular kind of care that the grantor may want in specific circumstances. A physician who has any concerns about the validity of a "power of attorney" should obtain legal advice.

According to the *SDA*, health care providers may not be appointed attorneys for patients under their care, with some limited exceptions.[5]

No Advance Directives

If a person has not granted a power of attorney and becomes incapable, a substitute decision-maker will be designated in accordance with the hierarchy set out in the *Health Care Consent Act* (see the Consent to Medical Treatment policy).

Where the patient is under the age of 16, the *SDA* requires that his or her advance care instructions and wishes be considered; however, these are not binding on substitute decision-makers.

2.2 Testamentary Issues

When physicians are asked to comment on or have a concern about testamentary capacity they should make sure that they understand the legal standards for testamentary capacity and the conditions for making a valid will.[6] Physicians who have concerns in such circumstances should obtain legal advice.

"Influencing a patient to change his or her will or other testamentary instrument in favour of a member" is an act of professional misconduct.[7] Physicians must not pressure their patients to designate them as beneficiaries in the patient's will.

PART 3: INTERVENTIONS AND CARE MANAGEMENT

3.1 The Role of Palliative Care

Palliative care, also known as hospice care, aims to relieve the patient's suffering and improve the quality of living and dying. It may complement and enhance disease-modifying therapy or it may become the total focus of care.[8] Palliative care can be involved at any time during a progressive life-threatening illness.

The role of palliative care practitioners and programs is to assist physicians and other team members in helping the patient and family address physical, psychological, social, spiritual and practical issues, and the associated expectations, needs, hopes and fears. Physicians should be aware that there are palliative care resources that can be consulted throughout Ontario. They should make referrals to such resources wherever appropriate and available.

Palliative care should be provided to the patient regardless of any decisions that are made concerning resuscitation or other life support measures.

3.2 CPR and Other Potentially Life-Sustaining Treatments

Physicians are not obliged to provide treatments that

---

[3] Alzheimer Society of Ontario, Initiative #7: Advance Directives on Care Choices. Education Initiative: Advance Care Planning, January 2002.

[4] There is no specific Power of Attorney for Personal Care (POAPC) form; rather, the requirements for creating a POAPC are that it must be a document and it must comply with the legislation. The Public Guardian and Trustee does, however, publish a booklet on Powers of Attorney, which contains forms that can be used to create a POAPC. See: www.attorneygeneral.jus.gov.on.ca/html/PGT/poa.pdf.

[5] Section 46(3), *Substitute Decisions Act.*

[6] More information is contained in the CMPA Information Sheet, *Physicians and their Patients' Wills: Issues to Consider*, April 2002. The CMPA website is found at: www.cmpa.org.

[7] Ontario Regulation 856/93, as amended (made under the *Medicine Act, 1991*) s.1(1) paragraph 31.

[8] Ferris et al (ed.), *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice.* Canadian Hospice Palliative Care Association. Ottawa, 2002, p 17.

will almost certainly not be of benefit to the patient.

For some patients, decisions have to be made about life support treatments. As with other decisions for the end of life, decisions regarding CPR and other potentially life-sustaining treatments should be made according to the likelihood of benefit to the patient and should take into account his or her goals, values and beliefs. The following criteria should be used to guide decision-making:

Patient is likely to benefit:
There is a reasonable likelihood that CPR and other life support will restore and/or maintain organ function. The likelihood of the person's returning to his or her pre-arrest and life-support condition is at least moderate.

Benefit to patient is unlikely or uncertain:
It is unlikely that or uncertain whether CPR and other life support will restore organ function. The subsequent prognosis is poor or uncertain and the likelihood of adverse consequences is high.

Patient almost certainly will not benefit:
There is almost certainly no chance that the person will benefit from CPR and other life support, either because the underlying illness or disease makes recovery or improvement virtually unprecedented, or because the person will be unable to experience any permanent benefit.

Physicians should initiate timely discussions about treatment choices and likely outcomes with patients or substitute decision-makers, and families if there is consent, and in general, these persons should be involved in the assessment of benefit. Physicians should ensure that information about a patient's and, where appropriate, family's preferences, is elicited. This may be done by the physician or other members of the health care team.

Patients have the right to receive life-sustaining treatments that may be of benefit to them and that take into account their goals, values and beliefs. When it is not clear whether treatment might be of benefit, the choice should be made on the side of providing life-sustaining treatment. When the potential use of life-sustaining therapies is being discussed with patients or substitute decision-makers, and families if there is consent, the discussions should include the option of a trial of therapy and the circumstances under which such therapy might be withdrawn. The initiation of life-sustaining therapies does not necessarily imply that their ongoing provision will be of benefit to the patient.

Where a physician makes a judgment about whether a treatment may be of benefit, including the initiation of life support, he or she should discuss the implications with the patient or substitute decision-maker, and family if there is consent. As with other decisions, patients who are capable with respect to decision-making have the right to refuse or withdraw consent to any treatment, including life-sustaining treatment. When the patient is not capable, the patient's substitute decision-maker can make these decisions.

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. Any recommendation not to initiate life support, or to withdraw life support, should be discussed with the patient or substitute decision-maker, and family if there is consent. If the patient or substitute decision-maker, or family if there is consent, specifically requests the physician to provide or continue the treatment notwithstanding the recommendations of the health care team, the physician should turn to the conflict resolution measures discussed in Part 4.1 of this policy in an effort to achieve consensus.

A decision not to initiate CPR or other life-sustaining treatments does not necessarily mean that any other treatment or intervention should be withheld or withdrawn. Palliative care should continue to be provided.

Physicians should recognize that decisions concerning resuscitation and other life-sustaining treatments might change over time. These decisions should be reassessed whenever it is appropriate to do so; in particular, when the condition of the patient changes and when the patient or substitute decision-maker indicates that he or she has changed the decision about such treatment.

Physicians should ensure that other members of the care team are informed about treatment decisions relating to resuscitation and life support and that the discussions are carefully documented in the patient's health record.

3.3 Expected Death at Home

At the end of life, patients often express a preference for staying at home as long as possible and for dying at home. When physicians make a commitment to care for a patient at home at the end of life, they should ensure that the following questions are addressed:

- Is home care a manageable option? The assessment of the viability of this option should be based on the patient's wishes, the family's ability to cope, safety considerations, the availability of sufficient home care resources to meet the needs, and the availability of a health care team to provide support in the home.
- Can regular care be provided at home? If this is not possible, can the patient be referred to home palliative care physicians or to regional programs where such resources exist?
- Is it possible to ensure round-the-clock on-call coverage that will provide care in the home? Members of the health care team other than the physician may provide some of this coverage.
- Will it be possible for the patient to be admitted to an appropriate institution if the patient and his or her family can no longer cope with the situation at home?
- Is the physician prepared to undertake to certify death in the home and to arrange for another qualified person to do so when he or she is unavailable? When death of the patient at home is the expected outcome, the persons responsible for signing the medical certificate of death are to be designated in advance. It is not acceptable to rely on the coroner to certify the death.[9]

Caregivers of patients dying at home often call emergency services because they are confused about the dying process or ambivalent about foregoing life-sustaining treatment. Caregivers of dying patients need to know what to do when the patient is facing imminent death or has just died. Physicians, perhaps along with other members of the care team, should educate and prepare them for what to expect, and in particular, explain that emergency services, once called, are likely to use resuscitative measures and transfer the patient to hospital, regardless of the patient's wishes.

3.4 Euthanasia and Assisted Suicide

Euthanasia is a deliberate act undertaken by a person with the intention of ending the life of another person to relieve that person's suffering where that act is the cause of death.[10] Euthanasia is prohibited under the *Canadian Criminal Code.*

Assisted suicide is the act of intentionally killing oneself with the assistance of another who provides the knowledge, means, or both.[11] Under the *Criminal Code*, counselling, aiding or abetting suicide is an offence, and the consent of the deceased to his or her own death does not prevent criminal liability from attaching to the person who assisted in bringing about the death.

None of this is to suggest that physicians should refrain from the aggressive management of a patient's pain and symptoms, as appropriate.

PART 4: CONFLICT MANAGEMENT

4.1 Conflict Resolution

Where it becomes evident in the course of making decisions for the end of life that there is disagreement over appropriate treatment between patients or substitute decision-makers, or families if there is consent, and health care providers, physicians should ensure that appropriate conflict resolution processes are followed.

Physicians should work to bring about consensus concerning the treatment plan among the members of the health care team. Any conflicts among team members should be addressed in the absence of the patient or substitute decision-maker and the family.

To help avoid conflict, physicians should communicate in a timely manner with the patient or substitute decision-maker, and family if there is consent, concerning treatment options, any assessment of those options made by the health care team, available supportive services (e.g., social work, pastoral care) and palliative care resources. Physicians should carefully document the discussions in the patient's health record.

In the case of conflict resulting from any misinformation or misunderstanding regarding the disputed treatment, physicians should attempt to ensure that any misinformation is corrected and that any questions are answered.

If the conflict continues, where appropriate, physicians should offer the patient or substitute decision-maker, and family if there is consent, a referral to another professional with expertise in the relevant area, and should be prepared to facilitate the obtaining of a second opinion.

---

[9] Physicians can sign medical certificates of death unless there is reason to notify the coroner of the death (see the *Vital Statistics Act*, the *Coroners Act* and the CPSO's Mandatory Reporting policy). Registered nurses in the extended class are now also able to sign medical certificates of death in certain situations. Registered nurses are authorized to pronounce death, and the physician may sign the death certificate subsequently. Physicians should be aware, however, that many funeral homes will not accept a body unless a death certificate accompanies it.

Physicians should also offer the patient or substitute decision-maker, and family if there is consent, access to any mediation, arbitration or adjudication processes available within the facility. This will often include consultation with an ethicist or ethics committee.

If the patient or substitute decision-maker, or family if there is consent, insists on a course of treatment that the physician feels will not be of benefit to the patient, the physician may offer to transfer care of the patient to another facility or care provider who is willing to provide that treatment. This option should be considered only after alternative methods of conflict resolution have been exhausted. In following such a course, the physician must comply with the College's policy on Ending the Physician-Patient Relationship.

The *Health Care Consent Act* provides a structure for managing conflicts about treatment decisions for incapable patients that cannot be resolved in other ways. Physicians should be aware of the relevant legislative processes.

Conflicts between health care providers and authorized substitute decision-makers arising from questions of whether the substitute decision-maker has followed the principles set out in the *Health Care Consent Act* can be addressed to the Office of the Public Guardian and Trustee (see Consent to Medical Treatment policy).

When the patient is a child who requires medical treatment, and the child's parent or the person who has charge of the child does not provide or refuses the treatment or is unavailable or unable to consent to the treatment, the physician must personally make a report to the local Children's Aid Society (see Section 1 of the College's Mandatory Reporting policy).

Conflicts about the treatment instructions contained in a Power of Attorney for Personal Care, questions of clarification about the meaning or application of such instructions, and the existence of conflicting Power of Attorneys can be addressed to the Consent and Capacity Board or the courts.

If more than one person is authorized under the *Health Care Consent Act* to consent to treatment on behalf of an incapable patient and no other individual ranks ahead of them, and they disagree about whether to give or refuse consent, the Public Guardian and Trustee must make the decision in their stead. If a dispute arises between joint guardians or joint attorneys under a Power of Attorney in the performance of their duties, the Public Guardian and Trustee may mediate the dispute if the parties are prepared to pay the mediation fees set by the Public Guardian and Trustee, and enter into a mediation agreement as part of the process.

Physicians who have concerns about their obligations should seek legal advice.

PART 5: ORGAN AND TISSUE DONATION

5.1 Organ and Tissue Donation

The *Trillium Gift of Life Network Act* sets out requirements relating to organ and tissue transplantation measures for health facilities designated by the Minister.

Facilities prescribed in regulation under the Act must notify the Trillium Gift of Life Network of a patient's death or imminent death where a physician is of the opinion that the patient's death is imminent by reason of injury or disease.

Designated facilities must establish policies and procedures for identifying and approaching potential donors and their families to provide information, and to seek consent.

Physicians working in designated health facilities should cooperate with and contribute to any policies and procedures established in accordance with the legislation.

Physicians who do not work in designated health facilities are encouraged to provide their patients with the opportunity to make choices with respect to organ donation, ideally in the context of an ongoing relationship with the patient and before any medical crisis arises.

PART 6: DOCUMENTATION

Physicians should ensure that all interactions and discussions with patients or substitute decision-makers, and families if there is consent, as well as treatment plans and decisions, are documented in patient health records and that the records are available to the persons involved in providing medical care.

---

[10] Special Senate Committee on Euthanasia and Assisted Suicide, 1995.

[11] Special Senate Committee on Euthanasia and Assisted Suicide, 1995.

APPENDIX: Definitions

Advance care planning:

the process of communication among patients, their health care providers, their families, and important others regarding the kind of care that will be considered appropriate when the patient cannot make decisions.

Advance directive:

a form of advance care planning; a communication prepared by a mentally capable person setting out the kinds of treatment that would be accepted or rejected by that person in the event he or she becomes incapable at some time in the future. The advance directive may also designate a substitute decision-maker. An advance directive does not have to be in written form.

Assisted suicide:

the act of intentionally killing oneself with the assistance of another who provides the knowledge, means, or both.

Cardiac arrest:

the cessation of the effective pumping of the heart.

Cardiopulmonary resuscitation (CPR):

measures such as chest compression, cardiac defibrillation (applying shocks to the chest over the heart), endotracheal intubation (insertion of a breathing tube down the throat), and inotrope/vasopressor administration (emergency drugs to stimulate the heart and clamp down on blood vessels). Other modalities of life support may also be attempted.

Euthanasia:

a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person's suffering where that act is the cause of death.

Family:

those closest to the patient in knowledge, care and affection. Family may include the biological family, the family of acquisition (related by marriage/contract), and the family of choice and friends. The patient defines who will be involved in his/her care and/or present at the bedside.

Informed consent:

consent given after the patient has received information about the nature of the proposed treatment, its expected benefits, the material risks (i.e, both common and serious risks), special risks or material side effects associated with it, alternative courses of action and likely consequences of not having the treatment.

The information provided to the patient about such matters must be the information a reasonable person in the same circumstances would require in order to make a decision about the treatment. As well, the person must have received responses to his or her requests for additional information about those matters.

Life support:

refers to, but is not limited to, any of: positive airway pressure (forcing air through a facial mask manually or via a machine), endotracheal intubation, mechanical ventilation (having a machine breathe for the patient by pumping in air), temporary cardiac pacing, inotrope/vasopressor therapy, or renal replacement therapy (dialysis).

Palliative care (also hospice care, hospice palliative care):

the combination of active and compassionate therapies intended to comfort and support individuals and families who are living with a life-threatening illness. During periods of illness and bereavement, palliative care strives to meet physical, psychological, social and spiritual expectations and needs, while remaining sensitive to personal, cultural and religious values, beliefs and practices. Palliative care may be combined with therapies aimed at reducing or curing the illness, or it may be the total focus of care.

Power of Attorney for Personal Care:

a legal document in which one person gives another person the authority to make personal care decisions on his or her behalf in the event he or she becomes mentally incapable.