Planning for and Providing Quality End-of-Life Care: Frequently Asked Questions

1. Are there any resources I can use in my practice or that my patients can use to help with advance care planning?

Yes. There are a number of organizations that have information on advance care planning or materials to help physicians and patients with this process.

For example, the Speak Up Campaign’s website (www.advancecareplanning.ca) has information intended for both physicians and patients and includes a workbook tailored to Ontario patients (http://www.makingmywishesknown.ca/get-started/).

Additionally, the Ontario Seniors’ Secretariat has developed a Guide to Advance Care Planning to provide valuable information on making choices about personal care, including health care treatment and services. The Guide has also been made available in French and Chinese. For more information visit: www.seniors.gov.on.ca/en/advancedcare/index.php.

2. The policy says that palliative care does not have to be provided by specialists in palliative care. Who else can provide palliative care?

Palliative care focuses on relieving pain and other symptoms, as well as addressing psychological, social, and spiritual distress and can be provided at any stage of a patient’s life-threatening illness or life-limiting chronic condition.

Many physicians (including most family physicians) may have the knowledge, skill and judgment necessary to provide basic palliative care with the aim to alleviate pain and to keep the patient comfortable. In complex situations or when the palliative care required is beyond the clinical competence of the treating physician, it will be necessary to seek the support or involvement of specialists in palliative care and/or hospice care.

3. Does the law require that I obtain consent prior to writing a no-cardiopulmonary resuscitation (no-CPR) order? (sometimes referred to as do not resuscitate (DNR) or do not attempt resuscitation (DNAR) orders)

The legal requirements regarding consent to a no-CPR order are currently unclear. The College is aware of decisions of the Consent and Capacity Board, the Health Professions Appeal and Review Board, and of various Ontario courts which relate to this question, but is of the view that it is not currently clear whether there is a legal requirement for a physician to obtain consent prior to writing a no-CPR order.

Given this legal uncertainty, the College has set out professional expectations of physicians in relation to no-CPR orders. The College requires physicians to discuss a no-CPR order with the patient and/or substitute decision-maker at the earliest and most appropriate opportunity, to explain why CPR is not being proposed, and to engage in conflict resolution practices if the patient or substitute decision-maker disagrees with the no-CPR order and insists that CPR be provided.

4. If a patient or substitute decision-maker disagrees and insists that CPR be provided, can I write a no-CPR order while conflict resolution is underway?

No. As stated in the College’s policy, while conflict resolution is underway physicians are not permitted to write a no-CPR order. If an event requiring CPR occurs while conflict resolution is underway, physicians must provide CPR unless the patient’s condition would prevent the intended physiologic goals of CPR from being achieved. In these cases, physicians may make a decision about whether or not to provide CPR while attending to the patient. In those instances where physicians must provide CPR, they must do so in good faith and use their professional judgment to determine how long to continue providing CPR.

5. What are the intended physiologic goals of CPR and when would a patient’s condition prevent these goals from being achieved?

The intended physiologic goals of CPR are to provide oxygenated blood flow to the heart and brain. In some cases, the patient may have a condition which would prevent these intended physiologic goals from being achieved. This could include raised intracranial pressure so that blood cannot enter the brain, refractory hypoxemic respiratory failure where it is impossible to oxygenate the blood, or uncorrectable exsanguination where circulation to the brain cannot be attained by chest compressions.
6. If I determine that the patient’s condition would prevent the intended physiologic goals of CPR from being achieved but the patient or substitute decision-maker disagrees with my recommendation to write a no-CPR order, what are my obligations?

As stated in the policy, if the patient or substitute decision-maker disagrees with the recommendation that a no-CPR order be written and insists that CPR be provided even when the patient’s condition will prevent the intended physiologic goals of CPR from being achieved, physicians may not write the no-CPR order and must engage the patient or substitute decision-maker in conflict resolution. Physicians may wish to note in the patient’s record their opinion that the patient’s condition would prevent the intended physiologic goals of CPR from being achieved and that conflict resolution regarding the recommendation that a no-CPR order be written is underway. While conflict resolution is underway, if the patient arrests, physicians may make a decision about whether or not to provide CPR while attending to the patient.

7. Does the policy require that I provide CPR in all instances? For example, am I obligated to provide CPR during an emergency if the patient’s wishes are not known and there is no substitute decision-maker to ask?

The policy only requires that CPR be provided in a very narrow set of circumstances: when there has been a recommendation that a no-CPR order be written, the patient’s condition will not prevent the intended physiologic goals of CPR from being achieved, the patient or substitute decision-maker has voiced their disagreement with the recommendation to write a no-CPR order, and an event requiring CPR happens before the disagreement has been resolved.

The policy focuses on and sets out expectations for those instances where a physician is of the opinion that a no-CPR order should be written, and so focuses on those instances where there is an opportunity for the patient and/or substitute decision-maker to participate in a discussion about whether or not to write a no-CPR order.

This is different from, for example, an emergency situation where a patient experiencing a cardiac or respiratory arrest presents to a physician and the physician is not aware of the patient’s wishes and there is no substitute decision-maker to ask. As in all emergency situations, in this case if there is no reason to assume the patient does not want the treatment and the physician has made a reasonable effort to confirm that there is no substitute decision-maker available to discuss the treatment decision with, then the physician may rely on his or her judgment in determining what care to provide.

8. If a patient or substitute decision-maker disagrees with my recommendation to withdraw life-sustaining treatment or to write a no-CPR order, what can I do to help resolve the conflict?

The policy outlines a number of steps physicians must take in order to resolve conflict, including, identifying and correcting any misinformation or misunderstandings, offering a second opinion, and seeking the support of an ethicist or ethics committee, as appropriate and available.

Physicians may also apply to the Consent and Capacity Board (CCB) for a review of the case and a determination of whether or not the substitute decision-maker is making a decision in accordance with the patient’s prior capable wishes or best interests. The CCB is an expert tribunal, comprised of lawyers, psychiatrists, and members of the public and is supported by a full-time legal counsel. The CCB has the ability to convene hearings quickly and has the authority to direct substitute decision-makers to make decisions in accordance with the patient’s prior capable wishes or best interests.

The Supreme Court of Canada has identified the CCB as the appropriate authority to adjudicate disagreements between physicians and substitute decision-makers regarding the withdrawal of life-sustaining treatments and the CCB has heard and decided on cases regarding no-CPR orders.

9. How do I apply to have the CCB review my case?

The CCB’s website (www.ccbboard.on.ca) has information regarding their services and links to the forms required to have a case reviewed.

For a determination of whether or not the substitute decision-maker is making a decision in accordance to the patient’s prior capable wishes or best interests, physicians will need to complete and submit a “Form G”.

Physicians may wish to contact the CCB directly for more assistance or seek assistance from legal counsel, either from the institution within which they work or from the Canadian Medical Protective Association.

10. Am I required to certify the death of a patient when it would be difficult for me to do so (e.g. distance, length of time away from practice, outside of normal practice hours, etc.)?

By law, the medical certificate of death must be completed by a physician who has been in attendance during the last illness of a deceased person, or who has sufficient knowledge of the last illness. In limited circumstances, nurse practitioners are also able to complete and sign a medical certificate of death.

When death is expected, the policy recommends planning
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in advance who will be available to attend to the deceased in order to complete and sign the medical certificate of death. The policy also advises physicians to take into consideration any local or community strategies that are in place to facilitate the certification of death.

Where possible, planning in advance may help to overcome any practical challenges associated with completing and signing the medical certificate of death.

11. The Supreme Court of Canada’s decision about medical assistance in dying, Carter v. Canada, and the federal government’s response have both been well-publicized. What implications does this decision and the government’s response have for this policy?

Professional expectations regarding medical assistance in dying have not been articulated in this policy. Those looking for more information about medical assistance in dying or the Supreme Court of Canada’s decision in Carter v. Canada should consult the College’s Medical Assistance in Dying policy.

12. Are there any resources to help patients make decisions regarding organ and tissue donation? Where can patients register their consent for organ and tissue donation?

Physicians and patients can visit the Trillium Gift of Life Network’s website (http://www.giftoflife.on.ca/) for more information on organ and tissue donation in Ontario. The website also includes a link where patients can register to become a donor.

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