

A CANADIAN APPROACH TO ASSISTED DYING: CMA Member Dialogue

Summary Report



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A Canadian Approach to Assisted Dying: A CMA Member Dialogue Summary Report

Table of Contents

Executive summary.....	2
Background.....	5
Supreme Court ruling.....	5
Online dialogue.....	6
Conscientious objection.....	8
Principles-based approach.....	11
Clinical specifications.....	13
Palliative care.....	15
Support for physicians.....	16
Conclusion.....	18

(Note on terminology: In this report the phrase “assisted dying” is used to refer to any situations where a physician is involved in actively assisting a patient to end his or her life. In some instances direct quotes have been adjusted to reflect this to maintain consistency in the report.)

Executive summary

The Canadian Medical Association (CMA) has been conducting consultations with members as well as the public on end-of-life issues since 2014, as a direct result of the proceedings of the CMA General Council meeting in August 2013. This consultation process has taken on more urgency in the wake of the unanimous Supreme Court of Canada decision in the *Carter* case in February 2015, which ruled that Criminal Code provisions banning assisted dying were unconstitutional.

At its May 2015 meeting, the CMA Board of Directors gave approval for the document “Draft Principles-based Recommendations for a Canadian Approach to Medical Aid in Dying” to be released for consultation with members and stakeholders in advance of discussion and feedback at the CMA’s General Council meeting in August 2015 in Halifax.

The CMA conducted an online dialogue with members on some fundamental issues surrounding the assisted dying framework between June 8 and July 20, 2015. The dialogue was moderated by Dr. Jeff Blackmer, CMA Vice-President, Medical Professionalism.

A total of 595 members registered to participate in the online discussion and posted 545 comments.

In addition to comments posted online by members, the CMA also received several dozen emails relating to the topics under discussion as well as direct feedback from several medical and non-medical stakeholder groups.

The online dialogue was configured around questions relating to six themes:

1. Principles-based approach to assisted dying
2. Responding to a request for assisted dying
3. Oversight and data reporting
4. Conscientious objection and equitable access
5. Clinical specifications or requirements
6. Supporting resources for physicians

Many members applauded the CMA for taking leadership on the challenging issues involved and also praised the association for reaching out to its members for feedback and input.

Many comments were made in opposition to the Supreme Court decision and/or the CMA’s attempt to provide a balanced perspective respecting all member views on the issue of assisted death.

However, recent polls show that CMA members are evenly divided on the issue of legalizing assisted dying, and a significant minority of respondents to these polls said they will participate in offering this service to their patients. Given these results as well as the fact that the procedure will soon become legal, the CMA remains committed to continuing to encourage policy-makers to implement legislation or policies that will respect the Supreme Court decision while protecting the rights of all its members.

“Whether you agree with assisted dying or not, whether you decide to participate or not, we will be at the table to protect your rights and interests,” wrote Blackmer at one point during the discussions. “Legalization of assisted dying is a societal prerogative. It is a done deal. But we still have an opportunity to help shape what it will look like in practice.”

The issue of reconciling the right of a physician who chooses not to participate in assisted dying while ensuring access to this service for eligible patients was by far the most hotly debated issue in the online dialogue. Discussion threads on this issue spilled beyond the designated theme (“Conscientious objection and equitable access”) into all other areas of the online dialogue.

Many participants posted lengthy statements as to why they were conscientious objectors on this issue. Others noted that “failure to refer that patient on to an appropriate physician is inappropriate and unacceptable” and that “routine clinical care, palliative care and urgent care should continue to be offered (and) conscientious objectors should not be absolved of duties to communicate with and consult with those physicians providing medical aid in dying around relevant clinical concerns.”

Most conscientious objectors rejected the CMA proposal that physicians not wishing to be involved with assisted dying should refer these patients to an independent third party who would provide information and assistance for the patient; they proposed instead that patients self-refer to these services.

Others pointed out that self-referral may not be feasible or would force the patient to face undue hardship, and Blackmer wrote that a self-referral approach was unlikely to be accepted by legislators. He said the CMA proposal was intended to be a “middle ground” and that most patients receiving a referral to a third party would not access assisted dying but would learn about the options available, including palliative and spiritual care.

Most respondents in the dialogue endorsed the CMA’s nine underlying principles for developing a legislative approach to assisted dying, with a typical response being “these nine foundational principles are definitely required and must be respected in all areas of medicine and I highly commend the CMA for the work they have put into these topics.”

However, as with the conscientious objector issue, some respondents were unhappy about giving the same weight to the principles of respect for physician values and respect for patient autonomy.

Many individuals and stakeholder groups commented on, and generally supported, the mechanism proposed by the CMA for dealing with requests for assisted dying – especially the requirement for two physicians to be involved and the need for a cooling-off period.

There were some differences of opinion, however, about whether an explicitly stated cooling-off period was necessary to give all patients time to properly assess their decision or rather whether it may cause undue suffering for some patients.

Many members expressed concern about the ruling of the Supreme Court that a request for assisted dying could not be documented in an advance directive.

Although not specifically identified as a theme of the online dialogue, the importance of palliative care services and the interaction between palliative care and assisted dying was noted by many physicians in a number of the discussions in the dialogue. “My greatest fear is that people end up having easier access to lethal injection than palliative care (currently accessible to only 30% of Canadians),” one respondent stated.

Many participants commented on the need to provide formal education or some form of certification and other support for physicians providing assisted dying and to better inform all physicians on the issues involved. Blackmer noted that the CMA is in the process of developing such educational tools.

While some members feel strongly that the CMA should not be complicit in facilitating the Supreme Court decision permitting assisted dying in Canada, CMA leaders feel that the organization has an obligation to accurately reflect the views of all members and to support efforts to institute assisted dying in a way that protects the vulnerable and respects physician autonomy.

“The CMA is to be commended for taking a measured approach to this very difficult new reality,” commented one respondent. “In the coming weeks and months we as physicians will be characterized by press, politicians and advocates on all sides of this issue. It behooves us as a profession to listen [to] and digest all sides and views. I am proud of the way the CMA has shown leadership for patients, physicians and policy-makers in this vitally important debate leading up to the recent Supreme Court decision.”

Background

The Canadian Medical Association (CMA) has been conducting consultations with members and with the public on end-of-life care issues since 2014, as a direct result of the proceedings of the CMA General Council meeting in August 2013. This consultation process has taken on more urgency in the wake of the unanimous Supreme Court of Canada decision in the *Carter* case in February 2015, which ruled that Criminal Code provisions banning assisted dying were unconstitutional.

In October 2013, in response to discussions at the General Council meeting in August, the CMA Board of Directors endorsed having the CMA lead an interactive dialogue within the profession and with the public on end-of-life issues that would incorporate advance care planning, palliative care and physician-assisted dying. The board also directed the association to clarify the terminology on end-of-life issues.

At its December 2013 meeting, the board approved an advocacy strategy to engage members and the public on end-of-life care and to demonstrate CMA's leadership role on these issues. The board also approved terminology to be used when discussing end-of-life care, developed by the CMA Committee on Ethics, to educate the public and the profession and to try to resolve some of the confusion surrounding these issues.

The CMA conducted a series of six meetings with members in the spring of 2014, many in conjunction with its five public town halls. The association also created a website for members to comment on various end-of-life care issues and respond to three polls dealing with different aspects of end-of-life care. The online dialogue opened in late February and continued until the end of May 2014. More than 1,200 members registered for the site and almost 200 comments were posted.

A survey of 5,000 members conducted in advance of the August 2014 CMA General Council meeting indicated that 45% of respondents favoured legalizing physician-assisted death, while 27% said they would probably participate if the act is legalized.

Armed with all of this feedback, 91% of delegates at the 2014 General Council meeting voted in favour of amending the CMA's policy on euthanasia and assisted death to state that rather than opposing these activities "the CMA 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 as defined in this policy."

Supreme Court ruling

The *Carter* case began in 2011, when the BC Civil Liberties Association (BCCLA) joined Dr. William Shoichet, Gloria Taylor, who had an incurable, progressive disease, and the family of Kay Carter, who also had an incurable disease and had travelled to Switzerland for assisted dying, to challenge the law against this intervention.

In 2012, the BC Supreme Court ruled that the Criminal Code of Canada provisions against assisted dying violated the rights of the gravely ill. The federal government appealed that decision. In October 2013 the BC Court of Appeal overturned the lower court ruling and upheld the ban, citing the 1993 case of Sue Rodriguez. The Supreme Court of Canada granted the BCCLA, the Carter family and others permission to appeal the case.

The Supreme Court of Canada held hearings on Oct. 15, 2014, to consider whether the existing ban on assisted death is unconstitutional under the Canadian Charter of Rights and Freedoms. The CMA appeared as an intervener in the case with the status of a “friend of the court” to offer its perspective on these complex issues. It was not arguing for or against a change in the laws but rather was presenting the views of the medical profession.

The CMA highlighted the complexities of the situation and the many challenges posed to physicians’ understanding of their traditional roles if the court were to change the law.

The Supreme Court issued its decision on Feb. 6, 2015, ruling that the existing law prohibiting assisted dying was unconstitutional.

The court suspended its ruling for 12 months, meaning medical aid in dying remains illegal until February 2016. The court deferred to Parliament and provincial legislatures to respond, should they so choose, with legislation that would respect the Charter rights of patients and providers.

The court set out some criteria for eligibility for physician-assisted dying, noting that eligible individuals must be competent adults who clearly consent and are suffering with a “grievous, irremediable medical condition” that they find intolerable.

The court also noted that a physician’s decision to participate in assisted dying is a matter of conscience and in some cases religious belief, and it stated that nothing in its decision would compel physicians to provide assistance in dying.

In the immediate wake of the court decision, the CMA stressed it would respect all members’ views and would provide as much support to those members who choose not to offer assisted dying as to those who do.

Online dialogue

Following the CMA General Council meeting in August 2014, the CMA Board of Directors charged the Committee on Ethics with developing a principles-based legislative framework for how assisted dying might be enacted in Canada.

At its May 2015 meeting, the board gave approval for the document “Draft Principles-based Recommendations for a Canadian Approach to Medical Aid in Dying” to be released for consultation with members and stakeholders in advance of CMA’s General Council meeting in August 2015 in Halifax. The goal of the process was to promote discussion and generate recommendations on a suite of ethical-legal principles and to seek input on specific issues that are particularly physician-sensitive and are worded ambiguously or not addressed in the court’s decision. The anticipated outcome was that physicians’ perspectives would be reflected in future

legislation as well as patients' views, with the touch points of reasonable accommodation for all perspectives and patient-centredness.

The CMA conducted an online dialogue with members on some fundamental issues addressed in the draft recommendations between June 8 and July 20, 2015. The dialogue was moderated by Dr. Jeff Blackmer, CMA vice-president of medical professionalism.

A total of 595 members registered to participate in the online discussion and posted 545 comments. More than a third of the members who registered for the discussion visited the site more than once, indicating an intense level of engagement. Many members posted comments on more than one theme or participated in ongoing dialogue with other participants.

Despite the fact that some participants expressed very strongly held ethical and moral views at opposite ends of the spectrum on some of the key questions, the dialogue was conducted in a respectful and civilized manner.

In addition to comments posted online by members, the CMA also received several dozen emails relating to the topics under discussion as well as feedback from several medical and non-medical stakeholder groups.

The online dialogue was configured around questions relating to six themes:

1. Principles-based approach to assisted dying
2. Responding to a request for assisted dying
3. Oversight and data reporting
4. Conscientious objection and equitable access
5. Clinical specifications or requirements
6. Supporting resources for physicians

It is worth noting that many of the posted comments were made in opposition to the Supreme Court decision and/or the CMA's attempt to provide a balance perspective respecting all member views on the issue of assisted death.

However, results of recent polls show that CMA members are evenly divided on the issue of legalizing assisted dying, and a significant minority of respondents to these polls said they will participate in offering this service to their patients. Given these results as well as the fact that this intervention will soon become legal, the CMA remains committed to continuing to encourage policy-makers to implement legislation or policies that will respect the Supreme Court decision while protecting the rights of all its members.

The intent of the dialogue was neither to reopen discussion of the morality or "rightness" of the Supreme Court decision nor to retread the well-worn pathways concerning the language used in discussing assisted dying. While the CMA recognizes that its proposed nomenclature will not satisfy everyone, the terminology is finding a high degree of acceptance in the Canadian context.

“Whether you agree with euthanasia or not, whether you decide to participate or not, we will be at the table to protect your rights and interests,” wrote Blackmer at one point during the discussions. “Legalization of assisted dying is a societal prerogative. It is a done deal. But we still have an opportunity to help shape what it will look like in practice.”

Many members applauded the CMA for taking leadership on the challenging issues involved and praised the association for reaching out to its members for feedback and input.

Conscientious objection

The issue of reconciling the right of a physician who chooses not to participate in assisted dying while ensuring access to this service for eligible patients was by far the most hotly debated issue in the online dialogue. Discussion threads on this issue spilled beyond the designated theme (“Conscientious objection and equitable access”) into all other areas of the online dialogue.

Many participants posted lengthy statements as to why they were conscientious objectors on this issue. This post is representative of these views:

“As a compassionate physician, I need not – indeed, I cannot – aim to end a patient's life in order to do them good. I have other means at my disposal to relieve their physical suffering, and I do not know on the basis of biomedical science what it is like beyond the grave.”

The opposing viewpoint on this issue was well captured in this statement:

“Physicians who don't want to participate in physician assisted suicide should clearly have the right to opt out. However, failure to refer that patient on to an appropriate physician is inappropriate and unacceptable. Being a physician does not mean you get to force your patient to live their life in accordance with your personal choices.”

Others wrote that conscientious objectors still had responsibilities concerning a patient who wanted to take advantage of assisted dying. One member said, “Routine clinical care, palliative care and urgent care should continue to be offered (and) conscientious objectors should not be absolved of duties to communicate with and consult with those physicians providing medical aid in dying around relevant clinical concerns.”

“We must never abandon our patients and must continue to care for their other medical needs and concerns unless/until the patient requests a transfer of care to another provider,” another agreed. “And if a patient does request that their files be transferred to another medical provider then this should be done in a professional and timely matter. But I do not believe that we have the obligation to provide everything a patient requests in every circumstance.”

In its draft recommendations, the CMA proposal to balance the right to conscientious objection while ensuring access to assisted dying for eligible patients is as follows:

“Physicians are not obligated to fulfill requests for medical aid in dying. There should be no discrimination against a physician for their refusal to participate in medical aid in dying. In order to reconcile physicians’ conscientious objection with patient access to care, a system should be developed whereby referral occurs by the physician to a third party that will provide assistance and information to the patient.”

Many members who identified themselves as conscientious objectors rejected this proposal because they said any referral would make them complicit in the act of assisted dying even if it was to a neutral individual or organization.

This view is well articulated in one email received by the CMA:

“When a doctor makes a referral, she puts her name behind the request and, in effect, indicates that she believes a patient would benefit overall from the service being sought ... making a referral is a deliberate action undertaken by a doctor that has intended consequences for the patient. Although the referring doctor does not directly provide the requested service to the patient, in making a referral her actions are closely linked to and play a causal role in what ultimately happens ... the principle that one shares responsibility for an action performed by another person if one facilitates or arranges that action is engrained in our society’s norms and legal code. Carrying out an activity oneself or arranging for someone else to do it are morally equivalent. Therefore, requiring doctors to refer for services to which they morally object coerces them to become active participants in acts that they believe to be wrong and, hence, to grossly violate their consciences.”

Many proposed the self-referral approach instead, saying that this had worked effectively with abortion services, although others disagreed with the effectiveness of self-referral for abortion.

“There is no single case in law that a woman has been affected by a doctor refusing to refer for an abortion,” one comment stated. A contrasting view was that “women attempting to access abortion services are frequently impeded by physicians who refuse to make referrals.”

Typical responses on the self-referral issue can be seen below:

“As a palliative care provider I discuss plenty of “requests to die” with my patients because they often arise in the context of pain and symptoms. These are long and difficult discussions and it includes an exploration of their psychosocial and spiritual distress that may contribute to their request. In 6 years of practice I have seen 95% of requests dissipate with good palliative care (and I am still early in my practice/skills). This is similar to studies that have looked at requests to die. So I certainly won’t stop doing this, but I will start including the soon-to-be legal option of physician-assisted

suicide/euthanasia in my discussion. I will not, however, refer them to it if they conclude that this is their wish. I will provide them the necessary information for a self-referral.”

“My solution would be that there be an independent facility set up and managed by those who support medical intervention by killing. Patients today very frequently assess and access prospective specialists and family doctors on the Internet. So the expressed concern that patients need me to guide them to a good facility is moot.”

“There should be public knowledge of the agency/organization who helps patients coordinate end-of-life matters, so that patients may self-refer without putting pressure on physicians who are entirely uncomfortable with assisted dying to even be involved in referring onwards, which is, in effect, involving conscientious objectors by complicit consent. If my patients want to partake in assisted dying, I would appreciate them being able to organize it through a central agency such that I do not need to be involved whatsoever.”

Others were critical of the self-referral proposal, noting that patients seeking assisted dying may not be healthy enough or have the resources to find the necessary assistance on their own. They also pointed to the difficulties of self-referral in more isolated regions.

“I have also heard from many patients and families who have indicated that this might be an unacceptable burden under what will likely be extremely difficult circumstances,” said one physician.

“Saying patients can self-refer without offering them the means to do so is medical abandonment,” another commented. “It is our duty to educate patients on their available options and assist them in navigating our complex medical system so that they can make informed care [decisions] based on patient values, not physician values.”

“If (as is hoped) restrictions are in place so that those seeking these services must be near end of life, they often cannot simply search out a source and go visit the doctor down the street or in the next town – they are simply too ill,” another commented.

“To me, a referral is that I enact a formal process to send information from myself to another provider. Informing a patient of how to access (information) through a website or central intake phone number is not a referral,” another wrote.

Others pointed out the differences between caring for in-patients – who may not have options – and patients in the community.

“As an ICU physician, if I receive a request for physician-assisted suicide/euthanasia, I intend to transfer the patient’s care to a different most responsible physician (MRP),” read one comment.

“In-patients do not get to choose their physician – accordingly they have the right to request a different MRP.”

One national specialty society wrote, “The process of establishing a patient’s qualifications for medical assisted dying should not be seen as an activity that is appropriate for an emergency department setting.”

In response to the discussion on the issue of conscientious objection, Blackmer commented that “the CMA will work with regulators and others to try and find a solution that will not force physicians to participate in assisted dying against their moral beliefs, while at the same time making sure access is available for patients who qualify.”

He noted the opposition to referral to a third party but said the CMA proposal is intended to serve as a “middle ground” and that most patients receiving this referral will not access assisted dying but will learn about the options available, including palliative and spiritual care.

“It does not facilitate access to assisted dying. It facilitates access to information,” he wrote.

Blackmer said he did not think the option of self-referral would be acceptable to regulators given the vulnerable nature of this patient population. “If the CMA adopts this position (self-referral), I am not optimistic that it would be taken up in legislation or regulations. Instead, we would be likely to have a system of ‘effective referral’ imposed on us.”

Blackmer’s call for a balanced approach was echoed by one member who wrote, “I think that if both sides own the full implications of their positions, then we truly have the basis for abiding mutual respect. From that mutual respect, good policy can be crafted which accommodates both solitudes.”

“Not everyone will be happy in this middle ground. Perhaps we should try instead to make everyone just a little bit unhappy,” another wrote.

While it explicitly avoided dealing with the Supreme Court decision on assisted death, a recent College of Physicians and Surgeons of Ontario policy decision requiring physicians to refer patients to other physicians if they have a conscientious objection to providing a service provoked the ire of a number of dialogue participants.

“I commend the CMA for trying to ‘own’ this conversation and stepping into this void,” said one of the participants who had a more moderate response, “although I worry that some of the provincial colleges have stepped out ahead already with policies of ‘effective referral’ and I worry these policies have been adopted without broad consultation with physicians who again are going to be saddled with the ethical weight of doing the work. “

Principles-based approach

Many dialogue participants supported the CMA’s underlying principles for its proposed legislative framework on assisted dying.

“The foundational principles in the draft statement are well-put” was how one physician put it, with another stating that “these principles are definitely required and must be respected in all areas of medicine and I highly commend the CMA for the work they have put into these topics.”

“In summary ... I find these principles to be reasonable on the whole (and) I think it will be very difficult to work out the practical details. Nevertheless, it is very important to work through the difficult details in order to protect vulnerable Canadians whose right to life is now in danger,” another commented.

However, as with the conscientious objector issue, many respondents were unhappy about giving the same weight to the principles of respect for physician values and respect for patient autonomy.

Two detailed responses were as follows:

“These principles are contradictory because physician values will not always agree with the patient’s “autonomy” (i.e., health and treatment wishes) and simply farming the problem out to another physician does not work well in practice. May I suggest that this scenario is reminiscent of a previous one in history, namely, the provision of abortion care, where there was no set standard of care for quite some time, and there was a “patchwork quilt” of different approaches to the issue. Repeating this approach with regards to euthanasia and assisted suicide seems rather ill-conceived and quite frankly, would be a disaster for the notion of “equitable care.” One cannot guarantee that physician values “must not result in undue delay in patient care to access such services” – this is simply impossible. If a physician’s values disagree with the patient’s autonomy, they are obligated to look for a different provider – this is not always possible in all parts of the country. Thus, the “patient autonomy” principle, together with physician’s values has the potential to render to principle of “equity” to be merely lip service to the public.”

“It is unclear why the CMA has not used the principles and values of medical ethics: compassion, beneficence, non-maleficence, respect for persons, justice and accountability – as articulated in the Code of Ethics. These have a certain justification in the 2,500 year old Hippocratic tradition and in modern medical professionalism as it emerged in the 1800s. The proposed list is a strange one for directing the responses of doctors, especially as it begins with respect for patient autonomy and then identifies equity (re access). Respect for physician values is listed third and then clarity re regulations, consent & capacity, dignity, protection of vulnerable persons, accountability and solidarity. Each of these contains important concepts but as listed they are confusing.”

In response to this and similar comments, Blackmer wrote, “there is not an irreconcilable difference between the right to patient autonomy and protection of physician autonomy. The key is finding a solution that will ensure both ...”

Clinical specifications

Many individuals and stakeholder groups commented on and generally supported the specific details proposed by the CMA for dealing with requests for assisted dying – especially the requirement for two physicians to be involved and the need for a cooling-off period.

“It is important that 2 physicians be involved in the decision-making process,” one physician said in an email response. “But the crucial point here is that one of them is competent in palliative and in the technique / legal issues surrounding assisted dying. It would be unwise to vest two neurosurgeons or two hematologists [with] the sole authority over the decision.”

“We must not make the process so cumbersome as to impede the timely delivery of the requested care,” one member wrote. “Third party interveners must be barred from the process out of compassion for the dying patient. It should take the opinion of two doctors familiar with the patient and the case to initiate treatment. As we will be by definition only treating those with the mental capacity to choose, no other participants are needed or wanted.”

Another disagreed and said barring third party interveners “is not reasonable. There very well [might be] relevant situations where the input of a third party (e.g., family member, close friend) can be helpful for us to confirm the intentions of our patient and that their choice is truly voluntary. It is better for us to be open to their input rather than reject it a priori – it can help ensure that the foundational principles ... are satisfied.”

On the issue of the requirement for a cooling-off period, one member wrote, “a cooling-off period (and preferably, some documentation of discussion between the patient and their loved ones) would help reduce the chance that the patient is making an impulsive decision.”

“An appropriate period of time should elapse between the original request and actual time that the assisted suicide take[s] place,” one doctor said in an email. “During this time the patient should be afforded counselling. Considerations for the family must also be part of this (and) there should be at least one meeting with the patient and the family.”

“I agree with a waiting period to allow reflection, education and consultation but there doesn't seem to be any mandated counselling or education built into the two waiting periods. As written, these could be two schedule[d] phone calls which then get a patient in the door to begin to receive services. I wonder whether there could be contact with the patient during the waiting period to begin to explore the reasons for the request and provide resources for education and alternatives during the first cooling-off period.”

Others expressed concern that such a waiting period may be unreasonable or not feasible.

“While that is ideal I also fear there will be situations where a cooling-off period may delay an intervention in a manner that causes unnecessary suffering,” one person wrote. “Why not strongly suggest a cooling-off period and be prepared to manage time-sensitive presentations rather than prescribe a cooling-off period?”

“Timeliness may be of importance in this decision under certain circumstances. For example, a 102 year old patient, who was otherwise healthy and on no medications except 50 micrograms of L-thyroxine, suffered a stroke rendering her hemiplegic with serious dysphagia and recurrent aspiration. Her mode of death was essentially six weeks of starvation with continual choking. It was apparent from the beginning that there were no other options for her. Assisted dying would have been a blessing in this situation. But if the process were to have taken six weeks, nothing would have been accomplished to benefit her in her suffering.”

“An arbitrary waiting period is, in my mind, foolish unless it is accompanied by full transparency – an honest explanation of why it is preferred and a process by which it can be [circumvented] in alignment with accepted principles. Why not explain to patients the value of a waiting period and ask them to provide rationale should they feel it is unreasonable – a truly collaborative interaction that respects all views, which can be engaged in a meaningful time frame, and which has teeth? This is consistent with the view of the CMA that there should be a process that ensures adaptability. The process can then be made as detailed as is seen necessary as long as there are provisions to ensure there are no delays in providing timely access from patients’ perspectives and there is a commitment to QI [quality improvement] and continual revision.”

One concern expressed by many members was the ruling of the Supreme Court that a request for assisted dying could not be documented in an advance directive:

“Remember the aim of this is to alleviate unnecessary suffering,” commented one member. “A blanket restriction on advanced directions is not desirable. We have the technology to record a video statement by the patient to set the conditions under which they would prefer assistance with dying.”

“The prohibition of advance directives makes no sense and I don’t see it holding up in court,” wrote another member. “We have no barrier to withdrawing care if an advance directive so specifies. This should be no different.”

Another physician couched his response on this topic in personal terms:

“Personally I would welcome the opportunity to sign an advance directive that ensured a peaceful end to my life should I develop and have confirmed a diagnosis of progressive dementia when complicated by severe agitation and aggression. It would be a grievous loss of my dignity and be contrary to all of my values and the love I have for my family should I reach that point where I am striking out and overburdening them or my caregivers.”

Although the majority of participants in the dialogue were in general support of the clinical pathways outlined in the CMA document, some had concerns.

“I am struck by the high amount of bureaucracy surrounding this act,” one wrote. “Compare this to, for example, a patient consenting to open heart surgery, a procedure with a much higher risk of medical and medicolegal negative outcome but less paperwork than assisted dying.”

Palliative care

Although not specifically identified as a theme in the recent online dialogue, the importance of palliative care services and the interaction between palliative care and assisted dying was noted by many physicians in a number of the discussions in the online dialogue.

This is in keeping with the importance that the CMA has placed on the need to make palliative care services available to all Canadians who need them and the need for a palliative care strategy at the national level.

“My greatest fear is that people end up having easier access to lethal injection than palliative care (currently accessible to only 30% of Canadians),” one commenter said.

One of the primary messages from the current online dialogue – expressed predominantly by palliative care physicians themselves – is the need to clearly differentiate between delivering palliative care and being involved in providing assisted dying:

“The protection of palliative care is crucial if we are to allow assisted dying in our country since the majority of requests for hastened death are related to pain and symptoms that can be controlled by specialized Palliative Care teams and studies have shown clearly that the majority of those requests dissipate along with the symptoms. I have encountered such cases many times in my practice and I am confident that even the most staunch supporter of assisted dying would want to prevent such premature deaths. The CPSO [College of Physicians and Surgeons of Ontario] policy on conscientious objectors will jeopardize the continued practice of high-quality palliative care and the CMA needs to take a clear stand on this issue.”

“The crucial point is that assisted dying is not part of palliative care (most notably according to the WHO [World Health Organization]) and therefore the two options need to be distinct. Therefore, a palliative care provider should not be involved in assisted dying within his/her role in palliative care, which means that he/she should not have to give a direct referral since it is not an act that is consistent with palliative care principles.”

“My concern is, as a palliative care physician, getting consulted for all patients who [have] requested physician-assisted suicide but who are not actually fitting the criteria of a palliative care patient – e.g., people with mental illness refractory to treatment, etc.”

Others felt the link between palliative care and assisted dying was essential.

A national medical organization noted that “palliative care is often offered to patients, who may refuse because they do not know what palliative care entails, suggesting a lack of understanding of the concept of palliative care at the patient level. Once the patient has met the palliative care team, and has had his concerns explored and addressed, he/she may think differently than if the option of palliative care is just offered to the patient. As such, greater emphasis on explaining what palliative care entails is suggested.”

“... [I]t is extremely important to separate the concept that there are people who wish palliative care and comfort only, but are not yet ready for the assisted death component, and there will be those who wish palliative care and comfort and assisted death,” one physician wrote. “I agree with earlier comments that assisted death has to have a palliative care link.”

Support for physicians

Many participants commented on the need to provide formal education and other support mechanisms for physicians who elect to participate in assisted dying and to better inform all physicians on the complex and controversial issues involved.

“A reasonable certification standard should be considered, one acceptable to provincial colleges of physicians, with quality assurance controlled by the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada,” one physician noted. Another said, “Just as we provide a means for ACLS/ATLS [advanced cardiac life support and advanced trauma life support] certification for physicians treating cardiac arrest and trauma victims, we should develop and implement a certification program for all potential providers of assisted death.”

“As a recent graduate, I believe the Canadian Medical Association can work with the Canadian Federation of Medical Students, Association of Faculties of Medicine of Canada and other strategic partners to ensure that assisted dying becomes part of the curriculum from coast to coast,” another member wrote. “Instruction on the medical, legal and ethical aspects of assisted dying must become an essential component of our training. We would be doing our Canadian medical graduates a disservice by waiting until residency or practice before familiarizing them with assisted dying.”

“I would suggest being a bit clearer on the skill set required to do this work well,” another member wrote. “I can’t envision that all physicians are skilled to have the sort of in-depth discussions on this topic in the same way that all physicians are not skilled to place a coronary stent. Both sets of skills are gained through training and experience.”

Some talked of the broader supports needed by the profession:

“Physicians who choose to perform assisted dying should be specifically trained and educated through a designated course ... Physicians need other resources/team members to do this well. The team would need (a) social

worker, nurse and lawyer to help the individual patient navigate and understand the implications for them so the patient can make an informed decision whether to pursue assisted dying. There will be complex social issues [that] physicians won't have the time or expertise to manage – counselling of family members, financial implications – e.g., life insurance/pensions become void because of suicide. These details need to be sorted out and plans clearly delineated.”

“I do not want to be stuck with endless paperwork,” one physician wrote in reference to what he perceived would be the increased need for documentation surrounding the assisted dying process.

Others echoed this view:

“Front-line physicians do not need the added responsibility of doing all that may be required. The process needs to be as streamlined as possible and those with the most authority in the medical system and in government need to accept responsibility and be accountable.”

Those who commented on the data reporting requirements for assisted dying noted that the entire assisted dying process needs to be properly recorded.

“It is important that assisted dying is fully documented and periodically audited,” said one physician. “But the process should not be so onerous as to delay the implementation of the decision beyond a mandated ‘cooling off’ period.”

“The underlying indication for assisted dying needs to be recorded, as it could help identify local factors that could be prompting demand,” one person commented. “I believe that reporting needs to be as clear as possible,” another wrote. “Documentation should NOT include euphemisms. It should be clearly stated on the death certificate the immediate cause of death is a) lethal injection or b) oral ingestion of prescribed lethal medications. There should be provincial committees set up to review all cases. There should be federal oversight for evaluation and statistics.”

A national medical specialty organization noted, “If EMS [emergency medical services] is called and/or the patient is brought to the emergency department it would be very important that these patients have some clear, verifiable documentation (or some other robust process) that establishes their status as a patient who has qualified for assisted dying.”

Another national society wrote, “If the level of record keeping and form completion is high, consideration should be given to compensating physicians for the extra work that this new process will require, without burdening the patient with private billing requirements.”

Blackmer said the CMA was in the process of developing education opportunities for physicians who elect to participate in assisted dying.

“It will likely be a multi-day program addressing issues such as communications skills, medicolegal issues, medical ethics, religious considerations, comprehensive care at the end of life, and technical considerations in assisted dying,” he wrote. “We are currently engaging with our international colleagues to learn from their experiences in providing such programs.”

Conclusion

As delegates at the CMA General Council meeting in August prepare for their deliberations, the comments posted during the online dialogue and summarized above, as well as survey results and feedback from stakeholders, all provide important perspectives.

While some members feel strongly that the CMA should not be complicit in facilitating the Supreme Court decision permitting assisted dying in Canada, CMA leaders feel the organization has an obligation to accurately reflect the views of all members and to support efforts to institute assisted dying in a way that protects the vulnerable and respects physician autonomy.

As one member stated in an email:

“The CMA is to be commended for taking a measured approach to this very difficult new reality. In the coming weeks and months we as physicians will be characterized by press, politicians and advocates on all sides of this issue. It behooves us as a profession to listen [to] and digest all sides and views. I am proud of the way the CMA has shown leadership for patients, physicians and policy-makers in this vitally important debate leading up to the recent Supreme Court decision. Your current letter demonstrates the ongoing broad perspective and understanding the CMA has of the surrounding issues and its proactive stance in addressing them. Thank you all for your wisdom and action on behalf of all Canadians.”

An alternative view noted, “[A]t this time with only 6 months before this Supreme Court of Canada decision comes into effect we have a totally uncoordinated and sometimes conflicting response from the profession.”

But as another participant wrote, “There is no profession currently existing in Canada which would be better able to provide [patients with] and protect patients from assisted dying than physicians.”