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COFFEE TALK
A Health Industry Seminar Series

Considerations for End-of-Life Treatment Post-Rasouli

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Overview

- Consent and Capacity
  - Consent to Treatment
  - Substitute Decision-Making
  - Consent and Capacity Board
- *Health Care Consent Act* and *Criminal Code* Inconsistencies
- *Rasouli* Decision
- Trilogy of End-of-Life policies

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Consent to Treatment

- Common Law Principles (Court-made)
  - No treatment without consent
  - Lack of informed consent may constitute negligence, battery
  - Individual right to self-determination
  - Individual right to refuse treatment (including withdrawal of consent)
- Codified in Ontario *Health Care Consent Act* ("HCCA") →applies to **treatment**, admission to care facilities and personal assistance services

Consent to Treatment

- Health practitioner who proposes a treatment cannot administer the treatment and must take reasonable steps to ensure it is not administered unless:
  - The person has consented (and is capable of giving consent with respect to the decision); or
  - If person is incapable, the person's substitute decision-maker (SDM) has consented on behalf of the individual with respect to the decision

Consent to Treatment

- Treatment is broadly defined
- **"Treatment" =**

  "Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan…" → subject to limited exceptions

Consent to Treatment

- **"Plan of treatment" =**

  "A plan developed by one or more health practitioners that …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"

Consent to Treatment

- Consent = process of providing information
- Implied or express consent (→verbal or written)
- Elements of Consent
- Consent must be informed
- Consent to a treatment can be withheld or withdrawn (section 14)

Substitute Decision–Making

- Obligations of SDM (section 21): Consent by SDM must be in accordance with:
  - Patient's "prior capable wishes"
    - express (verbal, advance directive, gesture etc.)
    - made while capable; and
    - applicable to the circumstances
- Later wishes expressed by a capable person prevail over earlier wishes, regardless of form
- If no prior capable wishes, then best interests (subsection 21(2))

Consent and Capacity Board

- Application for direction where:
  - Wish is not clear
  - Not clear if wish applicable to circumstances
  - Not clear if wish expressed while capable
- Application regarding compliance with wishes/best interests
- Health practitioner can also make application for direction to depart from wishes
- Hearing to begin within 7 days
- CCB decision can be appealed to Ontario Superior Court of Justice

Protection from Liability (HCCA)

- Section 14 of HCCA

  "A consent [to treatment] that has been given by or on behalf of the person for whom the treatment was proposed **may be withdrawn at any time**…"

- Protection from liability (section 29 of HCCA)
  - Reasonable grounds
  - Good faith
  - Reliance on apparently valid consent to treatment

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Futile/ Non-Beneficial Treatment

- No obligation to propose/recommend medically inappropriate/ineffective treatment (e.g. futile, inadvisable, non-beneficial) and patients do not have right to insist on/demand such treatments
- Consent is not required to withhold such a treatment
  - Where no treatment is to be given, HCCA does not require consent

- Distinct Responsibilities
  - **Health practitioner**: responsible for exercising medical discretion in determining whether certain treatments are medically appropriate
  - **Patient/SDM**: responsible for decision making (giving or refusing consent) relative to "appropriate" treatment options available (offered) to the patient

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Futile/ Non-Beneficial Treatment

- **December 2013 CMA Statement on Life–Saving and –Sustaining Interventions**

  "There is no obligation to offer a person medically futile or non-beneficial interventions… As a general rule a person should be involved in determining medical futility in his or her case."

- **CPSO Policy Statement #1-06: Decision-Making for the End of Life**

  "Physicians are not obliged to provide treatments that will almost certainly not be of benefit to the patient."

  "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."

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Withdrawal of Treatment

- Once a treatment has been initiated, the health practitioner has no authority to unilaterally “revoke” (withdraw) a treatment
  - Consent obligations under the HCCA are triggered if the act falls within the definition of treatment
- **Distinguish in Policy and Practice**
  - Treatment decisions pursuant to the consent of the patient/ SDM; and
  - Clinical decisions by an attending physician to not initiate/withhold treatments (that are considered medically inappropriate) which does not require consent

Criminal Code of Canada

- **Duty of persons to provide necessaries (s. 215)**

"Every one is under a legal duty

[…]

(*c*) to provide necessaries of life to a person under his charge if that person

(i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and

(ii) is unable to provide himself with necessaries of life.

Criminal Code of Canada

- **Duty of persons undertaking acts dangerous to life (s. 216)**

  "Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing."

- **Duty of persons undertaking acts (s. 217)**

  "Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life."

Rasouli Decision

Facts:

- Unconscious and on life support since October 2010 due to severe brain damage resulting from infection after surgery to remove tumour in his head
- Drs of opinion that patient in persistent vegetative state, no hope of recovery, ongoing mechanical intervention will provide no medical benefit and may cause harm
- Drs proposed to:
  - Withdraw ventilation/other life-sustaining measures
  - Provide palliative care

. . . *Rasouli*

- Drs take position that consent is needed to administer palliative care, but not to withdraw life-sustaining measures that offer no medical benefit/ fall outside the standard of care
- SDM opposed proposed course of action
  - Need consent to withdraw life support *and* provide palliative care

- **Ontario Superior Court (2011)**
  - found that the withdrawal of life support constitutes "treatment" under the HCCA and requires consent
  - Treatment decisions must follow established statutory scheme (HCCA)

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. . . *Rasouli*

- **Court of Appeal (2011)**
  - In this case, withdrawal of life support is a necessary precondition to palliative care and cannot be separated
  - "Integrally linked" and comprise a "treatment package"
  - Consent must consequently be provided to withdraw life support and to provide palliative care
  - If concerns about decision-making by SDMs, recourse is to the CCB

. . . *Rasouli*

- **Supreme Court of Canada (2013)**
  - HCCA consent regime applies
  - "treatment" and "health-related purpose" not limited to procedures that are of medical benefit
  - Drs' recourse is to apply to the CCB (Is SDM's refusal to provide consent to the withdrawal of life support in Rasouli's best interests?)

Decision by SDM

- Once a treatment is proposed (offered) the health practitioner has no authority to unilaterally “revoke” (withdraw) a treatment
- But SDM must meet criteria – capacity of SDM?
- Informed consent process
- Meeting obligations for substitute decision-making?
- Recourse to the CCB
- Seek advice (Colleague, Legal/CMPA)
- Document, document, document

Trilogy of End-of-Life Policies

- **No Cardiopulmonary Resuscitation**
  - Treatment decisions relating to resuscitation pursuant to the consent of the patient/SDM
- **Withdrawal of Treatment**
  - Treatment decisions relating to withdrawal of life-sustaining treatment
- **Withholding of Treatment**
  - Clinical decisions by an attending physician to not initiate/withhold resuscitative measures

1. “No CPR” Order

- Convention has developed that consent for CPR will be presumed unless specifically refused
- Consent obligations under HCCA will be triggered if the act falls within the definition of treatment; “no CPR” order is considered an affirmative order for treatment by omission

1. “No CPR” Order

- DNR order is part of the “plan of treatment” and a physician should not alter this plan without consent
- Writing a DNR order without consent places the physician and facility at risk

2. Withdrawal of Treatment

- Treatment has been initiated and is being discontinued
- Consent obligations under the HCCA are triggered if the act falls within the definition of treatment

3. Withholding Treatment

- Signifies a passive or non-active role of health care provider
- Non-initiation of treatment
- Where no treatment is to be given, HCCA does not require consent
- General duty to inform patients/SDM of available treatment options

3. Withholding Treatment

- Difference between “No CPR” order and withholding treatment
  - If order for “No CPR” is written, physician has deliberately removed a specific element of treatment that would otherwise be within the standard of care
  - A decision to withhold treatment that is futile or non-beneficial will meet the standard

3. Withholding Treatment: Standard of Care

- Health care providers have a duty to provide treatment to patients, and make treatment decisions, with reasonable care and skill and to meet accepted standards
- “reasonable care” with respect to treatment is provided if an accepted and common standard is used and met

3. Withholding Treatment: Futile/ Non-Beneficial Treatment

- **December 2013 CMA Statement on Life–Saving and –Sustaining Interventions**

  "Where there is clinical agreement that a life-saving or-sustaining intervention is medically futile, that intervention need not be offered, and can be withdrawn where it has already been put in place. There is no ethical distinction to be made between the non-initiation or the discontinuation of a life-saving or life-sustaining intervention." → Change in light of *Rasouli*?

  "Some provinces have statutory mechanisms in place for physicians and/or family members to follow in cases of disagreement. Where these mechanisms exist, they must be adhered to."

3. Withholding Treatment: Futile/ Non-Beneficial Treatment

- **CPSO Policy Statement #1-06: Decision-Making for the End of Life**

  "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" → Change in light of *Rasouli*?

3. Withholding Treatment: Futile/ Non-Beneficial Treatment

- **CPSO Policy Statement #1-06: Decision-Making for the End of Life**
- Physician should discuss any recommendation not to initiate life support or withdraw life support with the patient or SDM
- If patient or SDM requests physician to provide or continue the treatment despite recommendations of health care team, use conflict resolution measures
- Policy does not differentiate between withdrawal of treatment and withholding treatment

3. Withholding Treatment: Fiduciary Duty

- Duty to the greater community
  - Finite amount of health care resources (personnel, equipment, budget)
  - Supply of health care resources vs. demand for resources
  - Reasonable to spend finite resources on provision of futile/non-beneficial treatment?

Final Thoughts

- *Rasouli* did not change the standard of care
- Continue to rely on standard of care in deciding whether to withhold or recommend withdrawal of treatment(s)
- Follow HCCA's scheme for dispute resolution where conflict arises between patient/SDM and health care team
- Each situation must be assessed on a case-by-case basis
- Clarity within end-of-life policies is critical
- Staff should become familiar with the organization's end-of-life policies

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Questions?

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Thank you!

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