When Dr. Carol Leet lost her father after a protracted illness in 2014, she had just become the chair of a working group struck with the responsibility of reviewing and revising a College policy providing guidance and direction to physicians on the issues of end-of-life care.

Her own personal experience confirmed that an emphasis on communication needed to ground the policy. “When my father suffered a sudden severe health problem, it was an intense and stressful experience for my family. Fortunately, he had made his wishes clear in advance, which helped us make some very difficult decisions as substitute decision-makers,” said Dr. Leet, who is also the College’s President.

“Throughout this experience, we benefited from open and honest communication with physicians on his medical team. Empathy and a full discussion of his options were what helped us make the best decisions, while dealing with our grief,” she said.

End-of-life care situations are highly charged and can be difficult for all those involved. That is why communication is of paramount importance. The Planning for and Providing Quality End-of-Life Care policy, which was just approved by Council, makes it clear that physicians must communicate effectively and compassionately with patients and/or substitute decision-makers, in a manner and tone that is suitable to the decisions they may be facing. This includes initiating communication as early as possible and as regularly and as often as is necessary to share information, helping patients and/or substitute decision-makers understand the information shared, and answering questions.

When a physician communicates effectively and frequently with a patient or the patient’s substitute decision-maker, it helps build trust and confidence in the relationship. And that, said Dr. Leet, will go a long way to making future difficult conversations easier.

The policy also recognizes the contributions of family members or others close to the patient and/or substitute decision-maker, and the role they can play in helping to manage a patient’s ongoing care.
Involving those close to the patient in discussions may be beneficial as it can, for example, help the patient understand their diagnosis, prognosis, medications, the tests that are required, and the decisions they have to make about treatment options.

“Such involvement can also help the family caregivers provide more effective care at home and mitigate their own distress,” states the policy.

Dr. Leet also believes that conversations around death and dying should not just be reserved for palliative care physicians and oncologists. In fact, the policy states that as part of routine care in an ongoing physician-patient relationship, all physicians have the responsibility to discuss with their patients the importance and the benefits of advance care planning and choosing a substitute decision-maker. The policy advises physicians that they may need to initiate these discussions sensitively, over multiple occasions as patients may not always be ready to participate.

“Patients are entitled to receive quality end-of-life care that allows them to live as well as possible until they die,” said Dr. Leet. “And I think this policy will help physicians as they plan for and provide quality end-of-life care that aligns with a patient’s wishes, values and beliefs.”

In early 2015, a draft version of the Planning for and Providing Quality End-of-Life Care policy was circulated for consultation feedback. Through this consultation we heard a number of objections to the proposed requirement that consent be obtained for a no-CPR or Do Not Resuscitate Order (DNR).

In response to this feedback and given that the law is unclear regarding a consent requirement for a no-CPR order, Dr. Leet and the Working Group articulated a new requirement for physicians that places emphasis on good and effective communication and a robust conflict resolution process.

The policy states that physicians must engage patients or substitute decision-makers in a discussion before writing a no-CPR order and engage in conflict resolution if there is disagreement.

As the requirements regarding no-CPR orders were an area of significant controversy in the consultation and leading up to the Council meeting, these requirements were the subject of intense discussion and deliberation by Council members. In particular, one key issue Council debated was the requirement that physicians provide CPR, should the patient arrest, while conflict resolution regarding a no-CPR order is underway.

Members of Council recognized the difficulties this requirement may put physicians in, but ultimately believed that the policy position was the best compromise the College could achieve. Council members reflected that:

• The policy requirements place an important emphasis on early, good and thorough communication and education to avoid conflicts regarding no-CPR orders;
• The policy respects patient autonomy in decision-making regarding end-of-life care and is responsive to the public’s expectation that they be involved in these types of decisions;
• To allow physicians to not provide CPR during conflict resolution regarding a no-CPR order would significantly undermine the conflict resolution process and the public may wonder how genuine or sincere the conflict resolution process is when physicians can make a decision at the bedside to just not provide CPR.

“We felt very strongly that the decision to write a no-CPR order could not be made unilaterally by physicians as this would not respect patient autonomy, and this decision was supported by our public polling results. In the end, we feel that the policy has struck the right balance,” said Dr. Leet.

The policy is inserted at page 19.