

Conscientious Objection and Medical Assistance in Dying (MAID) in Canada: Difficult Questions - Insufficient Answers

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There is always an easy solution to every human problem – neat, plausible, and wrong.”

— Henry Louis Mencken, American journalist, satirist, cultural critic¹

“Conscientious objection” typically implies refusal to participate in an action based on strongly held ethical beliefs. It is historically associated with refusing to fight on the grounds of personal conscience or religion.² Like other military allusions such as collateral damage or life in the trenches, its usage has spread into wider societal use. Conscientious objection is now used in regards to opposing euthanasia in Canada. Euthanasia, in turn, is now referred to by the less emotive term, Medical Assistance in Dying (MAID). Most medical practitioners and hospitals that object do so in part because of their disagreement or discomfort with the act of killing. As such, the analogy is not wholly unjustified. What is less clear is how this construct, and this terminology, will ultimately affect patients, practitioners, administrators and politicians.

Like many Canadians, the physician authors of this commentary would describe themselves as neither rabidly in favour nor universally opposed to MAID. Moreover, given that MAID is now the law of the land, it is the implication of conscientious objection that we wish to explore. Regardless of whether doctors, nurses, or members of the public define themselves as either pro, con, or conflicted, we may be better served by conscientious *engagement*. Conscientious objection as a principled stand is one issue, but if conscientious objection results in a patient being deserted then that is quite another issue.

Some patients might argue that medical conscientious objection is simply inappropriate. This is based upon a growing sense that physicians, as well as hospitals, nurses, or pharmacists, have a duty to carry out a patient’s wishes: end of debate. Whether we are discussing euthanasia at one extreme or resuscitation at the other, there is a growing sense that if the patient or family requests it then the health care team has a responsibility to make it happen. When talking to patients about MAID, it will probably be necessary to emphasize that Canadian medical law is currently less strident: patients have a right to refuse a medical intervention; they do not (yet) have the right to demand an intervention.

As outlined, there is more to decision-making than mere patient autonomy. The goal is to empower patients to make medical decisions that are not only legal but also appropriate. We do this by providing information and facilitating an unbiased understanding. Any treatment should be right for that individual patient, and freely consented to. If there is one without the other then it is not only appropriate for a physician to object; it is important that we do so. This is patient advocacy. However, MAID criteria have now been broadly sanctioned by society, the legal system, the medical fraternity and by Parliament. As a result, the question is whether a physician, nurse, or pharmacist can refuse to engage while still claiming to fulfill their professional

duty. Notably, bioethicist Julian Savelescu strongly opposes the idea of physician values eclipsing patient values. He went so far as to state: “when the duty is a true duty, conscientious objection is wrong and immoral; when there is a grave duty, it should be illegal.”³

We believe that it is appropriate to provide some ability to opt out. As such, it is appropriate that there be flexibility within both the MAID legislation and within regulations from provincial medical colleges. However, opting out cannot mean abandoning the patient. Conscientious objection is also not an acceptable excuse to avoid any medical interventions that are complex or time consuming or poorly recompensed, or legally perilous. We also cannot condone any system that creates an *undue* burden on vulnerable patients who will now have to find alternate providers. This last point is important because currently the only proviso when MAID is not being made available is for the patient who requests MAID to be provided with an effective referral. Unfortunately, this referral process is imprecisely defined, and varies between provinces.

Much of the language that informs MAID is legal (e.g., “medical conditions that are grievous and irremediable . . .”) rather than clinical. The time course has also been rapid. It was one thing for Canada’s Supreme Court to strike down the criminal code sections on assisted death but it was quite another to expect the government to pass new laws to operationalize this within the one-year deadline.⁴ Moreover, regional health authorities faced an even shorter timeline. This is because formal implementation had to wait for the legal framework, which in turn had to make its way through Parliament.⁵ Requests for MAID were received within a day of Bill C-14’s royal assent, and appropriate patients had the right to die as early as ten days later. It is understandable if some people might object to so much change in so little time.

Conscientious Objection: Not Always Inappropriate, or Illogical

That practitioners and hospitals can recuse themselves reflects Canada’s history of independent practitioners, autonomous institutions, and religious freedom. For example, Catholic Hospitals are unlikely to perform MAID. Whether it follows that any practitioner will be excused merely because they identify as Catholic is less clear. At the practitioner level, surgeons have also refused to offer operations such as transplantation, craniotomy, or laparotomy under various circumstances. Some physicians have refused to resuscitate patients with terminal diseases. Provocatively, the rationale need not be that the practitioner is inadequately skilled, nor morally conflicted, but rather that they deem the intervention not to be in an individual patient’s best interest.

Obviously, beneficence and non-maleficence (doing good and not doing harm which are defined from the care provider’s perspective) should be balanced against autonomy.⁶ For example, if a surgeon refuses based upon medical judgment, they are not usually forced to refer the matter forward and this is seen as justified paternalism. However, there are limits and medico-legal precedents for restricting conscientious objection that exist. Guidelines reign in Canadian physicians who refuse to prescribe birth control pills or countenance abortion. This could similarly inform our approach to MAID. However once again, these vary by province. They also vary from *requesting* that we “offer assistance and do not abandon the patient” to *stipulating* that we provide an “effective referral . . . made in good faith, to a non-objecting, available, and accessible physician.”^{7,8}

Conscientious objection is associated with moral distress. Unfortunately, like conscientious objection this latter term is also open to interpretation. Much like conscientious objection, it usually refers to a wide-ranging and imprecisely defined sense of psychological discomfort. This discomfort usually stems from a sense of being pressured to be involved in something that you believe to be morally wrong. This is different from feeling uneasy about something that is happening but without your involvement (for example, if MAID is happening in your hospital but you are not involved). However, distress may be a more a catch-all term that reflects the sense that Canadian doctors no longer feel that they are adequately supported: whether by legal statutes, societal deference or common sense. As outlined, MAID has come about in an era where patient autonomy is prioritized over medical judgment. Accordingly, a refusal to engage may be a safer response from any practitioners who feels that they will be forced to follow external dictates before internal moral codes.

Whether we are discussing resuscitation or palliation, practitioners need to be heard if they feel that they are hurting patients more than helping. For example, there is already an expectation that cardiopulmonary resuscitation (CPR) be performed on everyone without explicit contrary documentation.⁹ This reflects a sense that physician judgment is less sought after, and that we are becoming more technicians than consultants. As such, CPR conscientious objection may seem preferable, or at least safer, for practitioners who wish to avoid unpopularity and lawsuits. Objection to CPR is also more logical if it feels more like patient-assault and less like natural death. Objection is also a reflection of medical colleges and courts increasingly deciding against physicians.¹⁰ In other words we may not do the right thing (whether that is refusing MAID or CPR) because it is increasingly perilous to stick your neck out. Regardless, we should accept that attitudes toward those who object to MAID might well harden over time, just as they have for those who oppose indiscriminate CPR.

Comparing and contrasting MAID and CPR could offer further insights into whether our medical decision-making is consistent with our moral objections. For example, if a practitioner's major focus is to do everything to preserve life then they should presumably object to MAID, while promoting universal CPR. If the major concern is quality-of-life over quantity-of-life then they should support MAID, but not accept that CPR is a default action. If practitioners are uneasy about active euthanasia but comfortable with passive euthanasia, then presumably they would object to both MAID and widespread CPR. Regardless, the danger is that meaningful self-reflection never occurs, or is clouded by denial, discomfort, or fear. If so then objection is not a moral stance, it is a convenient excuse. Perhaps the best test of whether objection is appropriate is whether these decisions are individualized, include safeguards, and maintain an identifiable patient-focus. We need mechanisms to ensure that objection is principled, not merely expedient.

Conscientious Objection and the Need for Better Palliative Care

MAID has captured a lot of attention. The concern is that this could distract from providing more routine end-of-life care for greater numbers of dying patients who would prefer less rather than more medical intervention. Notably, palliative care can increase both the length and the quality of terminal life.^{11,12} However, it is not widely accessed and not universally appreciated. For example, in a 2014 public opinion survey on end-of-life issues over 90% of respondents felt that palliative care did not do enough for the terminally ill.¹³ Perhaps this reflects the fact that death is by its very nature often unpleasant no matter what. However, concerns with Canadian palliative care were further acknowledged in the 2016 parliamentary report on MAID. Along with policy and procedures, this report recommended a concomitant pan-Canadian strategy to improve access to palliative care.¹⁴ This does not appear to have happened. Accordingly, regardless of what one thinks about MAID, or CPR, we should all be objecting to the lack of focus, funding, and resources for palliative care.

Canada already has one of the highest rates of institutionalized and technology dependent death.¹⁵ Conscientious objection to MAID is more understandable if it is motivated by worries that it will further dilute or redirect existing palliative care services. However, we should also accept that some of the motivation for MAID is the belief that palliative care is underperforming and is unlikely to substantially change without outside pressure. MAID is to some degree the result of an objection to under-palliation. For anyone who has seen a loved one suffer, euthanasia can be the lesser of two evils.¹⁶

More than 80% of Canadians appear to currently support euthanasia.¹³ However, support may wane when the public discovers that MAID mandates lengthy screens, after which many (perhaps most) are turned down. Refusal may be because of the condition is not terminal, or because patients lose the ability to consent. The public may ultimately conscientiously object to our current version of MAID. Euthanasia also requires that the public overcome the cognitive dissonance of seeing trusted professionals and institutions offering curative therapy as well as lethal palliation. Opposition may also increase when patients, families and surrogates face the choice between local familiarity (i.e., remaining in their home town even though MAID is not offered) versus sacrificing those social supports in return for greater medical intervention. Canada's 1984 Health Act guarantees not just public administration but also comprehensiveness, accessibility, portability, and universality. MAID will challenge whether these tenets apply not just across the country, but also from birth to death.

What of other health care professions? For example, what if a hospital physician agrees to MAID but the bedside nurse or the pharmacist does not? This raises provocative questions, not the least of which is whether the doctor is the team leader, or just the first-amongst-equals (*primum inter pares*).¹⁷ Other questions include what to do when a health care worker agrees but is restricted by his or her hospital privileging? What if health care workers are willing but are restricted by technical skill set (inability to manage infusion pumps; inadequate knowledge of analgesics/anesthetics)? What if they are willing but inadequately skilled in communication or in dealing with terminal patients? MAID is forcing a lot of inconvenient questions, but it is not yet providing many definitive answers.

In Closing

Currently, conscientious objection can largely mean whatever you want it to mean. As outlined, without clear expectations, this vagueness leaves it open to abuse by anyone eager to avoid patients who are time consuming or emotionally draining. Conscientious objection might even be more a political statement ("nobody tells me what to do") than the result of genuine moral conflict. If it is overly easy for busy practitioners and over-subscribed hospitals to opt out, then they we should not be surprised that they do exactly that. Alternatively, if it is impossible for practitioners and hospitals to opt out (much like CPR), then we should not be surprised if the process is devoid of real patient advocacy.

In wartime, conscientious objectors are not excused to do as they please. Instead, they are expected to find ways to benefit the wider war effort. If we borrow the term, then we could more fully apply the analogy. We should expect more from medical conscientious objectors than to simply push the

problem onto others. In these cases, our professional obligation should be not to just oppose or accede but rather to redouble our efforts to service the patient, and this would include timely referral. But there is more. Even if you object to MAID there is no reason not to facilitate more discussion, better symptom control, fuller explanations, and closer follow-up. It is one thing to voice your opposition, it is quite another to remove yourself entirely.

In Greek mythology, Pandora opened a box and all the evils of the world flew out. This left her with only “hope.” Accordingly, the phrase “to open Pandora’s box” means to perform an action that may seem small or innocent, but has wider unintended consequences. Two thousand years on this story is still informative. It is not enough to “hope” that we get MAID right: it requires frank debate, lengthy commitment, clearer guidelines, and wider engagement.

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Message du rédacteur en chef (suite de la page 5)

Que ce soit face à l’un des enjeux mentionnés ci-dessus, ou à d’autres, comme la sûreté nucléaire, les conflits guerriers, la pollution, pour n’en nommer que quelques-uns, les médecins devraient choisir de s’impliquer dans un domaine de préoccupation hors des limites traditionnelles de la médecine clinique. Leur engagement personnel peut aider à améliorer le monde et, simultanément, avoir un effet positif sur les mesures traditionnelles offertes en matière de santé.