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Article abstract

This paper deals with changes in code status policy in Ontario and endorses a new College of Physicians and Surgeons of Ontario (CPSO) policy. We argue that the recent policy changes in this area necessitate an active educational strategy around end-of-life care to prevent harm to dying patients.

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**COMMENTAIRE CRITIQUE / CRITICAL COMMENTARY** (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

# New Developments and Old Dilemmas in Ontario's Resuscitation Policy at the End of Life

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**Résumé**
Cet article traite des changements apportés à la politique sur le statut des codes en Ontario et soutient une nouvelle politique de l'Ordre des médecins et chirurgiens de l'Ontario (OMCO). Nous soutenons que les récents changements de politique dans ce domaine nécessitent une stratégie éducative active autour des soins de fin de vie afin de prévenir les préjudices causés aux patients mourants.

**Mots-clés**
éducation médicale, médico-légal, NPR, réanimation cardio-pulmonaire, statut du code, politique de santé, fin de vie, soins palliatifs

**Abstract**
This paper deals with changes in code status policy in Ontario and endorses a new College of Physicians and Surgeons of Ontario (CPSO) policy. We argue that the recent policy changes in this area necessitate an active educational strategy around end-of-life care to prevent harm to dying patients.

**Keywords**
medical education, medicolegal, DNR, cardiopulmonary resuscitation, code status, health policy, end of life, palliative care

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## INTRODUCTION

Making medical decisions about resuscitation at the end-of-life create emotional strain for families, patients, and their physicians. In some jurisdictions, physicians make the medical decision not to offer cardiopulmonary resuscitation (CPR) to a patient if they believe invasive resuscitation will lead to worsening suffering without meaningful benefit (1). In other jurisdictions, a physician is expected to offer CPR regardless of its medical indication (2). These are complex medicolegal norms shaped by local cultural expectations of what modern medicine can deliver. Policies governing medical decision-making at the end of life in Ontario have undergone fundamental change four times in the past nine years with new College of Physicians and Surgeons of Ontario (CPSO) policies in 2015 (3), 2016 (4), 2019 (5), and 2023 (6). The recently replaced version of this CPSO policy (in place from 2019-2023) was the most ethically fraught of the four versions (7-13). Until March 2023, an Ontario physician treating a patient approaching the end of life was not obliged to offer CPR even if the patient's substitute decision-maker (SDM) disagreed and asked for CPR to be performed (5). But that same physician was prohibited from writing a no-CPR or do not resuscitate (DNR) order in the patient's chart to advise the rest of the medical team of their decision until the disagreement was resolved. Judicial precedent in Ontario (14) and clinical experts (7-13) long reported that this policy risked harming vulnerable patients.

We discuss the history of this policy, briefly recap its risks for patients as discussed more thoroughly by other authors (7-13) and then focus on a previously poorly understood aspect of the problem: its risks for medical learners (9) and the ramifications for medical education in Ontario. Lastly, in agreement with others (15-17), we here support one aspect of the new 2023 CPSO policy (18), i.e., that allows a physician to change a patient's code status to reflect the medical team's decision to not offer CPR even in the context of a disagreement between the medical team and the patient's substitute decision-maker. However, we argue that the simple approval of such a policy at the regulatory level will be insufficient to protect vulnerable patients. Instead, we call for the creation of a new educational consortium focused on educating physicians about their responsibilities at the end of life.

## HOW DID DECLARING A CODE STATUS AT THE END-OF-LIFE WORK FROM 2019-2023?

The case described in Figure 1 depicts Ontario's medicolegal policies from 2019-2023. In this case, a resident physician confronts a snap decision for a patient they barely know. The stakes are high. The resident must decide whether to unleash the interventional power of a medical system that can keep dying patients at the edge of death at the cost of physical suffering. The case is written colloquially and synthesizes aspects of case law (14,19-21), policy (4,5,7,22) and workplace experience.


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**Figure 1. Case example describing CPSO end of life policy 2019-2023**

After a long day in the clinic, a senior medical resident arrives at the hospital, picks up the pager, and prints the handover list before starting their overnight shift. The day resident tells her about the patients on the list until arriving at the last name:

> *Oh. This one is an 81-year-old male with metastatic rectal cancer, poorly tolerating dialysis, a new stroke, maybe septic, and unfortunately still full code at the family's insistence. The attending filed with the Consent & Capacity Board yesterday to request the family consent to comfort measures when the patient decompensates, but it will take a while for that to be sorted out. In the meantime, the team agrees we're not offering CPR. We just can't write the order, so I'm telling you now.*

It feels uncomfortable, this middle ground, but the night shift resident doesn't have time to linger on the topic. There are three consults already waiting to be seen in the emergency department.

Nine hours, two cups of coffee, and nine consults later, the code blue pager goes off at 2AM. As the senior resident starts jogging toward the room listed on the pager and, as the announcement rings out overhead, the resident realizes she's being called to attend to the last patient on the list. She's suddenly filled with dread. The elevator doors open and she's greeted by the clinical clerk caring for the patient overnight:

> *He's suddenly non-responsive, new respiratory distress, family is on their way in and they want him resuscitated.*

Policies in Ontario governing the expected response of the fly-in resident to this challenging overnight clinical problem have changed a remarkable four times in the past nine years (see Table 1). Practice standards are set by the CPSO and are considered binding legal requirements. Based on CPSO policy, between 2016 and 2019, if a substitute decision-maker (SDM) felt their dying loved one should be aggressively resuscitated (including CPR) then a physician was obliged to do so even if it was medically inappropriate, except in rare circumstances such as decapitation (4). More recently, between 2019 and 2022, if an SDM felt their loved one should be resuscitated while dying, a physician was not obligated to provide CPR but was not allowed to write a medical directive, or "code status," informing other members of the medical team about their decision (5). As in the case of the resident above, the most recent version of this policy left residents (and other physicians working overnight), in ethically fraught territory and likely to cause suffering to their patients as a result (8-10,23). Lastly, the new CPSO policy, approved in March 2023 (6), reaffirms the importance of code status as a means of communicating within medical teams; it clarifies that physicians should propose treatments (including CPR) and their patients or substitutes can then consent to or refuse treatments (7-13), rather than patients and SDM selecting from a menu of care options.

**Table 1. Changes in directives of CPSO end of life policies from 2008-2023**

| Years | Text | Obligated to perform CPR if requested? | Document a code status without SDM consent? |
|---|---|---|---|
| 2008-2016 | "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." (24) | No | Yes |
| 2016-2019 | "A decision regarding a no-CPR order cannot be made unilaterally by the physician… [W]hile the conflict resolution process is underway…[i]f an event requiring CPR occurs, physicians must provide CPR." (4) | Yes | No |
| 2019-2023 | "When code status designations are under dispute physicians are expected to make a determination at the time of the emergency and "must provide all resuscitative efforts required by the standard of care, which *may* include CPR" but "must not write the no-CPR order while conflict resolution is underway." (5) | No | No |
| 2023 | "A physician's decision to withhold resuscitative measures is not 'treatment' and therefore does not require the patient or SDM's consent. Where the risk of harm associated with resuscitation outweighs the potential benefits, physicians may decide it is appropriate to withhold resuscitative measures and write an order to this effect in the patient's medical record." (6) | No | Yes |

## WHY HAVE END-OF-LIFE POLICIES IN ONTARIO CHANGED SO FREQUENTLY?

Thoroughly understanding the revised end-of-life policy of the CPSO requires looking at the surrounding legal context. The 2019 policy on end-of-life care (5) attempted to set standards for writing no-CPR / DNR orders within the framework provided by two legal cases and against the backdrop of the province's 1996 *Health Care Consent Act* (HCCA). The first case, Cuthbertson vs Rasouli, was tried at the Canadian Supreme Court in 2013 (25). The Rasouli judgement was a landmark case that changed how physicians understood consent and life-prolonging care in Ontario (11). The second case, Wawrzyniak vs

Livingstone, was tried at the Health Professions Appeal & Review Board in 2014 (19) and the Ontario Superior Court of Justice in 2019 (14), and has played the central role in deciding how Ontario's doctors should treat disagreements about CPR (4).

**Case # 1:** Hassan Rasouli underwent neurosurgery for a benign tumor in 2010. Unfortunately, he developed meningitis that led to brain damage and, ultimately, caused him to fall into a permanently minimally conscious state. In the Rasouli case, the opinion of the Supreme Court was that doctors could not withdraw life-sustaining treatment without the consent of the patient's substitute decision-maker (SDM) (25). Future CPSO policy (4) and external review board decisions (19) would implicitly (and incorrectly) draw from Rasouli the conclusion that patients and their SDMs sometimes have the authority to determine what treatments a physician must offer, including CPR (9).

**Case # 2:** In Wawrzyniak vs Livingstone (14), the plaintiff's father was experiencing multi-organ failure, catastrophic gangrene in both legs, and was found by three attending physicians to be approaching the end of his life. The patient's attending physician decided not to offer CPR, wrote an order changing the patient's code status, and attempted to call the patient's daughter to inform her. She arrived later that day to find her father in respiratory distress and discovered that Dr. Livingstone had changed his code status. She then attempted to provide ventilatory support to her father herself before he died. Initially, the plaintiff's complaint was twice dismissed by the CPSO disciplinary committee, and she twice appealed to the Health Professions Appeal & Review Board (HPARB) (19). Ultimately, the Board ruled that Rasouli and the HCCA were inconsistent with the approach permitted by the CPSO; as a result, the Board ordered the CPSO to revise its policy (19). On this basis, the CPSO subsequently approved an end-of-life care policy in 2016 requiring physicians to discuss planned CPR code statuses with their patients and to abstain from writing a DNR order if a patient or SDM disagreed and requested that CPR instead be provided.

In 2019, the Ontario Superior Court heard the Wawrzyniak case, not as a result of an appeal to the Board's decision, but rather because Ms. Wawrzyniak sued the doctors for negligence and malpractice. Contrary to the Board – though, interestingly, making no reference to the Board finding – the Court found that *physicians are not obligated to offer a treatment* outside the standard of care, including CPR (14). All at once, the Sunnybrook physicians were largely vindicated, and the past five years of CPSO policy were cast in a new and uncertain light.

The CPSO subsequently adjusted its policy in an attempt to recognize the Superior Court judicial ruling in 2019 (5). However, the new policy still barred physicians from writing a DNR order for a patient if the patient/SDM disagreed (see Table 1). The CPSO flagged at the time that they intended, in the future, to complete a more thorough policy revision in light of the Superior Court ruling. Subsequently, after four years and multiple public consultations, in 2023, the CPSO returned physician practice in Ontario to something approximating the pre-2016 guidelines. Under the revision, physicians communicate clearly with patients or SDMs about their decisions on whether to offer CPR, and (subject to certain conditions) they are permitted to write a DNR order even with the patient's or SDM's refusal.

## WHY ARE CODE STATUS DESIGNATIONS SO NECESSARY?

The 2019-2023 version of the College of Physicians & Surgeons of Ontario (CPSO) policy drew extensive criticism (7-13), in part because it underestimated the necessity of code status designations. Code status designations were implemented in North America following a recognition of the right of patients to abstain from aggressive life-prolonging therapy (26). The purpose of a code status is to distill planning conversations with patients and families along with expert judgement about the medical indications for resuscitation into a single decision point. This single decision point is necessarily unequivocal (CPR or no-CPR, for example) because seconds matter during resuscitation. A designation of cardiac death can be made after 2 minutes of pulselessness (27), yet more than a third of patients with in-hospital cardiac arrest may not receive initiation of CPR until more than one minute has passed (28). The success rate of CPR is poor for frail and seriously ill patients. Clinically frail patients who undergo CPR in hospital have been found to die during that same admission 98% (29) to 100% (30) of the time. Clearly, the margin for error or delay in resuscitation is razor-thin and code status designations are necessary because emergent decisions require decisive guidance.

We commend the CPSO for attempting to reconcile Supreme Court (25) and Ontario Superior Court rulings (14) in the new end-of-life policy (7). We agree with the Medico-Legal Society of Toronto's view that the previous CPSO policy placed resident physicians and their patients at undue risk (9). Turning the decision to provide CPR to a dying patient whose code status is disputed into an exclusively bedside decision for an overnight fly-in resident "effectively places the decision-making burden of what constitutes the standard of care on a junior physician in the actual moment of a cardiorespiratory arrest… Most trainees would provide CPR in these conflict circumstances and subject the patient to harm" (9). The new CPSO policy (6) resolves this ambiguity by clarifying that physicians choose what treatments are reasonable to offer and these decisions must be recorded as code status designations in the patient's chart.

The merit of physicians alone deciding what treatments to offer is both worthy of further debate, and outside the scope of this discussion. Nuanced discussion of this issue in Ontario and other jurisdictions has favoured physician discretion to offer or not offer resuscitative treatment at the end of life (10,11,31-33). But what matters most for this discussion of policy ramifications in medical education is whether the new policy is clinically useable and unambiguous.

## HOW TO BEST ADAPT TO MULTIPLE POLICY CHANGES?

The Wawrzyniak ruling clarified that Ontario law and defines autonomy as a primarily negative right: in most cases, a patient or their representative can refuse treatment but cannot demand access to medically inappropriate care. The proposed CPSO policy is clearer regarding the specific question of whether physicians are required to offer CPR to patients if it is not part of the standard of care. Despite this recent improvement in clarity, physicians appear still to have poor understanding of their legal obligations regarding end-of-life care (34-36). Given this variability in physician understanding of their responsibilities and recent end-of-life policy fluctuations, we propose the creation of a new education consortium. Independently or in collaboration with existing national educational platforms (37,38), we call on the regulatory colleges (including the CPSO), hospital organizations (including the Ontario Hospital Association), medicolegal organizations (including the Canadian Medical Protective Agency), and medical school organizations (including the Council of Ontario Faculties of Medicine) to collaborate with clinical ethicists to develop and distribute a scenario-based educational module to ensure both physicians in training and independently licensed physicians are appropriately updated on this important policy change. Clinical ethicists are often involved in contentious end-of-life cases; as such, they could play a key role in developing the scenarios to highlight the relevant values conflict at play and recommend potential paths forward in these complicated cases (39,40). Other interprofessional team members should be included in these scenarios given their role in responding to patients in distress. This module should discuss positive and negative autonomy, remind physicians of their responsibility to help patients with life-limiting illness to plan for the future, and educate physicians on effective approaches to communication for patients with serious illness. The dignity and comfort of dying patients in Ontario hangs in the balance.

## NEXT STEPS IN POLICY DEVELOPMENT

For the purpose of this paper, we focused on the educational implications of medicolegal disputes about resuscitation in Ontario. We suggested that the practice guidelines in Ontario are sufficiently complex and have changed often enough in recent years to warrant the creation of an educational consortium to address this issue. Such a consortium would also provide the opportunity and venue to tackle additional issues in end-of-life policy that are beyond the scope of this paper. Such broader opportunities include building research and policy momentum for:

1. Practice-focused education on the potential benefits (15,41) and risks (42) of time-limited trials of life-prolonging therapy in the setting of clinical uncertainty about the effectiveness of medical management to achieve established goals for patients in the advanced stages of serious illness.
2. Practice-focused education on the decreasing necessity of referrals to the Consent & Capacity Board in the setting of resolvable disputes given policy change around the role of physicians in offering indicated treatments rather than substitute decision-makers deciding on interventions (15).
3. Practice-focused education on the distinction between *advance care planning* (which focuses on illness understanding and elicitation of values); *goals of care discussions* (which focuses on using information from advance care planning to align proposed care with patient values); and decision-making or *consent for treatments* and procedures required in the moment of delivery (45,46).
4. Potential national consensus on physician responsibilities regarding medical decision-making at the end of life given that some provinces, such as Manitoba (47) and Saskatchewan (48), have policies that follow the edict that physicians offer treatments based on clinical indication while other provinces, such as British Columbia and Alberta, offer no guidance in this matter.

An educational consortium promises broader engagement in CPSO policy development and a tangible means of educating physicians about their complex end-of-life responsibilities as policies shift with time. The outputs of this project could also be shared with other professional groups, such as nursing, so they can adapt and distribute the content to their members. We hope that the context provided in this paper and suggestions for future research and policy work will lead to new opportunities for collaborative efforts among clinicians, researchers, ethicists, and policy-makers working on this important issue.

## CONCLUSION

Previous Ontario policy put patients at the end of life at physical risk of harm and physicians working overnight at risk of moral harm. New CPSO policy in 2023 clarifies that physicians propose medically reasonable treatments, including CPR, and patients and their SDM can then choose from offered treatments. Targeted education will be necessary to assist physicians to recognize this change in their responsibilities. The complexity of Ontario's struggle with policy in this area can serve as an example for other Canadian jurisdictions considering drafting physician directives on medical care at the end of life.

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