

Appendix 1 – Contradictions within the CPSO End of Life Policy document

A) LINE 7 contradicts LINE 14 and 15. *'planning for end of life ensures care aligns with patient wishes, values and beliefs* – changes to LINE 14 and 15...physicians find *realistic* goals that *seek* to incorporate patient wishes... – NOTE: these are completely different from each other in practice – please have one achievable statement

B) LINE 9 – 11 Statements regarding palliative care provision are not in-keeping with health care resources available to provide idealistic, textbook palliative care to all dying patients in Ontario. This is what Palliative Care wishes for – but, systems are not in place to meet to psychological, social and spiritual needs of all dying patients as an expectation of practice. This sets up the likelihood of 'not meeting standard of care' in **most** end of life situations.

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. 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. 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.

C) Line 26 and 27: *Communicating sensitively and effectively with patients and/or their substitute decision-maker;*

- #3, communicating 'effectively' is a matter of perception and readiness for patients/families to hear the information, and the physician's prognostic certainty when providing information– it often does not necessarily reflect the 'approach to the conversation'

D) LINE 104- 107 *Physicians must ensure Quality Care* – yet – quality care as described reflects a fully functioning palliative care health care system – which unfortunately, does not exist throughout Ontario. The demands written within this document from the CPSO run the risk of placing the physician in an impossible position because they are individuals not health systems. One can only meet this documents description of 'standard of care' in clinical situations if they live in a region that has a very robust Palliative Care Health Care system.

Please separate the roles/duties of the physician from the health system.

E) Quality Care: Requires a fully functioning palliative care health care system which physicians do not have control over – Asks for physicians to take a ‘personal interest’ in their patients - what is meant by this statement? It appears to cross professional boundaries.

F) *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.*

Please provide references that we can read to reassure physicians there is evidence to support the CPSO’s request that we repeatedly approach the patient and family on this topic. My concern is that it may cause harm, as patients and families may feel threatened by the *content* of the discussion, even if the physician approaches to the discussion in a very sensitive, appropriate manner.

G) LINE 112 to 117 *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.***

Along with the above, please clarify the intention of line 124 in context. 124 *Physicians must obtain consent from the patient or substitute decision-maker to communicate*
NOTE: the paragraph prior to this says – *have frequent repeated conversations*. Then the document QUESTION: – do physicians need a consent to have the conversation with the patient? Secondly, **what if** - the patient and family feel burdened by ‘the conversation’ and explicitly ask physicians to ‘stop’ Note: this is a common response of patients/families. – ie. The patient is not ready to hear the information **What if** – the physician is not certain of the prognoses – how can they deliver news ‘early and frequently’ – Note: this is the usual situation on a frail patient’s trajectory towards death.

H) *Best Interest* (lines 22, 184 and 194)–is a very important concept. It is highly theoretical, and layered with significant ethical challenges. How will the CPSO judge the ‘physician’ when it is not uncommon to have situations in which the ‘best interest’ seems to be an illusion shadowed by perceptions of many different people. Please acknowledge challenges associated with identifying - *Best Interest*- in the document so that physicians are not set up for failure.

LINE 194-199. 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, 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.

- I) Please clarify – how sentences 221 and 228 relate to each other – as 228 may be referring to patient/family request for care ‘outside the standard of care’

LINE 221 – 230 *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.*

- J) Lines 240 and 244- *The College requires physicians to obtain consent for a “Do Not Resuscitate” order.*²⁹ Question – does the CPSO mean physicians are required to obtain a signed consent form for the DNR and for withdrawal of life sustaining therapies? Or is documentation of the conversation and decision making appropriate – as is mentioned earlier in this document?

- K) LINE 244 *must obtain consent to withdraw life-sustaining treatment.*³⁰ QUESTION: is a written, signed consent expected for WLST?

- L) Please clarify the semantics of this sentence. – *if a patient requests medical information be released to another jurisdiction with the intention of seeking euthanasia or PAS – (which is a criminal act) - then – is that ‘an exception to this right’ or not? This is section very confusing.*

Line 332-334 *information and unless the physician determines that an exception to this right is applicable, physicians are required to release the medical records or personal health information to the patient in these circumstances.*