# Delegate Motions
# End-of-life care

1. DM5 - 3
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**147th GENERAL COUNCIL**
**DELEGATES' MOTIONS**
**END-OF-LIFE CARE**
**(Note: Motion pages attached)**

**MOTION DM 5-3**
**MOVER** Dr. David Kendler
**SECONDER** Dr. Shirley Sze

The Canadian Medical Association recommends that the time to benefit of prescribed interventions and medications be considered when providing care for older adults and patients approaching the end of life.

**MOTION DM 5-4**
**MOVER** Dr. David Pontin
**SECONDER** Dr. Suraiya Naidoo

The Canadian Medical Association will investigate and communicate Inuit, Métis and First Nations' perspectives on euthanasia, physician-assisted death and end-of-life care.

**MOTION DM 5-5**
**MOVER** Dr. Doris Barwich
**SECONDER** Dr. Douglas McGregor

The Canadian Medical Association will engage in physician human resource planning to develop an appropriate strategy to ensure the delivery of quality palliative end-of-life care throughout Canada.

**MOTION DM 5-6**
**MOVER** Dr. Ewan Affleck
**SECONDER** Dr. Louis Hugo Francescutti

The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying.

**147th GENERAL COUNCIL**
**DELEGATES' MOTIONS**
**END-OF-LIFE CARE**
**(Note: Motion pages attached)**

**MOTION DM 5-7**
**MOVER** Dr. Darren Cargill
**SECONDER** Dr. Scott Wooder

The Canadian Medical Association supports emergency funding for end-of-life care for uninsured people residing in Canada.

**MOTION DM 5-8**
**MOVER** Dr. Adam Steacie
**SECONDER** Dr. Darren Cargill

The Canadian Medical Association supports development of a strategy for advance care planning, palliative and end-of-life care in all provinces and territories.

**MOTION FORM**
**CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2014**

**MOTION CATEGORY AND TYPE**
Delegates' Motions

**x Policy Motion**
**Directive Motion**

**MOVER** Dr. David Kendler

**SECONDER** Dr. Shirley Sze

**MOTION**

The Canadian Medical Association recommends that the time to benefit of prescribed interventions and medications be considered when providing care for older adults and patients approaching the end of life.

**1. SUBSTANTIVE RATIONALE**

Many older adults and patients who are at the end of life are at risk of polypharmacy, inappropriate medications and adverse drug events. In order to provide high quality patient-centred care, physicians should optimize pharmacotherapy and reconcile medications for these patients. This may include discontinuing medications for secondary disease prevention that may no longer be of value if the time to therapeutic benefit exceeds estimated life expectancy. Moreover, a growing body of evidence reveals that drugs primarily used for disease prevention have, in general, no place in the treatment of end-of-life patients.
Time to benefit in clinical decision-making should be a key consideration when providing care to seniors and end-of-life care. Research reveals that many medications for chronic or co-morbid conditions can be safely discontinued without adverse effects. For instance, while discontinuing medications for cardiovascular conditions may cause concern that an acute cardiac event may occur, it has been demonstrated that unless a statin is withdrawn immediately following an episode of acute coronary syndrome, there is no short-term increase in the risk of acute cardiac events on statin discontinuation.
There is an opportunity to expand on existing CMA policies on optimal prescribing and medication use in seniors. In the absence of formal guidelines, prescribing for older adults and patients at the end of life should aim to maximize quality of life by optimizing symptom control and minimizing medication burden, adverse side effects, and drug to drug interactions. As such, time to benefit of interventions and medications is an important factor to be considered.

**2. KEY STAKEHOLDERS**

CMA, provincial/territorial medical associations

**3. SUGGESTED IMPLEMENTATION**

CMA will update its policy statement "Health and Health Care for an Aging Population" to include that the time to benefit from prescribed interventions and medications be considered when providing care for both older adults and patients who are at the end of life.

**4. RELEVANCE TO CMA MISSION, VISION, VALUES AND STRATEGIC OBJECTIVES**

This motion supports the CMA's vision to improve the health of the Canadian population.

**5. ESTIMATED RESOURCES REQUIRED (money, time, human)**

| HR less than one person week | HR more than one person week – less than one person month | HR over one person month | Under $5,000 | $5,000-$50,000 | Above $50,000 |
|---|---|---|---|---|---|
| **x** | | | **x** | | |

**6. ADDITIONAL COMMENTS**

n/a

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**MOTION FORM**
**CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2014**

**MOTION CATEGORY AND TYPE**

Delegates' Motions

**Policy Motion**
**x Directive Motion**

**MOVER** Dr. David Pontin

**SECONDER** Dr. Suraiya Naidoo

**MOTION**

The Canadian Medical Association will investigate and communicate Inuit, Métis and First Nations' perspectives on euthanasia, physician-assisted death and end-of-life care.

**1. SUBSTANTIVE RATIONALE**

The discussion of euthanasia and physician-assisted suicide has become increasingly prominent in Canada's media, legislative bodies and in the public. The CMA has led important discussions among physicians regarding the potential implications of legislative change for physicians and patients. However, the voices of some populations - including Aboriginal patients and communities - have been largely absent from these discussions. Topics that have not yet been explored from an Aboriginal perspective during these discussions include the relative value of autonomy (in the context of community role and spiritual beliefs), the impact of high suicide rates in First Nations and Inuit populations, and historical relationships between the Canadian health-care system and Aboriginal people. Given these considerations, and given the majority Aboriginal population in two of thirteen Canadian jurisdictions, we propose that CMA actively seek, articulate and honor Inuit, Metis and First Nations perspectives on euthanasia, physician-assisted suicide and end-of-life care.

Article 7 of the United Nations Declaration on the Rights of Indigenous states: "Indigenous individuals have the right to life, physical and mental integrity, liberty and security of person." Furthermore, Canada's ongoing Renewal and Reconciliation policy toward Aboriginal Peoples requires that Aboriginal perspectives on an issue as important as physician-assisted suicide and euthanasia be sought. Considering the importance of spirituality, traditional knowledge and community connection in defining personhood, promotion of autonomy may hold a different degree of importance for some Aboriginal patients and thus may contribute to a perspective which may be at variance with Canadian mainstream. In addition, high rates of suicide - particularly among the young - and poor penetration of mental health services into Aboriginal communities may color their discussion of euthanasia and physician-assisted suicide. Unfortunately, the forced relocation of Aboriginal people for educational or health-related justifications has sometimes compromised trust between health care providers and Aboriginal patients and communities.

Given these factors, it is crucial that Aboriginal voices and opinions be actively sought out during national and provincial/territorial discussions of euthanasia and physician-assisted suicide. First Nations, Inuit and Métis communities deserve the opportunity to have their voices heard on whether this is a significant issue for their communities, and to translate the issues if necessary into language and structures appropriate to their cultures. In addition, the majority-Aboriginal territories (the Northwest Territories and Nunavut) should be encouraged to engage in these difficult discussions at the time and in the venues that are most appropriate for their communities.

**2. KEY STAKEHOLDERS**

Inuit Tapiriit Kanatami (ITK) and regional Inuit organizations, Assembly of First Nations (AFN) and provincial/territorial organization members, Métis National Council and regional Métis governments

**3. SUGGESTED IMPLEMENTATION**

CMA representatives can set up a local meeting with all three national organizations - the Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK) and Métis Canada - to initiate discussions on this issue. They should allow time for consultation with regional bodies and with Aboriginal communities. Alternatively, the CMA could seek spots on the agenda for national meetings and seek more direct consultation with all partners. Targeted consultations with Aboriginal health care providers, and/or with clinicians in predominantly Aboriginal settings, could provide an initial sampling of opinion and help to direct strategy for reaching Aboriginal patients and communities.

**4. RELEVANCE TO CMA MISSION, VISION, VALUES AND STRATEGIC OBJECTIVES**

The CMA mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care. Aboriginal individuals and communities are part of this constituency. Values of responsiveness and accountability require CMA to seek out opinions that may not surface through the usual channels of media and national discussion, particularly when considering our obligations to vulnerable or dispersed populations.

CMA can cultivate integrity, compassion and professionalism by directly involving First Nations, Metis and Inuit

communities in discussions on end-of-life care, physician-assisted suicide and euthanasia. CMA will also bring together diverse communities of interest in the pursuit of a common goal, reflecting the value of rassembleur.

**5. ESTIMATED RESOURCES REQUIRED (money, time, human)**

| HR less than one person week | HR more than one person week – less than one person month | HR over one person month | Under $5,000 | $5,000-$50,000 | Above $50,000 |
|---|---|---|---|---|---|
| | **x** | | | **x** | |

**6. ADDITIONAL COMMENTS**

n/a

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**MOTION FORM**
**CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2014**

**MOTION CATEGORY AND TYPE**

Delegates' Motions

**Policy Motion**
**x Directive Motion**

**MOVER** Dr. Doris Barwich

**SECONDER** Dr. Douglas McGregor

**MOTION**

The Canadian Medical Association will engage in physician human resource planning to develop an appropriate strategy to ensure the delivery of quality palliative end-of-life care throughout Canada.

**1. SUBSTANTIVE RATIONALE**

Currently only 30% of Canadians have access to palliative care services and supports. There is an urgent need to train and equip both new physicians and practising primary care and specialist physicians in compassionate, accessible, comprehensive care at end of life. A national palliative care strategy will require both generalist and specialist physicians who can deliver palliative care services and provide academic supports. Currently it is estimated that there is a relative shortage of palliative care physicians in Canada. Benchmarking from the U.K. and Australia suggests that there should be two full-time equivalent (FTE) palliative care specialists per 250,000 population which would suggest that Canada (population 35 million) needs 280 FTE specialist palliative care physicians. These shortages are particularly acute in rural areas which also have a shortage of primary care physicians.

Standards and guidelines for workforce planning and care delivery are needed to ensure an adequate number of specialist palliative care physicians.

**2. KEY STAKEHOLDERS**

CMA, Canadian Hospice Palliative Care Association, Canadian Society of Palliative Care Physicians, Association of Faculties of Medicine of Canada, provincial/territorial medical associations

**3. SUGGESTED IMPLEMENTATION**

Implementation will need to ensure appropriate funding for undergraduate education, postgraduate training and attachment to palliative care services for residents, funding to support implementation of the two-year Royal College of Physicians and Surgeons of Canada sub-specialty training program at all Canadian universities and enhanced skills training for family physicians and other specialties.

**4. RELEVANCE TO CMA MISSION, VISION, VALUES AND STRATEGIC OBJECTIVES**

This motion will support expansion of palliative care education and access to palliative care services throughout Canada.

**5. ESTIMATED RESOURCES REQUIRED (money, time, human)**

| HR less than one person week | HR more than one person week – less than one person month | HR over one person month | Under $5,000 | $5,000-$50,000 | Above $50,000 |
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**6. ADDITIONAL COMMENTS**

In order to ensure adequate numbers of physicians able to provide palliative care services, there is an urgent need for workforce planning.

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**MOTION FORM**
**CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2014**

**MOTION CATEGORY AND TYPE**
Delegates' Motions

**x Policy Motion**
**Directive Motion**

**MOVER** Dr. Ewan Affleck

**SECONDER** Dr. Louis Hugo Francescutti

**MOTION**

The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying.

**1. SUBSTANTIVE RATIONALE**

CMA recognizes that assisted death is illegal in Canada, and it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. CMA's mandate is to best support physicians in their effort to provide quality patient care. Recognizing the polarizing nature of the assisted-death debate, unanimity of the CMA membership on this matter is unlikely; just moral and ethical arguments form the basis of those both supporting and refuting assisted death. Rather than choosing to prohibit or approve physician-assisted death, CMA will best serve Canadians seeking quality health care by highlighting that physicians may follow their conscience when deciding whether to participate within the bounds of existing law. The CMA Board supports bringing this motion forward to General Council as a Board-sponsored motion.

**2. KEY STAKEHOLDERS**

CMA, provincial/territorial medical associations, federal/provincial/territorial governments

**3. SUGGESTED IMPLEMENTATION**

CMA would update its policy to reflect this motion should it be accepted by General Council.

**4. RELEVANCE TO CMA MISSION, VISION, VALUES AND STRATEGIC OBJECTIVES**

This motion supports CMA's mission of "Helping physicians care for patients" as well as its vision of "The CMA will be the leader in engaging and serving physicians, and the national voice for the highest standards for health and health care."

**5. ESTIMATED RESOURCES REQUIRED (money, time, human)**

| HR less than one person week | HR more than one person week – less than one person month | HR over one person month | Under $5,000 | $5,000-$50,000 | Above $50,000 |
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| **x** | | | **x** | | |

**6. ADDITIONAL COMMENTS**

The current policy on euthanasia and physician-assisted suicide does not sufficiently reflect the broad spectrum of opinions on the matter held by Canadian physicians, and may adversely impact patients with terminal conditions and unremitting suffering from obtaining compassionate care. CMA's policy states Canadian physicians should not participate in euthanasia or assisted suicide and that the membership is divided. The definitions found in the CMA's policy (http://policybase.cma.ca/dbtw-wpd/Policypdf/PD14-06.pdf) are helpful and serve as the definitional standard for this document.

The debate surrounding assisted death hinges on the moral and ethical right of individuals who are suffering as a consequence of end-of-life illness to electively terminate their lives on compassionate grounds. Canadians appear to be divided, some arguing that assisted death for compassionate reasons and under the supervision of a trained professional should be a service available to alleviate suffering in the terminal phase of life, while others suggest that assisted death is immoral and unethical regardless of circumstance.

Implicit in CMA's mission statement, helping physicians care for patients is the centrality of the patient in the mandate of Canadian physicians. CMA's current policy on euthanasia and assisted suicide suggests that Canadian physicians should not participate in assisted death. This poses a dilemma for CMA, as it could be suggested that a prohibition on physician-assisted death bars physicians from providing a service desired by some patients to alleviate pain and suffering. The CMA Code of Ethics states that physicians should "provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support." Further the Code states that physicians should "respect the right of a competent patient to accept or reject any medical care recommended," and "ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment." This implies the paramount importance of honouring the will of the patient in determining the course of therapy they receive, including end-

of-life therapy. Given that evidence supports that there are competent Canadians with terminal illness who seek the services of physicians to assist them with dying, how then can Canadian physicians justify withholding a service against the will of a patient? Rather than choosing to prohibit or approve physician-assisted death, CMA will best serve Canadians seeking quality health care by highlighting that physicians may follow their conscience when deciding whether to participate within the bounds of existing law.

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**MOTION FORM**
**CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2014**

**MOTION CATEGORY AND TYPE**
Delegates' Motions

**x Policy Motion**
**Directive Motion**

**MOVER** Dr. Darren Cargill

**SECONDER** Dr. Scott Wooder

**MOTION**

The Canadian Medical Association supports emergency funding for end-of-life care for uninsured people residing in Canada.

**1. SUBSTANTIVE RATIONALE**

Despite having universal health care in Canada, there are some instances when an individual is not eligible for publicly funded health care. In particular, people new to Canada and visitors are not eligible and for those in need of end-of-life care, there should be funding to ensure people die with dignity.
This motion would ensure that patients and their caregivers have access to care without the worry of the cost and availability of end-of-life care. In addition, universal availability of end-of-life care for patients would allow physicians and other health care providers the opportunity to focus on the specific care based on need and not be distracted by funding issues.

**2. KEY STAKEHOLDERS**

Federal/provincial/territorial governments would need to be consulted to ensure alignment on this issue as well as to ensure a seamless process to administer funding for patients regardless of which government is responsible.

**3. SUGGESTED IMPLEMENTATION**

n/a

**4. RELEVANCE TO CMA MISSION, VISION, VALUES AND STRATEGIC OBJECTIVES**

This motion will allow physicians to provide seamless care to all patients requiring end-of-life care. Providing end-of-life care to all patients in Canada supports the CMA's vision to provide the highest standards for health and health care for all patients.

**5. ESTIMATED RESOURCES REQUIRED (money, time, human)**

| HR less than one person week | HR more than one person week – less than one person month | HR over one person month | Under $5,000 | $5,000-$50,000 | Above $50,000 |
|---|---|---|---|---|---|
| **x** | | | **x** | | |

**6. ADDITIONAL COMMENTS**

n/a

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**MOTION FORM**
**CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2014**

**MOTION CATEGORY AND TYPE**
Delegates' Motions

**x Policy Motion**
**Directive Motion**

**MOVER** Dr. Adam Steacie

**SECONDER** Dr. Darren Cargill

**MOTION**

The Canadian Medical Association supports development of a strategy for advance care planning, palliative and end-of-life care in all provinces and territories.

**1. SUBSTANTIVE RATIONALE**

On May 28 2014, the House of Commons passed motion 456 calling for a pan-Canadian strategy on palliative and end-of-life care. The motion had overwhelming support of all parties in the house and is an important step forward for hospice palliative care in Canada. The motion was introduced by NDP MP Charlie Angus and supported by all parties. This motion calls for a pan-Canadian strategy to support and improve access to palliative and end-of-life care across Canada.

It calls upon the government to establish a Pan-Canadian Palliative and End-of-life Care Strategy by working with provinces and territories on a flexible, integrated model of palliative care that: (a) takes into account the geographic, regional and cultural diversity of urban and rural Canada as well as Canada's First Nation, Inuit and Métis people; (b) respects the cultural, spiritual and familial needs of all Canadians; and (c) has the goal of (i) ensuring all Canadians have access to high-quality home-based and hospice palliative end-of-life care, (ii) providing more support for caregivers, (iii) improving the quality and consistency of home and hospice palliative end-of-life care in Canada, and (iv) encouraging Canadians to discuss and plan for end-of-life care.

Concurrently, following a year-long engagement and study process, the Ontario Medical Association (OMA) released its Advance Care Planning and End-of-Life Care Strategy for Ontario at the Faculty Club on the University of Toronto campus. OMA Past-President Dr. Scott Wooder officially launched a provincial framework to enhance care for people at the end of their lives. Ontario's doctors are committed to thoughtful and patient-focused end-of-life planning to help manage patients' health care needs.

The Framework for End-of-Life Care was presented to health care stakeholders, including the Ontario Hospital Association, the Registered Nurses Association of Ontario and the Ontario government. It was an opportunity to recognize the efforts of the many organizations and individuals who contributed to the development of the framework and to continue to develop the partnerships moving forward. The framework helps to identify the key elements for high quality end-of-life care, including increasing the number of Ontarians who do advance care planning (ACP), bridging advance care planning and palliative care, and improving access to palliative supports.

**2. KEY STAKEHOLDERS**

This motion will require the involvement of all provincial and territorial medical associations and will require consultations with hospital associations and hospice palliative associations. In addition, the First Nation, Inuit and Métis communities and the federal government will need to be consulted.

**3. SUGGESTED IMPLEMENTATION**

This motion calls for CMA to advocate for the development of a strategy for advanced care planning, palliative and end-of-life care nationwide.

**4. RELEVANCE TO CMA MISSION, VISION, VALUES AND STRATEGIC OBJECTIVES**

This motion supports CMA's mission to help physicians care for patients.

**5. ESTIMATED RESOURCES REQUIRED (money, time, human)**

| HR less than one person week | HR more than one person week – less than one person month | HR over one person month | Under $5,000 | $5,000-$50,000 | Above $50,000 |
|---|---|---|---|---|---|
| **x** | | | **x** | | |

**6. ADDITIONAL COMMENTS**

References:
www.ontariosdoctors.com
www.hpco.ca

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