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Article abstract

This paper examines the recent policy update by the College of Physicians and Surgeons of Ontario (CPSO), which allows physicians to override patient wishes for cardiopulmonary resuscitation (CPR) without consent. It critically analyzes the ethical implications of this shift, emphasizing the juxtaposition between the legal protections for patient's Last Wills and the relatively diminished safeguarding of their end-of-life care preferences. The paper highlights the potential for bias in physician decision-making, the risk of reverting to a more paternalistic healthcare model, and the challenge of balancing patient autonomy with medical authority. The study underscores the need for a nuanced approach to healthcare policy that respects patient autonomy while addressing the complexities of end-of-life decisions.

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TÉMOIGNAGE / PERSPECTIVE

Ethical Implications of End-Of-Life Decisions

Elisheva Nemetz[a], Ryan S. Huang[a]

Résumé
Ce texte examine la récente mise à jour de la politique de l'Ordre des médecins et chirurgiens de l'Ontario (CPSO), qui permet aux médecins de passer outre les souhaits des patients en matière de réanimation cardio-pulmonaire (RCP) sans leur consentement. Il analyse de manière critique les implications éthiques de ce changement, en mettant l'accent sur la juxtaposition entre les protections légales des dernières volontés des patients et la protection relativement réduite de leurs préférences en matière de soins de fin de vie. Le texte met en évidence le risque de partialité dans la prise de décision des médecins, le risque de revenir à un modèle de soins de santé plus paternaliste et la difficulté de trouver un équilibre entre l'autonomie du patient et l'autorité médicale. L'étude souligne la nécessité d'une approche nuancée de la politique des soins de santé qui respecte l'autonomie du patient tout en tenant compte de la complexité des décisions de fin de vie.

Abstract
This paper examines the recent policy update by the College of Physicians and Surgeons of Ontario (CPSO), which allows physicians to override patient wishes for cardiopulmonary resuscitation (CPR) without consent. It critically analyzes the ethical implications of this shift, emphasizing the juxtaposition between the legal protections for patient's Last Wills and the relatively diminished safeguarding of their end-of-life care preferences. The paper highlights the potential for bias in physician decision-making, the risk of reverting to a more paternalistic healthcare model, and the challenge of balancing patient autonomy with medical authority. The study underscores the need for a nuanced approach to healthcare policy that respects patient autonomy while addressing the complexities of end-of-life decisions.

Mots-clés
bioéthique, réanimation cardio-pulmonaire, autonomie, Ordre des médecins et chirurgiens de l'Ontario

Keywords
bioethics, cardiopulmonary resuscitation, autonomy, College of Physicians and Surgeons of Ontario

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INTRODUCTION

The recent policy update by the College of Physicians and Surgeons of Ontario (CPSO), which now permits physicians to override a patient's wishes for cardiopulmonary resuscitation (CPR) without consent, has sparked a complex debate surrounding medical ethics and patient autonomy. This decision accentuates the complex dynamics of medical authority, where the practitioner's assessment of medical futility can pre-empt the patient's personal preferences for end-of-life care. Medical authority in this context is twofold: it encompasses the physician's expertise and discretion to act in what is perceived as the patient's best medical interest, and it confers the responsibility to make pivotal decisions when a patient's capacity for informed consent is compromised. The question arises, however, about how this medical authority can be reconciled with the legal and ethical imperatives to respect patient autonomy, especially when compared to the legally robust protections afforded to a patient's Last Will and Testament.

A SHIFT IN PRIORITIZING ASSETS OVER END-OF-LIFE DECISIONS

The policy shift by the CPSO underscores that safeguarding a patient's assets now takes precedence over their end-of-life wishes. Aligning with the precedent set by Wawrzyniak v. Livingstone (1), this policy grants physicians the authority to override a patient's request for CPR without the patient's or substitute decision maker's (SDM) consent (2). This intervention is deemed permissible when a physician judges that the potential harms of CPR outweigh its benefits. The policy requires the physician to inform the family that a DNR order will be written, explain why resuscitative measures would not be appropriate, and propose what care may be provided (2). While physicians are obligated to notify the individual or family of the shift from CPR to do-not-resuscitate (DNR), in cases where death is imminent, "the physician can write an order to withhold resuscitative measures in the patient's medical record" and inform the family at the earliest convenience (2). The policy asserts that CPR is not classified as 'treatment,' thereby exempting it from requiring consent; however, the policy lacks a clear definition of the term 'treatment.'

NAVIGATING THE POTENTIAL FOR BIAS

This policy becomes operative when a physician perceives CPR as harmful. Despite physicians' extensive clinical experience and their commitment to optimizing patient outcomes, including minimizing pain and promoting health and longevity, the interpretation of what constitutes 'harm' may vary between practitioners and patients, carrying inherent bias (3-4). For a practitioner, harm may involve causing additional physical injury with CPR, while for a patient, harm may manifest in the disregard of their values that led them to request CPR.

The delegation of authority to healthcare providers to supersede a patient's explicitly communicated preference for CPR raises various ethical concerns. A fundamental concern arises from the inherent susceptibility to bias, given that these determinations

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rest upon the subjective discretion of the healthcare provider. The distinctive predilections of the provider, as well as the choices they might make for themselves or their family, may diverge from the preferences of the patient under their care (5). Furthermore, physicians lack an intimate familiarity with the patient's pre-hospitalization life and values, creating an inherent disjunction in understanding the patient's distinctive perspective. The physician's formulation of a meaningful conception of life and death may sharply contrast with that of the patient and their family, underscoring the imperative for physicians to acknowledge and navigate the profound disparities in perspectives (6). This incongruity accentuates the requisite need to adopt a nuanced, patient-centric approach that esteems and upholds individual autonomy in end-of-life decisions, while concurrently mitigating the potential influence of healthcare providers' inherent biases and idiosyncratic viewpoints on matters of life and death.

LEGAL PROTECTIONS AND ETHICAL DILEMMAS

It is imperative to juxtapose the recently instituted policy by the CPSO with an individual's Last Will and Testament, with specific emphasis on individual assets (7). In the same province where a physician can override an individual's CPR preference, there are more stringent safeguards in place for an individual's assets within their Last Will and Testament. For instance, the execution of the Last Will and Testament mandates that the individual demonstrates testamentary capacity and signs in the presence of two witnesses (8). Any alterations to the testament necessitate the individual demonstrate testamentary capacity and must, once more, occur in the presence of two witnesses; an alternative option results in the annulment of the existing will, prompting the creation of a new one.

The disconcerting dissonance between the legal protections afforded to a patient's Last Will and Testament and the vulnerability of their value-laden request for CPR at the end of life poses significant ethical challenges. While a patient's Last Will and Testament is shielded by legal safeguards, requiring testamentary capacity, and witnessed execution, the parallel request for CPR lacks comparable legal binding. This incongruity places the deeply personal and value-laden healthcare choices of patients at risk of being easily overridden. From a bioethics standpoint, the ethical incongruity between the robust legal protections surrounding a patient's Last Will and Testament, notably encompassing their assets, and the comparatively limited legal safeguards for end-of-life wishes, particularly concerning CPR, presents a morally vexing scenario. Granting legal sanctity to a patient's Last Will and Testament signifies society's recognition of the profound autonomy that individuals wield in shaping the allocation of their assets. The most concerning aspect resides in the observable inclination within societal dynamics, whereby material assets are granted precedence over the value attributed to human life, which is a deeply problematic societal framework (9).

A REGRESSION TOWARDS PATERNALISM

The act of a physician overriding a patient's explicit request for CPR at the end of life raises profound ethical concerns, reminiscent of a bygone era characterized by paternalistic medical practices. This departure from patient autonomy harks back to a time when the medical profession operated under a paternalistic model, wherein physicians held unilateral decision-making authority, often determining what they believed to be in the patient's best interest (10). The contemporary ethos of medical ethics, anchored in principles such as autonomy, beneficence, and informed consent, signifies a departure from such paternalistic tendencies (10). The recent policy shift in Ontario, allowing physicians to supersede a patient's CPR preferences, threatens the hard-fought progress toward patient-centred care. This regression not only compromises the fundamental right of individuals to direct their healthcare decisions, but also raises ethical questions about the appropriate balance between medical expertise and patient autonomy in the delicate context of end-of-life decision-making. The evolving landscape of bioethics must grapple with these challenges to ensure that the ethical imperatives of respect for patient autonomy and shared decision-making prevail over historical inclinations towards medical paternalism.

The principle of autonomy is foundational in ethical medicine, asserting individuals' rights to navigate their healthcare journey, including the decisions they make as they face the end-of-life (11). However, the acknowledgment of this autonomy does not preclude the recognition of downstream effects inherent in such requests. Issues such as resource allocation, financial considerations, potential cognitive dissonance, and the risk of moral injury to healthcare practitioners are intrinsic to the complex landscape of end-of-life care decisions. These challenges underscore the intricate balance required to navigate ethical dilemmas surrounding individual autonomy and broader societal considerations. Acknowledgment of these complexities necessitates a comprehensive approach that involves both the protection of autonomy and the development of ethical frameworks addressing the multifaceted consequences of such decisions.

CONCLUSION

In summary, while complexities arise in ensuring patient autonomy in end-of-life preferences, the act of overriding such preferences introduces greater risks and ethical issues. This practice endows physicians with unilateral authority, raising concerns about a regression into paternalistic healthcare models and the inadvertent imposition of personal biases onto patients. This becomes particularly glaring when juxtaposed against the legal safeguards extensively provided to protect a patient's assets, thereby exposing a societal bias whereby material assets are granted precedence over the value attributed to human life. The contrast in legal protections highlights an ethical imbalance. Consequently, the unilateral override of patient preferences demands further scholarly attention though comprehensive studies and research to address the ethical implications and potential consequences associated with this contentious aspect of end-of-life care.

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