

Date: April 30, 2021

To: College of Physicians and Surgeons of Ontario (CPSO)

Re: Planning for and Providing Quality End-of-Life Care Policy Consultation

The Ontario College of Family Physicians (OCFP) represents 13,500 family physician members across Ontario providing primary and secondary care across all settings. We are pleased to share the following comments and recommendations on CPSO's proposed policy "Planning for and Providing Quality End-of-Life Care".

Under "Definitions":

- The definition of **palliative sedation** should articulate clearly how intensive this procedure is and the requirement for close monitoring along with ongoing access to a physician.

In expectation #1, under "Quality Care and Communication," the policy states:

When helping patients plan for or when providing end-of-life care, physicians **must** endeavor to understand what is important to the patient in order to ensure that the patient's goals of care are understood and that quality care is provided.

- a. In doing so, physicians are **advised** to provide assistance to patients or substitute decision-makers (SDM) in order to help them articulate the patient's goals of care.
- Are family physicians "advised" or "required" in this scenario? We are hearing from some family physicians that the word "advised" could create a lack of clarity. Current wording leaves open the potential to have no goals of care established with the patient's family physician/most responsible provider.

In expectation #4, under "Advance Care Planning," the policy states:

As it is never too early for physicians to discuss advance care planning with their patients, as part of routine care physicians are **advised** to:

- a. discuss the importance and benefits of advance care planning, choosing an SDM, documenting and disseminating advance care plans to their loved ones, SDM, and health-care providers, and reviewing advance care plans throughout life; and
 - b. help patients engage in such planning by providing necessary medical information and opportunity for discussion.
- We are hearing from some family physicians that the word "advised" leaves room for the physician not to have the ACP conversation, including discussing an SDM. Recognizing that the word "required" may not be appropriate in this context, is there nonetheless an opportunity for stronger wording for this expectation? Specifically, to underscore with physicians the importance of an ACP conversation for all patients in their roster to whom this conversation is relevant (i.e., those with chronic, life-limiting or terminal illnesses), including the importance of choosing an SDM.
 - For example, when a physician first diagnoses a patient with a chronic illness such as Chronic Obstructive Pulmonary Disease, the physician should explain to the patient what COPD is, how they can live with their disease, how to prevent it from progressing, treatment options, but also state that it is a terminal disease that could end the patient's life, and initiate a conversation about advance care planning as well as goals of care – which may change as an illness progresses.

- Given the importance of goals of care (GOC) and advance care planning (ACP) in planning for and providing quality end-of-life care, it may be helpful to include the following resources as part of the accompanying Advice to the Profession:
 - ACP: <https://www.speakupontario.ca/wp-content/uploads/2018/07/ACP-Conversation-Guide-Clinican-Oct-4.pdf>.
 - GOC: <https://www.speakupontario.ca/wp-content/uploads/2020/04/GoC-template-Oct-2019-final-document-1.pdf>.

In expectation #5, under “Advance Care Planning,” the policy states:

When significant life events or changes in the patient’s medical status occur, physicians are **advised** to:

- a. encourage patients who have already engaged in advance care planning to review existing advance care plans; or
 - b. where the patient has not already done so, remind patients of the importance of this process, create opportunities for discussion, and encourage them to engage in this process.
- Are family physicians “advised” or “required” in this scenario? We are hearing from some family physicians that the word “advised” could create a lack of clarity. Physicians should be *required* to encourage patients to review existing advance care plans (ACPs) and to remind them of the importance of the process. Furthermore, the physician should document the patient’s review of the ACP, with changes in the patient’s condition, to avoid a common situation in which a plan is developed once, without being re-visited later. Physicians should ask their patients when they last reviewed their ACP.

In expectation #7, under “Consent to Treatment,” the policy states:

In order for consent to be valid, physicians **must** ensure it is obtained from the patient if the patient is capable with respect to the treatment or from the incapable patient’s SDM, and it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.

- We are hearing from some family physicians that “misrepresentation or fraud” are strong words and miss an educational opportunity in helping physicians understand what would not be appropriate (perhaps in the Companion Resource).
- An example provided was of a MAID vs. palliative care sedation conversation, completed by an Internist, with a woman on ketamine post operatively. The family physician needed to halt the process of goals of care until she was off ketamine and of sound mind.
- This was not done with malice and the terminology here would make physicians feel defensive rather than helping them learn what is an appropriate time and what does constitute treatment may be affected by a number of health conditions.

In expectation #8, under “Consent to Treatment,” the policy states:

Physicians are entitled to presume the patient is capable unless there are reasonable grounds to believe otherwise (e.g., something in a patient’s history or behaviour raises questions about their capacity to consent to the treatment). However, physicians are **advised** to exercise caution regarding this presumption in the end-of-life context and to reassess capacity as appropriate, because in this context the capacity to consent to treatment may be affected by a number of health conditions.

- Given the fragility and other realities unique to patients who are candidates for end-of-life care, this important expectation can be significantly strengthened by providing additional educational resources (perhaps in the Companion Resource) that outline concrete examples and case studies to illustrate the above.

In expectation #9, under “Palliative Care,” the policy states:

When proposing or providing palliative care, physicians **must** clearly explain what palliative care entails. This includes being clear that palliative care involves providing active care focused on relieving pain and other symptoms and addressing psychological, social, and spiritual distress related to the patient’s condition, which can be provided in conjunction with **other treatments intended to prolong life**, or when these treatments have been stopped.

- We are hearing from some family physicians that the words we highlighted in red (“other treatments intended to prolong life”) is of concern, as there is compelling evidence to showcase that patients enrolled with a palliative approach to care live longer than those in “treatments intended to prolong life”. A suggested edit may be as follows:

“...This includes being clear that palliative care involves providing active care focused on relieving pain and other symptoms and addressing psychological, social, and spiritual distress. **Provision of palliative care early in a disease trajectory, has been shown to prolong life. It can be provided ideally in** conjunction with other treatments intended to prolong life, or when these treatments have been stopped. **When the time comes for someone to die, palliative care will assure a dignified death without pain or symptoms, taking into account goals of care on preferred location of death.**”

In expectation #10, under “Palliative Care,” the policy states:

While palliative care does not have to be provided by specialists, physicians are **advised** to seek the support or involvement of specialists in palliative care and/or referral to hospice care⁹ where appropriate and available.

- A suggested edit may be as follows, to reinforce the need for referral when a physician finds themselves outside of their scope and/or skillset:

“While palliative care does not have to be provided by specialists, physicians are advised to seek the support or involvement of specialists in palliative care and/or **refer when secondary or tertiary care is needed where appropriate and available.**”

Of note, the use of “advised” may imply that physicians need may be held to a standard of referral – further clarification is required.

In expectation #18, under “Dying at Home” the policy states:

When patients express a preference for staying at home as long as possible and/or dying at home, physicians **must**:

- a. help patients and caregivers assess whether home care and/or dying at home are manageable options, including assessing:
 - patient safety considerations;
 - the caregiver’s ability to cope with the situation; and

- **whether the patient can be** provided with necessary care (e.g., whether round the clock on-call coverage is needed and available, whether home palliative care physicians or community based programs are available to assist, etc.);
- We are hearing from some family physicians that the words we highlighted in red (“whether the patient can be”) could create a lack of clarity regarding the expectation that there indeed must be 24-hour access to a physician in home-based palliative care.

In expectation #21, under “Certification of Death,” the policy states:

Physicians are **advised** to plan in advance by designating the physician(s) or nurse practitioner(s) who will be available to attend to the deceased in order to complete and sign the death certificate and to take into consideration any local or community strategies that are in place to facilitate the certification of death.²²

- Given there is now an electronic version of the medical certificate of death, which is considered to be an accepted standard of care for certification of death, it would be important to reference it in the policy and add any additional specifications that may be required.

In expectation #24, under “Wishes and Requests to Hasten Death,” the policy states:

Patients have a right of access to their personal health information and physicians **must** release patient medical records or personal health information to the patient if they choose to explore medical assistance in dying, unless it is determined that an exception to this right is applicable.²³

- We are hearing that some family physicians are seeking guidance on requests for a patient’s personal health information from a Power of Attorney or the patient’s family, after a medical assistance in dying (MAID) procedure. It is not uncommon that the patient’s family and other stakeholders may have not been involved in, or aware of, the patient’s decision to seek MAID. It would be useful for family physicians to articulate their duty in releasing records when this happens.

In expectation #25, under “Managing Conflicts” the policy states:

- d. offer consultation with an ethicist or ethics committee, as appropriate and available;
- While a useful expectation, consulting with an ethicist or ethics committee can be very challenging in practice for family physicians, especially for those doing home care and/or who are not affiliated with a hospital. Family physicians would significantly benefit from a link with additional resources within this document.

Additional comments regarding the “Managing Conflicts” section:

- Somewhere under “Managing Conflicts,” there should be an expectation to recognize instances wherein physicians face situations where there is futility in any active treatments. To strengthen this expectation, it would be helpful to articulate the expectations for physicians when treatments or interventions become futile, and how this may be addressed; for example, perhaps the physician should seek a second opinion. As it relates to the need to engage in conflict resolution, it would be helpful to lay out a clearer framework of how that might occur.



Comments on the accompanying “Advice to the Profession” resource:

- It is missing guidance on discussing death with patients. We are hearing from some family physicians noting the physician has an obligation to take into account the patient’s preferred place of death, any special requests due to religious and/or cultural practices and to maintain pain and symptom management.
- As mentioned earlier, it would be useful to refer to the new electronic version of medical certificate of death.
- Also as referenced earlier, managing conflicts can be a very complex situation. Can the CPSO express support for physicians who face situations where there is futility in any active treatments?
- For physicians who work in rural and remote communities where it is not easy to access other clinicians, further clarification is needed on how this policy could practically be acted upon. This would be particularly helpful in the context of managing conflicts.