

THE COLLEGE OF  
FAMILY PHYSICIANS  
OF CANADA

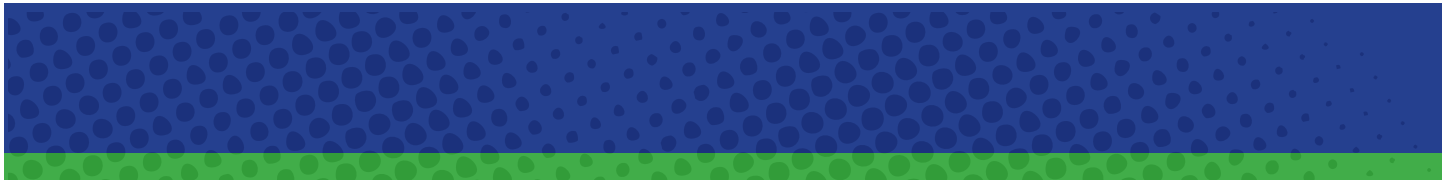


LE COLLÈGE DES  
MÉDECINS DE FAMILLE  
DU CANADA

# CFPC Task Force on End-of-Life Care

## Summary report

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**Prepared by the Task Force on End-of-Life Care of the College of Family Physicians of Canada**

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# Introduction

Over the past several years, the College of Family Physicians of Canada (CFPC)'s Committee on Ethics has actively discussed the ethical issues associated with end-of-life care, physician-assisted suicide, and euthanasia. This discussion was prompted and has been sustained by increasingly widespread media and public attention to these issues, changes to provincial law in Quebec,<sup>1</sup> Canadian court cases challenging the constitutionality of prohibitions against assisted suicide,<sup>2</sup> private member bills proposing changes to federal legislation, the landmark Supreme Court of Canada (SCC) decision regarding assisted suicide and euthanasia,<sup>3</sup> and probable new federal legislation in response to the SCC ruling.

Following the presentation of a brief to the College's Executive Committee (fall 2013), the Committee on Ethics was asked to establish a Task Force on End-of-Life Care. The Task Force's purpose was to make recommendations to the CFPC's leadership and general membership regarding messaging and education around these issues. In particular, it was recognized that a unique "family medicine voice" should be acknowledged, and that clarity in discussing these issues is paramount in light of the close relationships family physicians have with patients and their families. Task Force membership was determined by CFPC staff in consultation with the Chair of the Committee on Ethics. It included members of the Committee on Ethics, representatives from the CFPC's Palliative Care Committee, and selected additional members with complementary areas of expertise.

The primary purpose of this report is to summarize the Task Force's main output, *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia* (September 2015),<sup>4</sup> and to describe the process that led to the *Guide's* creation. The Task Force recognizes that this controversial and emotional topic will become more complex in the near future as new policies and regulations for family physicians are issued and new federal and/or provincial legislation is created. CFPC members and other Canadian physicians are encouraged to access the *Guide* for advice and reflection on the many complex issues concerning assisted dying, including patient autonomy and dignity and the right of physicians to conscientious objection.

# Process

Under the leadership and primary authorship of its chair, the Task Force prepared a preliminary education paper based on an earlier *Options Brief* (August 2013) presented to the College's Executive Committee. This paper was distributed internally as background reading for participants in a one-day colloquium held on June 23, 2014. The education paper was subsequently updated and revised on several occasions, and was used internally as a Task Force reference document.

The Task Force-led colloquium was attended by members of the College's Committee on Ethics, its Palliative Care Committee, the CFPC Board and staff, and invited guests.<sup>5</sup> Five specific colloquium objectives were identified:

- Understand how research on medical end-of-life practices can inform discussions regarding end-of-life care
- Understand how the involvement of family physicians in end-of-life care is changing
- Clarify terminology, in particular how family physicians should use the terms "physician-assisted suicide" and "euthanasia"
- Provide insights into the ethical and legal issues family physicians face with respect to end-of-life care
- Identify key messages for family physicians regarding the law and public policy on these issues, and advise on strategies the CFPC might consider using to reach and support family physicians

Insights gained at the colloquium in combination with further analysis and discussion informed and directed the Task Force through late 2014 and most of 2015, culminating in the September 2015 publication of *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia*. The *Guide* represents a collaborative, iterative effort involving multiple revisions in response to Task Force member review and widespread public and professional commentary in the wake of the February 2015 SCC decision. The Task Force Editorial Committee<sup>6</sup> received valuable suggestions and recommendations from CFPC members, staff, and executive, resulting in a final draft that had the unanimous approval and support of Task Force members.

# Summary of Task Force deliberations

Despite recent high-profile court cases and legal judgments directing legislators and medical professional organizations to develop laws and policies allowing and regulating assistance in suicide and euthanasia, requesting such assistance is likely to remain, for most Canadians, a measure of last resort. Widely accessible comprehensive medical, mental health, and palliative care will result in fewer patients feeling forced to choose between enduring poorly managed symptoms and requesting assistance in suicide or euthanasia.

However, even the best palliative care systems are unlikely to eliminate all such patient requests, due to the high degree of distress experienced by some patients and their families during challenging transitional phases of life. For some, the disintegration of quality of life, combined with a loss of abilities and an increased dependency on others, constitutes an existential crisis for which only one ultimate solution seems to exist. In these rare and distressing cases, family physicians will need to be able to reflect upon and intelligently discuss the values inherent in the doctor-patient relationship, values lying at the core of their profession. They will need ethical guidance and factual knowledge as they attend patients who are seriously ill and dying, and especially when patients wish to discuss assistance with suicide or euthanasia.

# Summary of *Guide* contents

- There have been notable changes to Canadian laws since the Task Force was formed. They include the passage of a Quebec Act allowing “medical aid in dying,” which came into effect December 2015, and the SCC’s decision to remove Criminal Code of Canada prohibitions, effective February 2016, against any individual assisting in another’s suicide and inflicting death on another, even if consensually (insofar as those prohibitions affect Canadian physicians).
- Legal changes have ethical implications for physicians. It will be up to physicians, collectively and as individuals, to determine whether legal changes will result in significant changes to their scopes of practice. Both of the legal changes mentioned above specifically state that physicians will not be legally bound to provide “medical aid in dying” or “assisted death.”
- Understanding and using more specific and well-accepted terms such as “physician-assisted suicide” and “voluntary euthanasia” is crucial. For instance, when using the term “physician-assisted dying,” the SCC did not distinguish between physician-assisted suicide and voluntary euthanasia, even though many physicians and ethicists believe there are significant psychological and ethical differences. Similarly, no ethical differentiation was made between “physician-assisted dying” and currently accepted practices of withholding or withdrawing life-sustaining interventions at the patient’s request. The intent of these latter practices, along with palliative sedation, should not be confused with the intent of counselling, prescribing, or administering lethal medications to induce a patient’s death.
- The legal changes mentioned above raise profound ethical questions for the medical profession regarding the goals and limits of medicine, the nature of the physician-patient relationship, and differing views regarding the ethical assessment of particular cases. Medical professional bodies are now compelled to encourage in-depth education and reflection on the ethical questions surrounding the philosophy of care, goals, and identity for the profession as a whole, as well as for individual members.
- Any regulatory or policy frameworks developed in response to these legal changes need to involve degrees of specificity that remain unaddressed in the law. For example, clinical indications, assessment of patient capacity to consent, assessment of patient vulnerabilities, and guidance regarding detecting mental health issues and assessing suicidality are areas requiring urgent debate, clarification, and education.
- As a matter of social justice, health care systems need to ensure that permissive legislative regimes cannot be allowed to undermine efforts to provide all Canadians with high-quality and comprehensive medical, mental health, and palliative care in times of serious and/or life-threatening illness. System-wide attitudes and practices that sometimes contribute to a patient’s fears, suffering, and sense of lost dignity must be addressed and remedied. These include but are not limited to: failing to recognize the limits of medicine; a lack of training in initiating and engaging in end-of-life conversations with patients; and treating particular demographic groups as being a burden to others, or of lesser value because of their medical status. Special system-wide attention should be given to developing and supporting continuity of care, especially during times when patients feel vulnerable.

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- The matter of protecting a physician’s right to freedom of conscience requires further value-based deliberation and clarification. Any legislative frameworks, regulatory guidelines, or policies—such as those currently being developed by provincial licensing authorities—must seek to protect both a physician’s freedom of conscience to refrain from or participate in assisted suicide and/or euthanasia and a patient’s right to information and informed decisions regarding available and legal options. Even in cases in which a physician can neither affirm nor support in conscience his or her patient’s self-evaluation and request, providing relevant information can be regarded as a matter of maintaining solidarity with his or her vulnerable patients.
  - Adequate ethical deliberation involves ample consultation and discussion with patients, family members, involved health care professionals, and, when appropriate, persons whose expertise and perspective will contribute to an informed decision. Additionally, physicians must consider the impact of their own attitudes and beliefs regarding disability, suffering, and death on decisions being made by patients and their loved ones. At times of conflict, principles can sometimes be prioritized in ways that are acceptable to all, but occasionally such a reconciliation cannot be attained. In such cases, appropriate options for the transfer of care to another physician, while ethically complex and personally challenging, will need to be discussed.
  - While the SCC decision addresses patient autonomy in the context of the state-individual relationship, physicians and patients also need to fully consider autonomy in the context of the physician-patient relationship. The ethical notion of respect for autonomy must be distinguished from the legal criteria for capacity to give consent. The ethical principle is much broader, and involves aspects of moral agency such as true and uncompromised voluntariness. Such discussions are acknowledged to be time-consuming and nuanced. They require physician training, skills, resources, and sensitivity.
  - A brief discussion of the term “dignity” and its prominence in opinions expressed both in support of and in opposition to the practices of assisted suicide and euthanasia is offered in the *Guide*. This notion, and the patient’s fear of losing his or her dignity, is central to the physician’s adequate understanding of patient concerns and fears, as the patient searches for meaning during times of serious and/or life-threatening illness.
  - The Task Force emphasizes the need for an ongoing commitment to patients and their families and loved ones. For patients who are seriously ill and for those who are dying, physicians can demonstrate meaningful advocacy by collectively and publicly affirming this commitment. Supportive behaviours and actions will include continuity of care, listening, honest discourse, adequate provision of information, protection of trust, relief of suffering, respect for autonomous refusal of medical interventions, and steady attendance in times of need. Consistent with professional obligations yet bound by individual conscience, it may also involve advocacy for receiving available options appropriate to specific circumstances.
  - The Task Force recognizes that education and resources will be needed to help physicians sort out and work through the ethical complexities surrounding these challenging medical, social, and ethical issues. The process of ethical deliberation is described in more detail in the CFPC’s online publication, *Ethics for Family Physicians: Faculty Handbook*.<sup>7</sup> As a follow-up project, the CFPC’s Committee on Ethics hopes to collaborate with palliative care specialists and others to develop a series of published Case Studies for educational use by family medicine residents, training programs, and practising physicians.



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