THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

STATEMENT

No. 1602

WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT

BACKGROUND

Purpose

The purpose of this Statement is to assist physicians, their patients and others involved with decisions to withhold or withdraw life-sustaining treatment by establishing a process for physicians to follow when withholding or withdrawing life-sustaining treatment is being considered. It stipulates the ethical obligations of physicians, emphasizes open communication aimed at achieving consensus and provides for conflict resolution in circumstances where consensus cannot be reached.

Medical, Legal and Ethical Context

The spectrum of clinical scenarios raising consideration of withholding or withdrawing life-sustaining treatment ranges from abstract discussions about foreseeable end of life circumstances[1] to unforeseen medical emergencies[2]. Within the confines of this Statement, physicians must use their best clinical and ethical judgment to tailor their approach to the particular concerns and circumstances of each patient and should recognize that decisions concerning life-sustaining treatment may need to be revisited as circumstances change.

This Statement is necessarily limited to standards of care and ethical requirements for physicians. It cannot impose legal obligations or create legal rights in respect to physicians, nor can it impose legal or ethical obligations on other health care providers or on institutions. Likewise, it cannot create legal rights for patients

Physicians often treat patients who lack capacity to make their own health care decisions and who have not completed a health care directive expressing their wishes or appointing a health care proxy. In such circumstances, the common practice is to consult with and/or seek consent to treatment from a member of the patient's family. Though this practice is not specifically sanctioned by legislation or the common law, it is consistent with physicians' ethical obligations.

Certain aspects of provincial law regarding who has legal authority to make decisions regarding withholding or withdrawing life-sustaining treatment are ambiguous. Significant aspects of the legal context in which this Statement has been developed include:

1. Neither legislation nor the common law recognize a right to demand life-sustaining treatment;

[1] e.g. Consulting with a patient in the course of preparing a Health Care Directive or regarding an advanced care plan to address anticipated end of life situations.

[2] e.g. Deciding whether to initiate resuscitative efforts following a cardiac or respiratory arrest resulting from an unforeseen event.

2. No one, including the patient's next of kin, has the legal authority to consent to or refuse medical treatment, including life-sustaining treatment, on behalf of an adult patient, unless that person has been granted that authority by the patient in a valid health care proxy or by Court appointment or pursuant to legislation.[3]
3. The Manitoba Courts have recognized that physicians have the authority to make medical decisions to withhold or withdraw life-sustaining treatment from a patient without the consent of the patient or the patient's family.[4]
4. Physicians' legal authority to make such decisions is subject to significant corresponding legal duties[5] and ethical obligations[6].
5. Legislation provides that the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs.[7]

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[3]Persons who may be legally authorized to consent to or refuse medical treatment may be:

a. statutorily authorized, 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.

[4] See Re: Child and Family Services of Central Manitoba v. Lavalee (1997), 154 D.L.R. (4th) 409 (Man. C.A.) and Sawatzky v. Riverview Health Centre Inc. (1998), 167 D.L.R. (4th) 359 (Man. Q.B.)

[5] These duties include, but are not limited to, specific duties associated with the doctrine of informed consent, patient confidentiality and the duty to exercise reasonable care and not to expose the patient to unreasonable risk of harm.

[6] These obligations include those established in the following provisions of The Code of Conduct:

> *12. Provide your patients with the information, alternatives and advice* they need to make informed decisions about their medical care, and answer their questions to the best of your ability.*
> *13. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.*
> *14. Ensure that information is available or has been provided to patients so that they know how to obtain care in your absence.*
> ** new wording added by CPSM*
> *15. Recommend only those diagnostic and therapeutic procedures that you consider to be beneficial to your patient or to others. If a procedure is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.*
> *16. Respect the right of a competent patient to accept or reject any medical care recommended.*
> *17. Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment.*
> *18. Respect the intentions of an incompetent patient as they were expressed (e.g. through an advance directive or proxy designation) before the patient became incompetent.*
> *19. Treatments that offer no benefit and serve only to prolong the dying process should not be employed. When appropriate, an effort should be made to explain non-provision of futile treatments with patients and families.*
> *20. When the intentions of an incompetent patient are unknown and when no appropriate proxy is available, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests.*
> *21. Respect your patient's reasonable request for a second opinion from a physician of the patient's choice.*
> *22. Recognize the need to balance the developing competency of children and the role of families in medical decision-making.*
> *23. Be considerate of the patient's family and significant others and cooperate with them in the patient's interest.*
> *23A. When a patient expresses discontent with medical care received from you, the ethical physician will attempt to resolve the issues. If the issues are not resolvable, the physician will provide the patient with information about the role of the College and its complaints process. (EN.06/02)*

[7] *The Vital Statistics Act*, C.C.S.M. c. V60, section 2.

Terminology

The following terms are defined for the purpose of this Statement. **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 Statement.

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 member of the College 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 Statement 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.[8]

[8] This person's authority is limited to that legally granted to him/her by the patient, Court, legislation or otherwise. See supra note 3 for examples.

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.

Guiding Principles

1. A patient is not just a physical being, but a person with a body, mind and spirit expressed in a human personality of unique worth.
2. Human life and dignity must be respected, recognizing that death is a natural and inevitable event.
3. Issues relating to end of life care should be addressed in a supportive environment.
4. Good communication with patients/proxies/representatives and amongst physicians and other members of the health care team is essential to the provision of a high standard of medical care.
5. The ethical foundations of the relationship between physician and patient are the sometimes competing principles of beneficence, nonmaleficence, respect for patient autonomy and justice. None of these principles should be considered in isolation. The physician's primary goal of treatment is to restore or maintain the patient's health as much as possible in a manner that maximizes benefit, minimizes harm and recognizes the objectives of the patient.
6. A physician cannot be compelled by a patient, proxy, representative or member of the patient's family to provide treatment that is not in accordance with the current standard of care.
7. When restoring or maintaining health is not possible, the physician's primary goal becomes palliative care focused on patient comfort.
8. The physician has an ongoing obligation to communicate with his/her patient, proxy or representative and, where appropriate, the patient's family, regarding withholding or withdrawing life-sustaining treatment from the patient.
9. A patient, either on his/her own behalf or through a proxy or representative, has the right to participate in decisions regarding withholding or withdrawing life-sustaining treatment, facilitated by open and honest communication with the patient's physician.
10. The physician must maintain patient confidentiality and is only authorized to disclose personal health information regarding his/her patient to others, including members of the patient's family, with the consent of the patient or a legally authorized proxy, except in limited circumstances[9]
11. A patient has the right to consent to and/or refuse medical treatment, including life-sustaining treatment, where it is possible for the patient to give or refuse consent. The consent or refusal must be voluntary and informed in that the nature of treatment and its benefits and risks and alternatives to treatment are understood.
12. A physician cannot be compelled to withhold or withdraw life-sustaining treatment from a patient where that physician believes that continuing treatment is in the patient's best interests unless the patient has made an informed decision to refuse treatment.

[9] See *The Code of Conduct*, Articles 24-26 regarding confidentiality and *The Personal Health Information Act,* C.C.S.M. c. P33.5, Section 22, which permits limited disclosure of personal health information about a patient to prevent or lessen serious and immediate threat to the health or safety of any individual, including the patient, and Section 23, which allows limited disclosure to family members when the disclosure is about current care, is in accordance with good medical and professional practice, and it is believed that the disclosure would be acceptable to the patient.

SCOPE

This Statement applies to all physicians.

REQUIREMENTS

The requirements in this Statement are personal and must not be delegated to other members of the health care team in other than exceptional circumstances. They must be met to the extent possible, recognizing that the manner in which they will be met may vary to accommodate unique circumstances and that it may not be possible to meet all requirements in some circumstances.

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 Statement 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[10] 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.

[10] "Recognize your limitations and the competence of others and when indicated, recommend that additional opinions and services be sought", Article 6, Code of Conduct.

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 the patient is not capable of participating in the discussion, the physician should inquire as to whether the patient has made his/her wishes known in a valid health care directive, and/or has designated a proxy.
- 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 should share personal health information and consult with the representative in accordance with this Statement to identify known preferences and/or interests of the patient and/or what treatment might be in the patient's best interests.
- In some cases, patients/proxies/representatives can be assisted by others, including, social work, spiritual care, clinical ethics, patient advocacy and/or other available members of the healthcare team, whose assistance should be sought by the physician where appropriate.
- 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 Statement, 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.[11]
- 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 Statement;
  - particulars of the communications required by this Statement, 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.

[11] See By-law #1, Article 29 and Guideline 117.

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.

A. NO CONSENSUS - THE PHYSICIAN OFFERS LIFE-SUSTAINING TREATMENT BUT THE PATIENT/PROXY DECLINES TREATMENT OR THE REPRESENTATIVE ADVOCATES WITHHOLDING OR WITHDRAWING TREATMENT

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.

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.[12]
- 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

[12] Where a proxy is legally authorized to refuse life-sustaining treatment and the physician believes that continuing treatment is in the patient's best interests and that physician has reason to believe that the proxy has an improper motive for refusing treatment on the patient's behalf, the physician should consider seeking legal advice.

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.

4. Documentation

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

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

1. Clinical Assessment

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

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.

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.

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.

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

1. Clinical Assessment

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

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. 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.

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.

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.

   ii. 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.

4. 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.

D. EMERGENCY SITUATIONS WHERE COMMUNICATION BETWEEN PHYSICIAN AND PATIENT/PROXY/REPRESENTATIVE CANNOT OCCUR

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.

2. Communication

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

3. Implementation

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

4. Documentation

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

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

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.

2. DNAR 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 Statement 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.

A statement is a formal position of the College with which members shall comply.

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