



CMA STATEMENT ON LIFE-SAVING AND -SUSTAINING INTERVENTIONS

(Update December 2013)

Life-saving interventions are understood to be those provided with the intent of reversing or interrupting a potentially fatal event. A life-sustaining intervention is any medical procedure which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function for a condition that could be either reversible (the person will eventually recover to a point where the intervention will no longer be required in order to sustain life) or irreversible in nature (the person will never be able to survive without the life-sustaining intervention). Life-sustaining interventions can include, but are not limited to, mechanical ventilation and medically assisted nutrition and hydration.

Cardiopulmonary resuscitation (CPR) is one commonly used example of a potentially life-saving intervention. It was developed as an intervention for cases of sudden unexpected cardiac or respiratory arrest. CPR is understood to include mouth-to-mouth resuscitation, chest compression, bag-and-mask positive-pressure ventilation intubation and defibrillation. It is now used in the

majority of cases of sudden cardiac or respiratory arrest, whether unexpected or not, unless a specific order to the contrary (do-not-resuscitate [DNR]) has been recorded on the person's health record by the responsible physician. However, CPR is not clinically indicated in all cases and hence cannot always be considered a standard intervention. (Throughout this document “arrest” is taken to include severe bradycardia in children.)

After several decades of experience and review, it appears that there are people who benefit from life-saving and -sustaining interventions, and others for whom there is no benefit and potentially significant harm. In this situation, “benefit” can mean both the likelihood of being able to make a recovery from a reversible illness, as well as the likelihood of regaining a state of meaningful interaction with one’s environment where the illness is not reversible and the person cannot survive without life-sustaining interventions.

For situations where there will not be any medical benefit, the intervention is not only

generally unsuccessful but also inappropriate, as it may serve only to increase pain and suffering and prolong dying. Withholding life-saving or -sustaining interventions does not imply the withholding of other clinically indicated treatment and supportive care, including palliative care.

The use of life-saving and -sustaining interventions should be considered in the context of a changing societal environment, which recognizes the autonomy of the individual, encourages increased public discussion of bioethical issues and stresses the need for empirical evidence of positive patient outcomes following treatment.

Guiding principles

1. Good health care requires open communication, discussion and sensitivity to cultural and religious differences among caregivers, potential recipients of care, their family members and significant others.
2. A person must be given sufficient information about the benefits, risks and likely outcomes of all clinically indicated treatment options to enable him or her to make informed decisions.
3. A competent person has the right to refuse, or withdraw consent to, any clinically indicated treatment, including life-saving or life-sustaining treatment. Competence can be difficult to assess because it is not always a constant state. A person may be competent to make decisions regarding some aspects of life but not others; as well, competence can be intermittent — a person may be lucid and oriented at certain times of the day and not at others. The legal definition and assessment of competence are governed by the provinces or territories. Health care providers should be aware of the laws (e.g., capacity to consent

and age of consent) regarding the assessment and documentation of incompetence.

4. When a person is incompetent, any clinically indicated treatment decisions must be based on his or her previously expressed wishes and values, if these are known. The person's decision may be found in an advance directive or may have been communicated to the physician, other members of the health care team or other relevant people. In some jurisdictions, legislation specifically addresses the issue of decision-making concerning medical treatment for incompetent people; the legislative requirements should be followed.

5. When an incompetent person's wishes are not known, clinically indicated treatment decisions must be based on the person's best interests, taking into account:
- a. the person's known values and preferences,
 - b. information received from those who are significant in the person's life and who could help in determining his or her best interests,
 - c. aspects of the person's culture and religion that would influence a treatment decision, and
 - d. the person's diagnosis and prognosis.

In some jurisdictions legislation specifies who should be recognized as designated decision-makers (proxies) for incompetent people; this legislation should be followed. The term "proxy" is used broadly to identify those people who make a treatment decision based on the decision a person would have made for himself or herself (substitute decision-maker), people who help in determining what decision would be in the person's best interest and people whose appropriateness to make treatment decisions for the person is recognized under provincial legislation.

6. There is no obligation to offer a person medically futile or non-beneficial interventions. Medically futile and non-

beneficial treatments are controversial concepts when applied to life-saving and life-sustaining interventions. For the purposes of this document, “medically futile” and “non-beneficial” are understood as follows: in some situations a physician can determine that an intervention is medically futile or non-beneficial because it offers no reasonable hope of recovery or improvement or because the person is permanently unable to experience any benefit; in other cases the utility and benefit of an intervention can only be determined with reference to the person's subjective judgment about his or her overall well-being. As a general rule a person should be involved in determining medical futility in his or her case. In exceptional circumstances such discussions may not be in the person's best interests. If the person is incompetent the principles for decision-making for incompetent people should be applied.

In cases of disagreement between the health care team and the patient or his/her proxy regarding non-initiation or discontinuation of a life-saving or -sustaining intervention, a second medical opinion should be obtained. Where there is clinical agreement that a life-saving or -sustaining intervention is medically futile, that intervention need not be offered, and can be withdrawn where it has already been put in place. There is no ethical distinction to be made between the non-initiation or the discontinuation of a life-saving or life-sustaining intervention.

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

7. In those exceptional circumstances where they are required, any legal or other appeals should be considered on a priority basis and in an expedited and timely manner.

8. A decision not to initiate or continue life-saving or -sustaining interventions does not imply the withholding or withdrawing of any other clinically indicated treatment or intervention.

A person who will not receive life-saving or -sustaining interventions should receive all other clinically indicated treatments, including palliative care, for his or her physical, mental and spiritual comfort.