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CMA's "third way" may be a third rail

Responding to articles by CMA officials (BMJ 2019; 364)

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It is disconcerting to find that the CMA's President-Elect thinks that Canadian law "does not compel any physician to be involved in an act or procedure that would violate their values or faith."[1] The state medical regulator in Canada's largest province has enacted policies that do just that, requiring physicians who refuse to kill their patients to find a colleague who will.[2,3] These policies do have the force of law,[4] and objecting physicians were forced to launch an expensive constitutional challenge to defend themselves.[5] The Protection of Conscience Project and others have intervened in the case to support them; the CMA has not.

Further, the Canadian Medical Association's assertion that it has successfully adopted a "neutral" position on euthanasia and assisted suicide (EAS),[1,6] is challenged in a *World Medical Journal* article by seven Canadian physicians. "For refusing to collaborate in killing our patients," they write, "many of us now risk discipline and expulsion from the medical profession," are accused of human rights violations and "even called bigots."[7]

The WMJ authors can't be dismissed as outlying cranks. Almost 60 Canadian physicians from across the country endorsed the article. Signatories included a Canadian Medical Hall of Fame member known as the father of palliative care in North America,[8,9] a member of an expert advisory group on euthanasia and assisted suicide convened by Canadian provinces and territories,[10] and a regional director of palliative care who resigned when a health authority demanded that objecting hospices permit euthanasia and assisted suicide on their premises.[11]

The authors of the WMJ article identify segments of the Canadian medical profession — including the CMA leadership — as having contributed to the redefinition of euthanasia and assisted suicide as medical acts, legalization of the procedures and threats now faced by objecting Canadian health care workers and institutions.

How does this square with the CMA claim that it has been successful in protecting both objecting and non-objecting physicians?

The dissonance between the CMA's glowing self-assessment and the experience of these physicians arises because the CMA is "neutral" in the sense that it supports both objecting and non-objecting physicians, but it is not "neutral" with respect to euthanasia and assisted suicide. The CMA approved both as as forms of end-of-life care even before the Supreme Court of Canada ordered legalization of the procedures.[12]

This development was hinted at when the CMA executive noted "the paramount importance of honouring the will of the patient" in explaining its much cited resolution on "neutrality," rhetorically asking how Canadian physicians could justify refusing EAS to willing patients. The executive offered the non-neutral view that allowing physicians to provide or refuse EAS would "best serve Canadians seeking quality health care."[13] Similarly, the CMA told the Supreme Court of Canada that it seemed wrong to deny assisted suicide and euthanasia to "grievously ill" (not terminally ill) patients simply because palliative care is unavailable.[14]

Acting upon the "neutrality" resolution, the CMA executive reversed Association policy and promised to support patient access to "the full spectrum" of legal end-of-life care, including euthanasia and assisted suicide.[12] When the Supreme Court of Canada later ordered legalization of the procedures,[15] the criteria set by the Court were more restrictive than the new CMA policy. These are not indications of "neutrality" with respect to euthanasia and assisted suicide. Indeed, after the Carter decision, the CMA President called them "therapeutic service[s]";[16] in current CMA policy they are called "legally permissible *medical* service[s]."[17]

Since there is no dispute that physicians have a professional obligation to provide or arrange for therapeutic medical services for their patients, the change in CMA policy implicitly made participation normative for the medical profession (and, by extension, for other health care workers and institutions). From that perspective, as the WMJ article notes, refusing to provide or arrange for EAS services for legally eligible patients "became an exception requiring justification or excuse." Hence, discussion in Canada is now largely about "whether or under what circumstances physicians and institutions should be allowed to refuse to provide or collaborate in homicide and suicide."[7]

The fundamental conflict generated by imposing an obligation to kill upon unwilling physicians was foreseeable and had been foreseen by CMA officials.[18] They knew that the overwhelming majority of Canadian physicians would refuse to participate in euthanasia or assisted suicide.[19] Attacks upon physician freedom of conscience, particularly with respect to referral, were predictable. However, the focus of the CMA leadership in reversing Association policy against the procedures was on the role physicians would play in providing euthanasia and assisted suicide should the law change. As a result CMA officials were willing but quite unprepared to mount a cogent, articulate and persuasive defence of physician freedom of conscience after the Supreme Court ruling.[20]

Since then the CMA has produced a strong defence of physician freedom of conscience in relation to referral,[21] and sound protection of conscience provisions have been incorporated into a revised CMA policy on the procedures.[17] However, by the time these statements appeared, objecting physicians were on the defensive in a treacherous and even hostile environment.

Moreover, to judge from the commentaries commissioned by the BMJ, the CMA leadership has not yet recognized that its decidedly non-neutral affirmation of euthanasia and assisted suicide as therapeutic, patient-centred medical services seriously undermines CMA support for objecting physicians.

Dr. Blackmer correctly states that issues arising from the legalization of euthanasia and assisted suicide remain unsettled in Canada. He fails to disclose that one of them is whether or not the state can compel unwilling physicians to collaborate in suicide or homicide, and punish them if they refuse. The current situation in Canada demonstrates that this is not something medical associations

can safely leave to be worked out after changing policy or law.

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