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**Title: Position Statement - Issues Related to End of Life Care**

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## The College of Family Physicians of Canada Statement on issues related to end of life care

Family physicians partner with other health care professionals and volunteers to play a significant role in providing end of life care in Canada. The College of Family Physicians of Canada (CFPC) recognizes the current Canadian legislative framework and acknowledges that discussion and debate related to palliative care and other important end-of-life care issues should and will continue to be carried out among all Canadians.

The CFPC has identified the following key issues related to end of life care:

### **Fundamental goals of medicine**

Among the fundamental goals of medicine are curing or controlling disease and relieving or controlling symptoms as much as possible through quality palliative care.

The World Health Organization (WHO) has defined **palliative care** as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care<sup>1</sup>:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;

- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

**Euthanasia** is “knowingly and intentionally performing an act that is explicitly intended to end another person’s life and that includes the following elements: the subject has an incurable illness; the agent knows about the person’s condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain.”<sup>2</sup>

**Assisted suicide** is “knowingly and intentionally providing a person with the knowledge or means or both required to commit suicide, including counseling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.”<sup>2</sup>

Palliative care can be distinguished clinically, legally, and ethically from euthanasia and assisted suicide, both of which are currently illegal in Canada.

### **Safety and efficacy of opioid analgesics and sedatives in advanced disease**

In patients with pain and/or shortness of breath because of advanced illness, opioid analgesics can be used without causing or hastening death. A growing body of medical literature is available to support this claim.<sup>3,4</sup>

In addition, sedation can be provided without hastening death in patients who

- have advanced disease;
- are nearing death; and
- have refractory suffering, such as delirium, dyspnea, and pain, which cannot be relieved by any other means.<sup>5</sup>

### **Suffering as the cause of a request to hasten death**

Requests for hastened death are often calls for the family physician’s urgent attention. Such requests may be prompted by poor symptom management, depression, isolation, fear of abandonment and the dying process, anxiety, and spiritual distress. The College encourages family physicians and patients to request consultations and insights from other health care professionals. These professionals may include palliative care specialists, social workers, ethicists, psychiatrists, and spiritual care providers, and their input can help clarify the patient’s needs and alternative ways to support him or her.

### **Patients’ and physicians’ rights and responsibilities**

Capable patients or substitute decision-makers have the right to make informed decisions to receive appropriate medical care. They also have the right to decide to forgo any treatment, even if the treatment may prolong or sustain life.

Physicians and patients or substitute decision-makers may not always agree on treatment decisions. When an impasse occurs because a patient's wishes for care run counter to the physician's judgment about benefits and risks, the physician must not abandon care; rather, he or she should seek to transfer the patient to another physician.

### **Withdrawing and withholding medical interventions and controlling symptoms**

A decision to withhold or withdraw certain medical interventions is ethically acceptable and legally permissible if these are foreseen or judged to be excessively burdensome to the patient and do not offer a reasonable hope of benefit to the patient.

The physician must make the decision carefully, thoughtfully, and in consultation with a capable patient or an incapable patient's substitute decision-maker.

Further, the physician's intention must be to respect the limits of medical intervention for a dying patient, not to hasten the patient's death, even though such a decision could result in earlier death because of the disease. All care should be aimed at alleviating symptoms due to advanced disease.

### **Substitute decision-making**

A substitute decision-maker for an incapable patient should make decisions in accordance with the patient's prior expressed wishes. If such wishes are unknown or inapplicable, the substitute decision-maker should always act in the patient's best interests, considering

- the patient's prior wishes, beliefs, and values;
- the effect of treatment upon the patient's well-being; and
- the balance between treatment benefits and harms.

### **Advance care planning**

Physicians should engage in advance care planning to understand a patient's views about end-of-life treatment. The aim of advance care planning is to encourage early discussions about treatment goals among health care providers, patients, and patients' substitute decision-makers or representatives for health care. These discussions can prepare patients and their families for the future and encourage realistic and ethically and legally acceptable end-of-life care.

### **Access to quality palliative care in Canada**

As a matter of social justice, all Canadians—regardless of age, disease, stage of disease, and geographical location—should have access to palliative care that meets national standards. Palliative care must be available in all health care settings. In addition, a variety of settings must be available for end-of-life care.

Policy is needed to support the integration of palliative care into chronic disease management. This will ensure that every Canadian with a life-limiting illness receives palliation as part of comprehensive care.

Funding should be sufficient to ensure that all Canadians have access to palliative care that meets national standards and the needs of each community.

## References

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