



February 18, 2015

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

Subject: *Planning for and Providing Quality End-of-Life Care Policy*

Thank you for inviting the Ontario Medical Association to review and comment on the College's recently updated policy entitled *Planning for and Providing Quality End-of-Life Care*. The policy update is timely given the recent legal, ethical and healthcare developments related to death and dying in Ontario and Canada.

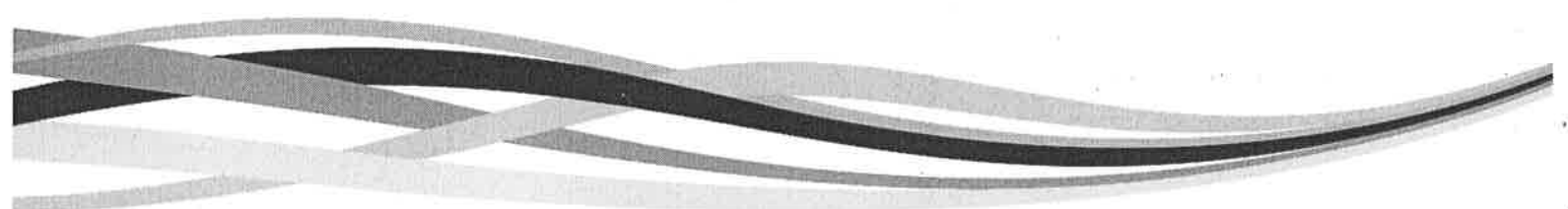
We commend the College for the emphasis its policy places on the importance of advance care planning and clear communication between a physician and his/her patient and their family. We are concerned, however, that the distinction between DNR and the question of CPR is not sufficiently clear. There will be circumstances that arise in which it is perfectly reasonable for a physician not to offer CPR as a treatment option because it is not considered to be clinically beneficial. Our submission points out that the *Health Care Consent Act* is predicated on the notion that a provider offers treatment and that a patient may accept or refuse. We respectfully suggest that the CPSO add a section to address this nuance.



Ontario Medical Association

Submission to the College of Physicians and Surgeons of Ontario's Policy: Planning for and Providing Quality End-of-Life Care

February 2015



OMA Submission to the College of Physicians & Surgeons of Ontario's Policy: Planning for and Providing Quality End-of-Life Care

The OMA welcomes the opportunity to provide comments on the College's significantly updated policy on providing quality end-of-life care. We commend the College for the strong stance it has taken on the importance of advance care planning and communication between the physician and the patient and family/SDM.

We offer the following comments for your consideration.

Palliative Sedation -- We suggest that a definition of Palliative Sedation be provided in the Terminology Section to make it clear that palliative sedation is only used for intractable, refractory symptoms to relieve the patient's suffering, not to hasten death. Both the Canadian Medical Association and the OMA have developed clear definitions^{ab}

Communication -- We support the emphasis on the importance of clear, regular communication with the patient and family. In pediatric palliative care, communication with the family, usually the primary caregivers, is particularly critical. You may wish to add that communication is critical when discussing the end-of-life treatment plan or goals of care with the patient and/or SDM. Treatment options, with their risks and benefits, should be discussed and the patient's consent received to the interventions or lack of interventions in the treatment plan. The patient should be reassured that not pursuing aggressive interventions when death is close does not mean the patient will be abandoned; quality palliative care, including adequate pain control, will be provided. Most patients' greatest fear related to death and dying is pain. If patients/SDMs knew that the survival rate after CPR in the frail elderly is less than 5% and less than 1% in those with advanced chronic conditions, fewer might choose this as an option.

Advance Care Planning -- You may wish in this section to emphasize the difference between ACP and treatment plans. ACP allows a person to articulate their values, wishes and beliefs, and may form the basis of later treatment decisions by guiding the SDM. Treatment plans (under the HCCA) are context-specific and require the consent of the person or SDM.

Palliative Care -- In section 5.1, the point could be made that all primary care physicians with a basic education in palliative care, willingness to provide opioids and with good communication skills should offer palliative care to their patients. The advice of a palliative specialist should be sought in complex cases. We should build to a situation where most communities have a community-based palliative care network with trained nurses and physicians.

Consent -- The policy outlines the physician's legal responsibilities under the Health Care Consent Act as interpreted through recent court/tribunal hearings (Supreme Court of Canada's reasons for judgement in the Rasouli case and the recent Health Professionals Appeal and Review Board case: EGJW v.MGC, 2014 Can LII 49888).

The ruling on Rassouli is based upon a specific set of facts: it addresses Do Not Resuscitate (DNR) in the context of a comprehensive treatment plan for a patient in life-limiting

^aCMA. Euthanasia and Assisted Death (update 2014). 2014

^bOMA. End-of-Life Terminology. 2014. Accessible at www.ontariosdoctors.com/End-of-Life Planning and Care

circumstances. In that circumstance, it seems reasonable to expect that DNR is raised with the patient/family as part of the consent that is given for the Treatment Plan. However, DNR for a patient with a life-limiting condition represents only a sub-set of the situations where Cardiac Pulmonary Resuscitation (CPR) may be clinically indicated. There will be circumstances that arise in which it is reasonable for a physician not to consider CPR as a treatment option because it is not perceived to be clinically useful. The HCCA is predicated on the notion that a provider offers a treatment and that a patient or substitute may then consent to (accept) the treatment or refuse the treatment. It also recognizes the fact that a physician may not have the ability to obtain consent in an emergency situation. The CPSO policy needs to deal with this nuance.

The OMA believes that taking the approach noted above may help to bridge the gap between this policy and the CMA's Statement on Life-Saving and Life-Sustaining Interventions. It is important that Ontario physicians have clear and unambiguous information about their expected standard of care.

Home Death -- In Section 6 it should be noted that many communities in Ontario have protocols to help manage an expected death in the home (EDITH). The EDITH package clearly states who will be pronouncing death, where the physician will sign the death certificate, who the family should call and contains all the required forms (i.e. the "Do Not Resuscitate Confirmation Form"). These protocols and accompanying guidelines can be obtained through the local CCAC or LHIN palliative care network. It is good practice, in any case, for a physician providing palliative care to patients at home to connect with palliative care resources at the local LHIN or CCAC.

Donation -- Section 10 on Organ and Tissue Donation is fairly brief and may appear to be an add-on. Organ and Tissue Donation in Ontario is relatively complex and probably merits its own guidelines. If the intent is just to tell physicians the basics about the Trillium Gift of Life Network, this section may suffice, but a more comprehensive policy on organ and tissue donation could make a difference in the number of donors and families consenting to donation, as well as physicians trained to diagnose brain and cardiac death and identify potential donors.

In summary, the OMA commends the College for producing this policy and its strong emphasis on advance care planning and communication. We are pleased to have been given the opportunity to comment.