

From Courtroom to Bedside - A Discussion with Dr. Jeff Blackmer on the Implications of Carter v. Canada and Physician-Assisted Death

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INTRODUCTION

On February 6th, 2015, the Supreme Court of Canada (SCC) concluded that “s. 241 (b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.” [1]. The Court added: “We would suspend the declaration of invalidity for 12 months” [1], to allow the government to respond with appropriate legislation to guide and regulate the practice of Physician-Assisted Death (PAD).

The Canadian Medical Association (CMA) will play a leading role in helping the Government of Canada craft this new legislation. We met with Dr. Jeff Blackmer, the Vice President of Medical Professionalism at the CMA. He holds a Master’s in Medical Ethics from the University of Toronto. He also served as the Executive Director of the CMA’s Office of Ethics, Professionalism and International Affairs and has been the interim Director of Ethics for the World Medical Association in Geneva. In an interview on February 11th 2015, Dr. Blackmer kindly agreed to help us navigate through an array of ethical and practical ramifications stemming from the decision in Carter v. Canada. In this interview, Dr. Blackmer addresses the ethical grounds on which the decision stands, who will potentially qualify for PAD, as well as issues moving forward as a medical profession and legislatively as a nation.

PART 1: RAMIFICATIONS

The SCC’s decision does not require one to be terminally ill to seek Physician-Assisted Death. How does this affect future legislation on who can access such a service?

We need to determine whether that closes that conversation constitutionally or if there is still scope for further input. My feeling is that there would be much more support for a tighter framework in terms of requiring that the patient be terminal.

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This is not to minimize in any way the suffering of people who do not have a terminal illness, it is just that for a lot of doctors, this opens too many doors and generates too many questions. If you look at most of the US states, the laws are very tight [regarding terminal patients]. There has not been any evidence of abuse or slippery slopes, because they are so clear. My conversations with doctors to date indicate more of a comfort level with tight parameters. The Netherlands has broader inclusion parameters and Belgium and Switzerland even more so. Our initial read [of the decision] is that we might have very little ability to influence [how those parameters will be developed in Canada].

The Supreme Court also defines a grievous and irremediable medical condition as including “an illness, disease or disability” [1]. How do we define what is admissible and what is not, for example blindness?

Because grievous [...] is not a technical medical term, what is grievous to one person may not be to another. I think what they intended by “irremediable” was that it is something that cannot be cured. For example blindness would fall into that category. This is where I think we need to be careful. Some people will say those are the type of patients who should qualify and this was the intent. Others say, that is not what this should look like. We will be reaching out to the [CMA] membership, to take the pulse on some of these issues.

The Supreme Court’s conclusion allows for “competent adults”. Do we deprive children of this service? If not, how do we regulate and safeguard that practice?

We have seen from the experience in Belgium and Holland that things have changed over time to include protocols for children and for newborns. In Holland, I do not think it is written into the legislation, but it is allowed implicitly and they have developed protocols [concerning euthanasia in newborns] called The Groningen Protocol [2]. There is definitely a feeling, and maybe for some people a fear that if there was a constitutional challenge based on age discrimination, PAD may have to be also made available to children. The term adult will need to be defined,

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because that varies by province, and I think this should also be federally legislated.

Would chronic depression be admissible as a “grievous and irremediable medical condition that causes enduring suffering intolerable to the individual” [1]?

My reading of it is that yes [chronic depression] probably [would be admissible for PAD]. For example, I look after spinal cord injured patients. For those folks, I think there are a lot of conditions where they would be able to say: I have this irremediable illness, my spinal cord is never going to be cured, I’m in intractable pain and suffering, and I want to access PAD. On a reading of the Court’s judgment, I think that they would qualify for [PAD], which causes some concern amongst medical practitioners. There have been very controversial cases in Europe. There was an elderly woman from Britain who said that she could not keep up with the pace of technology and change, she just did not want to live anymore as it was all too much for her. She was assisted in dying. There are many examples that are [of concern], that [could potentially] qualify based on what the Supreme Court has said.

PART 2: ETHICS

What are some of the ethical principles that guided this ruling and make this a positive outcome and some ethical areas in which this ruling may fall short?

From an ethical and moral standpoint, some CMA members are saying: This is not why I went into medicine. I went into medicine to cure when possible, care always, but not to hasten the dying process. Many CMA members say that PAD muddies those waters; it changes the foundational nature of the doctor-patient relationship. We will need to set parameters to be as clear as we can be, on how that process is going to work, so that when the doctor enters the room, one does not wonder why they are there. From the positive perspective, some members have told us, they feel it is their ethical responsibility to do everything they can to alleviate pain and suffering, up to and including assisted dying. The patient autonomy/self-determination piece is also a big ethical reason why a number of doctors say they want to participate. They want to be able to respect their patients’ final wishes.

You previously mentioned that “The Supreme Court has established this as a right and now it is a matter of defining the parameters of who qualifies”. If PAD is a right, is it not a right for everyone?

Not necessarily, and that argument was put forward at the SCC. Some civil libertarians say: one need not be sick, one just needs to want access. As a society, we can still define those parameters. We can have a justifiable infringement of Charter rights based

on other circumstances, and that is basically what the ruling was in Rodriguez. They said it is an infringement on your [section] 7 Charter rights, but it is a justifiable infringement, based on other societal considerations and concerns, and our obligation to protect the vulnerable.

How do we reconcile this new direction in healthcare with the Hippocratic Oath and other founding principles that have guided medicine thus far, like “first do no harm”?

There are members on both sides of this. Some say: I’m doing harm by allowing my patient to suffer. So, being able to assist them in the dying process is helping me to alleviate that harm, pain and suffering. Others view assisting in dying as harm unto itself. If you look back on the original Hippocratic Oath, it said you could not participate in abortion, yet abortion is legalized. Our approach to abortion has changed. Now, because of this ruling, our approach to assisted dying is also evolving. We need to keep that in mind when trying to interpret these things literally. At the same time, we must respect doctors who say: “No, I do take that literally, I do not want to do these things, that is not part of my job and that is not why I am here”. We respect [those views] and also respect the views of doctors who are comfortable participating in those activities, which are legal.

How will this new practice of PAD resemble and differ from the current end-of-life practices of escalating palliative sedation and withholding or withdrawing lifesaving or life-sustaining medical treatment [3]?

[One] can argue both sides, but [the difference between PAD and] terminal sedation [and] the escalation of doses, is all a question of intent. There is a fine line because it is very subjective. Some people consider this as a natural extension of aggressive pain and symptom management and there is something to be said for that. The Palliative Care Doctors Association has been very clear and very consistent that this is not something they intend to embrace, so it may be a situation where we need clarity between where palliative care ends and where assisted dying begins.

PART 3: MOVING FORWARD

What will be the CMA’s role moving forward in crafting the new legislation?

The CMA is coming up with a draft framework that will be reviewed and discussed by the CMA’s Committee on Ethics and Board of Directors, followed by a two-month consultation period with members. Then, at the General Council meeting in August, we will present what the CMA thinks legislation should look like. Many doctors do not like the decision and that is OK, but ultimately it is society, through its elected representatives and

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courts that is making these rules and decisions. Basically, the profession is saying OK, whether you agree with this or not, the SCC has ruled, so the time for that discussion has passed and now we need to make sure that we help the government get it right.

Who will decide who is admissible for this service? Will it be two physicians or a multidisciplinary panel, etc.?

The CMA's consultation process will [address] that. My [sense], is that it is going to require more than one physician. [There has been] talk about judicial panels, and I think that is probably a little bit far reaching, based on the SCC's decision and what would be practical and feasible. I think we are going to try to keep this as a medical rather than judicial decision. There are also some advantages to trying to involve physicians who really know the patient because these situations are very complex.

How do we protect the rights of medical professionals who choose to offer these services and those who choose not to?

The broad strokes are pretty clear; doctors who want to participate, can, and the CMA will support them. We are looking at what that support looks like. For example, in Holland, the Royal Dutch Medical Society has a whole unit that helps members who want to participate in assisted dying. For those who do not want to participate, the basic principle is this: If you do not want to, you do not have to do it and no one is going to force you to do it. I have not heard anyone say anything to the contrary. The real crux of the issue is what I call the referral question. If I refuse to participate, do I then have a moral, legal, or regulatory obligation to refer to someone who will provide that service? The Ontario and Saskatchewan Colleges of Physicians have draft guidelines, not finalized nor approved yet, but draft policy that would require physicians to make a referral. These do not specifically address euthanasia or abortion, but rather the whole issue of conscientious objection. Understandably, a number of our members are very concerned. Now the flip side of that is the issue of access. To what extent can physicians exercise their moral views if this has a detrimental impact on patient care? CMA policy is essentially silent on mandatory referral. As a result of [the CMA] being silent, the policy has been interpreted as saying [referral] should not be mandated, which is probably accurate. We need to have a more open discussion on this as part of discussions on the legislated framework.

The Court refers to the “limits of palliative care in addressing suffering” [1]. What can we do to improve palliative care across Canada and ensure that this new legislation strengthens it and does not diminish it?

This is a critical point. Only about a third of Canadians have access to good quality palliative care. What we have seen in other countries is that palliative care services actually seem to have improved in some of the jurisdictions where assisted dying has been

legalized. With the dialogue about dying being out in the open, there tends to be an increased focus on palliative care as well. The CMA is in the process of preparing a report to be released in May at the Palliative Care Doctors annual meeting looking at the current state of palliative care in Canada with recommendations to improve access to palliative care.

How can medical students, residents, physicians get involved in helping to craft this upcoming legislation?

The CMA will be reaching out to members, other organizations and stakeholders in the summer to get their views. We welcome medical student and resident participation. If people want to get in touch with me at Jeff.Blackmer@cma.ca, I will make sure they are included in those communications. All Canadians can participate by writing to their MP.

CONCLUSION

In the wake of this historic decision by the Supreme Court of Canada, Canadian physicians will shoulder the responsibility of helping the Government craft legislation to ensure the practice of Physician-Assisted Dying is safe and fair. As Dr. Blackmer said: “whether you agree with this or not, the SCC has ruled, so the time for that discussion has passed and now we need to make sure that we help the government get it right”. As this interview has illustrated, there are many facets and challenges to implementing PAD. With early indication that physician and public comfort levels are trending toward a more restrictive approach to who qualifies for PAD, it will be interesting to see how the legislation develops around the SCC's broad inclusion criteria.

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REFERENCES

1. Supreme Court of Canada. *Carter v. Canada (Attorney General)*, 2015. SCC 5. Supreme Court Judgments Case Number 35591. February 6th, 2015. Ottawa, Canada. Available at <http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>. (Accessed 2015 Feb. 9). Paragraphs: 6, 127 and 128.
2. Verhagen E, and Sauer PJJ. The Groningen Protocol – Euthanasia in Severely Ill Newborns. *The New England Journal of Medicine* 2005; 352:959-962.
3. Canadian Medical Association. *Euthanasia and Assisted Death (Update 2014)*. CMA Policy. 1867 Alta Vista Dr., Ottawa, Canada.