

Submission to the College of Physicians and Surgeons of Ontario Regarding End-of-Life Care

As the Ontario members of the Physicians Advisory Council of Dying with Dignity Canada and members of the College of Physicians and Surgeons of Ontario, we are pleased at the proactivity of the CPSO in drafting its new policy for End-of-Life Care. We feel that it is critical for Ontario's 25,000 doctors to be involved in shaping this policy, especially in light of the recent ruling by the Supreme Court of Canada.

It is also vital that the 86% of adult Ontarians who support Physician Assisted Death be broadly represented in this crucial discussion and we encourage the CPSO to solicit views from nurses, social workers and other health professionals too.

Dying With Dignity Canada (DWD Canada) is a national organization committed to alleviating needless suffering at end-of-life. DWD Canada serves as a vital resource of information, support and advocacy for Canadians who want a peaceful death and as a resource for those interested in the case for physician assisted dying. Accordingly we are pleased to respond to the CPSO's call for submissions.

DWD Canada proposes five guiding principles that can be used to assess and improve current and proposed end-of-life healthcare practices.

- Patient autonomy - Decision-making should ultimately rest with the patient. Patients should be allowed to choose from treatments that fall within the standard of care.
- Patient-centred care - The primary goal of care should be to give the patient the best experience at end-of-life. This may involve realignment of resources so patients have access to facilities better suited to their prognosis.
- Adequate pain and symptom control - No patient should be forced to endure unbearable suffering.
- Universal access - Agreed upon rights and options for patients should be universally available, including palliative care services as well as access to Physician Assisted Death.
- Patient education and effective communication - Patients cannot make good decisions without effective education. Communication systems which document and track patients' wishes over time are essential.

We are impressed by the College's draft policy, with one major exception in Section 5.2, which we deal with in detail below. We are pleased to see that several of the principles stated above are reflected in your policy. Any changes that will improve end-of-life care in this province or country are indeed welcome.

We do appreciate the call for earlier and better palliative care and agree that all physicians should have some competence in palliative care. You have highlighted the importance of

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good communication and the necessity of advanced directives, both areas where we are in accord. Your reference to the inability of physicians in some circumstances to prevent death is crucial to the understanding of physicians looking after sick and dying patients.

Finally we applaud the reference to “requests to hasten death.” This proved to be prescient, as the Supreme Court has now ruled on this matter. Clearly the College will want to revisit the document in view of this ruling and we strongly encourage you to seek our assistance in this endeavour.

Overall Concerns

1. Standard of care needs to be defined.

Standard of care is referred to several times in the policy.

For example, principle 2 states:

*Demonstrating professional competence, which includes meeting the **standard of care** and acting in accordance with all relevant and applicable legal and professional obligations.*

Standard of Care must be defined, especially with respect to end-of-life care. When dealing with end-of-life care what are the standards? Are all physicians aware of them?

Many physicians have difficulty dealing with dying patients not only because of their discomfort with death (as is common in much of society) but also because of the fear of reprisal, of not doing everything possible for that patient (which they may mistakenly believe results in not following the perceived “*standard of care*”). This may contribute to prolonging the dying of many hospitalized patients. You must clearly define what is entailed by the term *standard of care* in a dying patient.

2. The increasing role of hospitalists must be addressed.

The role of the family physician in hospitals has changed dramatically in the last decade. Most inpatients are cared for by hospitalists who are knowledgeable in the latest guidelines but unfortunately do not know the patient intimately and so may be less likely to really question them about their wishes for end-of-life treatment. It is often simpler just to “treat” than it is to discuss withdrawing treatment (especially without some changes to Section 5.2 Life-Saving and Life -Sustaining Treatment). So it is important that hospitalists be comfortable both with palliative care and with the College’s policy on end-of-life care.

3. The section on patient’s wishes for hastened death is outdated.

Clearly in view of the Supreme Court decision decriminalizing the prescription and administration of life-ending medication, this section will need to be re-written. In particular the College will need to ensure there is specific training for doctors who choose

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to assist patients to die and that the difficult questions of access to Physician Assisted Death by Advance Care Plan are addressed.

One of the key policies that will need to be formulated is that of the right of universal access. While we agree with the right of physicians not to provide assisted death should they so decide, we feel strongly that they should have the obligation to provide referrals to appropriate physicians if requested. In addition the difficult questions surrounding hospitals, long-term care facilities and hospices that would prefer to opt out of providing assisted dying must be addressed. As a minimum, it will be imperative that facilities disclose whether access to PAD is provided on their premises.

We do not believe the rights of patients and doctors are being balanced if entire communities are left without access to Physician Assisted Death.

Specific Areas Needing to be Addressed

1. Principles (Line 18):

The CPSO's policy states:

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-makers;*
- 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.*

We would like to see as a first principle: "Respecting the autonomy of the patient" as referred to in the draft . followed by the five principles above.

2. Terminology (Lines 37-55):

The CPSO's definitions of terminology include the following:

- a. **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.*

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This is sometimes referred to as physician assisted suicide.

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

The Supreme Court of Canada uses the term Physician Assisted Death to refer to both the prescribing and administration of medication. We believe it is critical that the CPSO (and the CMA) use similar terminology to avoid any misunderstanding in the media and among doctors and the general public.

We recommend that rather than using physician assisted death as used above (and in conflict with the Supreme Court's decision) the College refer to "*prescribing of medication at a patient's request with the specific intention of bringing about their death.*"

We do not consider the death to be a "suicide" and we encourage you to delete this term. We feel that the disease is responsible for the death of the patient.

The word "euthanasia," though a term that translates literally as "good death," has come to have negative connotations for some. Accordingly, we suggest that it be replaced with "the administration of medication at a patient's request *with the specific intention of bringing about their death.*"

At the very least, the Policy should refer to "Voluntary Euthanasia." Further to our previous comments, we suggest including "Standard of Care" in this section, with a clear definition.

3. Consent on Behalf of an Incapable Patient (4.3)

The CPSO's draft policy reads:

*Consent on Behalf of an Incapable Patient: A substitute decision-maker must give or refuse consent in accordance with the most recent and known wish expressed by the patient, while the patient was capable and was at least 16 years of age. 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.***

We feel that there should be more clarity around lines 183 and 184, specifically "the patient's best interests." Does this mean less suffering? prolonging life? prolonging death?

Perhaps the intent should be to make the decision the patient would have made for themselves if fully informed and capable of making their own decision.

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4. Life-Saving and Life-Sustaining Treatment (5.2)

We have serious concerns with this section. In the first three paragraphs of this section, the CPSO states:

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.

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.

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.

This section is without a doubt the most important section in the policy and unfortunately is the most problematic from our perspective. While we are well aware of time and resource constraints, if we are to truly see a reduction in instances of “prolonging death,” we have to allow for a less tedious process for both patients and substitute decision makers, one that involves more compassion and that addresses the reality and prognosis for the patient.

“Treatment” that “prolongs life even if there is no clinical benefit” sounds a lot like “prolonging death” to us and will only serve to confound physicians caring for the dying.

The “Do Not Resuscitate” reference is very cumbersome. If a patient has expressed a DNR to any member of the health care team then this should be recorded and honoured. There should be no need to ever revisit it and to suggest that the physician him/herself has to again obtain consent for a DNR will only confuse the patient or the substitute decision maker.

It sounds as if the College is viewing resuscitation as something other than a *treatment* and thus requiring special procedures to waive it. This seems to us inconsistent with the College's view that only treatments need be proposed which fall within the *standard of care*.

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OUR STRONG RECOMMENDATION regarding this section is that the College further consults the profession, particularly those physicians working in Intensive Care Units where these issues arise daily.

5. Conflict Resolution (8.1)

The CPSO's current piece on communication includes the following:

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.*

We suggest that you add to the communication piece Line 347: "Availability of physician assisted death."

Once more we thank you for the opportunity to comment on the CPSO's draft policy. We appreciate the work involved in such an endeavour and applaud the intent of the document. It is a very sincere effort to improve end-of-life care in Ontario. For this we are grateful.

Clearly there is a lot more work to be done not only in view of the Supreme Court ruling but also in view of our major concerns with Section 5.2.

There is no rush to publish the policy. In our view it is likely the most important document from the College in decades and it is worth taking the time to make sure that it will be a model for others. We strongly encourage you to accept our support in reviewing subsequent drafts.

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