

“Planning for and Providing Quality End-of-Life Care”

I heartily endorse there being a policy on planning for and providing quality end-of-life care. It is a particularly opportune time for this policy to be introduced.

I have the following concerns with the draft:

9 – make it clear that “standard of care” is a legal not medical determination. In my experience, physicians think it means “standard practice” and thus get led astray with respect to their authority. So line 9 could be “Physicians provide quality end-of-life care by meeting the standard of care (a legal not medical standard) and by addressing...”

22 – I was floored to see #1 be “Acting in the best interests of their patients”. I went and reviewed the College’s Practice Guide and was then doubly-floored to see that the word “autonomy” is mentioned only once. The absence of respect for autonomy in the Practice Guide and then in this Policy’s statement of Principles is deeply disturbing. Respect for a competent patient’s wishes should be paramount. This is clear from many Supreme Court of Canada cases.

23 – again the phrase “standard of care” is used and I believe will mislead physicians.

41 – the definition of “Physician assisted death” will confuse people. Physician assisted death actually includes both voluntary euthanasia and assisted suicide. I know the Canadian Medical Association defined the terms this way but I believe they were wrong to do so. This is made manifest in the SCC decision in *Carter v Canada (Attorney General)* in which physician-assisted death is the umbrella term and physician-assisted suicide and voluntary euthanasia fall under it.

159-171 – you should also reflect the decisions in Ontario post-*Rasouli* that state that withholding treatment also requires consent.

220 – should be “it is still appropriate to provide palliative care (if it is consented to).” Not everyone wants palliative care.

221- 235 – I disagree with this statement of the law. It will confuse physicians (with its reliance on the phrase “standard of care” without explanation as physicians frequently take this to mean “standard practice” and believe it to be something that is within the expertise of the physician (hence their authority). Also, the expression “clinical benefit” is problematic – it recognizes that values are at stake (“benefit” is a value-laden concept) but suggests that benefit can be clinically determined (hence within the expertise and authority of physicians). Also the term “warrant” suggests that there is something other than the patient’s autonomous wishes that will determine whether the treatment will be continued or not. Who determines

whether treatment is “warranted”? The implication here is that the physician performs that task. This is precisely what I would reject. “Consensus” (234) is not required.

238 – I would say “why they propose the order” rather than “why they propose not to provide the treatment”.

241-244 – I would argue (based on the post-*Rasouli* cases and common law analysis) that this paragraph should include “withhold” wherever it mentions “withdraw”.

253-259 – Palliative sedation is more complicated than this passage suggests. The intention can absolutely be to hasten death. If you have a patient who has more than a month to live who requests deep and continuous sedation and refuses artificial hydration and nutrition, the intention is to hasten death. This is a practice about which there is confusion and controversy with respect to its legal status (see trial judge’s decision in *Carter* and the academic literature). I would separate these two. You can quote from the trial judge in *Carter* to support a strong claim re: legality of “aggressive pain management.” But you can then also be much more circumspect in describing palliative sedation (when you don’t just mean reducing consciousness but you mean deep and continuous sedation without artificial hydration and nutrition).

308 – should be “physician-assisted suicide.” (see earlier)

323 – should be “Voluntary euthanasia and physician-assisted suicide” (see earlier)

321-334 – this obviously need to be revised in light of the SCC decision in *Carter*.

335 – I would argue that this section needs to end with a very clear statement of what the physician is required to do should the best efforts at conflict resolution not be successful. That is, where I would argue there needs to be a detailed process established which includes: information gathering; communication; and conflict resolution. The conflict resolution stage in the process should make it clear that when the physician disagrees with the patient or patient’s substitute decision-maker and the disagreement cannot be resolved, the physician must go to the Consent and Capacity Board and seek a resolution – i.e., be clear that physician’s do not have authority for unilateral decision-making. [See, for example, suggestions in Downie J and McEwen K, “The Manitoba College of Physicians and Surgeons Position Statement on Withholding and Withdrawal of Life-Sustaining Treatment (2008): Three Problems and a Solution” *Health Law Journal* 17 (2009).