COMMENTARY

Do physicians require consent to withhold CPR that they determine to be nonbeneficial?

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In the past few years, Ontario has made international news because of a series of landmark legal cases involving end-of-life conflicts. On Aug. 20, 2019, the Ontario Superior Court of Justice dismissed a key medical malpractice case brought by Joy Wawrzyniak against 2 physicians who wrote a do-not-resuscitate (DNR) order in her father's medical record without consent and refused to start cardiopulmonary resuscitation (CPR) when she requested it.[1] The plaintiff's father, an 88-year-old man with multiple comorbidities, had multiorgan system failure after a bilateral above-knee amputation for gangrene. Although his daughter — as his substitute decision-maker — had requested full resuscitation, the physicians believed the patient would "almost certainly not benefit" from CPR and withheld it despite her objection. In a lengthy decision (*Wawrzyniak* v. *Livingstone*), Justice Cavanagh found that the physicians did not need consent for "the medical decision not to offer CPR as a treatment option … and writing and acting on the DNR order." Although the ruling rested in part on Ontario's *Health Care Consent Act* (HCCA), the policy of the College of Physicians and Surgeons of Ontario and hospital policies, it has implications for practice across Canada.[2] Furthermore, it emphasizes the importance of policy as part of the court's determination of the standard of care. The *Wawrzyniak* case also addressed the common law, which is not binding outside Ontario, but may be persuasive, especially in jurisdictions where the case law on consent is unclear.

One aspect of the case interpreted the Ontario *Health Care Consent Act*.[3] In 2013, the Supreme Court of Canada, in the *Rasouli case*,[4] determined that (in Ontario) consent was required under the act to withdraw life-sustaining therapies even if the treating physician deemed them nonbeneficial, because withdrawing life support "entails physical interference with the patient's body and is closely associated with the provision of palliative care."[4] This decision did not consider whether consent was also required under the act or common law to withhold treatments (e.g., CPR) if deemed nonbeneficial.[5] Applying *Rasouli*, Justice Cavanagh ruled that physicians do not need consent to withhold medically inappropriate CPR under the act because, among other things, not offering or providing CPR does not involve medical interventions or physical interference with the body. Choosing not to offer CPR was not a treatment decision but "the physicians' professional assessment of whether CPR would or would not be of medical benefit to Mr. DeGuerre."[1]

KEY POINTS

- The Ontario Superior Court of Justice recently determined that, under both Ontario's health care consent legislation and common law, physicians do not require consent to withhold cardiopulmonary resuscitation (CPR) that they believe to be medically inappropriate.
- Physicians in Ontario need to distinguish carefully between a scenario where CPR would be outside the standard of care and should not be offered and a scenario where CPR is within the standard of care but the physician does not feel it is in the patient's best interests; each scenario demands a different response.
- Physicians still have a professional responsibility to communicate (or make reasonable efforts to communicate) honestly and compassionately about the limitations of CPR and the alternatives to aggressive care.

Justice Cavanagh emphasized that under the Ontario *Health Care Consent Act*, treatments must be proposed before patients or substitute decision-makers can consent to them, noting, "[t]he HCCA does not provide that a physician is required to propose every conceivable treatment to a patient and allow the patient to choose which treatment or treatments to receive."[1] Whether a physician is required to offer a treatment depends on "the physician's professional assessment of whether the treatment offers a medical benefit … a contextual assessment of the patient's circumstances, including the patient's condition and prognosis, the expected result of treatment for that patient, and any risks of treatment for that patient."[1]

Justice Cavanagh also found that policies in force at the time that were issued by the College of Physicians and Surgeons of Ontario and Sunnybrook Health Sciences Centre, which stated that physicians were not obliged to propose or provide treatment that would almost certainly not benefit the patient, supported the physicians' actions. Justice Cavanagh further ruled that proposing a treatment does not mean that physicians are forever bound to provide it. Even if patients or substitute decision-makers had previously consented to a "full-code" order,

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this would not compel physicians to provide CPR if they determined, because of a change in circumstances or context, it would no longer be beneficial.[1]

Justice Cavanagh also considered whether, under common law, the physicians needed consent to write the no-CPR order and refrain from CPR at the bedside. He rejected the plaintiff's argument that previous authorities were unclear and ruled that substitute decision-makers cannot insist on treatments that are medically inappropriate,[4] even if they consented to them at an earlier point when that treatment was offered. This reflects a long-standing legal principle, recognized in several Anglo-American jurisdictions, that autonomy is a negative right: although patients can refuse treatment or insist that it be withdrawn, there is no right to demand it.[6]

The recent Ontario case has important implications for clinicians in Ontario, and the College of Physicians and Surgeons of Ontario has already revised their policy to indicate that physicians are no longer obliged to provide CPR that is outside the standard of care.[7] However, the revised policy still indicates that "Physicians must not unilaterally make a decision regarding a no-CPR order,"[7] and directs physicians to engage in a process of conflict resolution when the patient or substitute decision-maker insists that CPR be provided. Notably, while that conflict resolution process is underway, "physicians must provide all resuscitative efforts required by the standard of care, which may include CPR."[7] Essentially, physicians are still obliged to respond to a cardiac arrest; however, that response does not have to include CPR that would be outside the standard of care. Unfortunately, because many cardiac arrests occur outside of daytime hours, there is always a chance that the person leading the resuscitation will not be familiar with the patient and would only be able to make a clinical judgment about the effectiveness of CPR after the CPR has already been started. This policy is due for a more comprehensive revision in 2020, when the question of whether a no-CPR order can be written over the objection of a patient or family member is likely to be addressed.

The next revision of the College of Physicians and Surgeons of Ontario policy (and other policies across Canada) will need to reflect the distinction between a situation where CPR will almost certainly provide no benefit and is outside the medical standard of care (e.g., a patient with a terminal illness with acute rapidly deteriorating multiorgan failure) and a situation where CPR may provide some benefit but is not felt to be in the patient's best interest (e.g., a person with an advanced incurable illness who suddenly develops ventricular fibrillation). This may be difficult because the standard of care and what constitutes a benefit may be uncertain or subjective.[8–11] Physicians and members of the public in all jurisdictions would benefit from a clearer standard of care around CPR, and a timely and transparent means of clarifying the standard at the bedside.

The public may fear that the decision on the recent *Wawrzyniak* case will lead some physicians to avoid a difficult discussion about nonbeneficial CPR with a patient or family members by writing a full-code order while planning to withhold CPR at the time of death. Such behaviour would be disingenuous and would ultimately undermine the physician–patient relationship and trust in the profession overall. Physicians have a professional responsibility to communicate (or make reasonable efforts to communicate) their concerns about performing CPR in cases where they do not feel that it is medically appropriate and to be honest when they feel that CPR would be outside the standard of care. The *Wawrzyniak* case changes nothing in this regard, and the revised College of Physicians and Surgeons of Ontario policy (like many other end-of-life policies) emphasizes the importance of honest and supportive communication, and the obligation for physicians to present alternatives to aggressive treatment.

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