Presenter Disclosure

Faculty: Dr J. David Henderson

Relationships with commercial interests:

- **Grants/Research Support:** Unrestricted grant for education for CSPCP
- **Speakers Bureau/Honoraria:**
- **Consulting Fees:** Breakthrough Cancer Pain National Advisory Board – Teva Canada Inovation
- **Other:**

Disclosure of Commercial Support

This program has not received financial support

This program has not received in-kind support

Potential for conflict(s) of interest:

Dr Henderson has no potential for conflict of interest.

Mitigating Potential Bias

I declare no bias for religious reasons as I suspect I will be going straight to hell……if there is such a place.

Integrated Palliative Care:

Planning for Action in Nova Scotia

Vision:

All Nova Scotians can access integrated, culturally competent, quality palliative care in a setting of their choice.

Canadian Society of Palliative Care Physicians

is a membership organization representing over 300 clinicians, academics, and researchers dedicated to the promotion of the highest quality palliative/end-of-life care through the advancement and improvement of palliative medicine and education.

Controversial topic

The Canadian Society of Palliative Care Physicians understands the controversial nature of this issue and encourages thoughtful dialogue on this issue.

WHO Definition of Palliative Care

Palliative care is 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.

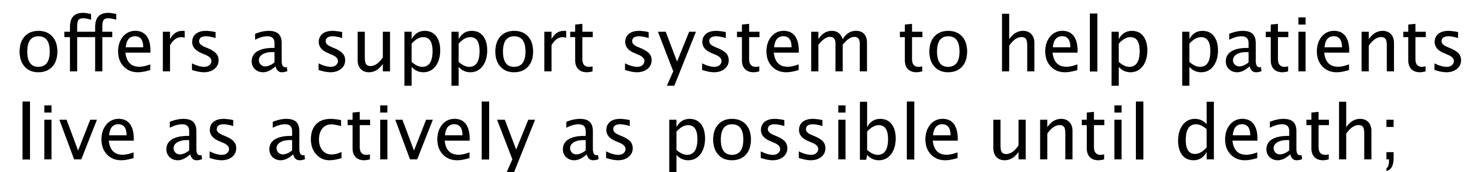
Palliative care:

provides relief from pain and other distressing symptoms;

affirms life and regards dying as a normal process;

intends neither to hasten or postpone death;

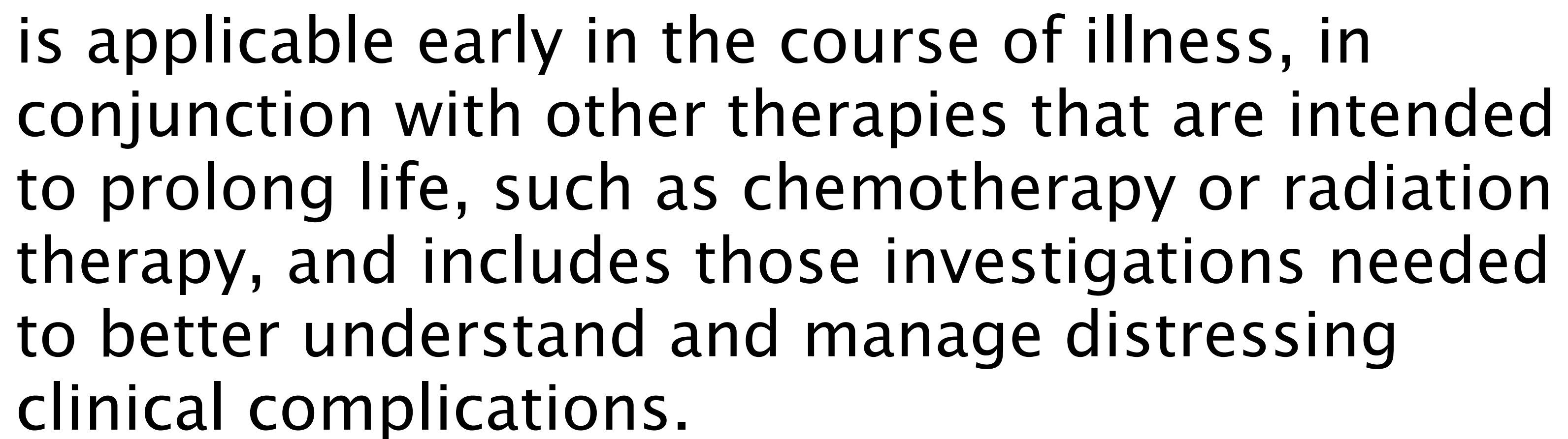
integrates the psychological and spiritual



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



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.

will enhance quality of life, and may also positively influence the course of illness;

The Society is opposed to the legalization of

Survey November 2011

overwhelming majority (88%) of CSPCP respondents were opposed to the legalization of euthanasia,

80% to the legalization of physician-assisted-suicide.

In the event of legalization,

90% of our members reported that they would refuse to participate in euthanasia,

83% would not take part in physician-assisted suicide.

We urge Canadians to become more informed about the many options available by means of which to minimize suffering at end-of-life, and thereby address their fears about the dying process.

As members of the CMA and partners with CHPCA

Advocate for policy change to ensure:

Improved access to affordable, equitable Palliative Care

Remains a challenge across Canada, especially in rural and remote areas. In 2010 the Economist's Intelligence Unit, which measures the quality and availability of end-of-life care, ranked Canada ninth out of 40 countries in an international "Quality of Death" index.

We are currently unable to provide valuable hospice palliative care services to over 70% of dying Canadians, and

Canadian families shoulder up to 25% of costs associated with home-based services, such as nursing and personal care.

Education & training of all health care professionals in the principles and practice of

A recent survey indicated that 10 of the 17 medical schools in Canada offer 10 hours or less of palliative care education in their undergraduate programs. There are no Canadian standards for palliative care education for physicians, nurses or social workers. This is an urgent priority given our aging population.

Advance Care Planning (ACP)

To empower Canadians to be active participants in health care decision-making. Abundant literature demonstrates that people who discuss advance care planning with their families and care providers receive fewer aggressive medical interventions at the end of life, in keeping with their expressed wishes. Their families feel less burdened by decision-making, take more advantage of palliative/ hospice resources, and have reduced suffering/distress in bereavement with better long term health outcomes.

Palliative Sedation Therapy

Conclusion: PST does not shorten life when used to relieve refractory symptoms and does not need the doctrine of double effect to justify its use from an ethical point of view.

- M. Maltoni et al. Annals of Oncology Volume 20, Issue 7 Pp. 1163-1169 **Palliative Sedation therapy does not hasten death: results from a prospective multicenter study**

Questions

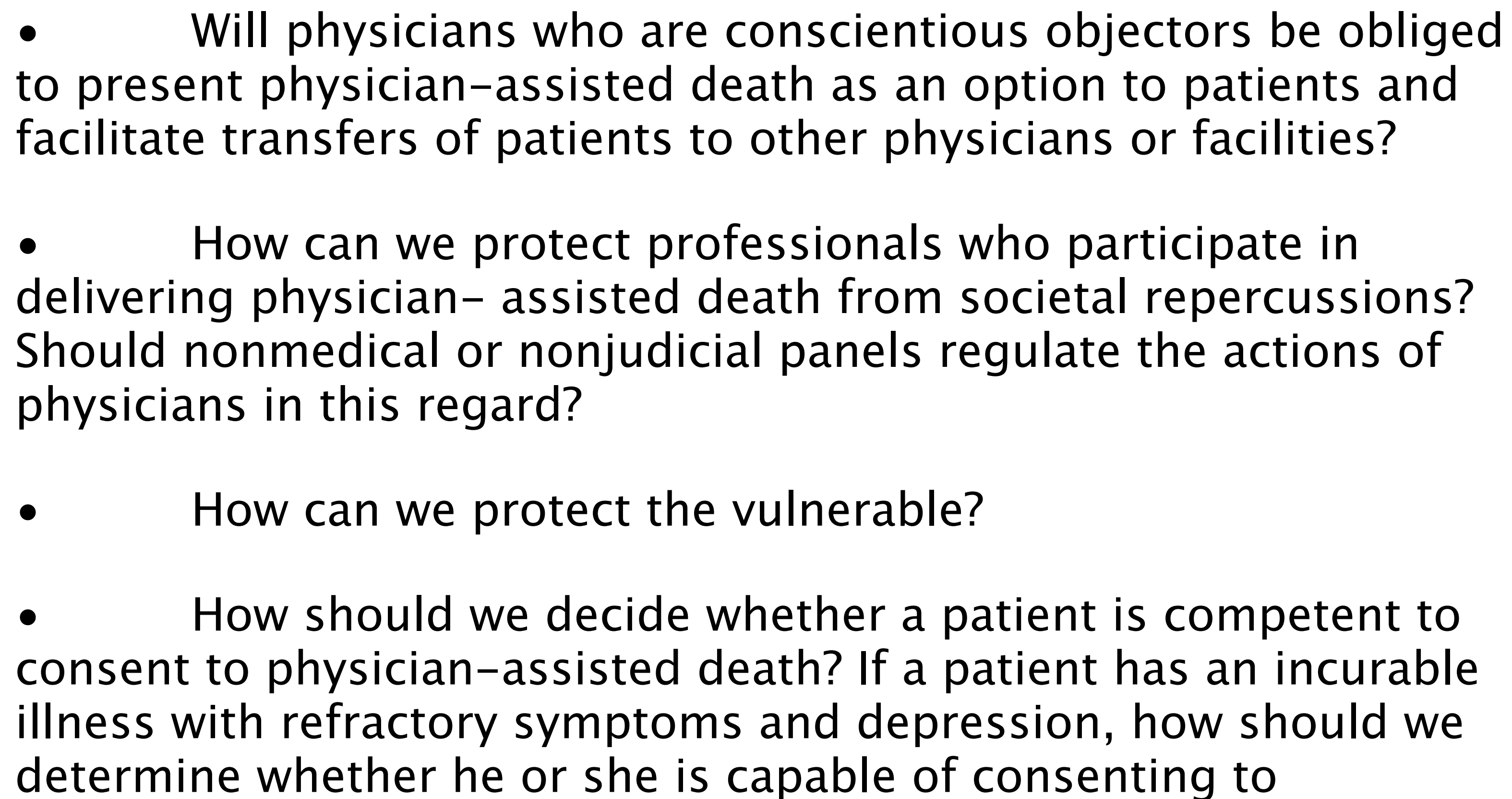
James Downar MDCM MHSc (Bioethics), Tracey M. Bailey BA LLB, Jennifer Kagan MD, S. Lawrence Librach MD CMAJ Apr. 2014

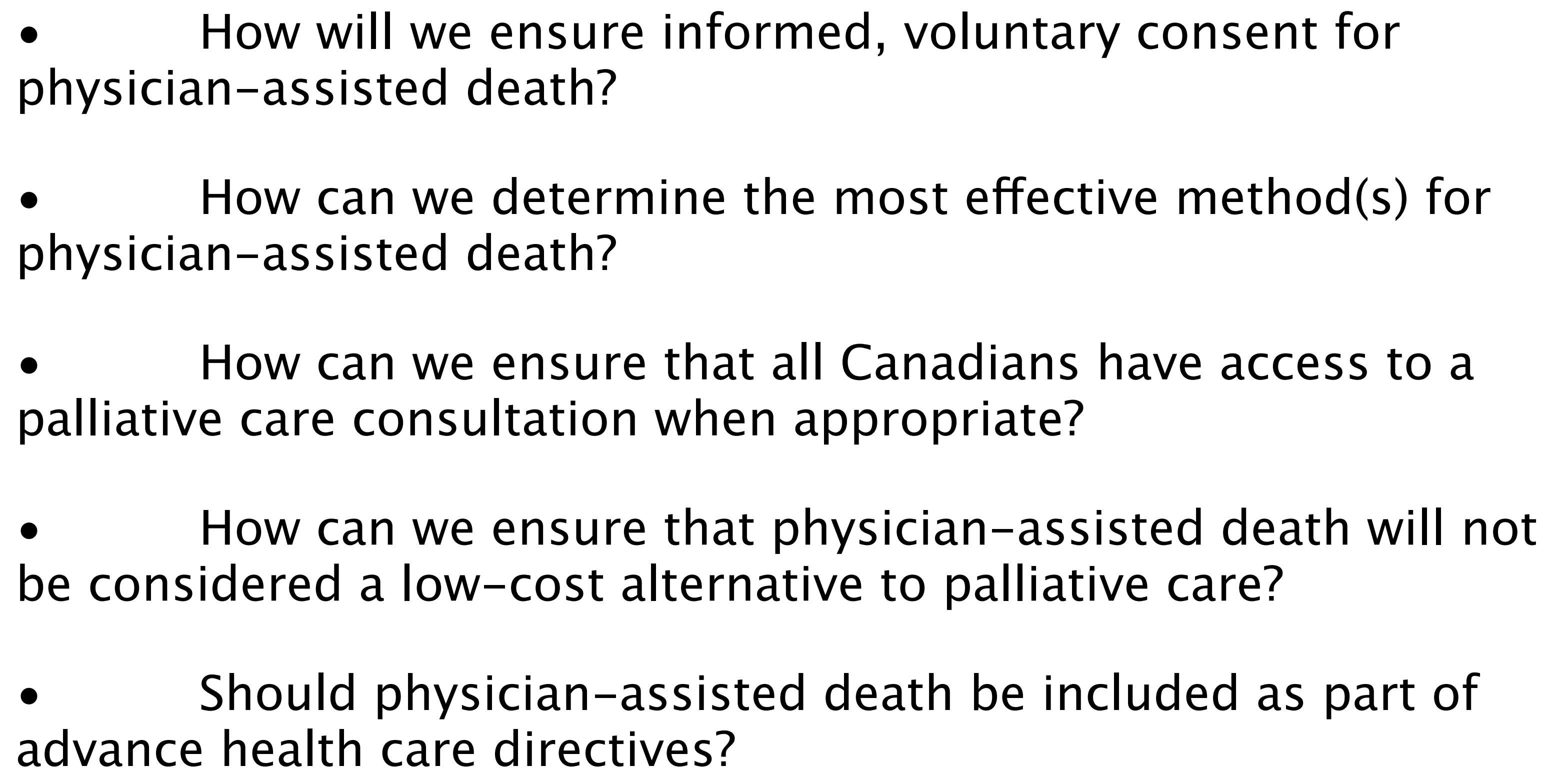
Box 1: If physician-assisted death is legalized in Canada, we may need to have answers for the following questions

- What conditions and prognosis would make a person eligible for physician- assisted death?

- What sort of suffering is "intolerable," and how long must it last before physician-assisted death can be offered? Can psychological or existential suffering be an indication for physician-assisted death?

- How can we ensure that physician-assisted death is available equitably to all patients?


• Will physicians who are conscientious objectors be obliged to present physician-assisted death as an option to patients and facilitate transfers of patients to other physicians or facilities?
• How can we protect professionals who participate in delivering physician- assisted death from societal repercussions? Should nonmedical or nonjudicial panels regulate the actions of physicians in this regard?
• How can we protect the vulnerable?
• How should we decide whether a patient is competent to consent to physician-assisted death? If a patient has an incurable illness with refractory symptoms and depression, how should we determine whether he or she is capable of consenting to


• How will we ensure informed, voluntary consent for physician-assisted death?
• How can we determine the most effective method(s) for physician-assisted death?
• How can we ensure that all Canadians have access to a palliative care consultation when appropriate?
• How can we ensure that physician-assisted death will not be considered a low-cost alternative to palliative care?
• Should physician-assisted death be included as part of advance health care directives?

- Should we delegate physician-assisted death to other health professionals, or should this be performed exclusively by physicians?

Others???

Thank you.