Dying with Dignity Tasmania (Inc)

THE CANADIAN MEDICAL ASSOCIATION AND VOLUNTARY ASSISTED DYING - A GOOD EXAMPLE FOR OTHER MEDICAL ASSOCIATIONS

"Physicians are committed to providing high quality care at the end of life. They are also committed to maintaining their patients' quality of life. There are rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying. In such a case, and within legal constraints, medical aid in dying may be appropriate. The CMA supports patients' access to the full spectrum of end of life care that is legal in Canada. 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."

This is the introduction to the updated Canadian Medical Association (CMA) policy, "Euthanasia and Assisted Death", Update 2014[1]. It replaced the previous one that no longer adequately reflected the views of its members and which had stated: "Canadian physicians should not participate in euthanasia and assisted suicide". It provides an excellent model for the AMA in the current review of its policy with a similar statement.

The new CMA policy and other action of the Canadian Medical Association related to voluntary assisted dying provide an example of responsible, professional and principles-based policy and action which should be emulated by the Australian Medical Association (AMA) and other medical groups in Australia. The CMA policy and other related reports and documentation provide valuable resources for them to do so.

This paper sets out why the CMA's approach is such a good example of responsible, professional and principles-based policy and action, what they have done (with links to more detailed, relevant material), and how it contrasts with the AMA policy, expressed views and approach.

WHY THE CMA APPROACH TO VOLUNTARY ASSISTED DYING IS A GOOD EXAMPLE OF RESPONSIBLE, PROFESSIONAL AND PRINCIPLES-BASED POLICY AND ACTION

1. The CMA has been pro-active, taking a leadership role in the debate in Canada on end of life issues, including voluntary assisted dying[2], so that the association could be "well-positioned to provide guidance that would serve patients and physicians better"[3].
2. The CMA acknowledges the reality that some people have high levels of suffering that cannot be relieved, even when they have access to palliative and other end of life care. It accepts doctors' responsibility to these patients and recognises that, when providing assisted dying, doctors' primary intention is to relieve patients' high levels of suffering.
3. The needs and wishes of patients are integral to the CMA approach which acknowledges and reflects the broad role and responsibilities of doctors to themselves, their colleagues, their patients and the society. Their policies are consistent with, and linked to, the core

values and principles set out in the CMA Code of Ethics[4] which guide the broad professional and ethical responsibilities of the medical profession.

4. The voluntary assisted dying issue is considered as an integral component of the broader issue of end of life care and action needed to meet the needs of patients and doctors.

5. The CMA policies and action are well-informed, based on thorough research, extensive consultation, interactive dialogue and open debate within the Association and with the broader public. Detailed material has been provided to members to inform them, to clarify issues and to report developments.

6. Their policy development has been fair and even-handed, presenting and respecting different views and the rights of doctors with different values and beliefs.

7. The approach recognises and reflects the changes in medicine and in the attitudes of the community and doctors that has led to higher levels of support for legal voluntary assisted dying. CMA surveys have found that their members are evenly divided on the issue of legalising assisted dying, and a significant minority have indicated they are willing to offer this service to their patients when legal.

WHAT THE CANADIAN MEDICAL ASSOCIATION HAS DONE

1. **Initiated a dialogue with doctors and the public on end of life issues, including voluntary assisted dying:** As a result of deliberations at its annual General Council meeting in August 2013, the Canadian Medical Association decided to take a leadership role and conduct an ongoing dialogue with both the medical profession and the public on end-of-life care issues.

   (a) The dialogue with Canadians early in 2014 included a series of 'town hall meetings' in all regions of Canada and live web chat "focussed on three main issues: advance care directives, palliative care and euthanasia and physician-assisted dying". Details are set out in the report, *End-of-life Care: A National Dialogue*, June 2014[5]. Key points include:
   - The aims of the dialogue were to seek input from Canadians to inform the medical profession, and to inform, educate and provide clarity to the public on terminology and the current situation in Canada and abroad.
   - Members of the public had diametrically opposed views on "euthanasia and physician-assisted dying".
   - Common ground included the importance of advance care directives and the need for a comprehensive palliative care strategy in Canada.

   (b) Member consultation in 2014 included meetings and a website for member comment on various issues. Details of this member dialogue process and the different views expressed are set out in the report, End-of-life Care: A National Dialogue - CMA Member Consultation Report, July 2014[6]. It was reported that "It was clear that the main issue the majority of members wanted to talk about was physician-assisted dying and the role of the medical profession" and "Given the diversity of views … the CMA was not given a clear cut mandate on future activity" dealing with the issue.

2. **Survey of members to get up-to-date, good quality evidence of the diversity of views:** At the annual General Council meeting in August 2014, the results of the 2014 survey of 5,000 CMA members were presented:
   - 44.8% were in favour of legalising 'physician-assisted dying' [patients self-administer]
   - 36.3% were in favour of legalising 'euthanasia' [drugs administered by doctors]

- 26.7% said "they would be likely or very likely to participate if physician-assisted death was legalised". [7]

3. **Ongoing discussion and debate leading to detailed policy updates and development :** These projects have been followed up by extensive discussions, debate at annual meetings and in the CMA Board, votes, research and policy development including:

   - **Decision adopted that doctors "have the right to follow their own conscience when deciding whether to provide medical aid in dying"[8]:** At the August 2014 General Council, 91% voted in favour of the resolution to allow doctors to follow their own conscience in deciding whether or not to provide assisted dying when it became legal.[9]

   - **Updated policy in response to members' support:** Also at the August 2014 General Council, "a straw vote of delegates taken at the meeting showed 70% felt the CMA should revise its existing policy on euthanasia and physician-assisted death, which opposes physician involvement in medical aid in dying. As a result, the updated policy (see endnote 1) was developed and adopted by the CMA Board at its December 2014 meeting.

     The features of the policy are:
     - The definitions which clarify the terminology
     - The statement of basic ethical principles underpinning the policy, all from the CMA Code of Ethics and reflecting doctors' responsibilities to their patients and the profession's responsibility to society
     - It reflects the decision that doctors have the right to follow their own conscience on providing 'medical aid in dying'
     - It "recognises that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted death should be changed" and "the CMA wishes to contribute the perspective of the medical profession". This includes key concerns that must be addressed, "whatever the legal status of euthanasia and assisted death", such as provision of adequate palliative care for all Canadians.

   - **Consultation with medical associations with experience in providing legal voluntary assisted dying:** The CMA has consulted with and received information and advice from medical associations with experience in providing legal voluntary assisted dying. This has included a presentation at the 2014 annual meeting by a representative of the Royal Dutch Medical Association who assured members that since the passing of the Netherlands legislation "there has been no 'slippery slope' or widening of indications for the practice"[10]. In anticipation of the then imminent Canadian Supreme Court decision[11], the CMA consulted other associations in order to be prepared for 'all eventualities' including being ready to provide input into any legislation that may follow the decision.[12]

4. **Development of principles-based framework on what CMA wants in legislation:** At the August 2015 annual meeting, a number of resolutions were passed on end-of-life care including: "21. The Canadian Medical Association will advocate for the adoption of a framework for physician participation in medical aid in dying that is based on the principles of respect for patient autonomy, equity, respect for physician values, consent and capacity, clarity, dignity of life, protection of patients, accountability, solidarity and mutual respect. (SP 0-13)"

Some consultation has taken place on the draft document, 'Principles-based Approach to Assisted Dying in Canada'[13], to represent the views of members and patients on what should be reflected in legislation. More details of the consultation on the document are included in a Summary Report prepared for the 2015 annual meeting, "A Canadian Approach to Assisted Dying: CMA Member Dialogue"[14].

The framework is based on the Canadian Supreme Court decision and is very close to the model generally being proposed in Australia including the Tasmanian 2013 Proposal and the *Voluntary Assisted Dying Bill 2013.* The sections of the framework include:

- Details of the Canadian Supreme Court decision in February 2015
- Recent CMA activities
- Strategic questions, eg For those physicians who refuse to participate in assisted dying for reasons of conscience, how do we reconcile this refusal with their obligation to ensure equitable access? What mechanisms can physicians employ to ensure this access?
- Detailed section - Draft Principles-based recommendations for a Canadian approach to medical aid in dying
- Comparison of legislative criteria across jurisdictions.

CONTRAST WITH THE AMA POLICY AND APPROACH

The policy and approach by the AMA and its State branches to the issue of voluntary assisted dying legislation are in stark contrast to the CMA approach. The groups representing the medical profession in Australia have provided no proactive leadership on the issue and there is no evidence of initiatives such as those of the CMA to research the issue and consult with other medical associations with experience of providing legal assisted dying.

They have not sought to inform, educate or seek the views of the members or the public on the range of issues related to voluntary assisted dying, including the different models and possible provisions of its regulation and monitoring. There has been no professional survey of members that would provide the quality of information required for effective representation of the diversity of members' views.

In fact, they seem to have engaged very little with the issue or to do the work required for a professional quality response. Submissions by the AMA and State branches (and other medical and medically based bodies) to parliamentary inquiries and consultations in the last few years demonstrate very poor knowledge and understanding of the issue and include poor quality information and arguments that do not meet their usual professional standards. For example, AMA Tasmania has made emotive claims that assisted dying legislation will "poison" the doctor-patient relationship and such laws pose "a very real danger to the most vulnerable in our community" while presenting no evidence or rational explanation for these beliefs and ignoring the evidence that exists to the contrary.

Andrew Denton in his presentation of the 2015 Di Gribble Argument reveals that the AMA was the only group that declined to be interviewed and answer important questions.[15] He provides other concerning examples about lack of awareness of medical bodies and bias, eg Palliative Care Victoria and the Royal Australian College of Physicians, and comments that he has "been struck, as I have spoken to doctors across the spectrum in Australia, at how little most seem to

know about what these laws mean for their colleagues overseas. They might be surprised to learn, for instance, that, as a direct result of these laws, doctor-patient relationships have improved in all three places". There are many more examples that could be provided.

Unlike the broad input invited by the CMA, the AMA has recently called for member-only input into the updating of their policy, *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007. Amended 2014.* It has also been stated that this input "will be used to inform the next stage of the review process. We will keep all members informed of the progress of the review and further opportunities for member engagement." A members-only process is very unlikely to meet the standard of informed policy development.

It is in five areas that the AMA approach (and that of other medical groups opposed to voluntary assisted dying legislation) is particularly poor compared to the CMA's. These are the flaws that need to be addressed in the review of policy and other responses to the issue of assisted dying to ensure their approach meets their espoused professional and ethical standards:

- The absence of acknowledgement of the people with intolerable and unrelievable suffering and/or the absence of any expression of care, responsibility, compassion or respect for their wishes and choices. For example, the AMA policy being reviewed states: "While for most patients in the terminal stage of an illness, pain and other causes of suffering can be alleviated, there are some instances when satisfactory relief of suffering cannot be achieved". The policy and their other submissions and commentaries are then silent about the people who are suffering without relief and the terrible impact on them and their families.

- The failure to advocate for patients in this situation or to suggest any practical, effective and timely[16] alternatives to voluntary assisted dying legislation. This is despite the claims to represent the interests of patients, eg the AMA Tasmania website states: "By our constitution, we are also 'the' prime body in Tasmania representing the interests of our patients and the whole community on health issues".

- The failure to recognise that the evidence shows the primary reason for patients' requests for assisted dying is the relief of intolerable, unrelieved suffering and the primary intention of doctors providing assisted dying is the relief of that suffering, but only after thorough exploration of alternatives acceptable to patients. The current AMA policy implies the acceptance of the fallacy that their primary intention is the ending of a person's life.

- The failure to provide any representation of the views of members in favour of voluntary assisted dying legislation, to recognise and acknowledge the differences in views or the changes in recent times or to acknowledge that a substantial minority are likely to support some form of assisted dying law reform. The policy under review merely states: "The AMA recognises that there are divergent views regarding euthanasia and physician assisted suicide".

- The failure to respect doctors' different ethical views and their right and professional responsibility to follow their own consciences on providing legal medical services, including voluntary assisted dying services when they become legal.

CONCLUSION

The Canadian Medical Association has provided an excellent example to the AMA and other Australian medical groups to address these flaws and respond effectively and fairly to the issue of voluntary assisted dying to meet the needs of patients, doctors and the wider community.

END NOTES

[1] Available at https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA_Policy_Euthanasia_Assisted%20Death_PD15-02-e.pdf#search=euthanasia

[2] The Australian term, 'voluntary assisted dying', is used in this paper to refer to different forms of legal doctor-provided assisted dying in response to patients' requests, except when quoting directly from documents the more commonly used terms in Canada - 'physician-assisted dying', 'medical aid-in-dying' or the older terms, 'euthanasia' and 'assisted suicide'. When used by the CMA, 'physician-assisted dying' usually means doctors provide a prescription to patients to obtain lethal drugs that patients self-administer. 'Euthanasia' usually refers to doctor-administered lethal drugs, usually delivered by injection.

[3] https://www.cma.ca/En/Pages/cma-updates-assisted-dying-policy.aspx

[4] The CMA Code of Ethics is very similar to the AMA Code of Ethics. The codes are available on their websites.

[5] Available at https://www.cma.ca/Assets/assets-library/document/en/advocacy/end-of-life-care-report-e.pdf

[6] Available at https://www.cma.ca/Assets/assets-library/document/en/advocacy/Englishreportfinal.pdf

[7] 'Physician perspective on end-of-life issues fully aired', CMA, 19 Aug 2014 (https://www.cma.ca/En/Pages/Physician-perspective-on-end-of-lfe-issues-fully-aired.aspx)

[8] Ibid

[9] "Conscience should guide doctors at end of life", http://www.cmaj.ca/site/earlyreleases/19aug14_conscience-should-guide-doctors-at-end-of-life.xhtml

[10] See note 7.

[11] For relevant details of the Canadian Supreme Court decision, see the document in note 13.

[12] http://www.thestarphoenix.com/health/Doctors+quietly+prepare+assisted+dying/10672703/story.html

[13] https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/care-at-the-end-of-life-cma-framework-june2015-e.pdf

[14] https://www.cma.ca/Assets/assets-library/document/en/advocacy/Canadian-Approach-Assisted-Dying-e.pdf

[15] DwDTas put similar questions to AMA Tasmania on two occasions in 2013 but did not even receive the courtesy of an acknowledgement, let alone answers.

[16] Future improvements in palliative care are essential but are not a panacea for all suffering and do nothing to relieve current suffering.

This paper has been prepared by Margaret Sing, President, Dying with Dignity Tasmania; 23 November 2015.