End-of-life care: Medical-legal issues

End-of-life issues are currently receiving considerable attention in Canada. The Supreme Court of Canada's decision declaring the criminal prohibition against physician-assisted dying unconstitutional,¹ and Québec’s legislation² permitting physician-assisted dying as of December 10, 2015 are important legal developments driving increased interest. Media coverage of survey results from physicians and the general public is helping to keep end-of-life care in the forefront, as are emerging statements, policies, and guidelines from physician groups, medical associations, and medical regulatory authorities (Colleges).
Many physicians have to deal with end-of-life care, and consequently CMPA members should be familiar with the associated medical-legal issues. While there are other matters related to end-of-life care such as withholding and withdrawing treatment, this handout focuses on end-of-life issues that are specific to physician-assisted death, including conscientious objection, advance directives, consent, and access to palliative care.

ADDRESSING THE SUPREME COURT RULING
The 12-month suspension of the Supreme Court’s unanimous decision gives time for Parliament and the provincial legislatures to enact legislation and for the Colleges to develop policies and guidelines for physicians. The Canadian Medical Association (CMA) has developed a draft regulatory framework that is intended to assist policy makers, and it will be reviewed at its General Council meeting in August 2015. Physicians have an important role to play in advancing discussions and ensuring their perspectives are reflected in any new legislation and policies.

PHYSICIAN-ASSISTED DYING STILL ILLEGAL
While the Supreme Court decision declaring the criminal prohibition against physician-assisted dying unconstitutional is important, the CMPA wants physicians to keep in mind that until legislation is enacted, it remains illegal for anyone, including physicians, to counsel, aid, or abet a person to commit suicide.

ASSISTED DYING: SAFEGUARDS AND CRITERIA
Patients, families, and physicians have concerns about adequate safeguards for assisted dying. All parties are attuned to the potential for conflicting wishes and to the sanctity and quality of life, and seek safeguards to protect the interests of vulnerable patients. Safeguards could include measures such as patient assessment by two independent physicians, waiting periods, oral revocation of the request by the patient at any time, and fully informing the patient about palliative care options.

Many doctors are also concerned about the eligibility criteria for physician-assisted dying. The Supreme Court ruled a patient would have to be deemed a “competent adult” and able to “clearly consent to the termination of life” while also experiencing “suffering that is intolerable” from a “grievous and irremediable medical condition.” In Québec, the legislation stipulates patients must be “capable adults at the end of their life in an advanced state of irreversible decline in capability. They must also be suffering from a serious and incurable illness with constant and unbearable physical or psychological suffering that cannot be relieved in a manner the patient considers tolerable.” While the Supreme Court attempted to clarify some of these terms and conditions, physician apprehensions remain regarding actual definitions, grey areas, and unanswered questions such as entitlement for those suffering from severe mental illness. Some physicians may be comfortable providing assisted dying for patients suffering from a certain condition or stage of disease, but not from other conditions. In every case, doctors want a robust process to correctly identify patients who may qualify for assisted death and who are clearly capable of meeting the legal consent requirements.

CONSCIENTIOUS OBJECTION
In 2014, the CMA updated its policy on euthanasia and assisted death. It stated it supports patients’ access to the full spectrum of end-of-life care that is legal in Canada. It also supports the right of physicians, within the bounds of the legislation, to follow their conscience when deciding whether to provide medical aid in dying. This is significant because some physicians would prefer a system that accepts their right not to participate in medical practices against their moral or religious beliefs. This may include the right to not refer patients to other providers who could administer these services.

The concern with a mandatory duty to refer a patient for physician-assisted dying originates, in part, from positions taken previously by some of the Colleges. Some Colleges have stated that physicians who are unwilling to provide certain medical services (e.g. abortions) due to their moral or religious beliefs must refer the patient to an alternate healthcare provider. While it is unclear whether any College would compel referral for physician-assisted death, issues with conscientious objection might be addressed in legislation enacted in response to the Supreme Court’s decision. Québec’s end-of-life legislation, for example, requires physicians who are unwilling to make a direct referral to advise the relevant authority (e.g. hospital), and that authority will refer the patient.
While the Supreme Court ruling is clear that doctors cannot be compelled to end a patient’s life, the Court acknowledged legislators and the Colleges must find a way to reconcile the rights of both patients and physicians. Doing so effectively is a formidable challenge.

**ADVANCE DIRECTIVES**

There is growing awareness among physicians and patients about the importance of end-of-life care discussions, including advance directives. Indeed, the need to improve doctor-patient communication at the end of life is the topic of several initiatives led by patient groups, physician groups, health regions, hospitals, long-term care organizations, and the CMPA.

Physicians should be prepared to engage in end-of-life care discussions, including advance directives. There is general agreement that crucial conversations among patients, families, and physicians can help prevent disagreements about end-of-life care. These conversations can lead to more realistic expectations about life-prolonging treatments and possibly less aggressive, invasive, and futile care at the end of life. The College of Family Physicians of Canada notes advance care planning discussions “…can prepare patients and their families for the future and encourage realistic and ethically and legally acceptable end-of-life care.”

**CONSENT ISSUES**

Having a discussion with the patient or their substitute decision-maker to obtain informed consent for end-of-life care is an important duty of physicians. From the CMPA’s perspective, allegations of inadequate consent and the failure to adequately document the consent discussion are recurring themes in medical-legal cases. Some Colleges and hospitals also have policies about physicians’ obligations with respect to withdrawing and withholding care that physicians believe will be of no benefit or harmful to the patient. For additional information about withdrawing treatment, please see the CMPA’s article “Update on law for withdrawing treatment.” Doctors should therefore be familiar with relevant legislation and policies, and document consent discussions and decisions in the medical record. Physicians may also consider consulting with colleagues for support regarding end-of-life care.

**THE CMPA EXPERIENCE**

In early 2015, the CMPA identified 96 closed medical-legal cases from the last five years that were associated with end-of-life issues.

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<th>Type of Case</th>
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<tr>
<td>College complaints</td>
<td>74%</td>
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<tr>
<td>Legal actions</td>
<td>16%</td>
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<td>Hospital complaints</td>
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Most of these cases were complaints to a College (74%), followed by legal actions (16%) and hospital complaints (10%). Communication was the most common clinical issue identified (mainly inadequate communication with the patient and family). Inadequate documentation contributed to the breakdown of the communication process. In these cases, the experts’ comments on communication issues were about the content of the discussions (e.g. explaining the different treatment levels available to the patient, treatment objectives, language used); ensuring family members understand what is being discussed and consented to; and documenting the discussions. Lack of clarity regarding the power of attorney for the family was also noted.
PALLIATIVE CARE

Stakeholders agree all Canadians should have access to quality palliative care. While funding for hospice palliative care is growing, coverage varies significantly across the country. By international standards, Canada has fewer doctors specializing in palliative care than comparable countries such as the United States and Australia, however not every patient approaching the end of life needs to be cared for by a specialist in palliative care.11 While the Royal College of Physicians and Surgeons of Canada is developing palliative medicine as a subspecialty, and the College of Family Physicians of Canada is developing a certificate of added competence in palliative care, the Canadian Society of Palliative Care Physicians believes all physicians should possess basic skills in palliative care.12 These initiatives underscore the need to address palliative care in medical schools, in post-graduate training programs, as well as in continuing medical education so that more physicians are able to integrate palliative care into their professional practice.

Additional reading at www.cmpa-acpm.ca

- “Update on the law for withdrawing treatment”
- “Providing quality end-of-life care”
- “After the diagnosis: How to communicate with terminally ill patients”

TAKING THE NEXT STEPS

Many different stakeholders play an important role in providing direction and assistance to physicians on end-of-life issues. Such guidance can flow from relevant federal, provincial, and territorial legislation, frameworks from medical associations and federations, and policies and guidelines from the Colleges and hospitals. Physician involvement in end-of-life care discussions and decisions is necessary, and will contribute to sound end-of-life policies and practices, which will benefit patients and the healthcare system.

The CMPA is well positioned and eager to assist stakeholders to address the issues associated with end-of-life care, and supports ongoing collaboration in this area. The CMPA also encourages members to contact the Association for individual advice on end-of-life care, if the need arises.