## CMA President response: physician-assisted death

Although Downar and colleagues[1] present a very detailed examination of many of the issues involved in our growing national examination of how Canadians expect to manage their care at the end-of-life, the authors unfortunately get the cart well before the horse by focusing solely on physician-assisted death. Addressing the dire need for improved access to palliative care services, for which the late Dr. S. Lawrence Librach was an eloquent champion, and Canada's lack of a national pain strategy would be much better places to start.

Contrary to the authors' assertion, delegates attending the Canadian Medical Association (CMA) annual meeting last August were clear that physicians needed to know more about how Canadian society viewed the full spectrum of end-of-life care before they could rush to any change in the CMA's current policy position on physician-assisted death.

This has led the CMA to conduct a national dialogue on end-of-life care, gathering input from Canadians online and at public town hall meetings in St. John's, Newfoundland and Labrador; Vancouver, British Columbia; Whitehorse, Yukon Territory and Regina, Saskatchewan. Meetings wrap up in Mississauga, Ontario on May 27, 2014. The CMA is also conducting extensive discussions of these issues with members online and at town hall–style meetings. Although physicians may need to be prepared for the challenges of physician-assisted death, we are hearing from Canadians that there is an even greater societal need for us to ensure we can provide high-quality palliative care to everyone who would need it and provide the public with a better understanding of advance care directives.

**Louis Hugo Francescutti MD PhD**
President, Canadian Medical Association, Ottawa, Ont.

### Reference

1. Downar J, Bailey TM, Kagan J, et al. Physician-assisted death: time to move beyond Yes or No. *CMAJ* 2014;186:567-8.

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## Of carts and horses … [the authors respond]

We agree with Francescutti's[1] goal of improving access to palliative care, but there is no reason to think that this is a prerequisite for discussing physician-assisted death. Legalization of physician-assisted death need not hinder efforts to develop palliative care, and our article[2] made this clear. Palliative care and advance-care planning improved considerably in Oregon after legalization, and Oregon is now a leader in the United States in a variety of palliative metrics.[3] But even the best palliative care may not be sufficient for some patients, since 90% of Oregonians who received assisted death were enrolled in a hospice program.[4] We have not put the cart before the horse. Francescutti should not overlook the main point of the article: the yes/no debate about assisted death could become practically obsolete in the very near future. While physicians are arguing about the relative positions of the cart and the horse, many Canadians have completed the journey on foot. Physicians do not need to lead or even agree with efforts to change Canadian law, but they have a professional responsibility to develop a Plan B at the very least. We need to begin the process of developing policies, protocols and guidelines, because we may need them in the near future.

We applaud the decision of the Canadian Medical Association (CMA) Board of Directors to hold national town hall meetings about end-of-life care, and to include as part of that a discussion of physician-assisted death. Dr. Francescutti himself has eloquently outlined the benefits of discussing physician-assisted death in this open manner.[5] We hope that the feedback received at these town hall meetings will convince the CMA to take the lead on developing a Plan B, even if it continues to oppose a change in the law.

**James Downar MDCM MHSc (Bioethics), Tracey M. Bailey BA LLB, Jennifer Kagan MD**
Divisions of Critical Care and Palliative Care (Downar), Department of Medicine, University of Toronto, Toronto, Ont.; John Dossetor Health Ethics Centre and Department of Psychiatry (Bailey), Faculty of Medicine and Dentistry, University of Alberta, Edmonton, Alta.; Division of Palliative Care (Kagan), Department of Family and Community Medicine, University of Toronto, Toronto, Ont.

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## Health care and refugees in Canada

I would like to address some of the inaccurate and misleading assertions Stanbrook made in his editorial in *CMAJ*.[1]

Stanbrook states "that the cuts to health coverage have, in particular, denied refugees access to primary and preventive care." That is absolutely false. Through the Interim Federal Health Program (IFHP), all genuine refugees in Canada receive primary health care coverage that is similar to that received under provincial or territorial health care programs.

Underlying the decision to reform the IFHP was the principle that those seeking asylum are not entitled to more generous benefits than those that Canadian taxpayers and legal immigrants receive.


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