Planning for and Providing Quality End-of-Life Care

Introduction
Within the interdisciplinary team,

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

Planning for end of life ensures that the care provided to patients aligns with their wishes, values, and beliefs, within the context of the Ontario health care system.

Physicians provide quality end-of-life care by meeting the standard of care and by addressing and managing the physical, psychological, social, and spiritual needs of patients, while being sensitive to their personal, cultural and religious values, goals, and beliefs. Quality end-of-life care aims to reduce suffering, respect the wishes and needs of patients, and lessen conflict and distress. This needs to explicitly mention the interdisciplinary team up front, here.

When engaging patients in end-of-life planning or when providing end-of-life care, it is important that physicians assist patients in identifying meaningful and realistic goals of care that are compassionate, respectful and that seek to incorporate patient wishes, values, and beliefs. Patients means patients and their important significant others. Somewhere in here we also need to state “...wherever possible”

Principles

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

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

#4 needs to be strengthened. I prefer “...by recognizing AND PROMOTING”
Purpose

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

Terminology

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

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

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

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

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

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

² Adapted from Canadian Medical Association, Euthanasia and Assisted Suicide. http://policybase.cma.ca/dbtw-wpd/Policypdf/PD14-06.pdf
⁴ Adapted from the University Health Network’s, Appropriate Use of Life-sustaining Treatment and CMA Statement on Life-Saving and –Sustaining Interventions.
⁵ Adapted from World Health Organization, Definition of Palliative Care. http://www.who.int/cancer/palliative/definition/en/
Policy

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

1. Quality Care
2. Communication
3. Advance Care Planning
4. Consent to Treatment
   4.1 No Treatment Without Consent
   4.2 Capacity at the End of Life
   4.3 Consent on Behalf of an Incapable Patient
5. Interventions and Care Management
   5.1 Palliative Care
   5.2 Life-Saving and Life-Sustaining Treatment
   5.3 Aggressive Pain Management and Palliative Sedation
6. Dying at Home
   6.1 Home Care
   6.2 Certification of Death
7. Wishes and Requests to Hasten Death
   7.1 Responding to Wishes and Requests to Hasten Death
   7.2 Euthanasia and Physician Assisted Death
8. Managing Conflicts
   8.1 Conflict Resolution
   8.2 Conflicts with Substitute Decision-Makers
   8.3 Conscientious Objection
9. Documentation
10. Organ and Tissue Donation

1. Quality Care

Again, this is missing the interdisciplinary team, and does not address the issue of self-care for physicians, in dealing with the dying and their families.

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

- Managing pain and other distressing symptoms, including psychological issues;
- Avoiding the unnecessary prolongation of dying, especially when there is little hope for meaningful recovery;
• Strengthening relationships with loved ones and continuing active involvement in social interactions to the extent that it is possible to do so;
• Attaining feelings of peace or closure, achieving a sense of control and meaning, satisfying spiritual needs, completing important tasks, and preparing for the end of life by resolving conflicts, saying goodbye, and preparing for death;
• Having trust and confidence in a physician and having a physician who is available and takes a personal interest in the patient’s care; This should be amended to trust in a team of health professionals
• Preserving dignity, being treated with respect and compassion, and being treated in a manner that affirms the whole person;
• Facilitating decision-making through clear, honest, consistent and timely communication, having the opportunity to address personal concerns, and being listened to; and
• Receiving support through the grief and bereavement process.

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

2. Communication  Again, where is the team in this?

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

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

Communication may be about different expectations at different times in the dying process
Physicians must obtain consent from the patient or substitute decision-maker to communicate personal health information about the patient and must document this decision accordingly.

3. Advance Care Planning

Advance care planning can lead to improved outcomes and quality of life, can help to ensure that the care provided aligns with the patient’s preferences, and can also encourage realistic treatment goals. Physicians have a professional responsibility to engage patients in advance care planning and to understand their patients’ wishes, values, and beliefs regarding end-of-life care.

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

Physicians are also advised to help their patients engage in such planning by providing necessary medical information and opportunity for discussion. This could include asking patients general questions about their wishes, values and beliefs regarding end-of-life care or discussing specific issues such as preferences for the location of their death, attitudes towards certain medical interventions (e.g. resuscitation, mechanical ventilation, etc.), and, as appropriate, their wishes with respect to organ and tissue donation. Physicians are advised that they may need to initiate these discussions sensitively, over multiple occasions as patients may not always be ready to participate. Physicians should remember and communicate with patients and others that wishes may change with time, and that we may wish to discuss these issues more than once.

Significant life events (e.g. death in the family or serious illness, becoming a parent, etc.) or changes in the patient’s medical status (e.g. diagnosis of terminal illness, illness progression, etc.) are opportunities for physicians to confirm that advance care planning has taken place. If the patient has engaged in advance care planning, physicians are advised to encourage patients to reassess existing advance care plans. If the patient has not engaged in advance care planning, physicians should advise patients about the importance of advance care planning and offer to assist them.

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6 See also the College’s Confidentiality and Personal Health Information policy.
8 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) and the Ontario Seniors’ Secretariat (www.seniors.gov.on.ca/en/advancedcare/index.php).
9 For more information see Section 10. “Organ and Tissue Donation” of this policy.
 Physicians should be aware that not all patients are willing to engage in advance care planning or provide an advance directive.

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

4. Consent to Treatment

The requirements for consent to treatment at the end of life are the same as the requirements for consent to treatment in other health care situations. The following is a high level overview of physicians’ obligations regarding consent to treatment. For a more detailed discussion of the legal and professional obligations for consent to treatment please see the College’s Consent to Medical Treatment policy.

4.1 No Treatment Without Consent

The Health Care Consent Act, 1996 (HCCA) requires that physicians not provide treatment unless consent has been obtained from the patient if the patient is capable or the incapable patient’s substitute decision-maker.

Situations may arise at the end of life where physicians propose that life-sustaining treatment be withdrawn. Physicians are advised that the withdrawal of life-sustaining treatment has been determined by the Supreme Court of Canada to constitute treatment under the HCCA. As

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11 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.
12 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.
13 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
14 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.
such, in order for life-sustaining treatment to be withdrawn, consent must be obtained from the patient if the patient is capable or the incapable patient’s substitute decision-maker.

In order for consent to be valid it must be obtained from the patient if the patient is capable with respect to the treatment or from the incapable patient’s substitute decision-maker, and it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.\footnote{Sections 10(1) and 11(1) of the HCCA.}

4.2 Capacity at the End of Life

Physicians are entitled to presume that a patient is capable of giving or refusing consent unless there are reasonable grounds to think otherwise.\footnote{Sections 4(2) and 4(3) of the HCCA.}

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

4.3 Consent on Behalf of an Incapable Patient

A substitute decision-maker must give or refuse consent in accordance with the most recent\footnote{Section 5(3) of the HCCA states that later wishes expressed while capable prevail over earlier wishes.} and known wish expressed by the patient, while the patient was capable and was at least 16 years of age.\footnote{Section 21(1) of the HCCA.} If no wish is known or the wish is impossible to comply with or not applicable to the circumstances, the substitute decision-maker must make decisions in the incapable patient’s best interests.

Wishes can be general or specific in nature and can be expressed in writing\footnote{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.} or orally. Later wishes expressed while capable, whether written or oral, prevail over earlier wishes.\footnote{Sections 5(1) through (3) of the HCCA.} This is the case even if, for example, the earlier wishes are expressed in an advance care planning document.

The Consent and Capacity Board (CCB)\footnote{For more information about the Consent and Capacity Board (hereinafter CCB) please visit their website: http://www.ccboard.on.ca/scripts/english/index.asp} can provide assistance to either a physician or a substitute decision-maker when a wish is not clear, when it is not clear whether the wish is
Line 193 needs to be amended to recognize that SDMs may depart from the express wishes of the patient, and still act in the patient’s best interests. Physicians are encouraged to consult with the CCB or PGT with questions should this issue arise.

applicable, or when it is not clear whether the wish was expressed while the patient was capable or at least 16 years of age. The CCB can also grant permission to depart from a wish in very limited circumstances.\textsuperscript{23} Physicians are encouraged to consult with the CCB or with the Office of the Public Guardian and Trustee where questions arise.

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

5. Interventions and Care Management

5.1 Palliative Care

Palliative care can be provided at any stage of a patient’s life-threatening illness or life-limiting chronic condition. However, physicians are advised that engaging in palliative care as early as possible can lead to improved quality of life for patients.\textsuperscript{26} Palliative care does not have to be provided by specialists in palliative care; however, physicians are advised to seek the support or involvement of specialists in palliative care and/or referral to hospice care\textsuperscript{27} where appropriate and available.

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

\textsuperscript{23} Sections 35 and 36 of the HCCA. More information can also be found on the CCB’s website listed in footnote 22.

\textsuperscript{24} 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.

\textsuperscript{25} Section 21 (2) of the HCCA.


\textsuperscript{27} 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).
5.2 Life-Saving and Life-Sustaining Treatment

As with all treatment, physicians must obtain consent from the patient if the patient is capable or the incapable patient’s substitute decision-maker to provide life-saving and life-sustaining treatment. Physicians are advised that if a patient or substitute decision-maker does not consent to life-saving or life-sustaining treatment, it is still appropriate to provide palliative care. Line 220 is confusing. If they refuse consent for life-sustaining treatment, and refuse palliative care as well, we need to provide a suggested approach to what to do next.

Physicians are not obliged to propose or provide life-saving or life-sustaining treatments that are not within the standard of care. However, when a life-saving or life-sustaining treatment falls within the standard of care, physicians must identify this treatment option for the patient and/or substitute decision-maker even if it is not the physicians’ preferred treatment option. Line 224 sets up the requirement to offer treatments that are not clinically indicated. From a policy standpoint, does this mean, for example, we offer TPN to all dying persons?

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

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

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

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

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For information on when emergency treatment can be provided without consent, please see the College’s Consent to Medical Treatment policy.

EGIW v. MGC, 2014 CanLII 49888 (ON HPARB)

Reference 29 is in jargon and needs to be better spelled out, with a link.
treatment and provide details regarding the treatment(s) they propose to provide. Physicians must obtain consent to withdraw life-sustaining treatment.  

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

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

5.3 Aggressive Pain Management and Palliative Sedation

In some cases, the management of a patient’s pain and symptoms at end of life may require the aggressive use of pain medication (e.g. opioids) or palliative sedation (e.g. the use of pharmacological agents to reduce consciousness). The intention of these interventions is not to hasten death. When physicians provide aggressive pain management or palliative sedation, they must provide the treatment in proportion to the pain and/or symptoms and closely follow any changes in the patient’s pain and/or symptoms to ensure that appropriate treatment is provided. Line 259 should include the statement that, appropriately used, even at the end-of-life, research demonstrates that opioid use does not increase the risk of dying.

6. Dying at Home

6.1 Home Care

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

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

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


Add new line 271: The availability of sufficient practical resources to enable death at home to be provided effectively, including care providers, home care, medications, and equipment
In addition, when considering whether dying at home is a manageable option, physicians must educate and prepare patients and caregivers for what to expect and what to do when the patient is about to die or has just died.

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

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

6.2 Certification of Death

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

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32 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
33 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
34 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.
35 Medical certificates of death can be obtained by contacting the Office of the Registrar General: 1-800-461-2156.
36 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;
deceased are also permitted to complete the medical certificate of death in limited circumstances. It is not acceptable to rely on the coroner to certify the death when the coroner’s involvement is not required and there are others involved in the patient’s care who have a legal responsibility to do so.

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

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

7. Wishes and Requests to Hasten Death

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

7.1 Responding to Wishes and Requests to Hasten Death

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

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

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.

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

7.2 Euthanasia and Physician Assisted Death

Under the Criminal Code of Canada, euthanasia⁴⁸ and the act of counselling, aiding or abetting suicide⁴⁹ are criminal offences.

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

There are jurisdictions in which euthanasia or physician assisted death are permitted by law. Patients may express interest in travelling to those jurisdictions to seek those services and in doing so, may approach physicians to obtain access to their medical records or their personal health information. Patients in Ontario have a right of access to their personal health information⁵⁰ and unless the physician determines that an exception to this right is applicable,⁵¹ physicians are required to release the medical records or personal health information to the patient in these circumstances.

8. Managing Conflicts

8.1 Conflict Resolution

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

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

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

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⁴⁸ Section 229 of the Criminal Code of Canada.
⁴⁹ Section 241 of the Criminal Code of Canada.
⁵⁰ Sections 1(b) and 52 of the Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Schedule A.
⁵¹ Section 52 (1) of the Personal Health Information Protection Act, 2004.
• Identify misinformation and/or misunderstandings that might be causing the conflict and take reasonable steps to ensure that these are corrected and that questions are answered;
• Offer referral to another professional with expertise in the relevant area and facilitate obtaining a second opinion, as appropriate;
• Offer consultation with an ethicist or ethics committee, as appropriate and available;
• Where appropriate, seek legal advice regarding mediation, adjudication or arbitration processes that are available (in some cases, this may involve an application to the Consent and Capacity Board); and
• Transfer the care of the patient to another facility or health care provider as a last resort and only when all appropriate and available methods of resolving conflict have been exhausted.42

8.2 Conflicts with Substitute Decision-makers

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

8.3 Conscientious Objection

Physicians who limit their practice44 on the basis of moral and/or religious grounds must comply with the College’s Physicians and the Ontario Human Rights Code policy.

9. Documentation

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

Every patient and/or substitute decision-maker encounter and all patient-related information45 must be documented and dated in the patient’s record, in accordance with the College’s Medical Records policy. For example, in the context of end-of-life care, patient records must include reference to discussions and decisions regarding treatment, goals of care, and advance care planning (e.g. wishes expressed while capable, advance directives, etc.). Do not resuscitate orders must be explicitly and clearly referenced in the patient’s record so that they are available to all involved in the patient’s care and who have access to the patient’s record.

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42 In following such a course, the physicians must comply with the College’s Ending the Physician-Patient Relationship policy.
43 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.
44 This may include, but is not limited to, refusals to provide care, withdraw care, and/or discuss care options.
For more information about the legal requirements and professional obligations for documentation see the College’s [Medical Records](#) and [Consent to Medical Treatment](#) policies.

### 10. Organ and Tissue Donation

The *Trillium Gift of Life Network Act*[^46] sets out requirements relating to organ and tissue transplantation measures for health facilities designated by the Minister of Health and Long-Term Care.

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

Physicians working in designated facilities must comply with any policies and procedures established in accordance with the legislation.[^50]

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

[^47]: 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*.
[^48]: Section 8.1(1) of the *TGLNA*.
[^49]: 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.
[^50]: 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*.
[^51]: For more information please visit the Trillium Gift of Life website ([http://www.giftoflife.on.ca/en/](http://www.giftoflife.on.ca/en/)) or call toll free 1-877-363-8456 or 416-363-4438 if within the GTA.