

Decision-making for the End of Life Preliminary Consultation

Online Survey Report and Analysis

Introduction:

An external consultation on the existing *Decision-making for the End of Life* policy was held from September 23 to November 22, 2013.

The purpose of the consultation was to obtain stakeholders' feedback on the existing policy to assist the College in updating the policy. In particular, to help determine how the policy can be improved in order to ensure it reflects current practice issues, embodies the values and duties of medical professionalism, and is consistent with the College's mandate to protect the public.

Invitations to participate in the consultation were sent out via email to all physician members and key stakeholder organizations, as well as individuals who had previously indicated a desire to be informed of College consultations. The consultation was also promoted through social media and respondents to a public opinion poll conducted in October, 2013 were also invited to participate in the consultation.

Feedback was collected via email, through a WordPress online discussion forum, via regular mail, and through an online survey using the website Survey Monkey.

In accordance with the College's posting guidelines all feedback received through the consultation is posted online. This report summarizes the stakeholder feedback received through the online survey.

Caveats:

207 respondents started the survey (see *Table 1* below). Of these, 75 respondents did not complete any of the substantive questions¹. These respondents were removed from the analysis below. Only 16 respondents partially completed the survey, completing at least one of the substantive questions². The results reproduced below capture the responses for both complete and partially complete respondents.

Table 1: Survey Status

Started	n=207
Complete	116
	56%
Partial Complete	16
	36%
Incomplete	75
	36%

¹ These respondents completed only the demographic or 'warm-up' questions and dropped out of the survey before answering questions assessing the existing policy.

² These respondents completed at least the section of questions assessing the clarity of the policy, but may have answered further questions as well.

The purpose of this online survey was to collect ‘feedback’ from physicians, organizations, and the public regarding the existing *Decision-making for the End of Life* policy. Participation in the survey was voluntary and one of a few ways in which feedback could be provided. As such, no attempt has been made to ensure that the sample is representative of the larger physician, organization or public populations and no statistical analyses have been conducted.

The *quantitative* data shown below is complete and the number of respondents who answered each question is provided.

The *qualitative* data captured below is a summary of the general themes or ideas conveyed through the survey. The comments in their entirety are included as *Appendix A* at the end of this document. Please note that in keeping with our consultation processes, feedback has been amended in accordance with our posting guidelines.

Respondent Profile:

Nearly all respondents indicated that they were completing the survey on behalf of themselves (see *Table 2*). Only 2 respondents indicated that they were completing the survey on behalf of an organization³.

Table 2: Respondents

Are you completing this survey on behalf of yourself or an organization?	n=132
Self	130
Organization	2

As shown in *Table 3* below, respondents were somewhat split between physicians (39%) and members of the public (46%).

Table 3: Respondents (cont’d)

Are you a....?	n=132
Physician	51
	39%
Member of the Public	61
	46%
Organization Staff (e.g. policy staff, registrar, senior staff)	3
	2%
Other health care professional (e.g. nurse, pharmacist)	8
	6%
Other (specify)	9
	7%

³ Historically organizations tend to provide feedback in written form, usually by way of a formal letter sent directly to the CPSO through regular mail or email. These submissions are posted in the WordPress online discussion forum for each consultation.

Experience with the Policy:

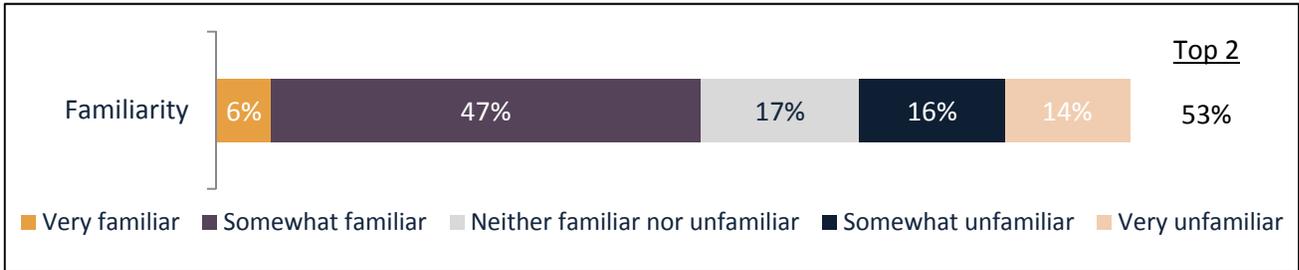
Just over three-quarters (78%) of respondents indicate that they have read the current version of the *Decision-making for the End of Life* policy (see *Table 4*).

Table 4: Read Policy

Have you read the current version of the <i>Decision-making for the End of Life</i> policy?	n=132
Yes	103 78%
No	29 22%

Familiarity with the policy is modest with around one-half (53%) of respondents reporting that they are either very (6%) or somewhat (47%) familiar with the policy (see *Figure 1*). It is worth emphasizing that the largest group is those who are ‘somewhat aware’ (47%).

Figure 1: Familiarity with Policy



Q4. Before today, how familiar were you with the College’s *Decision-making for the End of Life* policy? Base: n=132

Seven-in-ten (70%) respondents say they have never turned to this policy to help them address questions or circumstances that arise (see *Table 5*). Among those who do turn to the policy a number of different reasons were provided. Members of the public tended to report turning to the policy for help when caring for dying or ill family members or because they were curious, were conducting research, or wanted to know the College’s stance on end of life care. Physicians reported turning to the policy for primarily practice support or guidance regarding issues such as conflict resolution, caring for dying patients, and other difficult cases, but also mentioned teaching as a reason for turning to the policy.

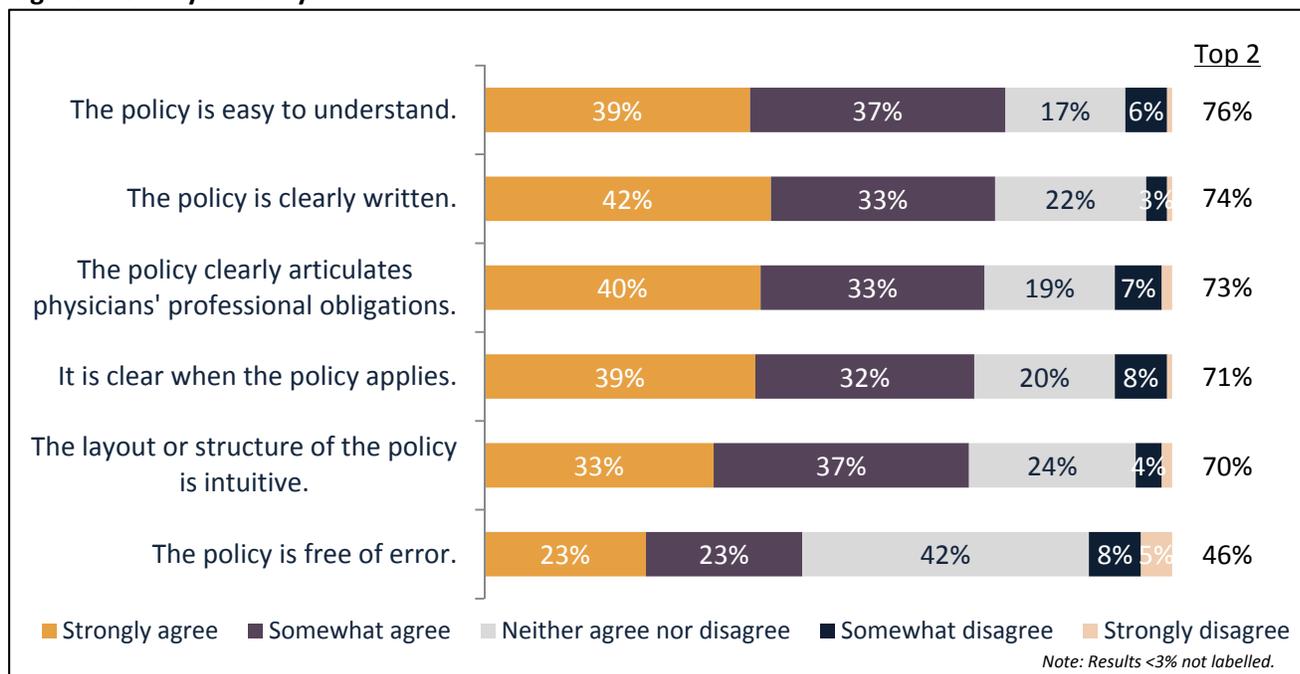
Table 5: Turn to Policy

Please tell us when you turn to this policy? (i.e. what questions or circumstances prompt you to look it up)	n=132
I have never referred to this policy.	93 70%
I refer to this policy when...(Please specify any instances where you have referred to this policy)	39 30%

Assessments of the Policy:

As reported in *Figure 2* below, seven-in-ten or more respondents think that the policy is easy to understand (76%), clearly written (74%), clearly articulates physicians' professional obligations (73%), is clear as to when it applies (71%), and has a layout or structure that is intuitive (70%). While fewer than one-half (46%) of respondents agree that the policy is free of error, many (42%) take a neutral position with respect to this metric.

Figure 2: Clarity of Policy



Q6. We'd like to understand whether the policy is clear. Please indicate whether you agree or disagree with each of the following statements regarding the clarity of the policy. Base: n=132

Open ended feedback regarding the clarity of the policy was collected from 50 respondents⁴. Feedback generally touched on similar issues:

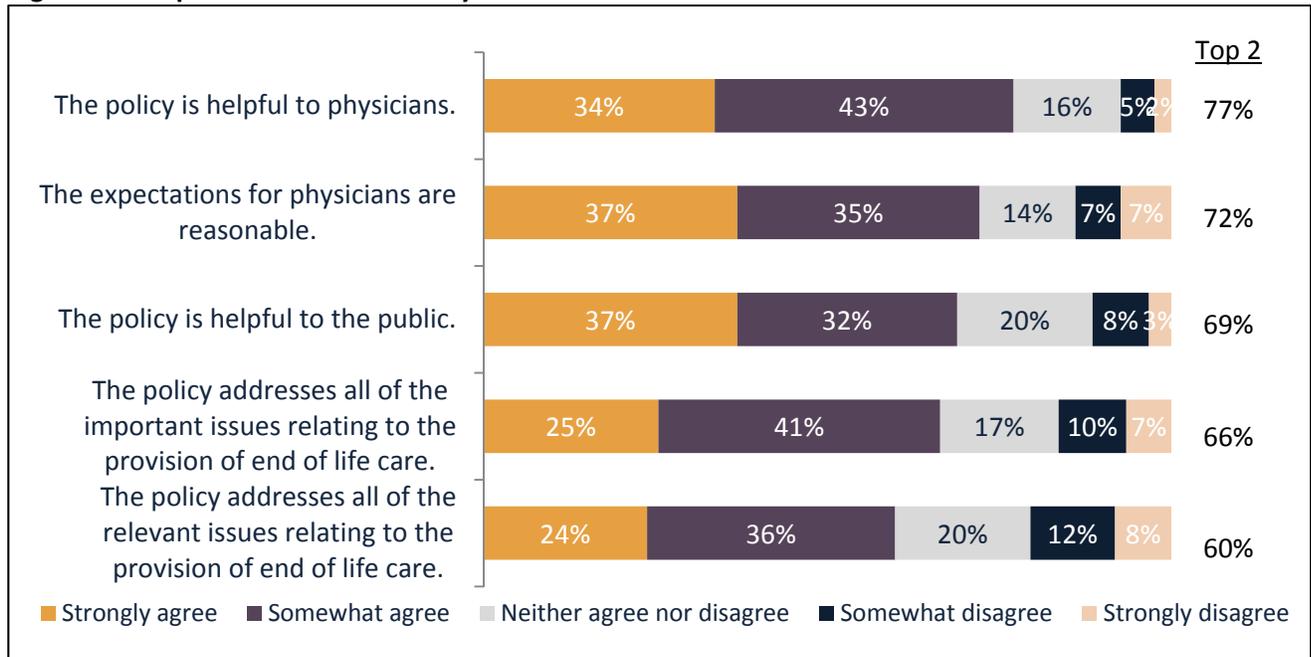
- Some commented that the policy was clearly written.
- Some requested that the College take an official position on physician-assisted suicide and euthanasia, not just citing that these practices are currently illegal; most of these commentators were opposed to physician-assisted suicide and euthanasia.
- The policy needs updating in light of the *Rasouli* decision from the Supreme Court of Canada.
- That the policy is too permissive or contains too many loopholes that would allow physicians to behave unethically or inappropriately.
- Better promote this policy to the public; improve public access and awareness of policy.
- The policy would benefit from additional support or guidance regarding:
 - Conflict resolution practices;
 - The role of the Capacity and Consent Board and the Public Guardian and Trustee;
 - Expected deaths in the home/patients expressing a desire to die at home;

⁴ How can we improve the policy's clarity? (Please feel free to elaborate on your answers above or touch on other issues relating to clarity).

- Palliative sedation, withdrawing life support, and the provision of ‘futile’ care.
- The use of case examples to limit misunderstanding and provide concrete examples for physicians.
- The policy may be too long/complex for easy use and reference.

A number of metrics were used to assess the comprehensiveness of the policy (see *Figure 3*). Nearly just over three-in-four (77%) respondents think that the policy is helpful to physicians while just under three-in-four (72%) think that the policy sets reasonable expectations for physicians. A majority also think that the policy is helpful to the public (69%), that the policy addresses all of the important (66%) and relevant (60%) issues relating to the provision of end of life care.

Figure 3: Comprehensiveness of Policy



Q8. We'd like your thoughts on whether the policy is comprehensive. Please indicate whether you agree or disagree with each of the following statements regarding the comprehensiveness of the policy. Base: n=122

Open ended feedback regarding the comprehensiveness of the policy was collected from 56 respondents⁵. Again, feedback was varied but often touched on a number of overlapping issues. In particular, respondents provided the following suggestions of comments:

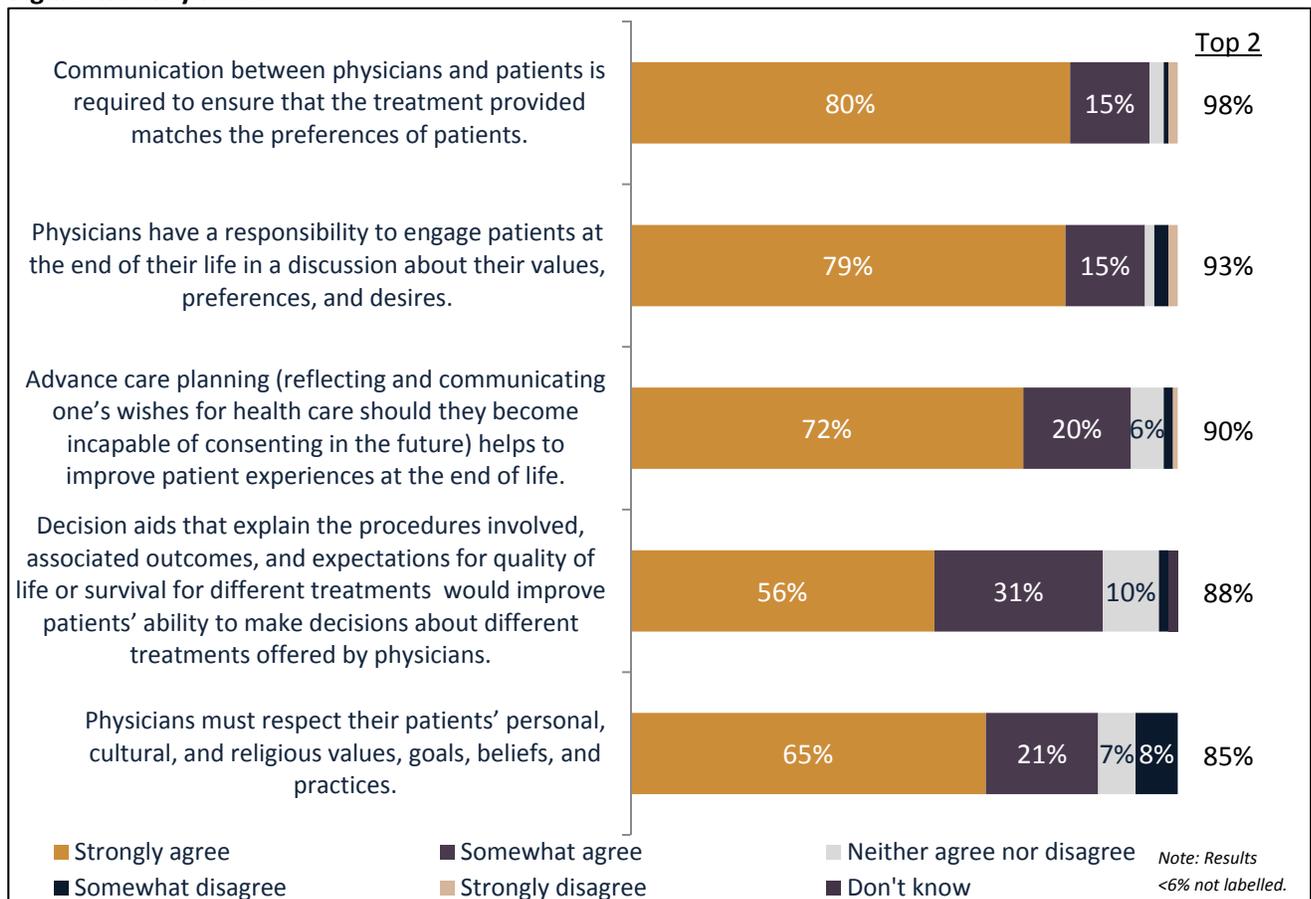
- Physician-assisted suicide and euthanasia:
 - Some expressed their opposition to these practices, often on ethical/principled grounds;
 - Some suggested that the College revisit this issue in more detail;
 - Some expressed their support for these practices.
- More guidance and support regarding:
 - The provision of futile care (including case examples);
 - Coordinating death at home (including avoidance of calling 911);
 - The withdrawal/withholding of treatment;

⁵ What issues or topics did we miss? How can we ensure the policy is helpful to both physicians and the public? How should the expectations for physicians be revised? (Please feel free to elaborate on your answers above or touch on other issues relating to comprehensiveness)

- The use of aggressive pain treatments that may hasten death (both clarity on, and protection for);
- The rights of physicians to refuse to provide treatment that goes against their moral/personal values (i.e. conscientious objection).
- Role and limits of substitute decision-makers:
 - Including impact of emotion on decision-making;
 - The role of an SDM does not permit them to dictate care;
 - Clarity on role of an advance directive.
- Conflict resolution guidance, including how to proceed past an irreconcilable disagreement.
- Importance of palliative care, early and throughout disease progression.
- Improve public access and awareness of policy.

As Figure 4 below reports, respondents are nearly unanimous in agreement that good communication is required to ensure that the treatment provided matches the preferences of patients (98%). Around nine-in-ten also say that physicians have a responsibility to engage patients at the end of their life in a discussion about their values, preferences, and desires (93%), that advance care planning helps to improve patient experiences at end of life (90%) and that decision aids would improve patients' ability to make treatment decisions (88%), and a strong majority also agree that physicians must respect their patient's personal, cultural, and religious values, goals, beliefs, and practices (85%).

Figure 4: Policy Issues



Q10. Thinking more generally about issues relating to the policy, please tell us whether you agree or disagree with each of the following statements. Base: n=117

When given the opportunity to provide any feedback they have not yet had the opportunity to voice, 48 respondents offered a response⁶. Key themes include:

- Support or opposition to physician-assisted suicide and euthanasia.
- Access to palliative care was identified as being an area of importance.
- Questions were raised about whether there were any limitations to respecting the wishes/values of patients.
- The rights of a physician to reject performing a treatment on religious or moral grounds.
- Increasing public awareness and knowledge of end of life care; engaging in a societal level discussion about assisted death and end of life care.
- The importance of early communication and advance care planning.

Appendix A – Open End Responses

Open ended responses were collected for a number of questions. While summaries of this feedback can be found above, the verbatim responses for these questions are displayed below. Please note that in keeping with our consultation processes, feedback has been amended in accordance with our posting guidelines. Additionally, verbatim responses are reproduced without correcting for any spelling or grammatical errors.

Question 5: Please tell us when you turn to this policy? (i.e. what questions or circumstances prompt you to look it up)

#	Response
1	...preparing teaching material for an ethics class.
2	Giving presentations about palliative care, ethics, EOL care.
3	When we are discussing end of life issues in class. Furthermore, the document is informative for planning future career paths. At the moment palliative care is an attractive specialty, because I can see a lot of satisfaction being derived from aiding patients with their pain and discomfort during palliative care. However, if there was to be a change in policy, and palliative care now includes a duty to aid in dying, I feel that such a specialty would no longer attract me.
4	Dealing with ill family members. Also the Decision-making for the End of Life policy review
5	dealing with difficult cases
6	explaining the CPSO stance on euthanasia and Physician-Assisted Suicide (PAS) to friends and family.
7	reviewing the care of dying patients
8	counseling palliative patients
9	Debating about euthanasia
10	Research
11	when my husband was dying of cancer
12	teaching medical students and residents
13	I look for the protection of Life. As a Catholic educator, I believe that Life begins at the point of conception. That each of us deserve the right to die a natural death. Natural Death, I define as something that is not interfered by medical personnel.
14	Talking about end of life issues in public context

⁶ If you have any additional comments that you have not yet provided, please provide them below, by email or through our online discussion forum.

15	Discussing the ethics of end-of-life decision making
16	for learning purposes (Class on bioethics)
17	I wrote an essay on end of life with a pro life stance for my class. When my grandfather was ill I looked up specifics for my family, concentrating on palliative care.
18	When I had an interest in what changes to the policy might be.
19	i need guidance regarding conflict resolution
20	When teaching medical students about end of life decision-making.
21	k
22	End of life decisions for family members
23	my first wife was dying. Or at least I should have turned to it, had I known that it existed.
24	MOTHER MOVED TO RETIREMNT RESIDENCE
25	Completed an online questionnaire that led to this
26	Close friends have been faced with decisions about palliative care, including my father-in-law. I have an active interest in supporting the role of my family as holders of power of personal care under my living will. Death with dignity is an important aspect of making my end of life decisions.
27	I stumbled on this on the Internet.
28	Have dealt with end of life issues for several relatives
29	I am retired now but when I was in practice I would have called the Physician Advisor at the CPSO for any advice; after having consulted any existing policies on the subject..
30	need to interact on a STAT basis with patient caregivers in Emerg when there is a failure of the medical system to adequately support patients who wish to die at home and their caregivers.
31	alternate decision maker (extended definition of family) conflict resolution
32	In most cases, EOL discussions and care plans go well. When there is conflict I refer to the priniples of this policy with my multidisciplinary team.
33	For many years, this was not necessary, other than in my own life
34	have families in conflict, when teaching
35	frequently as an ICU physician, mostly I refer other physicians and residents to it specifically regarding issues related to only being required to offer treatments to patients they are likely to benefit from
36	for the purposes of this survey.
37	Decisions regarding withdrawal of dialysis in a patient with advanced dementia
38	Very long since I had to consider this policy. Most recently when thinking about my own death and that of my spouse's death.
39	Difficult circumstances arise in the delivery of end of life care!

Question 7: How can we improve the policy's clarity? (Please feel free to elaborate on your answers above or touch on other issues relating to clarity)

#	Responses
1	I have not read the current version. Previous version was clear and well written.
2	I think it is reasonably clear.
3	The policy is very clear and well written.
4	to add a section of palliative treatments that do no represent euthanasia such as palliative sedation and removal of futile treatment
5	It would be nice to see the College take a stand on Euthanasia or PAS regardless of what the law

	says. For example, instead of saying that Euthansia is now illegal, say that it goes against the Code of Ethics/Conduct would be more clear.
6	The policy states that sustaining treatment should not be offered to patients who will be unable to experience and permanent benefit - this needs to be clarified to indicate that ordinary measures such as hydration would still be acceptable to patients in a permanent vegetative state.
7	Acknowledge that there is a need for increased resources for pain killers and at home support. A friend of mine had to administer a morphine-pump to her mother and had trouble finding the appropriate dose. Her mother remained in pain.
8	I was surprised (shouldn't be?) to see that the policy is very generic and seems open to interpretation by the doctor. Seems there are many loopholes to allow for euthanasia at the physician's whim. The policy is weak and does not preclude the physician using "aggressive" treatment. Overdoses of morphine would fit into this category.
9	Section 3.4 (Euthanasia and Assisted Suicide) should be strengthened by providing an ethical rationale behind the prohibition of euthanasia and assisted suicide, instead of simply stating they are prohibited under the Criminal Code. It would be advisable to strengthen the current position by explaining the fact that physicians are here to help patients, and that assisting a patient in their death would be contrary to that goal.
10	The section on euthanasia and PAS refers only to legality, and not to principle. It leaves the impression that the CPSO has no principles, only an anxiety to avoid the courts.
11	I have read the policy once. It seems clear and is written in lay terms which are understandable.
12	I think referencing to the recent court decision on the Rasouli case would be helpful As well, I would appreciate if the College can be clear that physicians' roles as healers should preclude them from administering death and that participation in euthanasia and assisted suicide is both illegal and unethical
13	- more information about palliative care - I have taken a course on palliative care and this section does not do this field justice - role of physician - we have been taught to 'do no harm' and should ensure that we treat our patients with respect and with adequate care until their deaths
14	Some statements are somewhat vague with regard to the negative interpretation of a positive statement. For example, what exactly constitutes "unnecessary prolongation of dying"? What is the minimum effort required to prolong a patient's life? While euthanasia is fortunately still prohibited under the Criminal Code, it worries me that there seem to be loopholes which might allow a physician to assist in ending a patient's life prematurely under the guise of ethical practice. Additionally it worries me that it looks as though advance directives made by patients could be easily modified to suit the whim of the substitute-decision maker since they "need not be written".
15	perhaps by giving examples of particular cases that have occurred so there is no misunderstanding.
16	The section on conflict resolution is a bit confusing as to the term "exhausting" all conflict resolution options. How long is long enough to go back and forth with the medical professional on treatments? What kind of care can a patient expect while this resolution process is taking place? Can a patient for go this process and request being transferred to a different medical professional instead of taking the time consuming process of conflict resolution? Who decides when enough is enough?
17	SCC seemed to suggest that Consent and Capacity Board would be included to resolve conflicts about best interests regarding an incapable patinet. Teh policy suggest the PGT be involved. Please calrify.
18	By discussing issues of withdrawal of care, duty of a physician to provide appropriate care, but no duty to provide care that is inappropriate or causing more harm then benefit because of the wishes of the patient or SDM to have it.

19	I think it is very clear. I particularly appreciate the clarity regarding euthanasia and assisted suicide. Also, I was happy to see the emphasis placed on the multifactorial influences that must be discerned and respected in a physician's approach to the dying patient. As recent media articles have shown, advances in technology will continue to blur the boundaries of death. A challenging question will be, in the face of fiscal constraints, what society can afford for the individual. It is not a new question but I think the College needs to lead, guiding physicians through these challenges to protect against non-physician interference (i.e. government) - such as the rumour during the last Ontario NDP government's time that anesthesiologists be forced to perform euthanasia. Great time and thought were put into this document. Thank you.
20	The name of the policy could be changed from decision making at the end of life to physician's professional obligations at the end of life, which is really what this particular policy addresses. I do not think that organ donation should be part of this policy. That is a different matter and should not be grouped under this policy. I also believe that this policy focuses on the end of life, which is OK. But it is important to include palliative care - an approach that needs to begin much earlier in the illness trajectory in life threatening or life limiting illnesses.
21	Need to address recent legal precedents (outcome of Rasouli case) which suggest that we cannot withhold or not offer treatments that are deemed non-beneficial- this is not what is written in your policy. I disagree with the SCC ruling however clinicians will be confused and unsure where to turn- the law or the policy? "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."
22	I will read the policy when time is available to me. I attended my local federal MP's town hall meeting re medically assisted end of life. The debate included four well known guests who represented both for and against followed by a very interactive Q&A with members of the audience who appeared to be more in favour of medically assisted end of life support. My preferred terminology is: medically assisted or supported death or end of life since we all will die, not legally assisted suicide. Dr Donald Low shared with Canadians with his posthumous video to greatly raise awareness of this important medical issue when the federal and provincial governments were deferring as was the Canadian Medical Association at their annual meeting in August of this year. After four tragic years, living with my spouse's brain tumour, I am grateful to Dr Low and I know what I would want for myself at that stage of my life.
23	i don't know, i've never read it.
24	The policy is lovely, but bears no relationship to what actually happens. In my experience doctors make rounds in the middle of the night and so avoid questions from the patient or the family – and also avoid learning about new symptoms, etc. In my experience doctors have no mechanism to keep themselves up-to-date on what is happening, they certainly make little effort to inform family. And they will all cite lack of time to excuse all of this. What this means is that the policy sounds fine, but I expect all physicians who read it will simply smile and nod, and then go back to doing what they are doing. Just another one of those policies that are in place but everyone knows is ridiculous and is never completely followed.
25	In Section 3.2, I was unable to understand how the Criteria listed at the beginning of the section apply to what follows. In other words, the Criteria are well-written but they are not addressed or referenced directly in the text which follows, which is also well-written. It seems like someone had a good idea in writing the Criteria, but wasn't too sure about where they should be placed.
26	REDUCE (VOLUME) AND SIMPLIFY (GOALS/ RESPONSIBILITY)
27	Make sure that every physician communicates his or her obligations and ability to perform these services. Then the physician must be required to find through the College's direct help of

	accessibility of a patient's desires from elsewhere instead of the doctor taking over decision making (labelling patient not qualified or getting further advice, just basically placing the patient in a drugged condition with no QOL, and possibly abandoning the patient as hopeless {personal experience}). When I was last sent to emergency two weeks ago by CCAC Specialist with letter, the emergency room doctor or anyone else did not even take my vitals. I was screaming in pain and had been sent because I was totally unable to walk in any form. I have a chronic, progressive condition. I only was asking to see if I had damaged anything or if my condition was progressing. Doctor did not want to examine me in any way. The hospital had me carried out of the hospital and placed in a cab and sent home. I can't even get to a commode. My condition is progressive and cannot be slowed.
28	I found the policy to be very clear. I do not understand the sentence above, "The layout or structure of the policy is intuitive."
29	TO ME THE POLICY'S CLARITY IS WELL STATED AND UNDERSTANDABLE
30	Propagate the Policy more actively. The public is unaware of the policy.
31	No
32	i'm not sure....
33	Make it readily available for patients and caregivers
34	There is no reason to waste time and resources on a change to this policy unless changes are actually made to the criminal code. Unlike documents produced by lawyers, this policy is clear, direct, concise, and easily understood. Suggest the committee do something else of more benefit with their time. Seems they are becoming unduly bureaucratic... job justification????
35	What do you mean by "it is intuitive"? How can anyone be sure that any policy is "free from error" until it has been implemented and tested in the court of real life issues...?
36	Make it clear that the policy applies not just at "end of life" but much earlier on in the disease trajectory. Advance care planning, conversations with the patient & family, communication between providers, etc. should start upon diagnosis or identification of an advancing chronic disease. "End-of-life" implies that you do not have to think about these things until death is imminent.
37	The policy is totally inadequate describing the role and responsibilities of the physician in ensuring adequate plans are in place to support patients who wish to die at home. The policy needs to be corrected regarding the interaction with EMS systems.
38	The comments related to Power of Attorney for Personal Care and advanced directives is not clear to me. I remain unsure whether a properly written and witnessed advanced directive is legally binding on Ontario physicians.
39	I think the policy is clear to those who have experience in providing care for patients who are dying in various settings. It doesn't provide enough detail or examples for those who haven't been exposed to patients dying in various settings, or under various circumstances. Also how not to start down certain roads of care when death is inevitable -- eg, putting in feeding tubes because family members fear it will hurt to for their dying loved one to starve. This isn't part of basic medical school training, and so it needs to get coverage in the policy. It is OK not to do things. And we need to be resource conscious and help families be ok with not doing everything all the time for every patient. That is not euthanasia, it is resource management and good palliation.
40	I find the policy quite clear as it is
41	Needs to address the whole issues of assisted suicide
42	Yes it can always be improved. In particular an algorithm for when conflict occurs would be helpful.
43	The issues relating to consent could be summarized in a sentence and included in the relevant area. ("Must have the capacity to understand the nature of the illness and treatment recommended and

	be able to understand the implications of refusal of treatment on the illness", or something to that effect)
44	I have no sure way of knowing if it is free of errors
45	The policy needs to be clearer about who should have an end of life discussion, and the most appropriate setting for this to occur. Family physicians and specialists with longstanding patient care interactions should be encouraged to have these discussions before the patient reaches a crisis. The section around withdrawing and withholding life sustaining therapy could be improved and align with the improvements and discussion which has taken place in some of the academic teaching hospitals in the past 5 years.
46	The primary problem is that the policy does not provide an effective answer to the problem. It quickly ends with, "conflict resolution" which really isn't providing any specific direction or support for physicians at all
47	I worry that the language for Expected Death in the Home 3.3 is not strong enough. I think many physicians need to be reminded of their obligation to patients, especially at the end of life. Palliative Care resources are currently scarce (less than 30% of Canadians have access to quality palliative care, when they need, where they need it).
48	Editing with more point by point expression rather than narrative detail open to interpretation
49	A summary, which is not trying to cover all the legalities, would be helpful. Normally I nor most busy physicians would take time to read this document because of its length.
50	The current policy is an adequate document

Question 9: What issues or topics did we miss? How can we ensure the policy is helpful to both physicians and the public? How should the expectations for physicians be revised? (Please feel free to elaborate on your answers above or touch on other issues relating to comprehensiveness)

#	Responses
1	I think it is critically important that our policy continues to affirm our commitment to helping patients live their lives fully and without undue hardship, with the understanding that we are very clear in our policy that the physician's role is not and never can be compatible with euthanasia and assisted suicide. These practices are anathema to what it means to practice medicine and care for the patient, and this has been recognized since the beginnings of medical practice and in all codes of conduct. Some societies have recently sought to overturn this ethical standard, and the result has included many instances of serious abuse of the laws, including as pertains to children and the disabled, as well as a more casual disregard for human life. As health care providers we must prevent the blurring of this very important boundary. Whether civil law allows for euthanasia or not, we are not and must never ourselves be in the "business" of killing people, regardless of perceived "benefit" to the patient or their caregiver. By virtue of the fact that we strive to have full participation of patient delegates and SDMs in the process of decision making, and the fact that we give a lot of weight to what family and loved ones say about what the (incapable) patient would have wanted, it is more important than ever that we have a clear boundary that protects the patient from unjust practices such as euthanasia and assisted suicide. This is important for all patients, but most critically for those (such as disabled children and adults) that will never have the capacity to act on their own behalf, those patients whose best interests can only be imagined by those who care for them. Often these people, the most vulnerable, are the first to be killed in situations where the law permits this. As a society we must also strive to better support people who feel their lives are nothing more than a burden to others. Thank-you.

2	Present form is very clear and addresses all relevant and important issues
3	The policy should strive to make a stronger push to delineate the spectrum of philosophy of care that many patients go through as their disease progress and as aggressive life-prolonging measures become more and more futile and symptoms become more and more prominent. By outlining this as a spectrum rather than a dichotomy, patients and physicians will gain a better understanding of how palliation is in fact fully beneficial to their care plan from an early point, which ultimately leads to better symptom control. I believe that the College of Physicians and Surgeons of Ontario should not intentionally avoid making any judgement call on the question of euthanasia and physician-assisted suicide, as it clearly does in this document. This question is not one that law-makers are in a better place to answer, or one that should be reserved for a few elite bio-ethicists. At a time when this notion is being challenged both abroad and within our borders, the College should have a voice to advocate for their patients. It may be reasonable to remind our medical community of the hippocratic oath, or that this represents an attack on the very character of human life, with enormous repercussion on our society. Perhaps what resonates more vividly in a physician's mind, however, is the notion that the request for euthanasia and physician-assisted suicide promptly vanishes when resources are available to provide effective and timely palliative care. I would want to see a College that is explicitly advocating for such a reality for all Ontarians.
4	We must emphasized the role that a physician has to first do no harm.
5	In terms of the section on Advance Care Planning, we would suggest adding the resource www.advancecareplanning.ca . Here physicians will find conversation guides and workbooks to assist both health care providers and patients.
6	see previous response
7	I think it is important that we continue to stress the availability of palliative treatments for the suffering. In particular, emphasis on the fact that all suffering is at least partially treatable must be made so that patients can make truly informed choices on their end-of-life care. Euthanasia is an option that is not necessary given the quality and efficacy of treatments. Family members too need to be aware of this fact.
8	The policy states that sustaining treatment should not be offered to patients who will be unable to experience and permanent benefit - this needs to be clarified to indicate that ordinary measures such as hydration would still be acceptable to patients in a permanent vegetative state.
9	Physicians need more permission to communicate the limitations of medicine for certain medical situations to their patients. They can't "save" a dying person and need to be able to convey the important process of dying to patients. We labour into this world and we labour out of this world. These are sacrosanct rites of passage and should be honoured more explicitly. Western culture has the tendency to gloss over and censure these important junctures in the human experience. The desire to anaesthetize natural death (and natural birth) is very strong and derives from puritan underpinnings.
10	Spiritual care is a big one. This is why Reiki is used in every hospice facility in Ontario. Perhaps it should state that in the case of a Catholic patient a Priest should be consulted and the Diocese should have a Priest that swears allegiance to the Magisterium and is trained in bioethics consistent with the Church's teaching. In other words, there should be something for physicians to turn to or someone to call in the case of Catholics.
11	It is helpful to both physician and the public. It would be more effective to clearly emphasize the dignity of the human person from natural birth to natural death in section 3.4. It should articulate that Euthanasia and Assisted Suicide is clearly offends that dignity
12	As in number 8, I think the College needs to articulate that the involvement in assisted suicide or

	<p>euthanasia by its members violates the fiduciary duty of doctors to patients and can potentially diminish trust between physicians and public</p>
13	<p>In the part under Euthanasia and Assisted Suicide, it should be stated that physicians have no obligation to follow patients' desires for euthanasia, not only because it's illegal in the Criminal Code but also because euthanasia is harmful for patients. Euthanasia should not be used as a method to alleviate suffering in place of attending to other issues at end of life, like lack of support, feeling like a burden, relieving pain, etc.</p>
14	<p>The policy speaks about the importance of ethics with drawing clear ethical lines in the sand. On the euthanasia issue there are statements about legality. If the law were to change would the practice suddenly become ethical? The association needs to articulate what is and is not within the realm of allowable acts based on the value of the people they are treating.</p>
15	<p>- this policy implies that if the criminal code was changed, the College's position on assisted suicide/euthanasia would also change - we need to be clear that in order to prevent elder abuse, in order to assist those living with disabilities and in order to ensure our patients trust us until the very end, we must not endorse assisted suicide or euthanasia</p>
16	<p>While euthanasia is fortunately still prohibited under the Criminal Code, it worries me that there seem to be loopholes which might allow a physician to assist in ending a patient's life prematurely under the guise of ethical practice.</p>
17	<p>More emphasis on why it is wrong to participate in assisted suicide or to want it for yourself.</p>
18	<p>Redraft the policy to permit euthanasia and assisted suicide</p>
19	<p>With our multicultural population can we every really address all cultural norms? What recourse does a doctor have if cultural differences clash? I do not believe that doctors should have to leave their beliefs at the door.</p>
20	<p>Withdrawal of care</p>
21	<p>N/A</p>
22	<p>Please see previous comment section. There should be clear obligations to physicians about non-abandonment at the end-of-life. It should also include and be very clear about dealing with the wish to hasten death - and how to respond in a humane and compassionate way within our current legal/regulatory environment. This is something that I believe is very important for the public and a very confusing issue for physicians. Policy (e.g. Issues like non-abandonment or conscientious objection) needs to be completely consistent with our current legal framework.</p>
23	<p>As i mentioned in the last white box, physicians are getting mixed messages from the courts and policy documents such as these. Expectations of physicians are extremely unreasonable: do everything you can to communicate well with family (OK), involve dispute resolution (OK) but then what?</p>
24	<p>I have not had the time to read it yet but plan to, very soon.</p>
25	<p>i don't know, i've never read it.</p>
26	<p>I feel this should be teh patients choice or care giver when required.</p>
27	<p>It provides no mechanism for patients who need to protect themselves from abusive family members. Especially if they have no other reasonable substitute decision-maker. This leaves the patient very vulnerable. The policy is only helpful if it is realistic and there is an expectation that it will be followed. While I think that these are reasonable expectations - they are so incredibly far from what actually happens that one might as well be reading science fiction. There is nothing in this policy that explains how it is supposed to happen, or how a patient or family member can access some of the promised consultations and information.</p>
28	<p>I do not know if physicians regard this policy as helpful. I would hope so. I do not think that</p>

	anything was missed, but in the light of what is currently in the media, it seems to me that the sections on Euthanasia and Assisted Suicide need to be elaborated.
29	RELIEVE PHYSICIANS OF LIABILITY WHEN PATIENT/POA/ DECISION MAKER REFUSES CARE. IN THIS CASE A PANEL OF DOCTORS SHOULD REVIEW THE CASE TO ENSURE NO PHYSICIAN ERROR HAS OMITTED A TREATMENT ACCEPTABLE TO THE PATIENT/POA/ DECISION MAKER
30	This topic needs to be discussed more in public forums. Most people would not know where to find this information.
31	It is not the fault of the policy that our current laws prohibit assisting patients to die with the dignity that is important to them and which has been an important aspect of living their life. Our current laws are nothing short of barbaric. We treat our animals with vastly greater care and dignity than we treat humans. My daughter was able to end the life of her beloved horse which she had had as a close companion for over twenty years with great care and compassion. By contrast, I was unable to assist my father to die with dignity, forcing him to live in a state of unawareness of his surroundings and requiring someone's care for all bodily functions for over three years. The College should not be simply accepting such barbarism as a necessary legal constraint, but should be actively working to change the law.
32	As far as making the patient comfortable during their last time, the policy seems to fit the bill so to speak. As far as the patients choice to not continue there is nothing allowing the medical personnel to help them in this endeavor. More discussion is needed on when/if the person has the right to end their life and what role the medical personnel should have in it. End of life rights need to be addressed and an acceptable policy put into place that considers the effect on the patient, medical personnel and family. It's indeed a tough one morally and emotionally for all concerned.
33	Communication must be required between physician and patient(or my substitute decision maker). I mean made LAW. We, the patients must not be just abandoned to pain and suffering, not being informed of our prognosis and time left to live. Doctors here treat symptoms, not diseases.
34	Perhaps the issue of how rational the family may be about impending death needs to be included. Sometimes one or more family members are incapable of facing reality at this time. Death is inevitable and are they wanting to keep the patient alive for the patient's benefit or actually for themselves as they can't face change/death.
35	My father died at home after long illnesses. My mother was his main caregiver. She received very little support from the CCAC and no help for the emotional anguish that she was going through. When my father died, we were at his bedside. I was holding his hand and was the first to notice that he was no longer breathing. He had made it clear to us that he did not want any measures taken to prolong his life. We called 911 and the operator wanted us to begin CPR. We told them that my father had expressed verbally and in writing that he did not want us to prolong his life. The police took my driver's license and made it clear that I could be charged if the coroner thought that we should have performed CPR. The coroner took quite a while to arrive but he agreed that we did the right thing by allowing my father to die with dignity. The police officers were very apologetic and I understand that they were doing their job. However, there should be co-ordination between the policies of doctors and emergency responders.
36	ASSISTED END OF LIFE FOR A PATIENT THAT HAS NO QUALITY OF LIFE LEFT AND IS ONLY SURFFERING SUCH AS THE LATE STAGES OF ALS. IT IS INHUMAN TO MAKE SOME WHO CAN NO LONGER DO ANYTHING FOR THEMSELVE AND HAVE REQUESTED THIS TO MAKE THEM CONTIUE TO LIVE IN PAIN AND OR UNABLE TO EVEN EAT AND MUST BE FEED BY A TUBE AND OF INTRAVINEUS.
37	Pain relief even if possibly speeding death has to be allowed when death is inevitable.
38	How will the public be made awared ot he policy? There may be situations where the policy

	cannot give directives because the specific case/situation is not easy to envisage.
39	What are physicians responsibilities in terms of communicating with other members of the patient/family's care team? e.g. home care nurse/PSW, long-term care home staff, volunteers, social worker. Physician should be obligated to act as part of an inter-disciplinary team, and upon consent from the patient, share information about that patient's care with other members of the team.
40	Ultimately people who do not wish CPR in the event of cardiac arrest (especially those with a terminal illness who wish to die at home) should work with their health care team to ensure 911 is not called as they enter the dying stages. Ultimately 911 is a resuscitation service and a call to 911 in the circumstances above is regarded by those of us in the EMS business as a failure to plan or implement the persons final wishes. This failure often occurs because of inadequate physician support. This is a frequently encountered problem that should not exist.
41	You didn't miss any topics. I would like to see one policy area changed, but I assume I will have time to comment on that later in the survey
42	I covered this under the previous comments. Primarily the public needs more examples and details to understand this policy. Also need to begin discussions with this topic that a patient is entitled to good pain management, and not be left alone with no MD ever visiting them in hospital because they are actively dying. More of their bill of rights would comfort them. BUT inform them they aren't always entitled to every medical intervention because it isn't reasonable, or cost effective. For example, when you tell a family that CPR on their 98 year old grandmother is going to break her ribs and be painful, they opt to not do it. Why can't we do some of that education of the public in advance. Full out ICU care for every patient every time isn't appropriate. ALSO - Federal gov't is asking the provinces to decide about euthanasia. This policy needs to protect MDs and nurses more around administering aggressive pain management at end of life, so that it isn't a case of watching a person suffer because a MD is nervous that the family might seek legal aid if the patient dies while sedated. Nurses become nervous because they do the administering when no one else is around of the every hour sedation. Need to engage in euthanasia discussions. When is it ok, what is ok, how would it look, etc, because the discussion won't go away.
43	I have no suggestions
44	Encourage physicians to have comprehensive training in Psychosocial Spiritual Bereavement issues/topics and/or ensure they will access experts in these areas to assist when necessary.
45	euthanasia and assisted suicide need to be re-examined and a more complete analysis made ideally, the CPSO should support the development of appropriate legislation and guidelines
46	assisted suicide
47	In Ontario the HCCA plays a major role and within the Act the clear role of the substitute decision maker needs to be publicized. Families cannot have the right to dictate medical care and request consent for every medication, families must understand that they help provide as clear as possible information of what the patients wishes are. SDM can consent to Critical Care; families cannot dictate the care provided in Critical Care when the care is not indicated.
48	The main issue that needs to be addressed is what should be done when the patient/family insist on medically inappropriate therapy ie CPR or ICU therapy when it is clearly medically inappropriate such as a case of advanced cancer with no remaining treatment options. Conflict resolution has not been able to resolve the conflict and there is no other physician willing to provide the requested therapy. Although not common this occurs frequently enough to be a problem.
49	"All" is a strong word. I doubt that any policy can comprehensively address ALL the relevant issues. It is very helpful to have the various possibilities regarding treatment outlined, in particular the

	situation where the medical team clearly finds treatment would be futile.
50	Please see above. Clarity around withdraw and withholding and the fact that physicians are not obliged to provide (or indeed offer ACLS)
51	Need to be much more clear about the role of life support/resuscitation and the limits/situations when it is not indicated, specifically a clear definition of what "benefit" is.
52	Futility. Not just CPR and life sustaining but therapy that will not under any circumstances provide a survival or symptom benefit yet the patient/family/SDM/POA insist upon futile treatment(s).
53	While the policy related to euthanasia is correct in law, there is potential legislative change in Quebec and some expressions of support for a limited policy of euthanasia, especially from patient support groups. While providing the legal information, addition of comment on the potential for change might be appropriate.
54	I can not identify, at this time, what else it might cover. I believe that the Euthanasia and Assisted Suicide section must remain definitive, no matter what the Criminal Code says. Palliate Care requires much more attention and support by all governing and non-governmental organizations. My recollection of the Health Care Consent Act as it relates to "No advance Directives" is rather complex. I recognize that it is trying to deal with a very complex situation. Those members of the family having had the longest association with the patient need to receive priority attention, with their opinions carrying the most weight.
55	Two additional issues may be appropriate for specific comment within this policy: - withdrawal of life-sustaining interventions - palliative sedation therapy
56	The entire concept that our policies on this topic is based on popular morality is flawed. Who are our ethical leaders? Personally, I turn to my church as my ethical guide on most of these issues. I implore the College to acknowledge the historical reality that most of our current values are derived from higher values and not a democratic process. Please address how individual physicians are to reconcile their own moral obligations when they conflict with the CPSO

Question 11: If you have any additional comments that you have not yet provided, please provide them below, by email or through our online discussion forum.

#	Responses
1	Life is an inalienable right and physicians should stand behind the timeless tradition of first doing no harm. The Canadian health care system has put in place a wealth of information and resources available for palliative care; of course, there's room for improvement, but Canadian physicians have been respected for their efforts in bringing relief to the dying without the need to euthanize them. Our intentions are very important when dealing with the privilege we have as physicians, and the intention to relief pain through proper use of opioids should never be equated to euthanasia, since good palliative care never aims at ending a life prematurely or directly.
2	Palliative care should be promoted as much as possible.
3	The current policy very clearly outlines the duties of the physician. We are not able to participate in euthanasia or assisted suicide. I fear any changes to such a policy will lead to incremental advances towards unfavourable outcomes. We can already see in the proposed Bill 52, grey areas and blurred lines. For example, one of the stipulations is that patients need to "suffer from an incurable illness". In modern medicine, unfortunately, most patients have chronic illnesses (i.e. diabetes, allergies, etc.). This does not necessarily mean they should be committing suicide. How does one decide how much "suffering" is borne by the patient? Such vague terminology is also seen in another stipulation that the patient must "suffer from constant and unbearable physical or psychological pain that

	cannot be relieved.". How often do we see patients that fit this description? How does one even go about evaluating severity of pain. It is still a concept with which the medical community itself struggles. Moreover, the Bill states that a physician needs approval from another physician before carrying out the lethal act. However, what is stopping the physician from contacting multiple doctors until they find one who does agree with them? I see too many cracks in any proposed changes to our current system, and I fear too many people will inevitably fall through them. We will only see the elderly and those with dementia or psychological illness being exploited. The policy should protect the most number of people and most especially the vulnerable sectors. As physicians that is our duty.
4	The existing policy is fine.
5	I would like to applaud the CPSO's policy on its comprehensiveness. I believe that the section of the policy related to Euthanasia could be further strengthened by including physician's moral obligation to heal and to help patients rather than simply rejecting Physician Assisted Suicide due to the Criminal Code ban on suicide.
6	A patient's wishes must be respected, as long as they are not against the ethics of the provider. Otherwise, the provider's autonomy is made inferior to that of the patient. The healthcare provider's rights are not less than their patients. So if a patient wants to do something harmful to themselves or others, we cannot respect their wishes in every case.
7	The emphasis on respecting the dignity of the individual person is most important. I am strongly against the devaluing of that person by the concept of assisted suicide.
8	As noted previously, The policy states that sustaining treatment should not be offered to patients who will be unable to experience and permanent benefit - this needs to be clarified to indicate that ordinary measures such as hydration would still be acceptable to patients in a permanent vegetative state.
9	Palliative care needs more resources. Physicians and patients need better access to more effective pain killers.
10	There is no guidance from the Church on these issues and no Catholic prolife hospice system in place, other than St Mikes and Providence. We need to take care of our people in keeping with the teaching of the Church in the Spiritual care of the dying. This is a critical time in the preparation for death and it has been neglected by the Church.
11	In my opinion, physicians, doctors, anyone working in the medical field, or anyone in general, should not do any action which intrinsically leads to the death of another person. Exempli Gratia, there should be no lethal injections. Nothing which is designed for the purpose of killing or harming persons shall be used on patients. Thank you for listening.
12	Euthanasia is a deliberate act undertaken by a person with the intention of ending the life of another person to relieve that person's suffering where that act is the cause of death. ¹⁰ Euthanasia is prohibited under the Canadian Criminal Code. Never allow euthanasia to become legal. It WILL be abused and terrible evils will befall this beloved country (as it already has seen evidence of though the killing of the innocent unborn human children). All life must be respected in the eyes of Truth, theological and philosophical, not popular and uninformed demand. Invest money into palliative care, pain medication treatment, and in didactic beauty of life in the midst of suffering. Do not make physicians chose against all the glorious truth of life, morals, conscience, and the supernatural reality.
13	Community consensus is an inadequate foundation for end of life policy, which should be based on clearly articulated principles that are not subject to change.
14	Patients have a range of ethical and philosophical outlooks that will affects the way they assess end

	of life option. Patients also rely on their physicians to understand how to "feel" about their condition and options. The CPSO needs to determine what is and what will ensure continued trust between doctors and patients. Patients need to know that there are some things that their doctor will not do and that the medical profession itself has a vision of the human person that's how all people should be treated. The policy needs to reflect that.
15	the preference and integrity of physicians needs to be considered in the decision making process just because a patient requests something, it does not mean that should be acted upon e.g. physician assisted suicide
16	I think there should be more of an emphasis on palliative care treatments, especially in regards to dementia patients. I think that families should have it explained to them what end of life looks like and how suffering can be eased with medication and spiritual fulfilment (if they identify with a faith institution). Families need closer when someone is sick and dying, and one way to achieve this closer is by seeing how life naturally ends. Abruptly ending someone's life is not going to give anyone in the family closer, and it goes against humanity.
17	As of now, it seems that the policy is against the use of euthanasia. I must stress the importance of this point being kept, as there are no 100% certainties that a person can not recover even if it seems that all hope is lost. If we grow in our suffering through every day trials, how is this not true of suffering the approach of death? The fact that there may still be hope for someone's life makes the use of euthanasia very wrong.
18	It is timely that the CPSO are now becoming more engaged with end of life issues at a time when the public are correctly speaking out about the need to support patient's wishes about the choice to have control over approaching death, including the right to have assistance from a physician. On the other hand, each physician can choose to opt in or out of providing such help.
19	Would be nice to emphasize advance care planning is really about unpacking patient values not about picking specific treatment options.
20	Thank you - I have written enough.
21	Re:religious and cultural values- these are often invoked as reasons why CPR must be offered or life support cannot be withdrawn. By your statement, I assume you mean treat them respectfully, do not dismiss their values and not that we should provide unhelpful and even harmful care because someone says their religion requires it.
22	Assisted suicide should not be criminalized. Although I personally clearly do not support this approach I feel that allowing this as an option for very special cases is a fundamental aspect of respect for individual patients' values and beliefs. Furthermore it seems problematic to force patients fighting for a right to die in court, to go abroad or use brute force...
23	I am grateful for my caring and competent family doctor and this topic has been discussed with him.
24	DNR discussion and permission should be on every drivers license along with organ donation.
25	We treat our pets in a more humane way at end of life compared to our loved ones
26	While physicians should respect beliefs and culture to some extent ... there must be limits. Limits should include beliefs which contradict Canadian values - ie. a male head of household should not have sole decision-making authority over all the household members (especially girls and women). Also I believe we need to have a discussion around placing limits on how long people are kept alive when they are essentially dead (eg. vegetative state, long-term coma, locked-in). These limits need to be assessed with several considerations: suffering of patient with locked-in syndrome, suffering of family members, monopolization of health care resources while others are being short-changed.
27	Your review of the policy is timely.
28	Critical decision. I feel CPSO must take leadership on this issue and am pleased to have been asked

	to participate.
29	The decision of end of life is one if not the most important decision we will make. This is a very confusing and stressful time and the more the doctor speaks with the patient the better. Life is important but we all will die and we require specific attention from the doctor even if it is not their usual outcome of prolonging life.
30	WHEN I am terminal or facing a life threatening illness I want the right to be able to choose when to end my life, in other words, I would like assisted suicide, by means of pain management drugs that might end my life simply and painlessly. if we can put down our beloved pets, then I want to be able to decide, not my children or my spouse (unless authorized) when I have had enough.
31	Current laws are barbaric and must be changed. The College should be actively engaged in advocating that change.
32	I strongly believe that euthanasia should be an option in end of life care. I have personally watched my mother suffer through her death, which, had she been an animal, would have been facilitated and made so much easier through euthanasia. Why can we treat animals more humanely than we treat people? The suffering she went through was, despite strong physician care, inhumane.
33	The option of permitting assisted suicide must be addressed and the medical community has a responsibility to move this debate forward -- that is to allow assisted suicide.
34	Physicians only need to talk to patient or family member that has been appoint by patient and not poll other members of family
35	no
36	Doctors need legal representation to help deal with religious end of life disputes. Too much pressure to understand everyone's wishes and choices.
37	Although religious and personal beliefs are an integral part of society they do not out weigh the inherent rights of an individual. To be blunt, if I am dying, no one else has the right to tell me to suffer. Living wills and family conversations do need to be part of the solution however. I have watched family and friends go through horrendous ordeals and consider what would be currently viewed as homicide. It is time to have a serious practical discussion.
38	I would like to see the policy currently labelled as euthanasia and assisted suicide changed. I would like to see the CPSO support medically assisted dying for grievously ill patients who have requested help in ending their suffering. Since this is currently against the law, I would like to see the CPSO lobby for legislation changes that would make this treatment legal.
39	In the last set of questions you ask if it is the physicians role to ask patient about end of life values etc when they need it. I would say that IF possible, this conversation should take place between patient and doctor and be billable to OHIP earlier than the end. Especially if there is a family practice relationship. Education for the family about end of life procedures -- when do you provide that? gather round for a video on intubation? not sure how it will be received if left too close to event. Finally, not all MDs are comfortable with the dying, and palliation. That is ok. BUT there has to be mechanisms in place where they can bring in other MDs or defer to others on the interdisciplinary team to ensure that the care is complete and done. So there needs to be an order set of what needs to be done at palliation decision. Just like there is for a new diabetic. Who taught what, what decision did the patient make and where is it recorded, and who knows. etc. Need clearer directions for who can pronounce death in what situations outside of hospital. Nursing Homes call ambulance because their own NH MDs don't want to come in to pronounce when they have full day jobs elsewhere. This needs clarity and enforcement. Thank u.
40	many patients are requesting information and assistance with euthanasia and end of life suicide it is the resposibility of physicians to discuss this with patients many physicians favour the

	development of euthanasia guidelines for the profession and I believe that it is the responsibility of the CPSO to assist us in this most difficult area; currently we are unable legally to fulfill patient wishes when they wish euthanasia; this is a catch 22 situation for practicing physicians; I am not assured that the college would not prosecute a physician for assisted suicide even if the law did not; there are not a lot of Dr Morgentalers out there who will put their own life in jeopardy for the benefit of the patient
41	I am not convinced we can ethically respect all patient wishes. We have some clearly identified priorities as Canadians and I suppose I feel those values do need to be supported and publicized.
42	Despite the federal criminal code, I believe that the current position on Euthanasia and Assisted Suicide should be the on-going policy. If the patient has not spoken with family members because it is too emotional a topic, it would be helpful for the physician to invite a third person, e.g. clergy, lawyer, friend, of the patient's choice to participate in an initial discussion. As soon as practical, close family members should be involved. Secrecy does not usually last too long in situations like this.
43	While I understand the difficulties involved, I believe that we need to have an open and frank discussion about the circumstances in which patients who are dying should be permitted to choose the means and timing of their death. I think we owe it to our patients and to the public in Ontario to be able to face these discussions.
44	Even the way the last questions were worded is concerning to me, they were all about "patient's wishes" not at all about appropriate or indicated therapies.
45	I worry that overly complicating the process of Advance Care Planning and Directives may lead to it happening less and less or being deferred to "another time." While I am in favor of making sure we do the best possible job, I think if we complicate these discussions or make them too onerous, they will simply cease to occur.
46	If the patient has not initiated such discussions or fears that it would be too emotional with close family members, the physician may gain much help by having another person as part of the end-of-life discussion with the patient. Such other person would be someone recommended by the patient, e.g. his/her clergy, lawyer, friend. There are times when this discussion needs INITIALLY to be done apart from emotionally related family members. Certainly, those family members must be brought into the conversation as soon as reasonable. Secrecy, is not a good policy nor does it remain secret for long.
47	The question of euthanasia is very topical. I believe that in the case of euthanasia it would be very detrimental to the patient-physician relationship at a societal level and at an individual patient level for physicians to assume the role of delivering the terminal event. The action of ending a human life is an action which engenders in Western culture and in many other cultures a very deep, fundamental philosophical response which is one of entering an area which is forbidden and destructive. The long term consequences of euthanasia on a society have not been adequately studied in the "modern sense" although we have historical documentation that in ancient cultures where practiced it was destructive.
48	I am seriously frightened that I might be asked to participate in assisting terminating life as legislation creeps towards this in Quebec. Please protect our individual practitioner rights too