

CMA MEMBER CONSULTATION REPORT
JULY 2014

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CANADIAN
MEDICAL
ASSOCIATION



EXECUTIVE SUMMARY

The Canadian Medical Association (CMA) made the decision to consult its members on end-of-life care issues directly as a result of deliberations at the association's annual General Council meeting in August 2013.

After two extensive discussions on advance care directives and palliative care at General Council, delegates at the meeting debated and adopted a number of resolutions aimed at improving education and communication concerning the end-of-life experience.

Following the meeting, the CMA Board of Directors endorsed having the association take a leadership role and conduct a dialogue with both the medical profession and the public on end-of-life care issues.

The CMA conducted a series of six meetings with members in the spring of 2014. 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. These were held in conjunction with public town hall meetings.

The face-to-face meetings were held in St. John's, NL (Feb. 21), Edmonton, Alta. (March 15), Fredericton, NB (March 28), Vancouver, BC (April 2), Whitehorse, Yukon (April 17), and Regina, Sask. (May 10). There were no consultations in Quebec because a government-led public consultation had already been held in the province. Attendance at the meetings ranged from 20 to 70 members.

The online dialogue opened in late February and continued until the end of May. More than 1,200 members registered for the site and more than 190 comments were posted.

The member meetings were marked by participation from physicians across the age spectrum and from a variety of specialties, with significant participation from palliative care experts across the country. It was clear that the main issue the majority of members wanted to discuss was physician-assisted dying and the role of the medical profession. This was graphically demonstrated in the online dialogue where 80% of comments posted dealt with euthanasia and physician-assisted dying and the current CMA policy opposing physician involvement.

The status of palliative care services and the fundamental association between the availability of palliative care services and the desire for medical aid in dying was also a major theme at all of the member meetings.

On the issue of medical aid in dying, all of the member meetings and the online dialogue featured diametrically opposed views and support for, or opposition to, the current CMA policy.

Supporters of the current CMA position cited the following main reasons for their position:

- Legalizing medical aid in dying would negatively affect the trust patients have in physicians and would jeopardize the physician–patient relationship.

- The physician role is to heal, not end life.
- Legalization is “a slippery slope” and would lead to an increase in the scope of conditions and patient populations for which physician-assisted dying can be applied — especially vulnerable populations.
- Legalizing medical aid in dying could be used for economic purposes to save money in the health care system. Those advocating a change in the CMA position cited the following in support of their views:
 - There must be respect for patient autonomy, and physicians need to accompany patients as a partner.
 - Medical aid in dying is a form of medical care and part of the palliative care continuum — despite most palliative care physicians consistently and definitively stating the opposite.
 - There are forms of suffering that palliative care services are not sufficient to ameliorate and/or reflective of patient wishes.
 - Strict regulations can protect against widening the indications if it became legal, as evidenced by other jurisdictions. Speakers and online commentators also repeatedly referenced practice issues associated with medical aid in dying. Among the issues cited were the following:
 - There may be difficulties in assessing competency and voluntariness in end-of-life situations in the emergency department and other acute-care settings.



- Medical aid in dying is already being practised illegally in Canada.
- Physicians fear they could be forced to participate in physician-assisted dying if it became legal.
- There are implications of legalizing medical aid in dying on the profession's Code of Ethics and malpractice insurance, along with broader resource considerations.
- "Overtreatment" can be a major factor influencing patient concerns about care at the end of life.

The current status of palliative care in Canada was another major issue of discussion at the member meetings and the online dialogue.

Comments by members focused on the link between inadequate palliative care services and calls for legalization of physician-assisted dying. Physicians also spoke about the lack of palliative care services outside of major urban centres, the lack of training of family physicians and others in proper palliative care and the lack of proper remuneration for providing palliative care services.

Members voiced support for the

importance of advance care directives and the need for earlier discussions with patients about end-of-life care issues. However, concerns were also raised about the lack of training physicians had in this area and also the time commitment required to properly communicate with patients about these issues.

Given the diversity of views on end-of-life issues, it is not surprising that the CMA was not given a clear cut mandate on future activity dealing with the sensitive area of euthanasia and physician-assisted dying. Participants at the meetings raised a number of practice-related issues concerning end-of-life care and every meeting saw consideration of the question of how the CMA should respond if the law in Canada concerning euthanasia and physician-assisted dying does change.

However, CMA members were aligned with the public in voicing support on many end-of-life issues:

- the importance of discussing advance care directives with patients in a timely manner
- the need for a national palliative care strategy and adequate resourcing of such

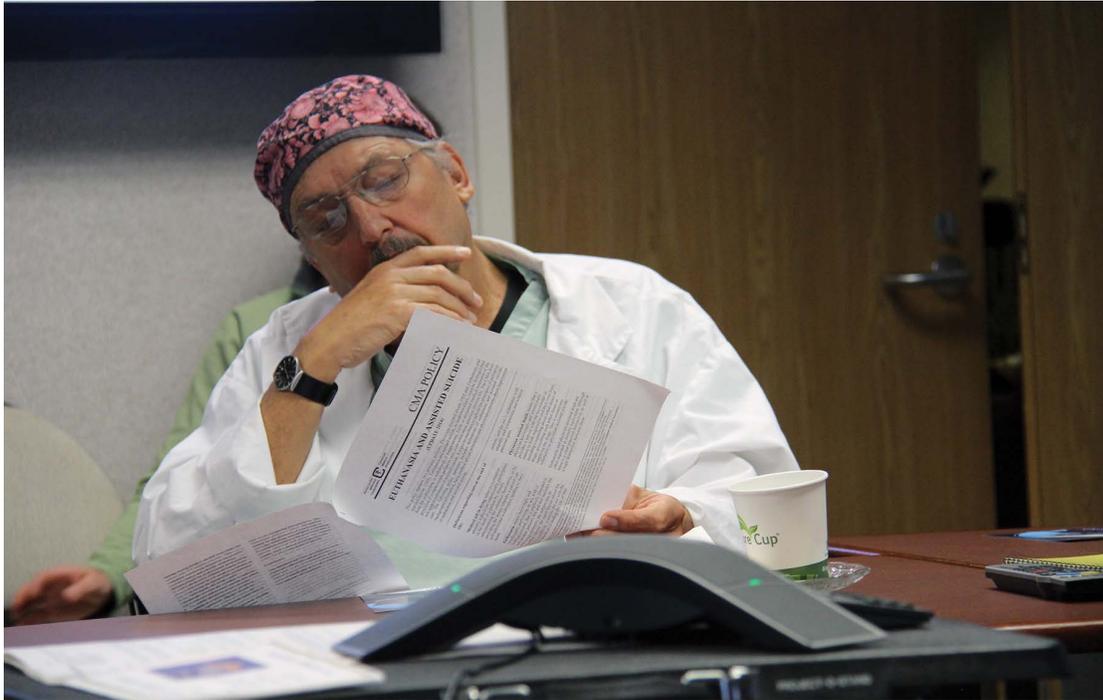
a strategy and adequate physician remuneration for providing palliative care services

- the need for better training for physicians in providing palliative care and discussing advance care directives at all levels and across a broad spectrum of specialties

Overall, a majority of the CMA members who participated in the dialogue either in person or online favoured maintaining the current CMA policy opposing physician involvement in euthanasia and physician-assisted dying.

A significant minority felt this policy should at least be reviewed if not revised to support some form of physician-assisted dying in Canada. Others expressed the viewpoint that it is premature to consider changing the law in Canada until a comprehensive and universal palliative care system is put in place.

There was also a general acknowledgment that society would make the final decision concerning euthanasia and physician-assisted dying and that it was not the role of the CMA or the medical profession to dictate what this should be.



BACKGROUND

CMA public dialogue

In conjunction with the member dialogue on end-of-life care and in partnership with *Maclean's* magazine, the Canadian Medical Association (CMA) conducted a series of town hall meetings and an online dialogue with the public on end-of-life care issues.

The national dialogue focused on three main issues: advance care directives, palliative care, and euthanasia and physician-assisted dying. The main aim of the consultation process was to seek input from Canadians on their perceptions and views about the status of end-of-life care in Canada. However, an important secondary purpose was to provide common definitions and terminology for discussing end-of-life care issues and to educate the public about the current legal and legislative situation in Canada and abroad.

Town halls for the public were held in St. John's, NL (Feb. 20), Vancouver, BC (Mar. 24), Whitehorse, Yukon (Apr. 16),

Regina, Sask. (May 7), and Mississauga, Ont. (May 27). A live web chat was also held on May 12 on the *Maclean's* website.

The town hall meetings were moderated by senior *Maclean's* editorial staff and conducted under the guidance of Dr. Jeff Blackmer, the CMA's executive director of ethics, professionalism and international affairs. Each meeting followed the same format, with discussions about the terminology of end-of-life care followed by questions to the audience and discussions about advance care planning and directives, palliative care, and euthanasia and physician-assisted dying.

While it was clear that members of the public often had diametrically opposed views on the controversial topic of euthanasia and physician-assisted dying, common ground was evident on many other important issues ranging from the importance of advance care directives to the need for a comprehensive palliative care strategy in Canada. Many CMA members participated in the public town

hall debates and Canadian palliative care experts sat as panellists for many of the meetings.

The public consultation culminated with the release of a summary of the meetings entitled *End-of-life Care: A National Dialogue* on June 10, 2014.

The main recommendations were as follows:

- The terminology developed by the CMA to discuss end-of-life care should be widely communicated to health care providers, policy-makers and the public.
- All Canadians should discuss end-of-life wishes with their families or other loved ones.
- All Canadians should prepare advance care directives that are appropriate and binding for the jurisdiction in which they live.
- Canadians should revisit their end-of-life care wishes periodically, recognizing that health care providers will interpret these wishes on the basis of a number of variables, including written advance care

directives, conversations with loved ones and input from a substitute decision-maker.

- A national palliative care strategy should be developed.
- All Canadians should have access to appropriate palliative care services.
- Funding for palliative and hospice care services should be increased.
- More education about palliative care approaches and as well as how to initiate discussions about advance care planning is required for medical students, residents and practising physicians.
- The Canadian public is divided on whether the current Canadian ban on euthanasia and physician-assisted dying should be maintained or not.
- If the law in Canada is changed to allow euthanasia or physician-assisted dying, strict protocols and safeguards are required to protect vulnerable individuals and populations.
- The potential impact on the Canadian medical profession of legalizing physician-assisted dying should be carefully considered and studied further.

MEMBER DIALOGUE PROCESS

"At its policy convention in Calgary, the Canadian Medical Association was poised to debate one of the most emotionally charged

and ethically perilous issues in medicine: doctor-assisted death. But physicians got bogged down in semantics, in lengthy discussions about the appropriate language to use ... and deferred real debate to a later, unspecified date and another unspecified time. ... Anna Reid, outgoing president of the CMA, ... [said]: "We didn't make any final decisions, but that wasn't our intention. Our goal was to begin the discussion."

— André Picard, *The Globe and Mail*,
Aug. 21, 2013

"Now is the time, here is the place."

— Dr. Jeff Blackmer introducing
member meetings

The decision to conduct consultations with CMA members on end-of-life care issues arose directly from the proceedings of the CMA General Council meeting in August 2013.

After two extensive discussions on advance care directives and palliative care at General Council, delegates at the meeting debated a number of resolutions aimed at improving education and communication concerning the end-of-life experience.

The most contentious debates centred on the terminology used in discussing physician involvement in end-of-life care. Many of the resolutions came from

delegates from Quebec, where Bill 52, the legislation concerning physician-assisted dying, was being debated in that jurisdiction at the time.

"It was very difficult to proceed without a common understanding of the language being used," Dr. Jeff Blackmer, the CMA executive director of ethics, professionalism and international affairs, explained in his introductions to the member meetings.

In October, the CMA Board of Directors met and 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 show that the CMA is taking a leadership role on these issues. A central element of this strategy was a series of town halls to be held across Canada to engage the public and members on end-of-life care.

The board also approved a series of definitions and terminology commonly used when discussing end-of-life care, developed by the CMA Committee of Ethics, to educate the public and resolve



some of the confusion surrounding these issues. The board also approved revisions to the CMA Statement on Life-Saving and -Sustaining Interventions made as a result of the Supreme Court decision in *Cuthbertson v. Rasouli* on medical futility and decision-making.

Several other events and circumstances magnified interest in physician-assisted death and associated issues in Canada and provided a backdrop for the CMA member dialogue. The two most significant of these were a Supreme Court challenge of current legislation banning physician-assisted death in Canada, and Quebec legislation in this area (see page 6).

Interest in the issues of physician-assisted dying and related end-of-life care issues was also fed by several high-profile activities by Canadian physicians as well as initiatives undertaken by some provincial and territorial medical associations during the period of the CMA dialogue.

At the end of May 2014, the Ontario Medical Association (OMA) released a provincial framework to enhance care for people at the end of their lives. *The Framework for End-of-Life Care* was the culmination of a series of town hall meetings held by the association across Ontario during 2013 and 2014. The report identifies the key elements for high-quality end-of-life care, including increasing the number of Ontarians who do advance care planning, bridging advance care planning and palliative care, and improving access to palliative supports. During his OMA presidency in 2013–2014, Dr. Scott Woodeer made end-of-life care a priority and focused on these issues during his presidential tour.

In March 2014, Doctors of BC (formerly the British Columbia Medical Association) released *It's Time to Talk: Advance Care Planning in British Columbia*. The report states that discussing end-of-life plans with loved ones is a necessary part of life but acknowledges that such conversations can be difficult. The report recommends integrating advance care plans with patient records so that all health care

providers know the patients' wishes, encouraging early planning by amending or expanding existing advance care planning resources and making advance care planning part of the required standard of care for patients with chronic or complex illness.

In September 2013 a posthumous YouTube video was posted on behalf of Dr. Donald Low, a leading Toronto microbiologist who played a major role during the 2003 SARS crisis.

"I know I'm going to die; what worries me is how I'm going to die," the 68-year-old Dr. Low says in the video, produced by the Canadian Partnership Against Cancer. Dr. Low had been diagnosed with terminal brain cancer seven months earlier and made the video eight days before his death. Dr. Low says he would have liked to have the option available to terminally ill patients in other countries where physician-assisted death is legal. By June 2014, the video had been watched more than 84,000 times.

In April 2014, *CMAJ* published a commentary prepared by Dr. James Downar and other Toronto palliative care experts including the late Dr. Larry Librach, urging Canadian physicians to start considering their options if the law is changed to make physician-assisted dying legal. Dr. Downar and colleagues wrote: "Whether or not physicians individually or collectively agree with physician-assisted death, it is clear that our profession must be prepared for the challenges to be faced if physician-assisted death is legalized in Canada." In a letter to the editor responding to the article, CMA President Dr. Louis Hugo Francescutti wrote that the authors "unfortunately get the cart well before the horse by focusing solely on physician-assisted death."

MEMBER ENGAGEMENT

"It is emotionally charged, but it is also reality."

— Meeting participant on the need for the discussion

"These conversations don't happen around the water cooler. I suspect they don't occur in doctors' lounges."

— Meeting participant

"I really don't think the CMA is going to be able to answer the divergent communities of doctors within the association. I don't think the medical associations are able to lead because a good many number of members feel very strongly on one side or another. I think our answer is going to come through court decisions and legislation, quite frankly."

— Meeting participant

The CMA conducted a series of six meetings with members in the spring of 2014, many in conjunction with the 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 face-to-face meetings were held in St. John's, NL (Feb. 21), Edmonton, Alta. (March 15), Fredericton, NB (March 28), Vancouver, BC (April 2), Whitehorse, Yukon (April 17), and Regina, Sask. (May 10). Attendance at the meetings ranged from 20 to 70 members. There were no consultations in Quebec because a government-led public consultation had already been held in the province.

The online dialogue opened in late February and continued until the end of May. More than 1,200 members registered for the site and almost 200 comments were posted.

All of the meetings and the online dialogue were moderated by Dr. Blackmer, with the exception of the Edmonton meeting, which was moderated by CMA Board of Directors Alberta representative and Board representative to the CMA Committee on Ethics, Dr. Chip Doig. Unlike the public town hall meetings, which were structured to educate the attendees and ensure the range of issues from advance care directives to palliative care and euthanasia and physician-assisted dying

THE CARTER CASE AND THE SUPREME COURT

In 2011, the British Columbia Civil Liberties Association, Dr. William Shoichet, Gloria Taylor, who had an incurable disease, and the Carter family challenged the law against euthanasia and physician-assisted suicide. In 2012, the BC Supreme Court ruled the Criminal Code of Canada provisions against assisted dying violate the rights of the gravely ill and gave Parliament one year to rewrite the laws.

The court also granted Taylor, who had Lou Gehrig's disease, the right to an assisted suicide, making her temporarily the only Canadian to legally have this right. However, Taylor died in 2012 without making use of this right. Kay Carter ended her life by travelling to Switzerland and availing herself of the right to assisted dying in that country.

The federal government appealed the BC Supreme Court decision; the BC Court of Appeal overturned the lower court ruling in October 2013 and upheld the ban, stating in part that it was bound by the Supreme Court of Canada's 20-year-old decision concerning the Sue Rodriguez case (in which the Supreme Court reached a 5-4 split decision to uphold the ban).

The Supreme Court of Canada granted the British Columbia Civil Liberties Association, the family of Carter and others permission to appeal the case. The Supreme Court of Canada is scheduled to hear the case on Oct. 14, 2014, and the CMA has been granted intervener status in the case as "a friend of the court." The federal government has said it has no intention of changing the existing criminal law against physician-assisted dying.

BILL 52 AND QUEBEC

In 2013, after four years of cross-province consultations, the Parti Québécois government introduced *Bill 52 — An Act respecting end-of-life care*. The bill would have legalized "medical aid in dying."

The legislation also mandated the provision of palliative care services in the province, set protocols for doctors sedating suffering patients until they die naturally and provided guidelines to help competent patients who want to end their life because of unbearable physical or psychological suffering. Two physicians would have to approve the request for medical aid in dying, which would have to be made in writing.

The Quebec Medical Association (QMA), the Quebec College of Physicians, the Federation of Quebec Medical Specialists and the Federation of Omnipractitioners of Quebec all publicly supported the legislation. The QMA released a poll in September 2013 showing that 66% of physicians in Quebec support medical aid in dying.

In February 2014, the Quebec National Assembly was dissolved and a provincial election was called before a final vote approving the legislation could be held. However, following his election in March, new Quebec Premier Philippe Couillard said one of the first actions of his government would be to reintroduce Bill 52. The legislation was voted on and passed by a free vote in the National Assembly in June 2014 by a majority of 94 to 22.

Legislators and the medical profession in Quebec have described the legislation as being health related and thereby subject to provincial jurisdiction. However, physician-assisted dying is banned under the Criminal Code and the federal government has stated that it will review the proposed legislation.

were all discussed, the member meetings were designed to provide members with more opportunity to focus on specific issues that concerned them. The same strategic questions, provided for framing purposes, were used in all the member sessions. In the online dialogue, discussion questions were posted by Dr. Blackmer and covered the spectrum of end-of-life care issues.

The member meetings were marked by participation from physicians across the age spectrum and from a variety of specialties, with a significant representation of palliative care physicians. As in the public town halls, many participants in the member meetings sought clarification about the language used in discussing end-of-life care and the situation in other countries and some US states where some form of physician-assisted dying is legal.

Each of the member meetings had a slightly different tone and emphasis. However, it was clear that the main issue the majority of members wanted to discuss was physician-assisted dying and the role of the medical profession. This was graphically demonstrated in the online dialogue, where 80% of the comments dealt with euthanasia and physician-assisted dying and the current CMA policy addressing these issues. The status of palliative care services and the fundamental association between the availability of palliative care services and the desire medical aid in dying was also a major theme at all member meetings.

ADVANCE CARE DIRECTIVES

Just as in the public town hall meetings, speakers at the member meetings were almost unanimous in voicing support for advance care directives and the need for earlier discussions with patients about these issues.

"I think we should make advance health care directives mandatory—either by incentivizing them as a tax credit or making them a requirement for keeping your drivers' licence at age 60. We have to push advance health care directives a lot more because

that starts the discussion that we need on end-of-life issues earlier when you are young and healthy.”

— Meeting participant

“I do believe more widespread use of advance directives will help resolve issues that can arise between physicians and families during a patient’s last days. The patient’s wishes should direct the care, and the advance directive, created when the patient is competent, should provide the guidelines. Advance care directives can save the health care system money (probably lots) by avoiding unwanted interventions which can be very expensive in end of life situations.”

— Online dialogue participant

“We keep talking about engaging the public on their journey and I think we need to start sooner. It’s too late when they’re lying in bed unresponsive after a massive stroke, explaining to the family that medical evidence indicates that you don’t suffer if we turn off your IV and you don’t suffer if we don’t feed you. We need to engage the public earlier on before the issue is even with them to be available to access resources to say ‘this is what we know about the dying process’ so that people are in a way better frame of mind way before they enter the palliative care process. I think North Americans are clueless about dying.”

— Meeting participant

“There need to be resources for different cultural communities with regard to advance directives. Some cultures have taboos around discussion of future death or serious illness, and we need to learn the acceptable ways to approach these subjects.”

— Online dialogue participant

One physician talked about the comfort level of physicians in discussing advance care directives and the “long, involved conversations with patients and their families. You can’t do that in 10–15 minutes. It’s taking hours to have these

conversations about end-of-life care. Yet our culture in medicine is not to be able to give that time.”

A resident at one meeting expressed concern about having to tell a patient with a chronic disease that she attended in hospital that the patient’s condition had a 100% mortality rate at three years. She said it was difficult and inappropriate for residents to have to deliver this kind of information in an acute care setting. Others also voiced the need for physicians to be more forthcoming with patients who had chronic or terminal illnesses about their prognosis and the probable course of their illness.

However, support for physician involvement in advance care planning was also voiced. “As family physicians we have to step up to the plate and realize that advance care planning is part of complex care management and it has to be integral to complex care planning. I don’t think we’re doing a very good job of it at present,” said one meeting participant.

“In family practice I find it very helpful if possible to have a conversation with the patient and their designated decision-maker. In a crisis so often family members or friends feel as if they are being asked to decide that their loved one must die by refusing heroic or futile treatment and this is a heavy burden. It really helps if they understand that instead they are being trusted to be the mouthpiece for the ill person, to tell us what he or she would say if they were able.”

— Online dialogue participant

Of the 108 members who responded to the online poll concerning advance care directives, only 11% said they discussed end-of-life issues with all their patients. The majority of respondents said they just discussed these issues with patients who had chronic or terminal conditions (55%).

Of those who said they did discuss such issues with patients, a slight majority (52%) said they advised these patients to complete an advance care directive. Asked whether they had the necessary resources

to advise patients on this, 55% responded positively.

Only 37% of those responding to the poll said they had prepared an advance directive for themselves, with the main reason being that they had not thought about it. Concerns that a written advance care directive may not be up to date or accurately reflect one’s views at a future date were expressed by some members, much as they were by members of the public during the public town hall meetings.

“The deep implicit knowledge my closest family have of me and of my worldview is a much safer basis to leave in place when I am at a stage in my life in which any number of unforeseen scenarios could arise and bring about either my death or my disability. An advance directive at a time when I have no terminal illness and no idea as to what my circumstances will be in the days prior to my death would be too blunt an instrument to put in place.”

— Online survey respondent

PALLIATIVE CARE

“Physician-assisted death is a very small part — if at all — of quality end-of-life care. I approach end-of-life care under the guise of quality improvement. Most of the time, in acute care, people don’t die suddenly. We really have an opportunity to make sure that we get things right. What I’ve come to learn through the years and what I have learned through our families is that someone can have an excellent health care experience [but during] the few days I spend with them [as a palliative care specialist] if we don’t get that right, it really marks the whole experience in a negative way. Similarly, we have folks who come through who’ve had a terrible health care experience. We do have an opportunity to turn that around and provide them with a good death.”

— Meeting participant

“I think the vast majority of Canadians do not have access to good palliative care.”

Until every Canadian has access to really state-of-the-art palliative care it's premature to talk about that [physician-assisted dying]."

— Meeting participant

"We have all the tools so people do not have to fear suffering."

— Meeting participant

The current status of palliative care in Canada was another major issue of discussion at the member meetings and the online dialogue.

Comments touched on the inadequacy of palliative care services driving demands for medical aid in dying, the lack of palliative care services outside of major urban centres, the lack of training of family physicians and others in proper palliative care, the need for enhanced training in pain and symptom management and earlier referral to palliative care to improve patient quality and length of life, and the lack of proper remuneration for providing palliative care services.

"We need primary care physicians to be able to do primary palliative care. After 25 years in this business [as a primary care physician] I'm delighted to notice the improvements in the basic knowledge of family doctors and their willingness to provide comprehensive care. The willingness of attending physicians in hospitals to do their own primary palliative care is amazing."

— Meeting participant

More than one physician talked about the professional and personal satisfaction to be gained from providing palliative care to dying patients. One mentioned a patient with ovarian cancer who talked about feeling guilty for using up so much of the physician's time every day, whereas the physician said she received more joy working with that patient than from any other part of her work. Another meeting participant talked about Aboriginal culture and the fact that participating in the death of an individual was seen as gift from that

person to those who participated.

"There is a generation of physicians out there who have never had the opportunity to get the training [about palliative care]," said one meeting participant. This comment was echoed by students and residents in the current system who felt their training concerning palliative care was still inadequate.

"It is essential that every family physician feel comfortable doing basic palliative care and not be afraid of narcotics."

— Meeting participant

"We need support to develop a strategy to support education and practice supports for both practising physicians (and other health care providers) and undergraduate and postgraduate students. This would enable the uptake of a palliative approach to care for all health care providers. As well, we need to implement more education at the undergraduate level. Currently 10 of 17 medical schools have less than 10 hours of palliative care education. That needs to be addressed. Another thing that should happen is that all medical and surgical specialties need to do a mandatory 2- to 4-week placement in palliative care to promote awareness and ensure appropriate referrals and linkages to palliative care specialists."

— Online dialogue participant

"Palliative care needs to be better remunerated so physicians will be more valued in that role," said one meeting participant. Another meeting participant detailed work done to improve the fee schedule for palliative care services that has not yet been implemented by the provincial government.

One member noted the perverse financial incentives in the existing fee schedules. He detailed his decision not to intubate a patient but rather hold four family meetings with different family members from 7:00 one evening to 7:00 the next morning to discuss the care being provided. When he submitted the bill, he said, he was told he could bill for only one

family meeting. "If I had intubated the guy and gone home to bed I could have billed \$150. You get 30 bucks to do the right thing or 150 bucks to do what I consider to be the wrong thing."

The changing scope of palliative care in Canada was recognized by some speakers who noted how it is now no longer considered just the domain of those treating patients with terminal cancer.

One speaker referenced the CMA General Council meeting of 1995 in which euthanasia was rejected but a call for a national forum on palliative care passed unanimously. He said this strong interest in enhancing the palliative care system failed to result in adequate resources being put into palliative care at that time and he called for physicians to unite to more vehemently lobby to properly fund these services.

However, some speakers questioned whether even outstanding palliative care services would totally resolve questions about physician-assisted dying.

"There are some kinds of suffering that palliative care cannot solve," said one speaker, specifically referencing the mental deterioration associated with dementia. Others referenced intractable but not terminal conditions such as depression or schizophrenia, for which palliative care approaches may not be appropriate.

One hundred and thirty members responded to the online quick poll concerning palliative care. Of these, more than 88% said they were somewhat or very familiar with the palliative care services available in their community with a further 6% stating that the question was not relevant to their practice. However, only a third of respondents felt the services in their community were adequate to meet the needs of their patients.

EUTHANASIA AND PHYSICIAN-ASSISTED DYING

"It's naïve for us to believe we will ever have full consensus on an issue like this."

— Meeting participant

The CMA policy (see sidebar) against physician involvement in euthanasia and physician-assisted dying and whether it should be either maintained or changed was a dominant theme both at the town halls and in the online comments. Discussion around the appropriateness of physician involvement in euthanasia and physician-assisted dying was wide ranging and swung from the personal to the philosophical and back in many venues. It is worth noting that despite the emotional nature of the subject matter and comments made, all of the town halls and the online dialogue were conducted with a high degree of decorum and respect for opposing viewpoints.

All member meetings and the online dialogue featured diametrically opposed views on physician involvement in medical aid in dying and support for, or opposition to, the current CMA policy. For example, one meeting featured participation by both the chair of the medical advisory committee of Dying with Dignity and the chair of the provincial euthanasia prevention coalition.

Another instance featured the following statements by two different participants:

"I am firmly against euthanasia. The day that my college and my profession say this is now a standard and that either I have to participate in it or I have to refer someone to it as part of my professional standard is the day that I actually drop my physician designation."

"My mum was diagnosed with early onset dementia in her early 50s. She was young and she was healthy and we watched and we waited. She was an empty carcass a long time ago. One day I was feeding her — she could still take soft food — and I noticed her tongue was torn in two. Nobody knew that this had happened. It probably happened during one of the procedures she had had. She suffered and suffered and there was no point to that suffering. There are patients out there who need our compassion and our strength. I'm not talking about palliative care. We were waiting for her to die and there was nothing but suffering.

It's not about denying appropriate care to patients. This is acknowledging there is suffering that is happening and maybe we can do something about it. There wasn't a time when I didn't think if I was a good daughter I would take care of this for her but there was not an avenue for that to happen."

The opposing views on medical aid in dying itself were matched by divergent opinions of the current CMA policy on euthanasia and physician-assisted dying. In one meeting, one participant said, "I don't like the current policy. To say it's not nuanced is an understatement." At the same meeting, another physician said he and his colleagues liked the policy. "We find its clarity refreshing," he said.

Supporters of the current CMA position cited the following main reasons for their position:

- Legalizing medical aid in dying would negatively affect the trust patients have in physicians and would jeopardize the physician–patient relationship
- The physician role is to heal, not end life.
- Legalization is "a slippery slope" and would lead to an increase in the scope of conditions and patient populations for which physician-assisted dying can be applied — especially vulnerable populations.
- Legalizing physician-assisted dying could be used for economic purposes to save money in the health care system.
- Those advocating a change in the CMA position cited the following in support of their views:
 - There must be respect for patient autonomy, and physicians need to accompany patients as a partner.
 - Medical aid in dying is a form of medical care and part of the palliative care continuum — despite most palliative care physicians consistently and definitively stating the opposite.
 - There are forms of suffering that palliative care services are not sufficient to ameliorate and/or reflective of patient wishes.
 - Strict regulations can protect against

The CMA Policy on *Euthanasia and Physician-Assisted Dying* states, in part:

"Physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition of euthanasia and assisted suicide."

"Canadian physicians should not participate in euthanasia or assisted suicide."

"For the medical profession to ... participate in these practices, a fundamental reconsideration of traditional medical ethics would be required."

"The CMA recognizes that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. The CMA wishes to contribute the perspective of the medical profession to the examination of the legal, social and ethical issues."

widening the indications for medical aid in dying if it became legal, as evidenced by other jurisdictions.

Speakers and online commentators also repeatedly referenced practice issues associated with euthanasia and physician-assisted dying. Among the issues cited by some were the following:

- There may be difficulties in assessing competency and voluntariness in end-of-life situations in the emergency department and other acute-care settings.
- Euthanasia and physician-assisted dying are already being practised illegally in Canada to hasten death, and there was some debate about the role of palliative sedation and the key issue of intent.
- Physicians could be forced to participate in physician-assisted dying if it became legal.
- There are implications of legalizing medical aid in dying on the profession's

Code of Ethics and malpractice insurance, along with broader resource considerations.

- “Overtreatment” can be a major factor influencing patient concerns about care at the end of life.

A sample of some of the differing views that were expressed is provided below.

Opposed to changing the CMA policy:

“As an orthopedic surgeon I routinely treat elderly patients with hip fractures. Surgery is considered a purely palliative procedure for a portion of my patients, even if they have multiple medical comorbidities and may not be expected to survive long post-operatively. I am personally alarmed by the possibility that I would have to be involved to any extent in euthanasia for these patients.”

— Online dialogue participant

“It takes time to get beneath the surface level with a patient and a relationship of trust to do so. But I feel that as a medical doctor, this is my calling: to take the time with my patients and to address their genuine needs and concerns. I would suggest that requests for euthanasia and physician-assisted suicide are symptoms that point to a deficiency in our medical system for ‘holistic’ care, and demand from us, the medical community, careful and thoughtful discussion. Rather than simply accepting such a request at its surface value, we need to recognize that such bidding is an indicator of deeper issues and take the time to address them. ... we need to hold fast to our ethical foundations. Our role as medical doctors is not that of executioner. Rather, our mandate, as in the words of Dr. Edward Livingston Trudeau, is to cure sometimes, relieve often, and comfort always.”

— Online dialogue participant

“With people coming into an extended-term care facility, there is really an underlying suspicion that I’m out to get them. I’m

talking about advance care directives and there are red lights going off with the patients thinking, ‘Oh, I’m not going to get the appropriate care and they’re going to let me die,’ etc.”

— Meeting participant

“... actively inducing death in a patient means that I have given up on options for palliative care. The field of palliative care has progressed to the point, in 2014, that death need not be a painful or anxious situation. If it is, we are failing our patients and not working hard enough to provide care.”

— Online dialogue participant

In favour of reviewing the policy and/or in support of euthanasia and physician-assisted dying:

“If some well-safeguarded method (for euthanasia) is produced and put into place in Canada I would be happy because it would give Canadians autonomy.”

— Meeting participant

“I agree that surrounded by a loving community, and provided with gold standard palliative care, most terminally medically or psychiatrically ill patients would in the end choose not to commit suicide. The unfortunate reality is that many individuals suffer the pain of their illnesses in isolation, or suffer from the kind of pain that is incompatible with any meaningful quality of life, and I find myself wondering why we would insist, still, that their lives must be preserved at all costs. There is no doubt in my mind that each and every life is worthy, beautiful, and precious, and that the loss of any life is tragic and irrevocable. However, the best palliative care does not always provide relief, and the idea that such a precious life would be forced to exist in interminable agony, moment after moment and day after day, horrifies me. If a life is truly that precious, surely a living being deserves relief from unbearable pain, and if that relief can only come in the form of death, surely there should be a humane way to allow this.”

— Online dialogue participant

One of the main areas of concern for those opposed to changing the current policy was the potential conflicting role facing physicians if they were to become involved in actively participating in medical aid in dying. One meeting participant noted that when the physician goes to the bedside of the patient the patient should not be confused about whether the physician is there to comfort or to cure them. If this becomes ambiguous, he said, “then our profession will be compromised.”

Others saw the issue as being much more straightforward, with physicians having a clear moral and professional obligation to heal and not to have any part in hastening the death of patients.

Those who felt it was time to revisit the CMA policy on euthanasia and physician-assisted dying focused on the need to respect patient autonomy and referenced the inadequate nature of current palliative care in Canada and the suffering that results as well as the need to reflect patient treatment choices to reject some forms of palliative care that do not accord with personal wishes.

The question of whether it was appropriate for physicians to bring their own personal values and beliefs into how they practise was also raised, and one meeting featured a fairly extensive discussion about physician’s views about how they would want their own life to end. The need to recognize conscientious objection on the part of physicians was referenced but so was the belief that physicians do not have the right to morally judge patient wishes. At one meeting it was noted that some of the most vociferous advocates for changing the current law against medical aid in dying are physicians

Asked in the online survey which life-sustaining treatments they would choose for themselves if they had irreversible brain damage and could not communicate with or recognize people, 85% selected pain medication but only a minority chose other interventions such as mechanical ventilation or use of a feeding tube.

Interpretations of the environment where some form of euthanasia or physician-

assisted dying is already legal varied widely among physician participants, as evidenced in the following statements. It was clear from the comments that there is clearly still a degree of misunderstanding about the current legal environment outside of Canada.

"No matter how stringent the protocols and so-called safeguards, studies of the PAD [physician-assisted dying] practices in Holland and Belgium show that they are not followed. A study that was published in the Canadian Medical Association Journal (June 2010) showed that 32% of euthanasia deaths in the Flemish region of Belgium were done without explicit request. A meta-analysis that appeared in The Lancet (July 11, 2012) concerning euthanasia and end-of-life practices in the Netherlands indicated that in 2010, 23% of all euthanasia deaths were not reported."

— Online dialogue participant

"Belgium legalized euthanasia about 10 years ago now and recent legislation this year will likely allow the euthanasia of children in that country. If that is what happens after only the 10 years then 'no thanks.' This is proof of the slippery slope. Need I say more?"

— Online dialogue participant

"Belgium has blazed the trail of what not to do. We have legions of physicians and non-physicians who would stand steadfast, shoulder to shoulder, to make sure we do not go down any kind of the slippery slope."

— Meeting participant

"The concept of the 'slippery slope' isn't necessarily there. It's largely people of white ethnic origin, with relatively good socioeconomic status, who are requesting euthanasia for a specific reason."

— Meeting participant

"Presumably the sky is not falling in Oregon or Belgium."

— Meeting participant

"In the Netherlands there is universal access to palliative care at no cost to the patient."

They warn that any country that doesn't have universal access to free palliative care services should be very, very careful in providing access to physician-assisted death."

— Meeting participant

The economic pressures facing Canada and the impact this might have on the health care system and the call to legalize physician-assisted dying were mentioned in several meetings.

"We will probably, as a society, go down the path of allowing some sort of assisted death because of the economic drivers. There will not be enough young people creating economic wealth for our country to sustain elderly people in their frailty in total care" was how one speaker characterized the situation.

Others talked about wanting to keep physician-assisted dying illegal so as to spare physicians undue pressure from hospital administrators wanting to free up hospital beds.

"We all want enhanced choices at the end of life but (it) may be naïve to expect that ... autonomy will be enhanced by giving this extra power to a state-run health care system to have the suicide option constantly dangling in front of those who could qualify for it."

— Meeting participant

One hundred and fifty-one members responded to the online poll concerning the CMA Policy on Euthanasia and Physician-Assisted Suicide. Of these respondents, 71.5% agreed with the existing policy while 25.8% said they disagreed with it and 2.6% said they did not know. These numbers are in keeping with the results of earlier polls conducted by the association. Of the 39 who provided suggestions for revising the policy, the majority advocated changing it to support some form of physician-assisted death.

Given a variety of options for what the CMA should do if the law was changed to make physician-assisted dying legal in Canada, respondents voted for the following:

- Ask that physicians be allowed to follow their own beliefs and refer patients requesting euthanasia or assisted suicide to other physicians if they do not agree (58.9% of respondents).
- Work to ensure procedures for enabling euthanasia or assisted suicide are clear for both physicians and patients (47% of respondents).
- Provide tools and resources to help physicians best comply with patient's wishes (33.8% of respondents).

PRACTICE ISSUES

The highly sensitive issue of possible current physician involvement in practices that may be illegal was raised at more than one meeting. If it does happen, "I want it to be done well and I want it to be done in a situation where the doctor is supported," one physician noted, underscoring comments made at other meetings about the need for better education about pain and symptom management. "Anecdotally we hear these things are happening but there is no way to know for sure," Dr. Blackmer said in response to a participant at another meeting who stated their opinion that the practice was taking place "under the radar."

"Euthanasia at some level has been going on for some time already. The people who are accessing it depend on the physician you are seeing. It is mostly higher functioning patients that are literate in their health care and hospital care. I think it's unfair when one section of society has possible access to something which could be of benefit that is not available to the greater portion of society."

— Meeting participant

"There are conditions where we actually assist death — it happens in the ER and it is occurring."

— Meeting participant

Discussions about use of morphine at the end of life were also prompted by varying interpretations of "palliative sedation."

Dr. Blackmer explained at the meetings

that while morphine may be used to alleviate pain in the final stage of life and may hasten death, the primary intent in this situation is not to end the patient's life but to relieve their pain and suffering. While some participants felt this emphasis on intent was quite correct others saw it as being somewhat hypocritical.

"The boundaries between some of these definitions are much more blurred and uncertain than the document would make out. The only difference in some of these terms is the intent of the practitioner. It's not as clear-cut as this document would have us believe."

— Meeting participant

The perspective of removing physicians from the equation if physician-assisted dying becomes legal in Canada arose at several public town hall and member meetings.

"We have no training in killing people, quite the opposite" was how one member framed it.

"I think that if the law is changed they need to pick on someone else to be the euthanologist. It's not going to be me and I suspect it's not going to be most of my colleagues," said an attendee at one meeting. However, other members felt it was the physician's duty to play a role even if they were not comfortable personally with physician-assisted dying as a reflection of supporting patient autonomy and consideration of patient-centred care.

CMA ACTIONS — NEXT STEPS

"It's not 'if' the law changes, it's 'when'."

— Meeting participant

Given the diversity of views on end-of-life issues it is not surprising that the CMA was not given a clear mandate on future activity dealing with the sensitive area of euthanasia and physician-assisted dying.

However, CMA members were aligned with the public in voicing support on other end-of-life issues:

- the importance of discussing advance care directives with patients in a timely manner
- the need for a national palliative care strategy and adequate resourcing of such a strategy and adequate physician remuneration for providing palliative care services
- the need for better training for physicians in providing palliative care and discussing advance care directives at all levels and across a broad spectrum of specialties

When the feedback from all of the consultations is considered, it is clear the majority of CMA members favour maintaining the current CMA policy opposing physician involvement in euthanasia and physician-assisted dying. However, a significant minority felt this policy should be revised to support some form of physician-assisted dying in Canada.

The majority sentiment of those participating in the dialogue is that the Canadian law will be changed sometime in the near future to allow some form of medical aid in dying.

"I think it is coming to Canada and I would argue that when it does come even if 99% of physicians don't agree with it, if it's ruled that it is no longer criminal and there are physicians who believe in it and are willing

to support patients with it, I think the CMA would have to support those physicians."

— Meeting participant

A strong minority voiced the viewpoint that it is premature to consider changing the law in Canada until a comprehensive and universal palliative care system is put in place.

Many dialogue participants spoke of the right of physicians to voice their views on the topic especially with respect to how it would affect how they practise.

"We need guidance for ourselves and we need to play a role to have structures like there are in Oregon so we don't end up in a situation where things are happening that are not in our control. If the law changes and public opinion changes, we're behind."

— Meeting participant

Many felt the CMA should advocate for removing physicians from the process of euthanasia and lobby for some other group to provide these services. Many called for the CMA, at a bare minimum, to protect the rights of physicians who do not want to provide euthanasia services, a stance that was adopted at the CMA General Council meeting last August.

Finally, there was a general acknowledgement that society would make the final decision concerning euthanasia and physician-assisted dying and that it was not the role of the CMA or the medical profession to dictate what this should be, as a reflection of patient-centred care.