Standard of Practice

Withholding & Withdrawing Life-Sustaining Treatment

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Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All registrants must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

Persons who may be legally authorized to consent to or refuse medical treatment on behalf of a patient include persons:

(a) authorized by statute, including:

(i) a health care proxy appointed by the patient in accordance with *The Health Care Directives Act*, C.C.S.M. c. H27;

(ii) a Committee appointed under *The Mental Health Act*, C.C.S.M c. M110;

(iii) a substituted decision maker appointed under *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M c. V90;

(iv) The Public Trustee, in limited circumstances.

(b) recognized by the common law, including:

(i) a parent or other legal guardian of a patient who is a minor;

(ii) a person with authority pursuant to a decision or order of a Court with jurisdiction.

The Vital Statistics Act, C.C.S.M. c. V60, s. 2. provides that the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs. As such, the requirements of this Standard of Practice do not apply to withholding or withdrawing life-sustaining treatment from a patient whose brain function has irreversibly ceased as that person has already died in accordance with the legal definition of the death of a person.

Definitions

The following terms are defined for the purpose of this Standard of Practice. **The definitions do not necessarily reflect the meaning of the terms used in other contexts.**

Family
Persons recognized by the patient as being closely linked to the patient in knowledge, care and affection, including biological family, those linked by marriage or common-law (same or opposite sex) and any other person chosen by the patient as his/her family.

Health Care Team
This term includes all personnel who are actively involved in the health care of the patient and to whom the physician may turn for input in accordance with this Standard of Practice.

Life-sustaining Treatment
Any treatment that is undertaken for the purpose of prolonging the patient's life and that is not intended to reverse the underlying medical condition.

Minimum Goal of Life-sustaining Treatment
This term is clinically defined as the maintenance of or recovery to a level of cerebral function that enables the patient to:

- achieve awareness of self; and
- achieve awareness of environment; and
- experience his/her own existence.

For pediatric patients, the potential for neurological development must be factored into the assessment.

Physician
A registrant of CPSM who is providing medical care to the patient. Where there is more than one physician involved in the patient's medical care, the physician who is the coordinator of the patient's medical care is responsible for ensuring that the requirements of this Standard of Practice are met.

Patient
The patient is the recipient of medical care whose well-being is the physician's primary concern.

Proxy
The person who is legally authorized to make health care decisions on the patient's behalf in circumstances where the patient lacks capacity to make such decisions, including, but not limited to, a health care proxy appointed in a health care directive.

Representative
The person who represents the patient and/or the patient's family in discussions about the patient's health care where the patient lacks capacity to make health care decisions and there is no proxy or it is not possible to communicate with the patient or the proxy for any reason. This person is usually a member of the patient's family. If the patient is in a health care facility, the representative may be determined in accordance with that facility's internal policy. In the absence of an applicable policy, or if the patient is in the community, it will be up to the physician to use his/her best judgment to identify a member of the patient's family who has the support of interested parties to assume this role.

Requirement

When a physician is confronted with a clinical scenario in which withholding or withdrawing life-sustaining treatment is being considered, the four main components of the process the physician must follow are the same in all cases:

1. Clinical Assessment;
2. Communication;
3. Implementation;
4. Documentation.

This Standard of Practice establishes:

- **General Requirements**, which apply to each of the four components described above in all circumstances. These are the only requirements when there is consensus between the patient/proxy/representative and the physician.
- **Specific Requirements**, which supplement and/or modify the General Requirements when consensus cannot be achieved in the following circumstances:
    A. No consensus - the physician offers life-sustaining treatment but the patient/proxy declines treatment or the representative advocates withholding or withdrawing treatment;
    B. No consensus - the minimum goal is not realistically achievable and the physician concludes that life-sustaining treatment should be withheld or withdrawn but the patient/proxy/representative does not agree and/or demands life-sustaining treatment;
    C. No consensus - the minimum goal is achievable but the physician concludes that life-sustaining treatment should be withheld or withdrawn and the patient/proxy/representative does not agree and/or demands life-sustaining treatment;
    D. Emergency Situations where communication between physician and patient/proxy/representative cannot occur;
    E. Cardiac arrest and resuscitation, including Cardiopulmonary resuscitation (CPR) and/or Advanced Cardiac Life Support (ACLS), and Do Not Attempt Resuscitation (DNAR) Orders.

General Requirements

1. Clinical Assessment

- The physician must clinically assess the patient by gathering and evaluating information about the patient's physical condition, diagnosis, prognosis and treatment options, including palliation, balancing the risks and benefits associated with identified treatment options.
- The assessment must be based on the best available clinical evidence, including, where appropriate, consultation with another physician and must include consideration of the feasible life-sustaining treatment options in the context of the minimum goal of life-sustaining treatment, which is clinically defined as:
    - maintenance of or recovery to a level of cerebral function that enables the patient to:
        - achieve awareness of self; and
        - achieve awareness of environment; and
        - experience his/her own existence.

For pediatric patients, the potential for neurological development must be factored into the assessment

- Where the physician is uncertain about any aspect of the assessment, including the range of treatment options, he/she must seek additional clinical input by consulting with at least one other physician before concluding that the minimum goal is not realistically achievable and/or that life-sustaining treatment should be withheld or withdrawn for any other reason.
- Based on the clinical assessment, the physician may conclude that:
    1. Life-sustaining treatment should be offered; OR
    2. Life-sustaining treatment should be withheld or withdrawn because the minimum goal is not realistically achievable.
- Where, based on the clinical assessment, the physician concludes that the minimum goal is realistically achievable, but is contemplating withholding or withdrawing life-sustaining treatment because of concerns that there are likely to be significant negative effects on the patient, including, but not limited to pain and suffering, the physician should explore the patient's values, needs, goals and expectations of treatment with the patient/proxy/representative before concluding that life-sustaining treatment should be withheld or withdrawn.

2. Communication

- The physician must identify the person(s) with whom he/she must communicate about withholding or withdrawing life-sustaining treatment and communicate with that person as early as possible and, where possible before life-sustaining treatment is withheld or withdrawn.

- Every effort must be made to communicate with the patient as early as possible, while the patient can identify his/her preferences for treatment and has the capacity to make his/her own health care decisions.
- Where there is a proxy, the physician must share personal health information and consult with the proxy in the same manner he/she would otherwise consult with the patient, unless he/she is made aware of limits on the proxy's authority.
- Where there is no proxy, the physician must share personal health information and consult with the representative in accordance with this Standard of Practice to identify known preferences and/or interests of the patient and/or what treatment might be in the patient's best interests.
- The physician must comply with reasonable requests of the patient, proxy or representative to include other person(s) in the discussion described below.
- The physician must ensure that relevant information is exchanged and strive for understanding and consensus when discussing withholding or withdrawing life-sustaining treatment from the patient. The nature and content of discussion will depend on the physician's assessment of treatment options and the individual circumstances of the patient. The discussion should, at a minimum, include:
  - a description of the underlying condition or ailment and prognosis;
  - an exploration of the patient's values, needs, goals and expectations of treatment;
  - the options for treatment and their expected outcome, including potential benefit and harm;
  - where the physician has concluded that treatment should be withheld or withdrawn, an explanation of the assessment and the basis for this conclusion;
  - assurances that the patient will not be abandoned if treatment is either withheld or withdrawn, including an explanation and offer of palliative care;
  - where there is a need or a request for additional assistance with psychosocial, cultural, spiritual, and/or informational needs by the patient or proxy or representative and/or family, an offer to seek support from institutional resources such as social work, chaplaincy, or clinical ethics;
  - where welcomed by the patient, proxy or representative, the patient's personal, cultural, religious and family issues insofar as they are relevant to the decision;
  - where appropriate, an exploration of potential guilt or regret associated with end of life decision-making.

3. Implementation

- Treatment may be withheld or withdrawn where there is consensus between the physician and:
  1. a patient who is capable of making his/her own health care decisions; or
  2. the proxy or representative, where the patient lacks capacity to make his/her own health care decisions.

- Provided that the physician has complied with the requirements of this Standard of Practice, decisions may be implemented in as timely a manner as possible, while respecting the grieving process for patients and families.
- Once a decision to withhold or withdraw treatment is made, the need for someone to communicate this decision to other family members who were not involved in making the decision should be explored. In such circumstances, with proper consent, the physician should be prepared to assist by providing appropriate information to such family members.

4. Documentation

- Accurate and complete documentation of the pertinent details of the physician's assessment and his/her interaction with the patient and others involved in decisions whether to withhold or withdraw life-sustaining treatment is essential.
- At a minimum, the physician must clearly record in the patient's health care record:
  - sufficient details about the assessment of treatment options to identify the basis for the conclusion that treatment should be withheld or withdrawn;
  - pertinent details regarding consultations with others and second opinions;
  - if it is determined that the patient lacks capacity to make his/her own health care decisions, the basis for that determination and the identity of the proxy or representative designated in accordance with this Practice Direction;
  - particulars of the communications required by this Practice Direction, including:
    - identity of the participants in the discussion;
    - where there is a proxy or representative, any limits on that person's authority to make decisions on the patient's behalf;
    - relevant information communicated by the physician;
    - concerns raised by others and the information provided by the physician in response;
    - whether or not consensus was reached;
    - where consensus was not reached, the nature of the efforts made to reach consensus;
    - the implementation plan.

Specific Requirements

The specific requirements for the circumstances identified earlier are set out in separate sections below. Where no specific requirements are identified, the general requirements apply. Where specific requirements are identified, those requirements supplement or modify the general requirements.

1. No Consensus – The physician offers life-sustaining treatment but the patient/proxy declines treatment or the representative advocates withholding or withdrawing treatment

1.1. Clinical Assessment

- Where the physician is confronted with a patient who declines life-sustaining treatment that is offered, that physician should consider taking additional steps to assess the patient's capacity to make his/her own health care decisions.

1.2. Communication

- Where a patient with capacity to make his/her own health care decisions or a legally authorized proxy declines life-sustaining treatment for that patient, the physician must be satisfied that the decision to decline treatment is informed and voluntary in that the nature of treatment, including its benefits and risks and alternatives, are understood.
- Where the patient lacks capacity and the decision to decline treatment is made by a proxy on behalf of the patient, the physician must be satisfied that the proxy's legal authority includes declining treatment on the patient's behalf in such circumstances.
- Where the patient lacks capacity, there is no proxy, and a representative advocates withholding or withdrawing life-sustaining treatment:
    - the physician should review with the representative the physician's concerns regarding that person's lack of legal authority to make such a decision on the patient's behalf and the representative's reasons for advocating withholding or withdrawing life-sustaining treatment; and
    - should consider looking to other members of the health care team and/or another physician as a source of information.
- The physician must be mindful of the general communication requirements, but should be prepared to meet the unique needs of the patient, particularly in respect to the physician's communication with the patient's family

1.3. Implementation

- If the physician has satisfied him/herself of the matters referred to in the Communication section above, he/she **must** withhold or withdraw treatment in accordance with the patient/proxy's wishes.
- If a representative is advocating withholding or withdrawing treatment against the recommendation of the physician that the treatment be provided, the physician must make his/her treatment decisions in accordance with the accepted standard of care.

1.4. Documentation

- There are no specific requirements; the general requirements apply.

2. No Consensus – The minimum goal is not realistically achievable and the physician concludes that life-sustaining treatment should be withheld or withdrawn but the patient/proxy/representative does not agree and/or demands life-sustaining treatment

2.1. Clinical Assessment

- There are no specific requirements; the general requirements apply.

2.2. Communication

- Where a physician concludes that the minimum goal is not realistically achievable and that life-sustaining treatment should be withheld or withdrawn and there is no consensus with the patient/proxy/representative, the physician is not obligated to continue to try to reach a consensus before withholding or withdrawing treatment, but must meet the implementation requirements set out below before treatment can be withheld or withdrawn.

2.3. Implementation

- WHERE THE PHYSICIAN CONCLUDES THAT THE MINIMUM GOAL IS NOT REALISTICALLY ACHIEVABLE AND THERE IS NO CONSENSUS, IF POSSIBLE, that physician must consult with another physician:
  1. Where the consultation supports the opposite conclusion, that the minimum goal is realistically achievable, the physician who sought the consultation must either provide the treatment or facilitate the transfer of care to another physician who will provide the treatment.
  2. Where the consultation supports the conclusion that the minimum goal is not realistically achievable, or it is not possible to consult with another physician, the physician who sought the consultation is not obligated to continue to try to reach consensus before withholding or withdrawing treatment, but must first advise the patient/proxy/representative:
     a. that the consultation supports that physician's assessment that the minimum goal is not realistically achievable, or that it was not possible to consult with another physician and attempt to address any remaining concerns; and
     b. of the specified location, date and time at which treatment will be withheld or withdrawn.

2.4. Documentation

- The information regarding the communication between the physician and the patient/proxy/representative following the physician's consultation with the other physician, including the specified location, date and time at which treatment will be withheld or withdrawn, must be documented in the patient's chart.

3. No Consensus – The minimum goal is achievable, but the physician concludes that life-sustaining treatment should be withheld or withdrawn, and the patient/proxy/ representative does not agree and/or demands life-sustaining treatment

3.1. Clinical Assessment

- There are no specific requirements; the general requirements apply.

3.2. Communication

- In this situation, communication is particularly challenging and important. The physician should be aware that careful discussion above and beyond what is generally required may be necessary;
- The concerns in these circumstances may not relate to clinical assessment or care and may involve subjective values and judgments regarding quality of life;
- When confronted with such concerns, the physician should consider seeking assistance from other members of the health care team and/or religious authorities and/or ethics and/or other consultants.

3.3. Implementation

- WHERE THE PHYSICIAN CONCLUDES THAT THE MINIMUM GOAL IS REALISTICALLY ACHIEVABLE BUT THAT TREATMENT SHOULD BE WITHHELD OR WITHDRAWN, that physician must consult with another physician.
    1. Where the consultation supports the opposite conclusion, that treatment should not be withheld or withdrawn, the physician who sought the consultation must either provide the treatment or facilitate transfer of care to another physician who will provide the treatment.
    2. Where the consultation supports the conclusion that treatment should be withheld or withdrawn:
        a. The physician who sought the consultation must advise the patient/proxy/representative that the consultation supports the initial assessment that treatment should be withheld or withdrawn
        b. If there is still a demand or request for treatment, the physician must attempt to address the reasons directly and with a view to reaching consensus. The physician should consider resolving the conflict by:
            i. offering a time-limited trial of treatment with a clearly defined outcome; and/or
            ii. involving additional or alternative methods to facilitate a consensus, including, but not limited to, available resources such as a patient advocate, mediator or ethics or institutional review processes.
        c. If consensus cannot be reached, the physician must give the patient/proxy/representative a reasonable opportunity to identify another physician who is willing to assume care of the patient and

must facilitate the transfer of care and provide all relevant medical information to that physician.

d. Where, despite all reasonable efforts, consensus cannot be reached the physician may withhold or withdraw life-sustaining treatment, but:
    i. in the case of a patient/proxy who is still not in agreement with the decision to withhold or withdraw treatment, the physician must provide at least 96 hours advance notice to the patient or proxy as described below.

3.4. Written Notice

The notice must be in writing, where possible, and must contain, at a minimum:

- name and location of the patient;
- name of the person to whom notice has been given;
- name, address and telephone number of the physician;
- diagnosis;
- description of the treatment(s) that will be withheld or withdrawn;
- date, time and location at which treatment will be withheld or withdrawn;
- date and time that notice was provided;
- name of the person who provided the notice.

3.5. Verbal Notice

Where it is not possible to provide notice in writing, notice to withhold or withdraw treatment may be given verbally, but must be witnessed and include:

- name and location of the patient;
- name, address and telephone number of the physician;
- diagnosis;
- description of the treatment(s) that will be withheld or withdrawn;
- date, time and location at which treatment will be withheld or withdrawn;
- name of the person who provided the notice.
    i. in the case of a representative who is still not in agreement with the decision to withhold or withdraw treatment, the physician should exercise his/her discretion as to what, if any, notice should be provided to the representative before treatment is withheld or withdrawn.

3.6. Documentation

- In addition to the general requirements of documentation, the following must also be documented:
    - Where written notice has been given, a copy of the notice;
    - Where verbal notice has been given:
        - the reason that it was not possible to provide written notice;

- all of the information required when verbal notice is given (see above);
- the signature of the physician and a witness to the notice.

4. Emergency situations where communication between physician and patient/proxy/representative cannot occur

4.1. Clinical Assessment

- In emergent situations, where the patient lacks capacity to make his/her own health care decisions and it is not reasonably possible to identify and communicate with a proxy/representative, the physician must make a rapid assessment based on the patient's clinical status as well as information from others who have interacted with the patient, including other involved members of the health care team, before deciding whether to withhold or withdraw life-sustaining treatment.

4.2. Communication

- The physician should communicate with the proxy/representative as soon as possible after the decision has been implemented.

4.3. Implementation

- The physician must decide when to withhold or withdraw life-sustaining treatment.

4.4. Documentation

- There are no specific requirements; the general requirements apply.

5. Cardiac arrest and resuscitation, cardiopulmonary resuscitation (CPR) and/or advanced cardiac life-support (ACLS), and do not attempt resuscitation (DNAR) orders

Situations involving cardiac arrest are unique because, unlike some potentially life-sustaining treatments which can be provided over a prolonged period of time, CPR and/or ACLS are interim measures implemented to achieve a return of spontaneous circulation.

Actual or impending cardiac arrest is very different from a situation where a DNAR order is being considered as a proactive element of advanced care planning. The specific requirements of physicians in each of these situations are addressed separately in this Practice Direction.

The requirements for Clinical Assessment, Communication, Implementation and Documentation are combined in this section.

5.1. Actual or Impending Cardiac Arrest and Resuscitation

- Actual or impending cardiac arrest often occurs unexpectedly and it is not possible to communicate and/or achieve consensus before either initiating or withholding resuscitative efforts.
- A physician is not required to initiate or continue CPR and/or ACLS, if, based on his/her clinical assessment, the physician determines that:
  - CPR/ACLS will not achieve return of spontaneous circulation; OR
  - resuscitation will not result in the patient achieving the minimum goal.

If the physician is uncertain about his/her clinical assessment, he/she must consult with another physician, where possible.

- In the setting of an impending cardiac arrest, where a physician determines that he/she will not initiate cardiac resuscitation based on one of these criteria, and it is possible to communicate the decision prior to the cardiac arrest, the physician will make reasonable efforts to communicate the decision to the patient, proxy or representative, and will document the discussion in the patient's medical record and write an DNAR order.

5.2. DNR Orders

- Where a physician determines that a DNAR order is appropriate, but cardiac arrest is not imminent/impending, that physician must identify the appropriate section in this Practice Direction which corresponds to the surrounding circumstances and attempt to meet the requirements of that section prior to writing a DNAR Order. If while attempting to meet the requirements of the appropriate section(s), the patient suffers a cardiac arrest or the physician determines that a cardiac arrest in imminent/impending, the requirements automatically change to those for Actual or Impending Cardiac Arrest and Resuscitation as set out above.

Legal Intervention

If at any time a physician becomes aware of anything such as a legal proceeding and/or a Court Order that may impact the legal right of a patient, proxy or representative to request or demand specific treatment(s), that physician must take steps to ensure that he/she complies with the law and should consider seeking legal advice.