



Canadian Society of Palliative Care Physicians

Terms of Reference:

Physician Hastened Death Working Group

Purpose

To support the Board of the CSPCP to advocate for palliative care physicians and their patients as we prepare for changing legislation regarding physician hastened death- physician assisted suicide and euthanasia. This is a unique moment in our history that as a Society we hope to leverage for the benefit of accessible, high quality palliative care.

The Working Group may provide support to the Board in the following ways:

1. Support individual members by providing access to articles, resources, policies and materials to stimulate reflection and evidence informed decision making
2. Provide members with an opportunity to contribute feedback through Working Group members
3. Increase the likelihood that the Board can make decisions regarding advocacy with some degree of confidence that they will be supported by/represent members

The Working Group acknowledges that consensus on the specifics of these issues is not always possible. Overall, members may support advocacy decisions of the Board if they feel the process used to reach these recommendations is fair and transparent.

Chair

Appointed by the Board - Monica Branigan.

Members

Eight members of the CSPCP in good standing who have submitted an Application to Participate and have been selected by the Selection Committee of the Board (Dr Susan MacDonald, Dr David Henderson and Dr Monica Branigan). The Selection Committee will assign an initial score to the Application to Participate and then select based on ensuring the necessary mix of expertise, experience and representation of multiple perspectives.

The term will be not less than until February 2016 with an option to extend annually as needed.

Expert guests will be invited as needed such as representation from the CHPCA, the CMA, law, psychosocial oncology, spiritual care, nursing, policy expert, communications etc.



Reporting Structure

Directly to Board.

Meetings

At group discretion likely q 4 weeks by phone and F2F at conference with tasks in between.

Components/Deliverables of such support to the Board *may* include:

1. Gather and disseminate clinical and educational resources and tools for responding to individual requests to hasten death.

This may help to

- *Articulate best practices*
 - *Support non palliative care colleagues to respond compassionately and effectively*
 - *Teach learners*
2. Position paper that clarifies the line between palliative care practices and physician hastened death, including dissemination of best practices regarding Continuous Palliative Sedation Therapy.

With as clear a line as possible between treatments with the intention of hastening death and treatments that seek to neither prolong nor extend death, patients and physicians will be less confused. This may ameliorate patient concerns over opioids or the appropriate use of Continuous Deep Sedation Therapy.

These first two priorities stand regardless of any legislative changes

3. A strategic plan for responding to changing legislation that may discuss
 - Advocating for improved access and quality of palliative care as a first priority
 - Advocating for legislation that balances the rights of physicians and patients that *may* include:
 - i. the use of comprehensible, consistent terms
 - ii. ways to operationalize a separation between palliative care and the practice of physician hastened death- such as creating position of ombudsperson, create a separate organization, self-referral, duty to inform
 - iii. the issue of possible mandatory consultation
 - iv. recommendations regarding criteria and waiting list period



- Process recommendations/resources within teams
- Process recommendations/resources within institutions
- Recommendations for learners in partnership with other CSPCP committees

June 8, 2015

DRAFT