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Interview: The CMA's president on assisted dying.
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John Geddes interviews Dr. Chris Simpson.

Geddes: You can't have been completely surprised by the decision this morning. Was it something that you were, that you and the CMA were braced for?
[00:06]

Simpson: Very much so. I, I think you're right. That I, I was not surprised, we were not surprised. Perhaps the unanimous decision was a little bit of a surprise. But, at the CMA, we've been, we've been preparing for this eventuality for the last year and a half or two years.
[00.24]

Geddes: Do you think there will be a lot of physicians who are, who are unsettled by this, are most sort of resigned to the idea that they're going to have to think about these things? How would you describe the mood in your membership?
[00:33]

Simpson: Well, we went through a very careful process. As you may recall, in partnership with Maclean's, we did some town halls last year . . .

Geddes: Yes.

Simpson: . . .and went across the country and heard from Canadians and heard from other doctors, as well. And that really critically informed, I think, the, the process of change in the profession and in our, our organization. Because at the end of the day, of course, there was no consensus achieved, but the, the really powerful stories on, on both sides of the debate, I think really had everybody step back and reflect, and say, you know, "There can't be a one-size-fits-all. We have to have the ability to fit everybody's legitimate concerns and aspirations here."

So, we, we did actually pass a policy at our last general council that said that we would support our members, doctors and their patients, who chose to pursue medical aid in dying, should the legal environment change. And today, of course, it did.
[10:47]

Geddes: Can you say something about the, what the court said about the, the ability of doctors who, have religious or just personal-conscience reasons for not wanting to help patients end their lives? So, were you satisfied with the wording of the

decision on that score?
[01:50]

Simpson: I think so. We, we're very clear that, and, and I think it's fair to say no patient would want a physician to be individually coerced into doing something that they felt was against their personal moral, morals or ethics or religious beliefs. That's not going to serve anybody well. And there was nothing in the language in the ruling today that suggested that individual physicians would, would be compelled.
[02:16]

So I think, over the next 12 months - - which is the time frame everybody has to, to think about this and, and get something robust in place - - we'll need to balance the, the need now to provide this service in an equitable way to the, to the small number of patients who need it and are eligible for it and protecting individual physicians from being coerced if, if they, as individuals, feel that they don't want to participate in this.
[02:43]

Geddes: Doctor, have you had a chance to talk to physicians in jurisdictions where this is already allowed? Do you, have you had a chance to, to learn something from their experiences?
[02:50]

Simpson: Well, only, only anecdotally in, in what I've seen written. But it, it appears that most of these jurisdictions lead to changes in the medical culture where there is general, overall comfort with, with the legislation that, that's in place. And where it works best, of course, and where it is the case everywhere as far as I'm aware, is that only physicians who have particular expertise in, in doing this and, and have a moral and ethical framework that allows them to do it is where it works well.
[03:25]

Geddes: So it's not going to be your average doctor having to deal on an *ad hoc* basis with this kind of request. There'll be some process where the decision, or the, I guess - I hate to use this word - it sounds very clinical - but the procedure would be in the hands of someone who's, who's got some kind of, some kind of expertise?
[03:39]

Simpson: Right. And that's that's a key part, and, and part of the leadership that I think we have to provide is, the educational tools and the framework and the, and the

regulatory framework that would, that would allow this to be done in a way that makes everybody feel that the vulnerable are meticulously protected, but that those who, who need this procedure do get it in a timely way.
[04:02]

Geddes: Doctor, I was lucky to have been involved in one of those town halls you referred to, that we did last year, the one up in, up in Whitehorse. And . . .

Simpson: [Undecipherable].

Geddes: . . . I was struck there by the degree to which it seemed like there's a huge overlap between people's concerns about doctor assisted dying and their concerns about just palliative care and good end of life care. Where a lot people, it, it seemed to me, were having trouble disentangling the two. Like, you know, thinking that, well, if only there was a really good, well-funded, well thought out system for palliative care and, and giving people the best chance they have of a decent end-of-life experience that that would alleviate a lot of the, the pressure for doctor-assisted suicide. Well, can you comment on that?
[04:48]

Simpson: It's, it's a very interesting and nuanced point. But I agree with you it's really important because we can't lose sight of the fact that, no matter how this all shakes out in the end, it's very unlikely that the number of patients who are going to be eligible for, and carry out, medical aid in dying is very small. And, and yet, we only have 16 per cent of Canadians who would benefit from it receiving good palliative care. So we can't lose sight of the, of the bigger end-of-life envelope in all of this. We do need . . .

Geddes: Can I. . .

Simpson: . . . better palliative care.
[05:19]

Geddes: Can I interrupt you just for a second? Could you repeat that statistic? What percent of Canadians that need good palliative care are getting it now?

Simpson: It's our estimate is that 16 per cent of patients who would benefit from palliative care in Canada actually receive it, out of the 250,000 people who die every year.

[05:33]

Geddes: On a practical level, what does that mean? What are they not getting?

Simpson: Sometimes it's something just as simple as appropriate pain control, or other symptoms, like shortness of breath, for example, that can often characterize some diseases at end of life. And what happens in a lot of places is they're brought into hospital, simply because that's the only place those medications are, are available, rather than being able to die at home, as they want. So there, we have pockets of great palliative care in Canada and then other pockets where it's completely non-existent.
[06:06]

But I, I think even if we had perfect palliative care in Canada, we, we know that there will be very rare cases where even the best palliative care is not good enough. And, and those are the patients, I think, for whom medical aid in dying may potentially be a, a solution for them.
[06:23]

Geddes: Can I ask about your own experience? You're, you're a, a heart doctor, right?

Simpson: [Undecipherable]

Geddes: Have you had cases where you've, where someone has either asked you about the, wanting some help in dying, or, or where you wondered if that could be an issue?

Simpson: No, I haven't. The, my particular type of practice is, is one where those issues don't, don't come up. Part of it, though, I think as well is I happen to be in a place where there's excellent palliative care, and so . . .

Geddes: Mm hmm. In Kingston, right?

Simpson: In Kingston, yeah. But the, it, it does underscore, I think, the point that this really is likely to be a rare event. And, and as important as it is, and as historic as this decision is, I'd really hate to see this distract from the, the bigger deficit in care, which is the, the lack of adequate palliative care in many places in Canada.
[07:09]

Geddes: Doctor, could I ask you just about one last, specific type of concern that's been

raised? I've heard it already today. There are people who think that just the availability of this as an option will have the effect of putting pressure on people with long term, severe long term disabilities to think that somehow, this is a way that they could be less of a burden on people? Could you comment on that particular concern, which just seems so emotionally fraught to me?
[07:33]

Simpson: Yeah, it's very emotionally fraught. And clearly we have to, in our rules and regulations and legislation really work hard to foster a culture that does not allow that to happen. You know, certainly we don't want anybody to feel compelled to seek medical aid in dying because they feel that, that they're a burden. And I think that's really part of the expertise in the counselling phase of this. Is that we need to really be able to make sure that we identify people who are, who have that as maybe a, a contributing factor in their, in their decision-making. And ensure that, that they're counselled away from that as a, as a reason. So, very, very good question, and, and definitely a concern, but I think that's among the top priorities of, of the nitty-gritty details that we need to work out over the next twelve months.
[08:30]

Geddes: A last question on what's going to happen over the next 12 months. In the past, when the Supreme Court has brought down not, not, similar decision but sort of parallels, in the sense that they've given the government a year, generally, to work on it. I'm thinking about the prostitution decision, for example. It's really been something that's been just been in the hands of, of federal lawmakers. This is not so straightforward. Do you think there needs to some form of, you, know, federal-provincial physicians' organization task force or group set up now to, to work on regulations? How do you think on a practical level the next 12 months should be spent in terms of coming up with an answer to the position of the, the position that the Supreme Court has now put everyone in?
[09:08]

Simpson: Yeah. Well, that's, that's exactly what we'll be seeking: is some mechanism for, for us to have a prominent role in the, in the crafting of the new rules and regulations and, and legislation. And, and I would expect that other stakeholders at the table would include both of the senior levels of government and, and the regulatory bodies, as well as patient groups. Everybody needs to be comfortable that, that the details are, you know, true to the, to the Supreme Court's intent, and also something that Canadians can be comfortable with on both sides of the debate.

Geddes: Wow. What a, you, you're, you're heading the biggest doctor's group in the country at such an interesting moment. This must be something that you wouldn't have invited, but it sounds like it could be a, a, a sort of a watershed year.

Simpson: It's, it's a really historic moment and I'm very mindful of, of the role that physicians have to play and, frankly, you know, I'm, I'm really, really proud of how the CMA has handled this over the last two or three years. You, I'm happy to hear you were at one of the town halls because my, my perception of the town hall experience was that it really brought a lot of humility to the profession and, and really injected a lot of patient-centredness and respect, and I, I think it's, the discussion's been really good. The, the issue's very, very tough and there will be lots and lots of concerns expressed, I think and differences of opinion going forward, but by, by talking about it, by maintaining that core of respect for all points of view I think we'll, we'll achieve what we need to achieve.
[10:45]