

# 1           **Planning for and Providing Quality End-of-Life Care**

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## 3           **Introduction**

4           Patients are entitled to receive quality end-of-life care that allows them to live as well as  
5           possible until they die. Physicians have an important role to play in planning for and providing  
6           quality end-of-life care.

7           Planning for end of life ensures that the care provided to patients aligns with their wishes,  
8           values, and beliefs.

9           Physicians provide quality end-of-life care by meeting the standard of care and by addressing  
10          and managing the physical, psychological, social, and spiritual needs of patients, while being  
11          sensitive to their personal, cultural and religious values, goals, and beliefs. Quality end-of-life  
12          care aims to reduce suffering, respect the wishes and needs of patients, and lessen conflict and  
13          distress.

14          When engaging patients in end-of-life planning or when providing end-of-life care, it is  
15          important that physicians assist patients in identifying meaningful and realistic goals of care  
16          that are compassionate, respectful and that seek to incorporate patient wishes, values, and  
17          beliefs.

## 18          **Principles**

19          The key values of professionalism articulated in the College's *Practice Guide* – compassion,  
20          service, altruism and trustworthiness – form the basis for the expectations set out in this policy.  
21          Physicians embody these values and uphold the reputation of the profession by:

- 22           1. Acting in the best interests of their patients;
- 23           2. Demonstrating professional competence, which includes meeting the standard of care  
24           and acting in accordance with all relevant and applicable legal and professional  
25           obligations;
- 26           3. Communicating sensitively and effectively with patients and/or their substitute  
27           decision-maker;
- 28           4. Collaborating effectively by recognizing and accepting the unique roles and  
29           contributions of other physicians, health care providers, and non-health care providers;
- 30           5. Participating in self-regulation of the medical profession by complying with the  
31           expectations set out in this policy.

## 33 **Purpose**

34 This policy sets out the College’s expectations of physicians regarding planning for and  
35 providing quality care at the end of life.

## 36 **Terminology**

37 **Advance care planning:** the process of reflection and communication where people consider  
38 what sort of treatment they may want at the end of life. It includes the deliberation and  
39 communication of wishes, values and beliefs between the individual, their loved ones, their  
40 substitute decision-maker and their health care provider(s) about end-of-life care.<sup>1</sup>

41 **Physician assisted death:** the act of intentionally ending one’s own life with the assistance of a  
42 physician who provides the knowledge, means, or both. This is sometimes referred to as  
43 physician assisted suicide.<sup>2</sup>

44 **Euthanasia:** a deliberate act undertaken by a person with the intention of ending the life of  
45 another person to relieve that person's suffering.

46 **Life-saving treatment:** treatment that is provided with the intention of reversing or interrupting  
47 a potentially fatal event (e.g., cardiopulmonary resuscitation, etc.).<sup>3</sup>

48 **Life-sustaining treatment:** any medical procedure or intervention which utilizes mechanical or  
49 other artificial means to sustain, restore, or supplant a vital function essential to the life of the  
50 patient (e.g., mechanical ventilation, medically assisted nutrition and hydration, etc.).<sup>4</sup>

51 **Palliative care:** active total care that improves the quality of life of patients and their families  
52 facing life-threatening illnesses or life-limiting chronic conditions, with a focus on relieving pain  
53 and other symptoms and addressing psychological, social, and spiritual distress; it is applicable  
54 in all phases of illness, from early in the course of illness to bereavement.<sup>5</sup>

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<sup>1</sup> Adapted from Ontario Medical Association, *End of Life Terminology*.

[https://www.oma.org/Resources/Documents/EOLC\\_Definitions.pdf](https://www.oma.org/Resources/Documents/EOLC_Definitions.pdf)

<sup>2</sup> Adapted from Canadian Medical Association, *Euthanasia and Assisted Suicide*.

<http://policybase.cma.ca/dbtw-wpd/Policypdf/PD14-06.pdf>

<sup>3</sup> Adapted from Canadian Medical Association, *Statement on Life-Saving and –Sustaining Interventions*.

<http://policybase.cma.ca/dbtw-wpd/Policypdf/PD14-01.pdf>

<sup>4</sup> Adapted from the University Health Network’s, *Appropriate Use of Life-sustaining Treatment and CMA Statement on Life-Saving and –Sustaining Interventions*.

<sup>5</sup> Adapted from World Health Organization, *Definition of Palliative Care*.

<http://www.who.int/cancer/palliative/definition/en/>

## 56 **Policy**

57 This policy is divided into ten sections addressing a number of issues that relate to end-of-life  
58 care:

- 59 1. Quality Care
- 60 2. Communication
- 61 3. Advance Care Planning
- 62 4. Consent to Treatment
  - 63 4.1 No Treatment Without Consent
  - 64 4.2 Capacity at the End of Life
  - 65 4.3 Consent on Behalf of an Incapable Patient
- 66 5. Interventions and Care Management
  - 67 5.1 Palliative Care
  - 68 5.2 Life-Saving and Life-Sustaining Treatment
  - 69 5.3 Aggressive Pain Management and Palliative Sedation
- 70 6. Dying at Home
  - 71 6.1 Home Care
  - 72 6.2 Certification of Death
- 73 7. Wishes and Requests to Hasten Death
  - 74 7.1 Responding to Wishes and Requests to Hasten Death
  - 75 7.2 Euthanasia and Physician Assisted Death
- 76 8. Managing Conflicts
  - 77 8.1 Conflict Resolution
  - 78 8.2 Conflicts with Substitute Decision-Makers
  - 79 8.3 Conscientious Objection
- 80 9. Documentation
- 81 10. Organ and Tissue Donation

### 82 **1. Quality Care**

84 There are a number of medical and non-medical elements that comprise quality care at the end  
85 of life. Research and clinical experience show that what is important to patients and their  
86 families regarding quality end-of-life care may often include, but is not limited to:

- 87 • Managing pain and other distressing symptoms, including psychological issues;
- 88 • Avoiding the unnecessary prolongation of dying, especially when there is little hope for  
89 meaningful recovery;

- 90 • Strengthening relationships with loved ones and continuing active involvement in social  
91 interactions to the extent that it is possible to do so;
- 92 • Attaining feelings of peace or closure, achieving a sense of control and meaning,  
93 satisfying spiritual needs, completing important tasks, and preparing for the end of life  
94 by resolving conflicts, saying goodbye, and preparing for death;
- 95 • Having trust and confidence in a physician and having a physician who is available and  
96 takes a personal interest in the patient's care;
- 97 • Preserving dignity, being treated with respect and compassion, and being treated in a  
98 manner that affirms the whole person;
- 99 • Facilitating decision-making through clear, honest, consistent and timely  
100 communication, having the opportunity to address personal concerns, and being  
101 listened to; and
- 102 • Receiving support through the grief and bereavement process.

103  
104 When planning for or providing end-of-life care, physicians must endeavour to understand what  
105 is important to their patient and/or the patient's substitute decision-maker in order to ensure  
106 that quality care is provided. It is also important for physicians to understand and personally  
107 acknowledge that in certain circumstances treatment cannot prevent death.

## 108 **2. Communication**

109 End-of-life care situations can be highly stressful and difficult for those involved. Therefore,  
110 communication is of paramount importance. Physicians must communicate effectively and  
111 compassionately with patients and/or substitute decision-makers, in a manner and tone that is  
112 suitable to the difficult decisions they may be facing. This includes, but is not limited to,  
113 initiating communication as early as possible and as regularly and as often as is necessary to  
114 share information, facilitating the comprehension of the information shared, and answering  
115 questions. Communicating effectively and often will build trust and confidence in the physician-  
116 patient relationship, help to relieve patient and/or substitute decision-maker anxiety and  
117 doubt, and may make difficult future conversations easier.

118 Patients and/or substitute decision-makers may want to involve family and/or others close to  
119 them in the patient's ongoing care. Involving family and/or others close to the patient in the  
120 ongoing care of a patient may be beneficial as it can, for example, help the patient understand  
121 their diagnoses, prognoses, medications, the tests that are required and the decisions they  
122 have to make about treatment options. Such involvement can also help the family caregivers to  
123 provide more effective care at home and mitigate their own distress.

124 Physicians must obtain consent from the patient or substitute decision-maker to communicate  
125 personal health information about the patient<sup>6</sup> and must document this decision accordingly.

### 126 **3. Advance Care Planning**

127 Advance care planning can lead to improved outcomes and quality of life, can help to ensure  
128 that the care provided aligns with the patient's preferences,<sup>7</sup> and can also encourage realistic  
129 treatment goals. Physicians have a professional responsibility to engage patients in advance  
130 care planning and to understand their patients' wishes, values, and beliefs regarding end-of-life  
131 care.

132 It is never too early for physicians to engage in advance care planning with their patients. As  
133 part of routine care in an ongoing physician-patient relationship, physicians are advised to  
134 discuss with their patients the importance and the benefits of advance care planning, the  
135 importance of documenting and disseminating advance care plans to their loved ones,  
136 substitute decision-maker, and their health care provider(s), and the importance of reviewing  
137 advance care plans throughout one's life.<sup>8</sup>

138 Physicians are also advised to help their patients engage in such planning by providing  
139 necessary medical information and opportunity for discussion. This could include asking  
140 patients general questions about their wishes, values and beliefs regarding end-of-life care or  
141 discussing specific issues such as preferences for the location of their death, attitudes towards  
142 certain medical interventions (e.g. resuscitation, mechanical ventilation, etc.), and, as  
143 appropriate, their wishes with respect to organ and tissue donation.<sup>9</sup> Physicians are advised  
144 that they may need to initiate these discussions sensitively, over multiple occasions as patients  
145 may not always be ready to participate.

146 Significant life events (e.g. death in the family or serious illness, becoming a parent, etc.) or  
147 changes in the patient's medical status (e.g. diagnosis of terminal illness, illness progression,  
148 etc.) are opportunities for physicians to confirm that advance care planning has taken place. If  
149 the patient has engaged in advance care planning, physicians are advised to encourage patients  
150 to reassess existing advance care plans. If the patient has not engaged in advance care

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<sup>6</sup> See also the College's [Confidentiality and Personal Health Information](#) policy.

<sup>7</sup> See for example Mack et al. "End-of-Life Discussions, Goal Attainment, and Distress at the End of Life: Predictors and Outcomes of Receipt of Care Consistent with Preferences" *J Clin Oncol*. 2010; 28(7):1203-1208 and Zhang et al. "Health Care Costs in the Last Week of Life: Association with End-of-Life Conversations" *Arch Intern Med*. 2009;169(5):480-488.

<sup>8</sup> Advance care planning materials and resources intended for both physicians and patients are available from a variety of organizations, for example, Speak Up! ([www.advancecareplanning.ca](http://www.advancecareplanning.ca)) and the Ontario Seniors' Secretariat ([www.seniors.gov.on.ca/en/advancedcare/index.php](http://www.seniors.gov.on.ca/en/advancedcare/index.php))

<sup>9</sup> For more information see Section 10. "Organ and Tissue Donation" of this policy.

151 planning, physicians are advised to remind patients of the importance of this process, to create  
152 opportunities for discussion, and to encourage them to engage in the process.

#### 153 **4. Consent to Treatment**

154 The requirements for consent to treatment at the end of life are the same as the requirements  
155 for consent to treatment in other health care situations. The following is a high level overview  
156 of physicians' obligations regarding consent to treatment. For a more detailed discussion of the  
157 legal and professional obligations for consent to treatment please see the College's [Consent to](#)  
158 [Medical Treatment](#) policy.

##### 159 *4.1 No Treatment Without Consent*

160 The *Health Care Consent Act, 1996 (HCCA)*<sup>10</sup> requires that physicians not provide treatment<sup>11</sup>  
161 unless consent has been obtained from the patient if the patient is capable<sup>12</sup> or the incapable  
162 patient's substitute decision-maker.<sup>13, 14</sup>

163 Situations may arise at the end of life where physicians propose that life-sustaining treatment  
164 be withdrawn. Physicians are advised that the withdrawal of life-sustaining treatment has been  
165 determined by the Supreme Court of Canada to constitute treatment under the *HCCA*.<sup>15</sup> As

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<sup>10</sup> [Health Care Consent Act, 1996](#), S.O. 1996, c.2, Schedule A (hereinafter *HCCA*).

<sup>11</sup> Section 2(1) of the *HCCA* defined treatment as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.

<sup>12</sup> This is the case even if the patient has an advance care plan, as advance care plans do not preclude a capable patient from making a different decision at the time of care and are not directions to a health care provider.

<sup>13</sup> Sections 20(1) and 20(5) of the *HCCA* set out a hierarchy of persons who may give or refuse consent on behalf of an incapable patient. The substitute decision-maker is the highest ranking person on this list who also satisfies the requirements set out in Section 20(2) (see footnote 14 of this policy):

1. Guardian
2. Attorney for personal care
3. Representative appointed by Consent and Capacity Board
4. Spouse or partner
5. Child or parent or individual/agency entitled to give or refuse consent instead of a parent (this does not include a parent who has only a right of access)
6. Parent with right of access only
7. Brother or sister
8. Any other relative (related by blood, marriage or adoption)
9. Public Guardian and Trustee

<sup>14</sup> Section 20 (2) of the *HCCA* sets out additional requirements for substitute decision-makers. Specifically, the substitute decision-maker must also be (1) Capable with respect to the treatment; (2) At least 16 years old, unless he or she is the incapable person's parent; (3) Not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf; (4) Available; and (5) Willing to assume the responsibility of giving or refusing consent.

<sup>15</sup> *Rasouli v. Cuthbertson*, 2013, SCC 53, [2013] 3 S.C.R. 341

166 such, in order for life-sustaining treatment to be withdrawn, consent must be obtained from  
167 the patient if the patient is capable or the incapable patient's substitute decision-maker.

168 In order for consent to be valid it must be obtained from the patient if the patient is capable  
169 with respect to the treatment or from the incapable patient's substitute decision-maker, and it  
170 must be related to the treatment, informed, given voluntarily, and not obtained through  
171 misrepresentation or fraud.<sup>16</sup>

#### 172 *4.2 Capacity at the End of Life*

173 Physicians are entitled to presume that a patient is capable of giving or refusing consent unless  
174 there are reasonable grounds to think otherwise.<sup>17</sup>

175 Physicians are advised that in the context of end-of-life care the capacity to consent to  
176 treatment may be affected by a number of health conditions. As such and given that capacity  
177 may fluctuate, physicians are advised to exercise caution regarding the presumption of capacity  
178 and to reassess capacity as appropriate.

#### 179 *4.3 Consent on Behalf of an Incapable Patient*

180 A substitute decision-maker must give or refuse consent in accordance with the most recent<sup>18</sup>  
181 and known wish expressed by the patient, while the patient was capable and was at least 16  
182 years of age.<sup>19</sup> If no wish is known or the wish is impossible to comply with or not applicable to  
183 the circumstances, the substitute decision-maker must make decisions in the incapable  
184 patient's best interests.

185 Wishes can be general or specific in nature and can be expressed in writing<sup>20</sup> or orally. Later  
186 wishes expressed while capable, whether written or oral, prevail over earlier wishes.<sup>21</sup> This is  
187 the case even if, for example, the earlier wishes are expressed in an advance care planning  
188 document.

189 The Consent and Capacity Board (CCB)<sup>22</sup> can provide assistance to either a physician or a  
190 substitute decision-maker when a wish is not clear, when it is not clear whether the wish is

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<sup>16</sup> Sections 10(1) and 11(1) of the *HCCA*.

<sup>17</sup> Sections 4(2) and 4(3) of the *HCCA*.

<sup>18</sup> Section 5(3) of the *HCCA* states that later wishes expressed while capable prevail over earlier wishes.

<sup>19</sup> Section 21(1) of the *HCCA*.

<sup>20</sup> This may include advance care planning documents, what is commonly known as an 'advance directive', in a power of attorney, or in another form. See Section 5(2) of the *HCCA*.

<sup>21</sup> Sections 5(1) through (3) of the *HCCA*.

<sup>22</sup> For more information about the Consent and Capacity Board (hereinafter CCB) please visit their website:

<http://www.ccboard.on.ca/scripts/english/index.asp>

191 applicable, or when it is not clear whether the wish was expressed while the patient was  
192 capable or at least 16 years of age. The CCB can also grant permission to depart from a wish in  
193 very limited circumstances.<sup>23</sup>

194 When making decisions based on the best interests of an incapable person, substitute decision-  
195 makers must consider the following: any values and beliefs the incapable patient held while  
196 capable; any wishes the incapable patient expressed that are not binding according to the  
197 above criteria; and the impact of providing and not providing the treatment on the patient's  
198 condition or well-being,<sup>24</sup> whether the expected benefit of the treatment outweighs the risk of  
199 harm, and whether a less restrictive or less intrusive treatment would be as beneficial.<sup>25</sup>

## 200 **5. Interventions and Care Management**

### 201 *5.1 Palliative Care*

202 Palliative care can be provided at any stage of a patient's life-threatening illness or life-limiting  
203 chronic condition. However, physicians are advised that engaging in palliative care as early as  
204 possible can lead to improved quality of life for patients.<sup>26</sup> Palliative care does not have to be  
205 provided by specialists in palliative care; however, physicians are advised to seek the support or  
206 involvement of specialists in palliative care and/or referral to hospice care<sup>27</sup> where appropriate  
207 and available.

208 Physicians who propose or provide palliative care must clearly explain to patients what  
209 palliative care entails as it is sometimes misunderstood by patients. This includes being clear  
210 that palliative care involves providing active care focused on managing pain and other  
211 symptoms and psychological, social, and spiritual distress related to the patient's condition,  
212 which can be provided in conjunction with other treatments intended to prolong life, or when  
213 these treatments have been stopped. Palliative care can be engaged at any stage in the  
214 progression of one's illness or chronic condition, not just in the final days or weeks of one's life.

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<sup>23</sup> Sections 35 and 36 of the *HCCA*. More information can also be found on the CCB's website listed in footnote 22.

<sup>24</sup> Section 21(2) (c) of the *HCCA*. This will include assessing whether the treatment is likely to: improve the incapable patient's condition or well-being; prevent their condition or well-being from deteriorating; reduce the extent to which, or rate at which, their condition or well-being is likely to deteriorate; and whether their condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

<sup>25</sup> Section 21 (2) of the *HCCA*.

<sup>26</sup> Temel et al. "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer" *N Engl J Med*. 2010; 363:733-742 and Zimmermann et al. "Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial" *The Lancet*. 2014; 383(9930):1721-1730;

<sup>27</sup> In Canada, both palliative care and hospice care are generally used to refer to an approach to care focused on holistic care of the patient with a life-threatening or life-limiting illness and their family. However, some may use hospice care to describe care that is associated with a particular time period (e.g. final few days or weeks of life) or location (e.g. community based) (adapted from the [Canadian Hospice Palliative Care Association](#)).

215 *5.2 Life-Saving and Life-Sustaining Treatment*

216 As with all treatment, physicians must obtain consent from the patient if the patient is capable  
217 or the incapable patient's substitute decision-maker to provide life-saving and life-sustaining  
218 treatment.<sup>28</sup> Physicians are advised that if a patient or substitute decision-maker does not  
219 consent to life-saving or life-sustaining treatment, it is still appropriate to provide palliative  
220 care.

221 Physicians are not obliged to propose or provide life-saving or life-sustaining treatments that  
222 are not within the standard of care. However, when a life-saving or life-sustaining treatment  
223 falls within the standard of care, physicians must identify this treatment option for the patient  
224 and/or substitute decision-maker even if it is not the physicians' preferred treatment option.

225 Physicians must involve the patient and/or substitute decision-maker in the assessment of  
226 those treatment options that fall within the standard of care and be prepared to provide a life-  
227 saving or life-sustaining treatment if the patient or substitute decision-maker chooses this  
228 option and provides consent. Physicians are advised that patients and substitute decision-  
229 makers may assess the proposed treatment options differently than the physician as they may  
230 consider, for example, whether the treatment prolongs life even if there is no clinical benefit.

231 Physicians may wish to propose life-sustaining treatment on a trial basis while being clear  
232 regarding the outcomes that would need to be achieved to warrant the continuation of  
233 treatment and outcomes that would warrant the discontinuation of treatment. This allows for  
234 the exploration of a potentially positive outcome while building consensus regarding the  
235 circumstances in which life-sustaining treatment will be withdrawn.

236 When physicians propose a "Do Not Resuscitate" order (i.e. that cardiopulmonary resuscitation  
237 not be provided if the patient experiences cardiac arrest at some point in the future), they must  
238 explain to the patient and/or the substitute decision-maker why they propose not to provide  
239 the treatment and provide details regarding the alternative treatment(s) that they propose be  
240 provided. The College requires physicians to obtain consent for a "Do Not Resuscitate" order.<sup>29</sup>

241 When physicians propose to withdraw life-sustaining treatment, they must explain to the  
242 patient and/or the substitute decision-maker why they are proposing to withdraw the

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<sup>28</sup> For information on when emergency treatment can be provided without consent, please see the College's [Consent to Medical Treatment](#) policy.

<sup>29</sup> *EGJW v. MGC*, 2014 CanLII 49888 (ON HPARB)

243 treatment and provide details regarding the treatment(s) they propose to provide. Physicians  
244 must obtain consent to withdraw life-sustaining treatment.<sup>30</sup>

245 Physicians are advised that a patient's or substitute decision-maker's decision concerning life-  
246 saving and life-sustaining treatment might change over time. As such, physicians must reassess  
247 these decisions with patients or substitute decision-makers whenever it is appropriate to do so,  
248 for example, when the condition of the patient changes.

249 If consensus between the physician and the patient or substitute decision-maker regarding the  
250 treatment that will be provided cannot be found, physicians must engage in the conflict  
251 resolution practices as outlined in the "Conflict Management" section of this policy.

### 252 *5.3 Aggressive Pain Management and Palliative Sedation*

253 In some cases, the management of a patient's pain and symptoms at end of life may require the  
254 aggressive use of pain medication (e.g. opioids) or palliative sedation (e.g. the use of  
255 pharmacological agents to reduce consciousness).<sup>31</sup> The intention of these interventions is not  
256 to hasten death. When physicians provide aggressive pain management or palliative sedation,  
257 they must provide the treatment in proportion to the pain and/or symptoms and closely follow  
258 any changes in the patient's pain and/or symptoms to ensure that appropriate treatment is  
259 provided.

## 260 **6. Dying at Home**

### 261 *6.1 Home Care*

262 At the end of life, patients often express a preference for staying at home as long as possible  
263 and/or for dying at home.

264 In these cases, physicians must help patients and caregivers assess whether home care and/or  
265 dying at home are manageable options. This includes, but is not limited to, assessing:

- 266 • Patient safety considerations;
- 267 • The caregiver's ability to cope with the situation;
- 268 • Whether the patient can be provided with the necessary care (e.g., whether round-  
269 the-clock on-call coverage is needed and available, whether home palliative care  
270 physicians or community based programs are available to assist, etc.); and
- 271 • The viability of admittance to hospice or other appropriate institution at a later date  
272 if the patient or their caregiver can no longer cope with the situation.

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<sup>30</sup> *Rasouli v. Cuthbertson*, 2013, SCC 53, [2013] 3 S.C.R. 341

<sup>31</sup> Physicians contemplating treating patients using palliative sedation are advised to consult the Framework for Continuous Palliative Sedation in Canada: *J Palliat Med.* 2012 Aug;15(8):870-9.

273 In addition, when considering whether dying at home is a manageable option, physicians must  
274 educate and prepare patients and caregivers for what to expect and what to do when the  
275 patient is about to die or has just died.

276 If a patient decides to stay at home as long as possible or to die at home and has expressed a  
277 wish to not be resuscitated, physicians are advised to order and complete the Ministry of  
278 Health and Long-Term Care “Do Not Resuscitate Confirmation Form”.<sup>32, 33</sup> This will ensure that  
279 if emergency services are called that resuscitation will not be performed and that, to the extent  
280 possible, palliative care to provide comfort or alleviate pain, will be provided. Unless this form  
281 is completed and presented, emergency services are likely to use resuscitative measures and  
282 transfer the patient to hospital. When completed, physicians must ensure that caregivers are  
283 instructed on the importance of keeping the form accessible and the requirement that it be  
284 shown to emergency services if called.

285 Physicians must ensure that caregivers are instructed regarding whom to contact when a  
286 patient is about to die or has just died. The point of contact may vary depending on, for  
287 example, local situations or processes, health care teams, and whether or not the “Do Not  
288 Resuscitate Confirmation Form” is completed.

## 289 *6.2 Certification of Death*

290 A physician who has been in attendance during the last illness of a deceased person, or who has  
291 sufficient knowledge of the last illness, is legally required to complete and sign a medical  
292 certificate of death immediately following the death,<sup>34, 35</sup> unless there is reason to notify the  
293 coroner of the death.<sup>36</sup> Nurse practitioners who have primary responsibility for the care of the

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<sup>32</sup> For more information about the “Do Not Resuscitate Confirmation Form”, please visit:

<http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ENV=WWE&NO=014-4519-45>

<sup>33</sup> These forms can be ordered by completing and submitting the Ministry of Health and Long-Term Care’s “Forms Order Request”. For more information please visit:

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-0350-93~2/\\$File/0350-93.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-0350-93~2/$File/0350-93.pdf)

<sup>34</sup> Section 35(2) of General, R.R.O. 1990, Regulation 1094 enacted under the *Vital Statistics Act* (hereinafter *Vital Statistics Act, General Regulation*). The certificate must state the cause of death according to the International Statistical Classification of Diseases and Related Health Problems, as published by the World Health Organization, and be delivered to the funeral director immediately.

<sup>35</sup> Medical certificates of death can be obtained by contacting the Office of the Registrar General: 1-800-461-2156.

<sup>36</sup> Section 10 of the Coroners Act requires physicians to immediately notify a coroner or police officer if there is reason to believe that an individual has died:

1. as a result of violence, misadventure, negligence, misconduct or malpractice;
2. by unfair means;
3. during pregnancy or following pregnancy in circumstances that might be reasonably attributed to the pregnancy;
4. suddenly and unexpectedly;

294 deceased are also permitted to complete the medical certificate of death in limited  
295 circumstances.<sup>37</sup> It is not acceptable to rely on the coroner to certify the death when the  
296 coroner's involvement is not required and there are others involved in the patient's care who  
297 have a legal responsibility to do so.

298 When a decision is made for the patient to stay at home as long as possible or to die at home, it  
299 is recommended that physicians plan in advance by designating the physician(s) or nurse  
300 practitioner(s) who will be available to attend to the deceased in order to complete and sign  
301 the medical certificate of death. It is also recommended that physicians inform caregivers of  
302 this plan.

303 Physicians are advised to take into consideration any local or community strategies that are in  
304 place to facilitate the certification of death.

## 305 **7. Wishes and Requests to Hasten Death**

306 Patients at end of life may express a wish to hasten death, and some patients may even request  
307 their physician's assistance in hastening death. This may include requests for euthanasia or for  
308 a physician assisted death.

### 309 *7.1 Responding to Wishes and Requests to Hasten Death*

310 A patient's wish or request to hasten death may be a genuine expression of a desire to hasten  
311 their death, but it may also be motivated by an underlying and treatable condition such as  
312 depression, psychological suffering, unbearable pain or other unmet care needs. Patients may  
313 also be attempting to exert control over their lives, expressing acceptance of an imminent  
314 death, or seeking information about any options that may exist.

315 Physicians must respond to these wishes and requests in a sensitive manner. Because these  
316 expressions may be motivated by an issue that can be treated or addressed, physicians must be  
317 prepared to engage patients in a discussion to seek to understand the motivation for their

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5. from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
  6. from any cause other than disease; or
  7. under circumstances that may require investigation.

<sup>37</sup> Section 35(3) of the *Vital Statistics Act, General Regulation* permits a registered nurse who holds an extended certificate of registration to complete and sign a medical certificate of death when:

- (a) the nurse has had primary responsibility for the care of the deceased during the last illness of the deceased;
- (b) the death was expected during the last illness of the deceased;
- (c) there was a documented medical diagnosis of a terminal disease for the deceased made by a legally qualified medical practitioner during the last illness of the deceased;
- (d) there was a predictable pattern of decline for the deceased during the last illness of the deceased; and
- (e) there were no unexpected events or unexpected complications during the last illness of the deceased.

318 expression and to resolve any underlying issues that can be treated or otherwise addressed.  
319 This may include providing more effective treatment, improving pain management strategies,  
320 providing or referring the patient for psychological counselling, seeking specialist support, and  
321 involving other professionals in the patient’s care (e.g., chaplaincy support, social workers, grief  
322 counselling, etc.).

## 323 *7.2 Euthanasia and Physician Assisted Death*

324 Under the *Criminal Code of Canada*, euthanasia<sup>38</sup> and the act of counselling, aiding or abetting  
325 suicide<sup>39</sup> are criminal offences.

326 Consent of the deceased does not absolve the person who acted to bring or assisted in bringing  
327 about the death from criminal liability.

328 There are jurisdictions in which euthanasia or physician assisted death are permitted by law.  
329 Patients may express interest in travelling to those jurisdictions to seek those services and in  
330 doing so, may approach physicians to obtain access to their medical records or their personal  
331 health information. Patients in Ontario have a right of access to their personal health  
332 information<sup>40</sup> and unless the physician determines that an exception to this right is  
333 applicable,<sup>41</sup> physicians are required to release the medical records or personal health  
334 information to the patient in these circumstances.

## 335 **8. Managing Conflicts**

### 336 *8.1 Conflict Resolution*

337 The requirements for conflict resolution at the end of life are the same as the requirements for  
338 conflict resolution in other health care situations, although the risk of conflict may be increased  
339 and emotions may be heightened in the end-of-life care context. As such, physicians must  
340 approach conflicts with sensitivity.

341 In order to minimize and/or resolve conflicts that arise, physicians must:

- 342 • Communicate clearly, patiently, and in a timely manner information regarding:
  - 343 ○ The patient’s diagnosis and/or prognosis;
  - 344 ○ Treatment options and assessments of those options;
  - 345 ○ Availability of supportive services (e.g. social work, spiritual care, etc.); and
  - 346 ○ Availability of palliative care resources.

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<sup>38</sup> Section 229 of the *Criminal Code of Canada*.

<sup>39</sup> Section 241 of the *Criminal Code of Canada*.

<sup>40</sup> Sections 1(b) and 52 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Schedule A.

<sup>41</sup> Section 52 (1) of the *Personal Health Information Protection Act, 2004*.

- 347 • Identify misinformation and/or misunderstandings that might be causing the conflict  
348 and take reasonable steps to ensure that these are corrected and that questions are  
349 answered;
- 350 • Offer referral to another professional with expertise in the relevant area and facilitate  
351 obtaining a second opinion, as appropriate;
- 352 • Offer consultation with an ethicist or ethics committee, as appropriate and available;
- 353 • Where appropriate, seek legal advice regarding mediation, adjudication or arbitration  
354 processes that are available (in some cases, this may involve an application to the  
355 Consent and Capacity Board); and
- 356 • Transfer the care of the patient to another facility or health care provider as a last resort  
357 and only when all appropriate and available methods of resolving conflict have been  
358 exhausted.<sup>42</sup>
- 359

## 360 *8.2 Conflicts with Substitute Decision-makers*

361 When conflicts arise because a substitute decision-maker has not met the requirements set out  
362 in the *HCCA*,<sup>43</sup> physicians are advised to apply to the Consent and Capacity Board for direction.

## 363 *8.3 Conscientious Objection*

364 Physicians who limit their practice<sup>44</sup> on the basis of moral and/or religious grounds must  
365 comply with the College's [Physicians and the Ontario Human Rights Code](#) policy.

## 366 **9. Documentation**

367 The requirements of medical record keeping at the end of life are the same as the requirements  
368 in other situations.

369 Every patient and/or substitute decision-maker encounter and all patient-related information<sup>45</sup>  
370 must be documented and dated in the patient's record, in accordance with the College's  
371 [Medical Records](#) policy. For example, in the context of end-of-life care, patient records must  
372 include reference to discussions and decisions regarding treatment, goals of care, and advance  
373 care planning (e.g. wishes expressed while capable, advance directives, etc.). Do not resuscitate  
374 orders must be explicitly and clearly referenced in the patient's record so that they are  
375 available to all involved in the patient's care and who have access to the patient's record.

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<sup>42</sup> In following such a course, the physicians must comply with the College's [Ending the Physician-Patient Relationship](#) policy.

<sup>43</sup> These requirements are set out in Section 21 of the *HCCA* and discussed in section 4.3 "Consent on Behalf of an Incapable Patient" of this policy.

<sup>44</sup> This may include, but is not limited to, refusals to provide care, withdraw care, and/or discuss care options.

<sup>45</sup> For more information see the College's *Medical Records* policy and Ontario Regulation 114/94, General, Sections 18, 19, 20 and 21, made under the *Medicine Act, 1991*, S.O. 1991, c.30.

376 For more information about the legal requirements and professional obligations for  
377 documentation see the College's [Medical Records](#) and [Consent to Medical Treatment](#) policies.

## 378 **10. Organ and Tissue Donation**

379 The *Trillium Gift of Life Network Act*<sup>46</sup> sets out requirements relating to organ and tissue  
380 transplantation measures for health facilities designated by the Minister of Health and Long-  
381 Term Care.

382 A designated facility<sup>47</sup> must notify the Trillium Gift of Life Network (TGLN) when a patient in the  
383 facility has died or a physician is of the opinion that the death of a patient at the facility is  
384 imminent by reason of injury or disease.<sup>48</sup> However, the legislation provides an exception to  
385 notification if the TGLN has established certain requirements that must be met by the  
386 designated facility.<sup>49</sup>

387 Physicians working in designated facilities must comply with any policies and procedures  
388 established in accordance with the legislation.<sup>50</sup>

389 Physicians who do not work in designated health facilities are advised to provide their patients  
390 with the opportunity to make choices with respect to organ and tissue donation, ideally in the  
391 context of an ongoing relationship with the patient and before any medical crisis arises.  
392 Physicians in these settings may wish to contact TGLN<sup>51</sup> for more information and/or for  
393 materials or resources, and physicians may also wish to direct patients to TGLN for more  
394 information.

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<sup>46</sup> [Trillium Gift of Life Network Act](#), R.S.O. 1990, c. H.20 (hereinafter *TGLNA*).

<sup>47</sup> The *TGLNA* defines designated facility as a hospital, health facility or other entity designated as a member of a prescribed class of facilities under section 8.2 of the *TGLNA*.

<sup>48</sup> Section 8.1(1) of the *TGLNA*.

<sup>49</sup> Section 8.1(2) of the *TGLNA*. A designated facility is not required to notify the TGLN if the TGLN has established requirements that set out circumstances in which notice is not required and those circumstances exist.

<sup>50</sup> Designated facilities must establish policies and procedures for identifying and approaching potential donors and their families to provide information, and to seek consent for organ and/or tissue donation. See section 8.4 of the *TGLNA*.

<sup>51</sup> For more information please visit the Trillium Gift of Life website (<http://www.giftoflife.on.ca/en/>) or call toll free 1-877-363-8456 or 416-363-4438 if within the GTA.