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School *of* Law

March 20, 2021

(via eolpolicy@cpso.on.ca)

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

Dear CPSO:

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

I am a law professor currently serving as the Fulbright Canada Research Chair in Health Law, Policy and Ethics at University of Ottawa. I appreciate the opportunity to participate in the preliminary consultations regarding the *Planning for and Providing Quality End-of-Life Care Policy*. Furthermore, I would be delighted to continue engagement with the CPSO as it revises the policy. Such work is precisely the mission of my Fulbright award.

I submitted comments through the CPSO survey tool on this consultation. The additional comments below focus on specific language. These comments are not designed to change the scope or meaning of the policy. Rather, they are designed to improve its clarity and effectiveness.

1. **Definition of "palliative sedation."** It would be useful to clarify whether the referenced "intolerable suffering" includes not only physical but also existential suffering.

2. **Section 2.** A mandate to "communicate effectively" is appropriate. But the following language on "manner and tone" implies that this will be all *oral* communication. Substantial evidence shows that communication is materially enhanced by using educational tools like patient decision aids. Note that Section 30(b) advises use of "materials or resources" in the organ donation context. That is also useful in the treatment context. *See, e.g.,* https://decisionaid.ohri.ca/

3. **Section 4(b).** An advisory to help patients discuss ACP by "providing necessary medical information and opportunity for discussion" is appropriate. But ACP would be materially advanced by also providing well designed tools that guide and facilitate these

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discussions (whether patient with physician or patient with family). *See, e.g.,* https://www.advancecareplanning.ca/resource/primary-care-toolkit/

4. **Section 6.** The statement here is categorical. "Physicians must obtain valid consent before a treatment is provided." But the emergency exception is noted in section 12. It would promote clarity and uniformity to add exception that here too.

5. **Section 8.** The advisory to "reassess capacity" is appropriate. But the caution here is in only one direction – to guard against erroneously presuming capacity. The opposite danger is equally real: wrongly determining the patient *lacks* capacity. Therefore, it would help to advise physicians undertake efforts to restore or support capacity in a patient who seemingly lacks it.

6. **Section 13.** Patients or SDMs may agree to a trial plan (*e.g.* "withdraw if no improvement after day x"). But they may later rescind that consent. Clarify the physician's rights under the original agreement and obligations under the later-amended instructions.

7. **Section 14.** You write that physicians "must obtain consent" to withdraw life-sustaining treatment. Clarify whether that consent can be tacit. For example, with respect to no-CPR you advise that physicians can be "straightforward and directive." Presumably, this means an announcement rather than a question (*e.g.* "We are writing a DNR for your mother"). Many contend that the absence of patient or SDM objection to such an announcement constitutes consent.

8. **Section 14.** There have been six recent tribunal cases in Ontario concerning brain death conflicts. There have been many more such conflicts at the bedside that have not escalated to tribunals. While mechanical ventilation is not technically "life-sustaining," it would be useful to clarify whether clinicians may withdraw it after determination of death on neurological criteria.

9. **Section 14(b).** Since sections 14(b) and 15(b) are similar, they should have a more parallel construction. At the end of 14(b) add: "Physicians must not withdraw life-sustaining treatment while conflict resolution is underway."

10. **Sections 14 and 15.** These sections use the same language "must not unilaterally make a decision." But that is inaccurate for two reasons. First, it is not the "decision" that is problematic, but the writing or implementation of the order. Second, it is confusing to use the same language in both these sections, because while Section 14 requires consent, Section 15 does not.

11. **Sections 14 and 15.** These sections address withdrawing life-sustaining treatment and writing a no-CPR order. But they do not address withholding treatment other than CPR. I realize that the first situation was directly at issue in *Rasouli* and that the second situation was directly at issue in *Wawrzyniak*. But the CPSO can and should provide

guidance even in the absence of direct judicial authority.

12. **Section 22.** Assume the physician has done what is mandated here and the patient really, truly wants to hasten her death. Physicians should discuss the available options. MAID is mentioned in Section 23. But what about VSED, palliative sedation? This is already an obligation under principles of informed consent but would be helpfully clarified here.

13. **Section 25(a).** A mandate to "communicate clearly" is appropriate. Substantial evidence shows that communication is materially enhanced by using educational tools like patient decision aids. *See, e.g.,* https://decisionaid.ohri.ca/

14. **Section 26(a).** Application to the CCB should be a last resort. Revise this section to advise an application to the CCB only after the conflict resolution processes in Section 25 have been tried and failed. The CCB has itself advised exhausting informal dispute resolution first. *See, e.g.,* In re DP, 2010 CanLII 42949 (ON C.C.B.)

15. **Footnote 12.** In describing the *Rasouli* case, the term "life support" is used. But it would be clearer to use the terms from the definitions of this policy: "life-sustaining treatment."

16. **Footnote 13.** You note that "patients may not be aware of the limitations of CPR." This is a particularly good opportunity for patient decision aids to eliminate a lot of this misunderstanding. *See, e.g.,* https://acpdecisions.org/

Sincerely,

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