May 14, 2021

Re: CPSO Policy on Medical Aid in Dying

Dear Members of CPSO Council:

I am writing to you to address the issue of effective referral for euthanasia (otherwise termed ‘medical aid in dying’) as stipulated in the current CPSO policy.

I recognize that euthanasia is a complex issue that engages deeply felt moral concerns on the part of patients, physicians, and the general public. I also recognize the very real challenges that the College faces as it seeks to guide the profession to respond to changes in the moral and legal environment within which we as physicians operate. I want at the outset to express my gratitude for the care and deliberation invested in these matters, and to thank you for your willingness to consult with the profession and the public for feedback on your approach.

Allow me to be transparent of my own position on this matter. I am persuaded that euthanasia is an unethical action on the part of physicians. Despite the good intentions of those who advocate for euthanasia, this act devalues patients because it eliminates them. Many claim that euthanasia is a matter of respect for patient autonomy, but respect for patient autonomy is founded upon an even deeper respect for the patient themselves. Euthanasia violates this foundational value by intentionally eliminating that foundation. Euthanasia renders persons non-persons. Moreover, it is an act that relies on blind assumptions about what it is like to be dead, thus bringing the physician’s own personal metaphysical and philosophical beliefs to bear on the question of medical benefit. It accepts the patient’s own sentiment that their suffering is pointless and that their existence, as a consequence, is worthless. Rather than reassuring the patient of their intrinsic worth and significance, we accept their verdict upon their existence and participate in ending their existence.

Of course, I know that a majority of the profession disagree with this assessment. We live in a pluralistic society and we must except that our ethical beliefs are powerfully shaped by profound differences in the way that we look at the world, human value, and the meaning of our existence. I appreciate and respect my colleagues who disagree with me. I know that their actions and efforts to advocate for euthanasia are well intended. They are not intentionally and knowingly acting unethically. Their views of euthanasia are shaped by their own personal understanding of our shared human existence.
Such marked and strong differences of opinion create challenges for how we may work and collaborate together as a unified profession. There is no question that the legal permissibility of euthanasia has been established and that many, perhaps most, Canadians regard this action as morally acceptable. Yet neither of these facts serves to establish that euthanasia is actually morally acceptable. Those who conscientiously object to euthanasia, like myself, may still be correct in our views of this practice, even if we find ourselves in the minority. Indeed, I am persuaded by the reasons outlined above that I would be wrong to join the majority opinion on this matter.

Given this moral conviction, I believe that it would be unethical to provide an effective referral for a patient who requests euthanasia. The reasons for this are easy to grasp if we simply remind ourselves of how a referral for euthanasia would have been viewed by the profession and by the College before euthanasia became legally permissible and socially acceptable. A referral would have been regarded as complicit participation in the act of causing the death of the patient. Such complicity would have been both moral and legal in nature and would have been subject to severe professional censure. We all recognize that offering an effective referral and proactively arranging for the patient to be seen by physician who will perform an unethical act is morally and professionally unacceptable. For example, to knowingly arrange for a patient to see a physician who will perform female genital mutilation or who would prescribe opioids inappropriately or in exchange for money would be deeply inappropriate and profoundly wrong. If euthanasia is unethical, then I ought not to refer for it. On the other hand, if euthanasia represents compassionate medical care, then I ought to refer for it. In other words, the moral and professional responsibility to provide a referral directly hinges on the moral character of the act itself.

This means that in requiring an effective referral, the College implicitly takes sides on the question of whether euthanasia is ethical. This is unjust, because it assumes that we objectors are wrong in our assessment. It requires us to set aside reason and moral judgement and to act against our commitment to honouring the patient’s value. In a liberal and pluralistic society, governing bodies have no authority to adjudicate moral questions. Certainly, the College must ensure that patients are treated with the very highest respect and dignity because this is medicine’s fundamental purpose. Yet to the extent that objectors like myself ground our objection to euthanasia in our commitment to the patient’s value, we are acting in accordance with and not in opposition to the basic values of our profession. We are acting in a manner that is consistent with the goals and values of the College.

Moreover, the College’s effective referral policy forces a minority of persons to submit their moral convictions to those of the majority. History teaches us that the majority is frequently wrong on matters of morality. If we allow the moral convictions of the majority to dictate the actions and beliefs of all, then we prevent the conscience of individuals from being a powerful moral force for good in the profession. Patients are better off today because individual physicians were permitted to practice according to their conscience conscientious commitment to the patient and the patient’s value.
I am not writing merely to offer concerns but also to suggest a positive solution. I recognize that while we disagree we need to find a way to work together to pursue our mutual goal of ensuring that patients are treated with dignity and compassion and respect, without judgement and without prejudice.

I practice critical care medicine and care only for patients in the inpatient setting. While I cannot comment on the outpatient setting, I believe I am positioned to suggest a model for enabling patients to access euthanasia in the inpatient setting that respects the moral and professional obligations of conscientious objectors while enabling patients to readily access a legally permissible intervention. If I was to receive a request for euthanasia from a patient under my care, I would of course discuss the request and explore the reasons behind the request in order to ensure that the patient’s medical needs are addressed as fully as possible. And if the patient felt that they wanted to explore access to euthanasia further, I would propose to allow someone else to take over their care as primary and most responsible physician, who could then make a referral as they see fit. While I think it would be unethical for me to be responsible for arranging access, I also think it would be wrong for me to obstruct access. That would be deeply disrespectful to the patients as a person. By allowing another physician to assume primary oversight of the patient’s care, I would be stepping out of the way. In no way does that reflect judgement on the patient, indeed I would be happy to continue caring for the patient as needed in the inpatient setting.

Other colleagues who share my moral convictions have indicated that such an arrangement for the inpatient setting would satisfy their moral concerns and responsibilities to the patient.

This proposal has generally been viewed favourably by my colleagues who advocate for euthanasia. A key concern has been raised that such a transfer of care represents an abandonment of the patient. I certainly agree that physicians should not abandon patients and that we have a duty of care to them. However the proposed transfer of care model does not in fact represent the abandonment of the patient. First, such transfers of care happen routinely in the inpatient setting on the ward or in the intensive care unit. These transfers are never regarded as an active abandonment. Second, as I noted above I and other objector’s would be happy to continue to be involved in the patient’s care is needed, without prejudice and without reservation. In good conscience I cannot be responsible for the act of causing the death of the patient but I am also certainly responsible to ensure that the patient receives the very best compassionate medical and palliative care.

An inpatient transfer of care is quite different from an outpatient transfer of care, where a patient relies on a long-standing relationship with a particular physician. An outpatient transfer of care might be abandonment if the patient was unable to access continued general medical care. In no way should an inpatient transfer of care be conceived of in the same light, since the patient will continue to receive medical care in the hospital context.
I would ask the College council to give serious consideration to modifying the policy to permit an arrangement along the lines of what I have described above. I believe this adequately meets the concerns of objectors like myself while allowing patients to access euthanasia in the inpatient setting.

Participation in a pluralistic society with a diversity of values and worldviews presents both benefits and real challenges. I hope that in its deliberations, the College can find a way to pursue a path for our profession in Ontario that allows us to work together and to collaborate despite our differences. Ultimately, the diverse patients that we serve are well served by an equally diverse profession that operates under a shared commitment to honouring the patient’s dignity and value, even if we disagree whether specific actions such as euthanasia are consistent with that shared commitment.

Yours sincerely,