

Long-Term Care Facility Policies on Life-Sustaining Treatments and Advance Directives in Canada

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OBJECTIVE: To describe the prevalence and content of long-term care facility policies regarding the use of life-sustaining treatments (cardiopulmonary resuscitation (CPR), artificial hydration and nutrition, dialysis, antibiotics for life-threatening infections, transfer to acute care hospital) and advance directives in Canada.

DESIGN: Cross-sectional mailed survey.

SETTING: Canadian long-term care facilities with 25 beds or more listed in the 1991–92 Directory of Long Term Care Centres in Canada. Institutions listed as, “general hospitals,” “psychiatric hospitals,” “children’s treatment centres,” “group homes,” or as purely residential facilities were excluded.

PARTICIPANTS: Chief Executive Officers or their designates.

MAIN OUTCOME MEASURES: Respondents’ self-reports regarding the existence of life-sustaining treatment or advance directive policies and content analysis of the policies themselves.

RESULTS: Of 1472 long-term care facilities, 1021 (69%) responded. Of these, 344 (34%) institutions had 397 policies regarding the use of life-sustaining treatments or advance directives. Three hundred twenty facilities (31%) had 349 do-not-resuscitate (DNR) policies (40% on CPR alone and 60% on CPR plus other life-sustaining treatments). Seventeen institutions (2%) each had one policy addressing life-sustaining treatments other than CPR, and 31 institutions (3%) each had one policy addressing advance directives. Of the 397 policies, 171 (43%) required routine discussion with all patients, 156 (39%) mentioned futility, 331 (83%) indicated that the competent patient had the right to make a decision about life-sustaining treatment, 265 (67%) indicated that the family of the incompetent patient had this right, 27 policies (7%) mentioned conflict resolution, 378 (95%) had an explicit requirement for recording the deci-

sion, 10 (3%) required explicit communication of the decision to the competent patient, 10 (3%) required such communication to the family of the incompetent patient, 260 (66%) required updating of the decision, and 213 (54%) mentioned rescinding or changing the decision.

CONCLUSIONS: Only one-third of Canadian long-term care facilities have do-not-resuscitate policies, and even fewer have policies on advance directives or life-sustaining treatments other than CPR. The policies themselves could be improved by encouraging routine advance discussions, scrutinizing the use of the futility standard, stipulating procedures for conflict resolution, and explicitly requiring communication of the decision to competent patients or substitute decision makers of incompetent patients. *J Am Geriatr Soc* 42:1150–1153, 1994.

Landmark cases such as those of Nancy Cruzan¹ in the United States and Nancy B. in Canada,² have resulted from conflicts between the wishes of patients and the treatment philosophy of health providers or health care facilities.³ Such cases are becoming increasingly common.⁴ Institutional policies governing the use of life-sustaining treatments (LSTs) and advance directives (ADs) may provide clarification for patients and health care providers.⁵ These policies may be of particular relevance to Long-Term Care facilities since do-not-resuscitate (DNR) orders tend to be written more often for patients who are older, have increasing severity of illness, and reside in nursing homes.^{6–12} Although studies in the United States have examined the prevalence of institutional policies regarding DNR orders^{13–15} and ADs,¹⁶ and although a study in Canada has examined the prevalence and content of LST (including but not limited to DNR) and AD policies in hospitals,¹⁷ we are unaware of any studies examining LST/AD policies of Canadian long-term care facilities. Furthermore, we are unaware of comprehensive national studies from any country examining LST/AD policies in long-term care facilities. The purpose of this study was to describe the prevalence and content of policies regarding the use of life-sustaining treatments (cardiopulmonary resuscitation (CPR), artificial hydration and nutrition, dialysis, antibiotics for life-threatening infections, transfer to acute care hospital) and advance directives in Canadian long-term care facilities.

METHODS

All long-term care facilities with 25 beds or more listed in the Canadian Hospital Association 1991–92 Directory of Long Term Care Centres¹⁸ were included. Institutions listed

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as, "general hospitals," "psychiatric hospitals," "children's treatment centres," "group homes," or as purely residential facilities were excluded. The long-term care facilities were surveyed between June and September 1992 using a mailed questionnaire, in English or French as appropriate, addressed to the chief executive officer of the institution. The questionnaire, which was based on one used for a similar study examining hospital policies,¹⁸ had two sections: (a) questions about the existence of institutional policies regarding LSTs (including CPR, artificial hydration and nutrition, dialysis, antibiotics for life-threatening infections, transfer to acute care hospital) or ADs, as well as about which of these LSTs the institution provided (ie, self-report data); and (b) a request for respondents to send us copies of any relevant policies their institution had in effect (ie, data from the policies themselves). We consider policies regarding CPR (ie, DNR policies) as only one category of LST policy; other types include those listed above.

Institutions that did not respond within 1 month were contacted again by mail. When the response required clarification (for example, the long-term care facility indicated that it had a policy but failed to enclose it), a follow-up letter was sent. Policies were excluded if they did not pertain to medical ethics (for example, if they contained only technical or clinical details of administering a treatment) or if they had not yet been approved by the long-term care facility. Institutions that indicated they had no LST/AD policies or that sent policies that were excluded were counted as responding hospitals without policies. Institutions that indicated on the questionnaire that they had policies but failed either to enclose them, despite follow-up, or noted that the policies were unavailable, under review, or confidential were counted as responding hospitals without policies.

Content analysis of the policies was conducted by one observer using a structured data abstraction form containing the following criteria: type of policy (CPR only, CPR plus other LSTs, artificial nutrition and/or hydration only, dialysis only, advance directives, transfer to acute-care hospital, other), similarity of policy to Canadian Hospital Association (CHA), Canadian Medical Association (CMA), and Canadian Nurses Association (CNA) Joint Statement on Terminal Illness,¹⁹ requirement for routine discussion of the LST/AD policy with patients, restriction of policy to a particular class of patients, mention of futility/uselessness/no medical benefit or similar concepts, mention of patient competency/decision-making capacity, mention of persons involved in decision-making process, mechanism to resolve disagreements between patient/surrogate and physician, explicit requirement for recording decision or discussion, explicit requirement for reviewing/updating decision, and mention of rescinding/changing LST decision.

Univariate analysis was performed using proportions with the SAS computer program (SAS Institute, Cary, NC).

The study was approved by the Human Subjects Review Panel of the University of Toronto.

RESULTS

Respondent Characteristics

Of the 1526 long-term care facilities surveyed, four were excluded because they were doubles of other entries already included, 15 institutions had closed or moved, and 35 institutions indicated that this survey was not applicable to

them as they were residential facilities and did not provide any medical care. Of the remaining 1472 long-term care facilities, 434 (29%) did not respond, 17 (1%) returned blank forms, and 1021 (69%) provided usable responses.

Self-Report Data

Of the 1021 long-term care facilities responding to the self-report questionnaire, 965 indicated whether they had an ethics policy relating to CPR; 355 (37%) of these 965 reported having such a policy. Of the 519 institutions that indicated they provide CPR to their patients, 52% reported that they had a CPR policy; however, of the 384 institutions that indicated they do not provide CPR, only 17% indicated that they had a CPR policy. Of the 952 long-term care facilities that indicated whether they had an advance directive policy, 166 (17%) indicated that they did.

Types of Policies

Of 1021 respondents, 344 institutions (34%) sent 397 policies regarding the use of LSTs/ADs (Table 1). Of these, 296 facilities (86%) had a single policy, 43 (13%) had two policies, and five (1%) had three policies each. One hundred twelve institutions (11%) had 113 policies addressing CPR only (1 facility had 2 such policies). One hundred eighty-three institutions (18%) had 184 policies addressing CPR plus other LSTs (1 institution had 2 such policies). Twenty-three institutions (2%) had both a CPR only and a CPR plus other LSTs policy, and two institutions had two CPR only and one CPR plus other LSTs policies. Therefore, since we define DNR policies to be those addressing CPR only or CPR plus other LSTs, a total of 320 institutions (31%) had 349 DNR policies, of which 140 (40%) address CPR only and 209 (60%) address CPR plus other LSTs. In addition, 17 institutions (2%) each had one policy addressing specific LSTs other than CPR (eg, tube feeding, artificial nutrition and hydration, antibiotics), and 31 institutions (3%) each had one policy addressing ADs. There was considerable variation among provinces with respect to the prevalence of DNR policies: Alberta (57%), British Columbia (63%), Manitoba (48%), New Brunswick (18%), Newfoundland (50%), Nova Scotia (7%), Ontario (29%), Prince Edward Island (9%), Quebec (11%), Saskatchewan (19%), and the Yukon Territory (0%).

Table 1. Proportion of Canadian long-term care facilities with various types of LST/AD policies

| | |
|---|-----------|
| Total LTC Facilities Surveyed [n] | 1472 |
| Usable Respondents [n (%)] | 1021 (69) |
| LTC Facilities with CPR Only policies [n (%)] | 137 (13) |
| LTC Facilities with CPR+Other LSTs policies [n (%)] | 208 (20) |
| LTC Facilities with DNR* policies (total) [n (%)] | 320 (31) |
| LTC Facilities with LST policies other than DNR [n (%)] | 17 (2) |
| LTC Facilities with Advance Directive policies [n (%)] | 31 (3) |

LTC = Long-term care; LST = Life-sustaining treatment; AD = advance directive; CPR = cardiopulmonary resuscitation; DNR = Do not resuscitate.

*DNR policies are all those that address CPR Only or CPR+Other LSTs. The numbers in the DNR row do not equal the sum of the two preceding rows because 23 institutions had both CPR only and CPR+Others LSTs policies, and two institutions had two CPR only and one CPR plus other LSTs policies.

Content of Policies

Of the 140 policies that addressed CPR alone, 89 (64%) were based on the Canadian Joint Statement¹⁹ policy guidelines regarding resuscitative intervention for the terminally ill. The specific content of all 397 policies is detailed in Table 2. It is clear that some issues are addressed in most policies, for example competency and the requirement to record the actual decision, whereas other issues, such as conflict resolution and communication of the decision to the competent patient or family of the incompetent patient, are rarely addressed.

DISCUSSION

This study shows that only one-third of Canadian long-term care facilities have do-not-resuscitate policies. Even fewer institutions have policies addressing ADs or LSTs other than CPR. This relatively low prevalence suggests there is scope for policy development. An increased number of LST/AD policies would, perhaps, serve to enhance patient autonomy and aid in clinical decision-making,⁵ although this presumption has not been fully established.²⁰

When comparing questionnaire forms completed by respondents with the policies they actually sent, 37% of the institutions indicated that they had policies addressing CPR, while 31% sent such policies. This suggests that we have obtained a reasonable estimate for the prevalence of DNR policies. Conversely, while 17% of the institutions indicated they had a policy addressing ADs, only 3% sent AD policies. This discrepancy may in part be explained by the fact that many institutions indicated that they had AD policies, which, when analyzed, actually addressed CPR plus other LSTs.

The prevalence of LST/AD policies in Canadian long-term care facilities is 21% lower than in Canadian hospitals.¹⁷ This would support the hypothesis that policy development in long-term care facilities lags behind that of hospitals,⁵ perhaps because published model policies have

been designed for hospitals and because long-term care facilities are smaller and, therefore, have fewer resources to help with policy development.⁵ Moreover, studies of US nursing homes completed 5 years ago,^{13,15} found a prevalence of DNR policies similar to that of this survey.

The long-term care policies analyzed address a broader spectrum of treatment issues than the policies found in Canadian hospitals.¹⁷ Many long-term care institutions have adopted CPR plus other LSTs policies that allow patients to express their wishes regarding a variety of different treatment options for a variety of different health states including, but not limited to, CPR. This type of policy accounted for 60% of long-term care facility DNR policies but only 8% of hospital DNR policies, the majority (92%) of which addressed CPR only.

Only 3% of long-term care facilities sent policies that address ADs. Although this prevalence is equal to that found in Canadian hospitals,¹⁷ it is dramatically lower than that found in US hospitals.¹⁶ The low prevalence may be explained by the fact that only four Canadian provinces (Nova Scotia,²¹ Quebec,²² Manitoba,²³ and Ontario²⁴) have passed legislation on ADs.

The majority (64%) of protocols addressing CPR only were identical or similar to the Canadian Joint Statement on terminal illness. Two other studies^{14,17} have shown that the publication of model policies may influence policy development. Thus, the establishment of national guidelines by professional organizations may be an effective way to stimulate policy development.

LST and AD policy may further efforts to ensure patient-centered medicine. Presumably, discussion with patients about LST decisions would be central to achieving this goal. However, only 43% of the policies actually require routine discussion with all patients admitted to the institution. Conversely, in the US, health care facilities are required to inform patients on admission of their rights to forego life-sustaining treatment and to complete an AD.^{25,26}

Many of the policies (39%) made reference to futility. These policies typically referred to the irreparability and irreversibility of the patient's medical condition. Since use of the futility standard in health care decision making remains controversial,²⁷⁻³³ frequent reliance on futility in Canadian policies is disturbing and deserves further attention.

Possible disagreement among patient, family, and staff is infrequently addressed in existing policies. Generally, those policies that addressed conflict resolution indicated that disputes should be mediated by a second doctor or an institutional ethics committee. Since the potential for conflict certainly exists, and since hospital policies may help in such cases,⁵ policies should be revised to provide mechanisms for conflict resolution.

It is of concern that only 3% of policies explicitly require communication of the LST/AD decision to the competent patient or the family of the incompetent patient. This may simply be a policy oversight since 83% and 67% of policies affirm the right of competent patients and the families of incompetent patients to participate in the decision-making process. Nevertheless, it would be reassuring if a specific requirement for communication of the decision were contained in the policies.

This study has five main limitations. First, because respondents may have differed from nonrespondents, our findings are susceptible to nonresponse bias. However, the

Table 2. Proportion of LST/AD policies (n=397) with specific content items

| Policies | (n) | (%) |
|---|-----|-----|
| Routine discussion required with all patients | 171 | 43 |
| Restriction of policy to particular class of patients | 87 | 22 |
| Futility or similar concepts mentioned | 156 | 39 |
| Competency mentioned | 281 | 71 |
| Policy indicates who has the right to make a decision | 344 | 87 |
| Competent patient | 331 | 83 |
| Family of incompetent patient | 265 | 67 |
| Other | 90 | 23 |
| Mechanism for conflict resolution mentioned | 27 | 7 |
| Policy indicates requirement for recording outcome and or process of decision | 378 | 95 |
| Policy requires communication of the decision to | | |
| Competent patient | 10 | 3 |
| Family of incompetent patient | 10 | 3 |
| Other | 96 | 24 |
| Reviewing/updating decision required | 260 | 66 |
| Rescinding/changing decision mentioned | 213 | 54 |

moderately high response rate (69%) helped to reduce the possibility of this bias. If none or all of the nonrespondents actually had LST/AD policies, the rate of 34% for such policies might actually be as low as 23% or as high as 54%. Second, content analysis of the policies is, by its nature, subjective. To minimize bias, a structured instrument was used. Third, because we sampled the entire population of long-term care facilities in Canada with 25 beds or more (with the above noted exclusions), our data are applicable to such institutions in Canada. However, caution should be exercised in generalizing the results to other countries. Fourth, our goal was to describe the prevalence and content of LST and AD policies in Canada, not to conduct a normative, ethical analysis of the merits of specific issues contained in the policies (for example, futility). However, ethicists can now begin such an analysis from a foundation of empirical fact rather than hypothetical conjecture. Finally, we did not examine the impact of policy on actual practices within hospitals. It is conceivable that some hospitals with no policy provide highly ethical care while some with outstanding policies do not.

In conclusion, only one-third of Canadian long-term care facilities have DNR policies. Even fewer have policies regarding ADs or LSTs other than CPR. The policies themselves could be improved by encouraging routine advance discussions, scrutinizing the use of the futility standard, stipulating procedures for conflict resolution, and explicitly requiring communication of the decision to competent patients or substitute decision makers of incompetent patients. Although descriptive surveys of the opinions of Canadian physicians,³⁴⁻³⁶ patients,³⁷ and the public³⁸⁻⁴⁰ suggest that LST/AD decision making is widely supported in principle, the low prevalence of LST/AD policies found by this survey demonstrates that this principled support has not been fully translated into practice.

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