College of Physicians & Surgeons of Alberta

Serving the public by guiding the medical profession.

February 19, 2015

Delivered via email

College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON M5G 2E2

Dear Sirs/Mesdames:

RE: Current Consultations

Thank you for the invitation to comment on the College of Physicians and Surgeons of Ontario (CPSO) policies currently under review. The attached enclosure provides comments and suggestions on *Consent to Treatment, Planning for and Providing Quality End-of-Life Care* policies.

Enclosure

Planning for and Providing Quality End-of-Life Care	We strongly support this document and provide suggestions for succinctness and clarity. • Line 11: Use consistent language and avoid confusing patient wishes and goals of care. Consider the word **wishes** to replace **goals**. • Line 104: consider **physicians must endeavor to understand what is important to their patient, which can be done directly through the patient or indirectly through the patient's substitute decision maker.** • Line 107: Consider **treatments cannot prevent imminent death.** (Given death and taxes are inevitable in life.) • Line 112: manner and tone should be suitable to any decision a patient may face. Consider removing the word **difficult** to avoid qualifying the type of decision being made. • Line 114 & 115: consider acknowledging effective communication also builds trust with the patient's support network, family and friends, which is broader than within the physician-patient relationship. • Line 127-129: strengthen the statement. Consider **advance care planning improves outcomes and quality of life, helps ensure the care provided aligns with patient's preference and encourages realistic treatment goals.** • Line 144: keep messaging consistent around early and often communication. Consider removing the word may. • Section 4: remove the majority of this section. Acknowledge consent requirements are the same as in other health care situations and refer the reader to the policy source. This approach is used in section 8.3 of this policy. • Line 176 – 178: use consistent language to what is included in the *Consent to Treatment* policy. Consider **capacity is fluid; it can change over time, and depends on the nature and complexity of the specific treatment decision**. • Line 202: palliative care can be provided in a broader context than life-threatening. Consider the word **serious** to replace **life-threatening**.

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	• Line 204: strengthen the statement. Consider **engaging in palliative care as early as possible improves quality of life for patients.** • Line 213 & 214: use consistent language that aligns with previous advice. Consider **palliative care should be engaged as early as possible in the progression of one's illness or chronic condition.** • Line 254 & 256: sedation does not require further qualification. Consider deleting the word **palliative**. • Line 262: The possibility that patients will request dying at home is the crux of this section, opposed to how often they do so. Consider replacing the word the word **may** to replace **often**. • Line 273 & 274: enable delegation to a care team. Consider **physicians must ensure patients and caregivers are educated and prepared for what to expect and what to do when the patient is about to or has just died.** • Section 7: revise in consideration of Supreme Court of Canada decision *Carter v. Canada (Attorney General)* recognizing the declaration that s. 241(b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. Consider further clarity on the following: o criteria for irremediable medical conditions must not require a patient to undertake treatments that are not acceptable to the individual. o physicians must ensure patients are properly informed of their diagnosis and prognosis and the range of available options for medical care including palliative care interventions aimed at reducing pain and avoiding the loss of personal dignity. o physicians must assess patient competence and voluntariness in the context of life-and-death decisions including assessing for the presence of coercion, undue influence and ambivalence. o Physicians who choose to limit the health services they provide for reasons of conscience or religion must do so in a manner that respects patient dignity, ensures access to care and protects patient safety. • Line 264: advising physicians to 'refer' to the Consent and Capacity Board should lower their threshold to seek information and support. Consider **refer to** to replace **apply to**. • Line 326: word tense requires commas. Consider **consent of the deceased does not absolve the person who acted to bring, or assisted in bringing, about the death from criminal liability.** • Section 10: lines 387 – 391 provide the information with clear simplicity. consider removing redundant statements to enhance clarity.

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	• Line 383: Provide further clarity regarding accountability. Consider **a physician working in a designated facility must ensure the Trillium Gift of Life Network is notified 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.**

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