Redefining the Practice of Medicine
Euthanasia in Quebec

Sean Murphy, Administrator
Protection of Conscience Project

Executive Summary

An *Act Respecting End-of-Life Care* ("ARELC") is intended to legalize euthanasia by physicians in the province of Quebec, a legally contentious project because of Canadian constitutional law. This paper does not take a position on the desirability of euthanasia or assisted suicide, but reviews ARELC in detail from the perspective of physicians who do not wish to be involved with such procedures for reasons of conscience. The Table of Contents following this summary outlines the paper, which consists of nine parts and three appendices. Each part opens with an abstract.

Part 1 offers an overview of ARELC and closes with a review of the long term prospects for the implementation of the law. Part 2 discusses the law in detail, including definitions of key terms and procedural requirements. It also explains how a revision of the original text authorizes two different kinds of euthanasia: a regulated process for competent patients, and an unregulated process for incompetent patients. This aspect of the new law has not received attention.

The issue of slippery slopes is addressed in Part 3, with particular reference to the guidelines provided in the law. Part 4 considers the tension among health care workers generated by the killing of patients, and closes with an overview of the institutional and legal mechanisms available to implement the law. Appendices “A” and “B” provide detailed information about these mechanisms.

Most physicians do not personally kill patients even in jurisdictions where euthanasia or assisted suicide are legal. This fact collides with ARELC’s declaration that access to euthanasia is a right. Part 5 discusses the implications of this collision in Quebec. Appendix “C” provides statistics on physician participation in euthanasia and assisted suicide.

Since most physicians will not actually kill patients, and most euthanasia proponents do not insist that objecting physicians should do so, attacks on freedom of conscience are more likely to take the form of demands that physicians facilitate the procedure by referral or other means. Accordingly, Part 6 uses the criminal law and examples of capital punishment, torture and female genital mutilation to explore the concept of morally significant participation in what is believed to be wrong.

Physicians may have reasons other than conscientious objection for refusing to kill a patient. The various reasons for refusal and ARELC’s provision for conscientious objection are noted in Part 7, including the continuing criminal prohibition of euthanasia by Canadian criminal law. Of particular interest is

Revision Date: 2014-08-12

the extent of immunity from prosecution being sought by physicians, and the degree of immunity that the government is actually willing to grant.

ARELC exempts palliative care hospices from the requirement to provide euthanasia, but the exemption has been challenged and hospice administrators are concerned that the legalization of the procedure will eventually compromise their operations. Part 8 offers an overview of the challenges and their concerns.

As a general rule, it fundamentally unjust and offensive to human dignity to require people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. Thus, it was a serious error to include this a requirement in *Code of Ethics* for Quebec physicians and pharmacists. Part 9 uses the concept of "examined emotions" to demonstrate that this error became intuitively obvious to the Collège des médecins and College of Pharmacists when the subject shifted from facilitating access to birth control to facilitating the killing of patients.

TABLE OF CONTENTS

Part 1: Overview

Part 2: ARELC in Detail

Part 3: Evolution or Slippery Slope?

Part 4: The Problem of Killing

Part 5: An Obligation to Kill

Part 6: Participation in Killing

Part 7: Refusing to Kill

Part 8: Hospitality and Lethal Injection

Part 9: Codes of Ethics and Killing

Appendix A: Health Care Delivery in Quebec

Appendix B: Disciplinary and Complaint Procedures

Appendix C: Statistics

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Redefining the Practice of Medicine
Euthanasia in Quebec
Part 1: Overview

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

An *Act Respecting End-of-Life Care* ("ARELC") is intended to legalize euthanasia by physicians in the province of Quebec. It replaces the original Bill 52, the subject of a previous commentary by the Project. The original text of the Bill 52 did not define medical aid in dying (MAD), but ARELC now makes it clear that Quebec physicians may provide euthanasia under the MAD protocol. In addition, substitute decision makers can order legally incompetent patients who are not dying to be starved and dehydrated to death. This practice, identified here as Euthanasia Below the Radar (EBTR), is completely unrestricted and is not even reportable.

Neither ARELC nor MAD guidelines can abolish the criminal prohibition of euthanasia, so physicians who kill patients in the circumstances contemplated by the new law would still be liable to prosecution. However, the Quebec government has promised that it will refuse to prosecute physicians who kill patients in accordance with MAD guidelines, thus circumventing the criminal prohibition. Beyond that, Quebec general practitioners have asked for immunity from prosecution for failing to conform to MAD guidelines. Some Quebec physicians may be unwilling to provide euthanasia while the criminal law stands. Quebec's Attorney General may be unwilling to provide the extraordinary kind of immunity sought by physicians, and some physicians may be unwilling to provide euthanasia without it.

The introduction of euthanasia will require the complicity of thousands of health care workers and administrators. Many are likely to comply because official representatives of the legal and medical establishments of Quebec have formally declared their support for the new law. On the other hand, palliative care physicians, hospices and an undetermined number of other physicians and health care workers are opposed to euthanasia and assisted suicide.

Section 4 of ARELC states that eligible patients have a right to "end-of life-care," which includes euthanasia and palliative care. The statutory declaration of a "right" is the most powerful weapon in the legal arsenal likely to be used to enforce compliance with ARELC and to attack freedom of conscience among those who refuse to facilitate the procedure. It appears that, even where euthanasia or assisted suicide is legal, the majority of physicians do not actually provide the services. The Act may lead to discriminatory screening of physicians unwilling to kill patients, effected by denying them

employment in their specialties and denying them hospital privileges. However, objecting physicians not only refuse to kill patients, but also often refuse to do anything that they believe makes them morally responsible for the killing. Hence, it is likely that most of the attacks on freedom of conscience resulting from ARELC will be precipitated by refusal to participate indirectly in killing.

Physicians may refuse to provide euthanasia if the patient is legally ineligible, and for other reasons, including conscientious objection. ARELC requires physicians who refuse to provide euthanasia for any reason other than non-eligibility to notify a designated administrator, who then becomes responsible for finding a MAD physician. The idea is to have the institution or health care system completely relieve the physician of responsibility for facilitating the procedure.

The protection of conscience provision in ARELC distinguishes physicians from other health professionals, providing less protection for physicians than for others. Physicians may refuse only "to administer" euthanasia - a very specific action - which seems to suggest that they are expected to participate in other ways.

Palliative care hospices and a single Quebec hospital may permit euthanasia under the MAD protocol on their premises, but they do not have to do so. Patients must be advised of their policy before admission. The exemptions were provided for purely pragmatic and political reasons. The exemptions have been challenged by organizations that want hospices forced to kill or allow the killing of patients who ask for MAD. Hospice representatives rejected the first demand and gave mixed responses to the second. A prominent hospice spokesman predicted that hospices refusing to provide euthanasia will operate in an increasingly hostile climate.

Refusing to participate, even indirectly, in conduct believed to involve serious ethical violations or wrongdoing is the response expected of physicians by professional bodies and regulators. It is not clear that Quebec legislators or professional regulators understand this. A principal contributor to this lack of awareness - if not actually the source of it - is the *Code of Ethics* of the Collège des médecins, because it requires that physicians who are unwilling to provide a service for reasons of conscience help the patient obtain the service elsewhere.

As a general rule, it fundamentally unjust and offensive to human dignity to require people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It was a serious error to include this a requirement in a code of ethics. The error became intuitively obvious to the Collège des médecins and College of Pharmacists when the subject shifted from facilitating access to birth control to facilitating the killing of patients.

A policy of mandatory referral of the kind found in the *Code of Ethics* of the Collège des médecins is not only erroneous, but dangerous. It purports to entrench a 'duty to do what is wrong' in medical practice, including a duty to kill or facilitate the killing of patients. To hold that the state or a profession can compel someone to commit or even to facilitate what he sees as murder is extraordinary.

Since ARELC explicitly authorizes physicians to kill patients deemed eligible for MAD by the Act, the federal government can go to court to have the statute declared unconstitutional. However, it is possible that the federal government will take no action until after the Supreme Court of Canada ruling in *Carter v. Canada* and after the 2015 federal election.

It seems unlikely that Quebec physicians who provide euthanasia under MAD guidelines will be prosecuted even if the prohibition of assisted suicide and euthanasia is maintained by the Supreme Court of Canada, and even if ARELC is ultimately struck down as unconstitutional. The continued de facto decriminalization of euthanasia in Quebec would probably generate considerable pressure in other provinces to follow suit.

Those who refuse to provide or facilitate euthanasia for reasons of conscience will likely find themselves in increasingly complicated and contentious working environments. In the end, freedom of conscience for Quebec health care workers who object to euthanasia may come to mean nothing more than the freedom to find another job, or the freedom to leave the province.

The Medical Act

An Act Respecting End-of-Life Care, hereinafter "ARELC")[1] is intended to legalize euthanasia by physicians in the province of Quebec. It was introduced as Bill 52 by the Parti Quebecois government and debated in the Quebec National Assembly in 2013. It failed to pass before an election was called and the legislature was dissolved. While the Parti Quebecois was defeated and replaced by the Liberal Party of Quebec, in 2014 the Liberal party reintroduced the bill. It passed on 5 June, 2014. It does not actually come into effect until the end of 2015.[2]

The potential impact of ARELC on freedom of conscience in health care must be evaluated in the light of one of the routine amending provisions intended to bring other provincial statutes into line with the proposed legislation. ARELC makes the following changes to Section 31 of Quebec's Medical Act, which defines the practice of medicine.

Former Medical Act Section 31[3]	**New Medical Act Section 31**[4]
The practice of medicine consists in assessing and diagnosing any deficiency in health and in preventing and treating illness to maintain or restore the health of a person in interaction with his environment.	The practice of medicine consists in assessing and diagnosing any health deficiency in a person in interaction with their environment, in preventing and treating illness to maintain or restore health **or to provide appropriate symptom relief.**

The provision of appropriate symptom relief has always been considered part of the practice of medicine, so the addition of the phrase would seem to be inconsequential. However, ARELC adds a new sub-paragraph to the list of activities identified in Section 31 as "reserved to physicians":

> (12) administering the drug or substance or allowing an end-of-life patient to obtain medical aid in dying under the Act respecting end-of-life care.[5]

"Medical aid in dying"

Definition

The original text of Bill 52 did not define medical aid in dying, a strategically ambiguous term that everyone understood to mean euthanasia. The government dispensed with the winks and nods and revised the text, so that ARELC now states that it consists of "the administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death."[6]

Eligibility

The statutory MAD guidelines for euthanasia restrict it to legally competent persons at least 18 years old who are insured under the provincial Health Insurance Act are "at the end of life," are suffering from serious and incurable illness, are in an "advanced state of irreversible decline in capability," and "experience constant and unbearable physical or psychological pain which cannot be relieved in a manner the patient deems tolerable"(Part 2).

Interpretation

These criteria can be broadly interpreted, so that, without changing a word of the statute, euthanasia under MAD protocols need not be restricted to a period immediately preceding death, and that it could be made available to the legally incompetent, the uninsured, and the mentally ill. In addition, a number of powerful and influential groups supporting ALERC recommend that access to euthanasia be expanded. It is thus reasonable to believe that ARELC's criteria for euthanasia will be broadened by interpretation, by statutory amendments and by court rulings or decisions of quasi-judicial tribunals, so that, as time goes on, there will be more euthanasia, not less. (Part 3).

Euthanasia vs. assisted suicide

ARELC requires that a physician who determines that "medical aid in dying" (MAD) may be administered to a patient "must administer such aid personally and take care of and stay with the patient until death ensues."[7] It is abundantly clear that the new law intends that Quebec physicians should, in defined circumstances, provide euthanasia: that is, kill their patients. This is recognized by the Quebec medical establishment and other supporters of the law (Part 4).

ARELC indicates that "medical aid in dying" is an action by a physician; that would seem to preclude assisted suicide, which would involve a lethal act by a patient. However, during committee hearings on Bill 52, law professor Jocelyn Downie pointed out that "administration" of a substance could be taken to include writing a prescription for a lethal drug and giving it to the patient to consume, which would, arguably, constitute assisted suicide.[8] Whether or not that would be the case, Professor Downie suggested that the bill be clarified.

> It is important to clearly allow for this as some patients would automiously [autonomously] choose this kind of medical aid over a lethal injection, and some physicians may also find it a kind of medical aid that they are more comfortable providing.[9]

Though Professor Downie's suggestion was not taken up, euthanasia and assisted suicide are both forbidden under Canadian criminal law, so there is an obvious conflict between Canadian criminal law and Quebec's ARELC.

Euthanasia Below the Radar (EBTR)

The MAD provisions are limited to legally competent patients. They include statutory restrictions, procedural guidelines and reporting requirements, and have understandably been the focus of most public and professional attention. However, ARELC also provides that substitute decision makers can order legally incompetent patients who are not dying to be starved and dehydrated to death. This practice, identified here as Euthanasia Below the Radar (EBTR), is completely unrestricted and is not even reportable. (Part 2)

Constitutional law

As a preliminary to a further review ARELC, it is necessary to consider key elements of Canadian constitutional law: the jurisdictions of the federal and provincial governments in criminal law and health care.

The federal government has exclusive jurisdiction over Canadian criminal law, which prohibits assisted suicide and consensual homicide (and, thus, physician assisted suicide and euthanasia). Provincial governments cannot change the criminal law, but they are constitutionally responsible for enforcing it and prosecuting criminal offences. The provision of health care, on the other hand, is within the exclusive jurisdiction of provincial governments.

Circumventing the criminal prohibition

Since neither ARELC nor MAD guidelines can abolish the criminal prohibition of euthanasia, physicians who kill patients in the circumstances contemplated by the new law would still be liable to prosecution. Thus, the provincial government plans to adopt the recommendation of the Select Committee on Dying with Dignity:

> Although criminal law falls under the purview of the federal government, Québec is responsible for the administration of justice and application of criminal law. As such, the Attorney General of Québec decides whether to lay charges and prosecute. To ensure doctors have peace of mind when practicing their professions, the Attorney General of Québec should issue directives, in the form of "guidelines and measures", to the Director of Criminal and Penal Prosecutions so that physicians who provide medical aid in dying in accordance with the criteria provided by law cannot be prosecuted.[10]

The Select Committee pointed out that the province adopted such a policy to prevent the enforcement of the criminal law on abortion,[11] and the Federation of General Practitioners of Quebec stressed their concern about this during legislative hearings. Dr. Godin asked for "a clear directive from the Minister Justice" guaranteeing that "that there would be no criminal prosecution," which, he said was "essential. . . if we want to suggest that doctors, especially family physicians, do this medical procedure."[12]

Then Minister of Health, Véronque Hivon, assured him that the Minister of Justice would issue the appropriate directive.[13]

Physicians seek immunity from prosecution when law disobeyed

Beyond the guarantee the doctors would not be criminally prosecuted for providing euthanasia under ARELC, the Federation of General Practitioners also sought immunity from prosecution for failing to conform to the MAD guidelines set out in the law. The Federation objected not only to the fines proposed for physicians who fail to report euthanasia as required,[14] but to the possibility of prosecution if they violate MAD guidelines when a patient is killed. According to Dr. Godin, Quebec general practitioners are prepared to accept the guidance or discipline of the Collège des médecins if they violated the guidelines, but not the prospect of being charged for murder or manslaughter.

Pour nous, les autorités compétentes, dans ce cas-là, demeurent le Collège des médecins. C'est un acte médical. Si je ne le pose pas correctement selon les règles déontologiques, les règles de l'art, je veux dire, le Collège des médecins est là. Pour nous, c'est lui, l'autorité compétente, et ça ne devrait pas être transmis à d'autres autorités que celle-là.	For us, the competent authorities, in this case, remain the Collège des médecins . This is a medical procedure. If I do not act properly according to the rules of ethics, rules of art, I should say, the Collège des médecins is [the authority]. For us, it is the competent authority, and [an allegation] should not be passed to other authorities than this.[15]

The concerns were accepted, at least in part. The government dropped Bill 52's provision for $1,000.00 to $10,000.00 fines for physicians who fail to report when they perform euthanasia. Instead, ARELC states that anyone who discovers that a physician has failed to report euthanasia must notify the Collège des médecins "so that it can take appropriate measures."[16] It also removed the requirement that the Commission on End-of-Life Care report a physician's failure to adhere to MAD guidelines to authorities other than the Collège des médecins and the institution concerned.[17]

However, it seems doubtful that prudent public policy would now authorize a professional class to kill, and also guarantee its members immunity from prosecution. As a result, Quebec's Attorney General may be unwilling to provide the extent of immunity sought by physicians, and at least some physicians may be unwilling to provide euthanasia without it (Part 8).

Expectations of complicity

ARELC states that policies giving effect to the law will be determined by the Minister for Social Services and Youth Protection.[18] It also envisages the development of MAD guidelines by professional regulators, and requires protocols be developed by institutional councils of physicians, dentists or pharmacists or institutional medical directors.[19] Thus, the introduction of euthanasia will require the complicity of thousands of health care workers and administrators, who will be expected, by their actions, to formally accept and facilitate euthanasia as a form of health care under the rubric of "appropriate symptom relief." (See Appendix "B")

The expectation of this support was voiced by Dr. Louis Godin, President of the Federation of General Practitioners of Quebec at committee hearings in the fall of 2013. Dr. Godin also emphasized how important this is for physicians. Referring to the "burden" the law imposes on physicians ("un poids sur les médecins"), he stressed that physicians must be given the necessary resources:

> . . . qu'offrir des services en soin de vie, que ce soit des soins palliatifs, de la sédation palliative, que ce soit de l'aide médicale à mourir, ça ne peut pas se faire seul. Le médecin ne peut pas se retrouver seul à faire ça. C'est un acte médical, mais le médecin doit pouvoir être entouré, et on doit pouvoir le supporter.

> . . . offering life care services, whether palliative care, palliative sedation, whether medical help to die, it cannot be done alone. The doctor cannot be left alone to do it. This is a medical procedure, but the doctor must be surrounded, and we must support it.[20]

While Dr. Godin was ostensibly referring to resource management issues, one might reasonably detect here a strong desire for moral approbation. If this is correct, it is also reasonable to expect those participating in euthanasia to be highly sensitive to "judgementalism," likely to be perceived in continued public expression of opposition to euthanasia and in conscientious objection by colleagues and other professionals.

Probability of complicity

The committee hearings in the fall of 2013 demonstrated that large numbers of people involved in the delivery of health care in Quebec are likely to cooperate with the government in implementing ARELC. While the Quebec Medical Association (Association médicale du Québec)[21] and the Interprofessional Health Federation of Quebec (Fédération interprofessionnelle de la santé du Québec)[22] both expressed neutrality on the subject of euthanasia, the prospect that physicians would be allowed to kill patients in accordance with MAD guidelines was supported and even applauded by many health care professions and institutions that appeared before the legislative committee, including:

- the Collège des médecins (Collège des médecins du Québec)[23]
- the Federation of General Practitioners of Quebec (Fédération des médecins omnipraticiens du Québec)[24]
- the Federation of Quebec Medical Specialists (Fédération des médecins spécialistes du Québec)[25]
- the College of Pharmacists of Quebec (Ordre des pharmaciens du Québec)[26]
- the Pharmacists Association of Health Facilities of Quebec (Association des pharmaciens des établissements de santé du Québec)[27]
- the Quebec Order of Nurses (l'Ordre des infirmières et infirmiers du Québec)[28]
- the Quebec Association of Health and Social Services (Association québécoise d'établissements de santé et de services sociaux)[29]
- the Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Association

des conseils des médecins, dentistes et pharmaciens du Québec)[30]

Transcripts of the committee hearings suggest that official representatives of physicians, pharmacists and nurses seem to equate participation in the killing of patients as a mark of professional status and competence. The Collège des médecins admits that ARELC authorizes euthanasia - "an active act with the intention of causing death"[31] - but argues that the term "medical aid in dying" is more appropriate because the law requires that the lethal act be done by a physician, and that the MAD guidelines require "medical judgment of the medical conditions that should be part of a continuum of care."[32]

Similarly, the Federation of General Practitioners insists that the act of killing the patient must be "an act reserved for doctors."[33] When asked by the Minister of Health to justify this position - why, for example, nurses should not be allowed to administer a lethal drug - Dr. Louis Godin said that "it is a gesture that still remains very, very important, which requires a great capacity for evaluation, which involves a lot on a professional level." Thus, he said, "it is clear that it must be a medical procedure."[34]

The Quebec College of Pharmacists asked that the bill include reference to pharmacists "because his professional responsibility is engaged every time he dispenses drugs."[35] College spokesman Diane Lamarre said that it is a pharmacist's responsibility to monitor drug therapy, which "implies that pharmacists should assess whether the dose is appropriate, if it is too high or if it is too low."[36] She argued that is appropriate, given this "new reality," to entrust this responsibility to pharmacists, suggesting that it might even prevent patients from being involuntarily killed:

Le pharmacien est le dernier filet de sécurité, je vous dirais. . . Alors, je pense qu'il faut que le pharmacien réalise bien ces activités-lá. Il a la formation pour le faire, et ça fait partie de ses responsabilités...	The pharmacist is the last safety net, I would say . . .So I think we need the pharmacist to perform these activities. He has the training to do it, and it's part of his responsibilities . . .[37]

The absence of any reference to the participation of nurses in euthanasia surprised and offended the Order of Nurses:

L'infirmière, c'est le membre pivot de l'équipe interdisciplinaire. Les infirmières sont présentes sept jours par semaine, 24 heures par jour. De par leur relation privilégiée avec les personnes, elles apportent une contribution unique aux discussions avec les médecins et les autres membres de l'équipe interdisciplinaire. Or, nous sommes très étonnées de constater que, malgré cette réalité bien présente, le projet de loi élude complètement la contribution des infirmières, ne les mentionnant qu'en	The nurse is the key member of the interdisciplinary team. Nurses are present seven days a week, 24 hours a day. By their special relationship with the people, they make a unique contribution to discussions with physicians and other members of the interdisciplinary team. However, we are very surprised to find that, despite this reality, the bill totally ignored the contribution of nurses, not mentioning them in

référence à l'exercice de leur profession quand elles sont en cabinet professionnel.	reference to the exercise of their profession when they are in the consulting room.[38]

Nurse representative Mme. Lucie Tremblay told legislators, "[T]he doctor is important, but the contribution of the nurse is unique, because she is always there,"[39] so that "it was like really unthinkable that we find nothing in the bill that reflects the really important contribution of the nurse."[40]

Nous . . . croyons que l'encadrement des interventions dans les établissements doit intégrer l'apport des infirmières. . . . nous croyons que les infirmières devraient être davantage impliquées. La représentation des infirmières, aussi, au niveau de la commission des soins de fin de vie est incontournable. Nous sommes présentes auprès de ces malades-là et nous croyons que les infirmières devraient avoir une place sur cette commission des soins de fin de vie.	We . . . believe that guidelines for interventions in institutions should include the contribution of nurses. . . . . . we believe that nurses should be more involved. The representation of nurses, too, at the Commission on End of Life Care is essential. We are present with these patients and we believe that nurses should have a place on this End of Life Care board.[41]

The pharmacists did not receive additional recognition in ARELC, but a provision was added to the law requiring institutional councils of physicians, dentists and pharmacists to collaborate with the council of nurses in developing protocols for palliative care and euthanasia, and another amendment added a representative of the Order of Nurses to the Commission on End of Life Care, which will oversee the operation of ARELC.[42]

The Observatory for Aging and Society (l'Observatoire Vieillissement et Société) did not take a position on euthanasia,[43] but other organizations closely involved in health care delivery supported ARELC:

- the Provincial Association of User Committees, representing 600 (about 80%) committees in health care facilities throughout the province,[44]
- Quebec Association of Gerontology (Association Québécoise de Gérontologie)[45]
- College of Social Workers & Marriage & Family Therapists of Quebec (Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec)[46]
- the Institute for Care Planning (l'Institut de planification des soins)[47]
- the Council for the Protection of Patients (Conseil pour la protection des malades)[48]

Of particular note, notwithstanding criminal law to the contrary, Quebec's MAD law secured the support of the Quebec legal profession - the Quebec Bar (Barreau du Québec)[49] and the Chamber of Notaries of Quebec (Chambre des notaires du Québec)[50] - as well as the province's human rights establishment, represented by the Commission on Human Rights and Youth Rights (Commission des Droits de la Personne et des Droits de la Jeunesse)[51] and the Quebec Ombudsman (Protecteur du citoyen).[52]

Resistance to complicity

Palliative care physicians were prominent in their opposition to euthanasia and assisted suicide and expressed their views through professional organizations. These were joined in dissent by groups with broader membership:

- Physicians' Alliance for Total Refusal of Euthanasia (Collectif de médecins du refus médical de l'euthanasie)[53]
- Coalition of Physicians for Social Justice (Coalition des médecins pour la justice sociale)[54]
- Quebec Palliative Care Network (Réseau des soins palliatifs du Québec)[55]
- Quebec Society of Palliative Care Physicians (Société Québécoise des Médecins de Soins Palliatifs)[56]
- Christian Medical Dental Association[57]

Two of these organizations (Physicians' Alliance and the Quebec Society of Palliative Care Physicians) were formed in 2013, and some physicians are members and even executive members of more than one of the groups - a fact that then Minister of Health Véronique Hivon described suspiciously as "a little too normal." ("mais c'est normal un peu aussi").[58]

Be that as it may, the rejection of euthanasia by palliative care specialists was echoed by representatives of hospices and palliative care organizations (Part 8). Opponents of the law included:

- the Alliance of Quebec Hospices (l'Alliance des maisons de soins palliatifs)[59]
- Michel Sarrazin Home (La Maison Michel Sarrazin)[60]
- NOVA Montreal[61]

Alone among this group, the Palliative Home Care Society of Greater Montreal adopted a neutral position on MAD, apparently because the Society does not include physicians or assigned medical teams.[62] Madam Hivon understood this to mean that the Society would respect the wishes of patients who wanted euthanasia; she found the Society's neutrality "refreshing."[63]

Physicians (and, presumably, some other health care workers) were also reported to be members of other anti-euthanasia groups, like the Quebec Rally Against Euthanasia (Rassemblement québécois contre l'euthanasie),[64] and Living with Dignity (Vivre dans la dignité).[65]

So marked was the evidence of opposition to euthanasia that doubts were raised about the possibility of implementing the law. Since the law was passed as a result of assurances from the Quebec medical establishment that it could be implemented, a committee member who is now a minister of the Quebec government warned that they would be called to account if it is found that few physicians are willing to participate. (Part 4)

Enforcing complicity

Rights claims

Section 4 of ARELC states that eligible patients have a right to "end-of life-care," which includes euthanasia and palliative care. Dr. Laurent Marcoux, President of the Quebec Medical Association, was keenly aware of the effect of granting a statutory right:

Ce mot-là est vraiment nouveau dans la dispensation des soins, on dit que les soins palliatifs deviennent un droit; ce n'est pas un privilège, ce n'est pas s'il y en a, c'est un droit. Quand on a un droit, on peut exiger qu'il soit exercé. C'est quelque chose de très puissant, le droit.	That word is really new in the provision of care, it is said that palliative care becomes a right, not a privilege, it is not [a privilege], it is a right. When you have a right, you may require that it be exercised. This is something very powerful, a right.[66]

ARELC attenuates the right by recognizing limits inherent in law, institutional structures, policies and "human, material and financial resources."[67] The Quebec Ombudsman observed that realization of a "right" to end-of-life care was likely to be impacted by "organizational realities and budgetary constraints," making particular note of the existing shortage of palliative care beds.[68] Similarly, the Quebec Division of the Canadian Cancer Society warned the legislative committee not to allow the qualification "to be used as an excuse" not to provide palliative care.[69]

During the committee hearings, Mme. Stéphanie Vallée asked, "Do we have what it takes? . . . Are we ready to Quebec to codify the right to palliative care?"[70]

The physicians from Quebec Rally Against Euthanasia who answered her said that good palliative care was available in the province, but that political will was required to ensure that it was accessible to all citizens.[71] On the other hand, Dr. Serge Daneault of the Physicians' Alliance for Total Refusal of Euthanasia warned that the actual effect of a statutory right to both palliative care and euthanasia would tend to ensure the provision of euthanasia, not palliative care, since euthanasia is relatively cheap "while palliative care involve personnel costs and infrastructure are far from negligible."[72]

Be that as it may, from the perspective of those who object to euthanasia for reasons of conscience, ARELC's assertion of a "right" to the procedure is significant for two reasons. First, as then Minister of Health Véronique Hivon observed during the legislative hearings in the fall of 2013, the law creates expectations among the population.[73] In consequence, as noted by the Society of Palliative Care Physicians, patients will be more likely to demand that physicians provide euthanasia:

Ici, l'espace de concertation entre soignant et médecin est dominé par l'imposition au médecin d'un soin demandé par le malade. Pourquoi imposé? Parce que le médecin aura le devoir, si ce soin est un droit, de donner au malade l'accès à son droit. . .	Here, the space for dialogue among the caregivers and physician is controlled by the imposition of the medical care demanded by the patient. Why imposed? Because the doctor has a duty, if care is a right, to give the patient access to his right. . .

Dans un dialogue de partage de décision de soins, ni le médecin ni le malade n'imposent rien à l'autre. Nous partageons ensemble et nous choisissons ensemble un chemin. Dans le cas qui nous intéresse, je crois qu'il est possible - et notre conseil s'en inquiète - il est possible que le malade puisse dire : Monsieur, ceci est mon droit. Veuillez accomplir ce geste.

In a shared decisionmaking, neither the doctor nor the patient impose anything on each other. We share together and we choose a path. In the case before us, I believe it is possible - and our board is concerned - it is possible that the patient can say, sir, this is my right. Please do this.[74]

The second point follows from the first, and ehcoes Dr. Marcoux's comment to the effect that one who has a right may demand that others accede to it. For example: the Quebec Association of Gerontology wants patients "to be informed and supported in their efforts . . . to go to medical help to die."[75] It recommended that, "in the event of non-compliance with their rights," the right to use the statutory complaints process be acknowledged.[76] Apparently as a result, a new section was added to the final text of the Act requiring that complaints about end-of-life care be given priority in the statutory complaints process and by the Collège des médecins.[77] (See Appendix "B")

Beyond complaints, ARELC opens the door to coercive regulation and litigation, especially potentially ruinous human rights prosecutions. Professor Margaret Somerville, who was testifying against Bill 52, told the legislative committee about the Declaration of Montreal,[78] an internationally recognized statement approved by the World Health Organization. Professor Somerville explained that the Declaration means that "for health care professionals to leave a person in serious pain is actually a breach of human rights."[79] She was emphasizing the point that pain management is traditional and acceptable medical treatment and must always be provided, but that a doctor killing a patient has never been considered medical treatment. She added, "and I don't think that it should be regarded as medical treatment."[80]

However, ARELC has redefined medical practice to allow doctors to kill patients in accordance with MAD guidelines as a form of "symptom relief," and the Declaration of Montreal is silent on the subject of euthanasia and assisted suicide. Hence, the Declaration can be cited by euthanasia proponents as evidence that, in establishing a right to both palliative care and euthanasia, ARELC is entirely consistent with the Declaration. Indeed: they may argue that establishing a right to euthanasia is actually required by the Declaration, inasmuch as it states that failure to establish "laws, policies and systems" to ensure access to "fully adequate pain management" is not only unethical, but "a breach of the human rights of people harmed as a result."[81]

This is precisely the approach taken by Quebec's Commission on Human Rights and Youth Rights, though it cites the Charter of Rights and Freedoms of Quebec rather than the Declaration of Montreal. Commission representative Jacques Fremont told the legislative committee that "the legal framework of medical aid in dying as a right is needed to implement the rights and freedoms under the Charter."

"In other words," he said, "it is the absence of legislation [i.e., permitting euthanasia: Administrator] that could have the effect of violating the fundamental rights of Quebecers."[82]

Thus, the statutory declaration of a "right" is the most powerful weapon in the legal arsenal likely to be used to enforce compliance with ARELC and to attack freedom of conscience among those who refuse to facilitate the procedure. At the very least, it exposes them to the rhetorically deadly accusation that they are denying patients their rights.

Rather than deny either patients' access to euthanasia or physicians' freedom of conscience, several mechanisms have been proposed to accommodate both. Delegation is not permitted by law, and transfer of patients will not normally be feasible. However, workable alternatives include the advance identification of willing physicians in each region, the use of electronic communication services to permit remote consultation and the establishment of mobile "flying squads" of euthanatists to provide services not otherwise available in some parts of the province. (Part 5)

Discriminatory screening

Euthanasia proponents deny that they intend to force physicians to personally kill patients, but the exercise of freedom of conscience by objecting physicians who refuse to kill patients can lead to unjust discrimination against them. Discriminatory screening of physicians unwilling to kill patients can be effected by denying them employment in their specialties and denying them hospital privileges. By such strategies one can truthfully affirm that physicians are not actually being forced to kill, although those unwilling to do so may be forced to change specialties, leave the profession or emigrate. (Part 5)

Forced participation

It appears that, even where euthanasia or assisted suicide is legal, the majority of physicians do not actually provide the services. Often for purely pragmatic reasons, euthanasia supporters do not usually insist that an unwilling physician should be compelled to personally kill a patient.

However, objecting physicians not only refuse to kill patients, but also often refuse to do anything that they believe makes them morally responsible for the killing. This includes actions that indirectly support or facilitate it. Hence, it is likely that most of the attacks on freedom of conscience resulting from ARELC will be precipitated, not by a refusal to kill directly, but by this kind of refusal to participate indirectly in killing. Refusing to participate, even indirectly, in conduct believed to involve serious ethical violations or wrongdoing is the response expected of physicians by professional bodies and regulators in order to avoid physician complicity in such procedures. (Part 6)

Refusing to kill

Generally

Physicians may refuse to provide euthanasia if the patient is legally ineligible, and for other reasons, including conscientious objection. ARELC requires physicians who refuse to provide euthanasia for any reason other than non-eligibility to notify a designated administrator, who then becomes responsible for finding a MAD physician. The idea is to have the institution or health care system completely relieve the physician of responsibility for facilitating the procedure. (Part 7)

Conscientious objection

The protection of conscience provision in ARELC distinguishes physicians from other health professionals, providing less protection for physicians than for others. Other health care professionals may refuse to "take part" (participate) in killing a patient for reasons of conscience. Physicians may refuse only "to administer" euthanasia - a very specific action - which seems to suggest that they are expected to participate in other ways. (Part 7)

Criminal law

Some Quebec physicians may be unwilling to provide euthanasia while the criminal law stands, even if they do not object to the procedure. Quebec's Attorney General may be unwilling to provide the extraordinary kind of immunity sought by physicians, and some physicians may be unwilling to provide euthanasia without it. As long as euthanasia remains a criminal offence, physicians or other entities responsible for issuing or administering MAD guidelines may respond to requests for euthanasia with total refusal to co-operate. Even a partial and scattered response of this kind would likely be administratively troublesome. (Part 7)

Complaints

Patients may lodge complaints against physicians who refuse to provide or facilitate euthanasia with institutions and the regulatory authority, regardless of the reasons for refusal.(Part 7)

Palliative care hospices

Palliative care hospices may permit euthanasia under the MAD protocol on their premises, but they do not have to do so. Patients must be advised of their policy before admission. The government included another section of ARELC to provide the same exemption for La Michel Sarrazin, a private hospital. The exemptions were provided for purely pragmatic and political reasons. The exemptions have been challenged by organizations that want hospices forced to kill patients who ask for MAD, or at least to allow physicians to come in to provide the service. Hospice representatives rejected the first demand and gave mixed responses to the second. A prominent hospice spokesman predicted that the pressures would increase after the passage of ARELC, and that hospices refusing to provide euthanasia would operate in an increasingly hostile climate. (Part 8)

Codes of ethics

Refusing to participate, even indirectly, in conduct believed to involve serious ethical violations or wrongdoing is the response expected of physicians by professional bodies and regulators. It is not clear that Quebec legislators or professional regulators understand this. A principal contributor to this lack of awareness - if not actually the source of it - is the Code of Ethics of the Collège des médecins , because it requires that physicians who are unwilling to provide a service for reasons of conscience help the patient obtain the service elsewhere.

As a general rule, it fundamentally unjust and offensive to human dignity to require people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It was a serious error to include this a requirement in code of ethics for Quebec physicians and pharmacists. The error became intuitively obvious to the Collège des médecins and College of Pharmacists when the subject shifted from facilitating access to birth control to facilitating the killing of patients.

A policy of mandatory referral of the kind found in the *Code of Ethics* of the Collège des médecins is not only erroneous, but dangerous. It establishes the principle that people can be compelled to do what they believe to be wrong - even gravely wrong - and punish them if they refuse. It purports to entrench a 'duty to do what is wrong' in medical practice, including a duty to kill or facilitate the killing of patients. To hold that the state or a profession can compel someone to commit or even to facilitate what he sees as murder is extraordinary. (Part 9)

Federal options

Unlike the original Bill 52, ARELC explicitly authorizes physicians to kill patients deemed eligible for MAD by the Act. Thus, it is now clear that the federal government could go to court to have the statute declared unconstitutional. However, should the federal government mount a constitutional challenge to ARELC, the province is well-positioned to argue that the medical profession has decided (through its official representatives) that euthanasia is a legitimate form of medical intervention, that the Quebec legal profession supports this view, and that the province's human rights commission insists that refusing to provide euthanasia is a violation of human rights. In effect, this would pit the federal government not just against the Quebec government, but against highly influential opinion makers and power blocks in the province.

For this reason, political considerations are likely to be much in play as the federal government considers its options in responding to the constitutional challenge to its jurisdiction in criminal law. While worries about "fanning the fires of separatism" seem misplaced following the decisive defeat of the separatist Parti Quebecois, it has been suggested that Quebec has undergone a gradual "de-Canadianization" so that it is, in reality, a politically, legally and socially distinct entity: that it has, in a sense, "pretty much already separated" from the rest of Canada.[83]

Hence, even if separatism is now a dead issue, challenging ARELC might well antagonize Quebeckers who would resent federal intervention as a violation of their right to self-determination. The federal Conservative Party, its grip on power maintained by a 17 seat majority in the House of Commons,[84] hopes to gain seats in Quebec in the next federal election,[85] which must be held by 19 October, 2015. While it is possible that Prime Minister Stephen Harper might be willing to jeopardize his party's chances in the province by going to court, there are two reasons to think that the federal government will take no action prior to the next federal election.

The first is that ARELC will not actually come into effect until the end of 2015;[86] no lives will be at risk before a federal election is held.

The second is that the Supreme Court of Canada will hear the case of *Carter v. Canada* in October, 2014,[87]87 and will rule on the current criminal prohibition of physician-assisted suicide. The government might decide that it is prudent (and consistent with its political interests in Quebec) to wait for the judgement of the Supreme Court in Carter before challenging ARELC, since euthanasia will not be available in Quebec before then. If the Supreme Court upholds the criminal prohibition of assisted suicide, the ruling is likely to be instructive in framing an argument against ARELC. On the other hand, if the Supreme Court strikes down the prohibition, the government may conveniently avoid responsibility for taking a position on a contentious issue.

Should the provincial government refuse to prosecute Quebec physicians who kill patients in accordance with *An Act Respecting End-of-Life Care*, the federal government could, in theory, appoint and pay lawyers to act as prosecutors. The preceding considerations make this highly unlikely prior to a Supreme Court of Canada decision in Carter and the 2015 federal election. More important, even if the federal government decided to hire prosecutors, it would face a significant practical problem. Federal prosecutors would be unable to act without the cooperation and assistance of the police, who investigate allegations and provide prosecutors with the evidence needed to support charges. Quebec police forces are under the jurisdiction of the provincial and municipal governments. While they are technically autonomous in their decisions about what to investigate, it is doubtful that they would be willing to go against the public policy of the province on an issue as contentious as euthanasia.

Long term prospects

Given the almost absolute control of criminal prosecution exercised by the provincial government, it seems unlikely that Quebec physicians who provide euthanasia under MAD guidelines will be prosecuted even if the prohibition of assisted suicide and euthanasia is maintained by the Supreme Court of Canada, and even if ARELC is ultimately struck down as unconstitutional. Note that the province refused to enforce Canada's criminal law on abortion for 12 years, despite changes in the governing party, so a policy of refusing to prosecute physicians providing euthanasia could have similar staying power. Finally, the continued de facto decriminalization of euthanasia in Quebec would probably generate considerable pressure in other provinces to follow suit.

Quebec's strategy in brief

To sum up, it appears that the strategy of the Quebec government includes four key elements:

a) Compliant medical regulators, professionals and health care authorities who have indicated that they will conform to ARELC, redefine medical practice to include euthanasia and establish it as a legitimate form of health care;

b) Use of existing state health care delivery organizations, institutions and state agencies to enforce compliance with ARELC by health care workers;

c) Reliance upon the legal profession, the human rights commission and provincial ombudsman to establish euthanasia as a human right;

d) Refusal to prosecute physicians who kill patients in accordance with MAD guidelines, thus circumventing the criminal prohibition of euthanasia.

Consequences for freedom of conscience

That official representatives of the legal and medical establishments of Quebec have formally declared their support for the view that physicians may kill their patients in order to relieve their symptoms is profoundly significant. Having formally approved of euthanasia, these establishments, including all of those who collaborate in drawing up MAD guidelines and protocols, will have a personal stake in defending the decision and proposing it as an ethical norm.

Thus, the legal and medical establishments will be inclined to assert that all physicians in Quebec have a professional duty to provide euthanasia, or, at the very least, a professional duty to facilitate it.

Logically, this would require modification of medical, pharmacy and nursing education so that students could be taught how to kill or assist in killing patients. Ultimately, it could make a willingness to provide or facilitate euthanasia a condition for admission to and progress within the health care professions.

Considering this in light of the government's strategy, those who refuse to provide or facilitate euthanasia for reasons of conscience will likely find themselves in increasingly complicated and contentious working environments. Their continued refusal to acquiesce in what they believe to be gravely wrong and their insistence that euthanasia is incompatible with the ethical practice of medicine is likely to become increasingly offensive to the powers-that-be and to colleagues who support and provide euthanasia.

In the end, freedom of conscience for Quebec health care workers who object to euthanasia may come to mean nothing more than the freedom to find another job, or the freedom to leave the province.

Notes

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. Bill 52, *An Act respecting end-of-life care.* (http://www.consciencelaws.org/background/procedures/assist009-041.aspx) (Accessed 2013-06-12) Hereinafter "ARELC."

2. Séguin, Rhéal, “Quebec first province to adopt right-to-die legislation,” *The Globe and Mail*, 5 June, 2014. (http://www.theglobeandmail.com/news/national/quebec-first-province-to-adopt-right-to-die-legislation/article19009781/) Accessed 2014-06-22)

3. *Medical Act*, RSQ, c M-9 (http://www.canlii.org/en/qc/laws/stat/rsq-c-m-9/latest/rsq-c-m-9.html) (Accessed 2013-06-12)

4. ARELC, Section 69. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#MEDICAL_ACT)

5. ARELC, Section 69. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#MEDICAL_ACT)

6. ARELC, Section 3(6). (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#003(6))

7. ARELC, Section 30. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#030)

8. Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill 52* (hereinafter "*Consultations*"), Wednesday, 9 October 2013 - Vol. 43 N° 45: Professor Joceyln Downie, T#019 (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#019)

9. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N° 45: Professor Joceyln Downie, T#020 (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#020)

10. *Select Committee Dying with Dignity Report* (March, 2012) p. 89-90. See also Recommendation 20. (http://www.dyingwithdignity.ca/database/files/library/Quebec_death_with_dignity_report.pdf) (Accessed 2013-06-13)

11. *Select Committee Dying with Dignity Report* (March, 2012) (March, 2012) p. 90. (http://www.dyingwithdignity.ca/database/files/library/Quebec_death_with_dignity_report.pdf) (Accessed 2013-06-13)

12. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#015 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#015)

13. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#021) (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#021)

14. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#014 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#014)

15. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#094 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#094)

16. ARELC, Section 46. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#046)

17. ARELC, Section 47. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#047)

18. ARELC, Section 19. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#019)

19. ARELC, Sections 33, 35. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#033)(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#035)

20. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#012 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#012)

21. 21. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Quebec Medical Association (Dr. Laurent Marcoux, Dr. Claude Roy, Mr. Norman Laberge) (http://www.consciencelaws.org/background/procedures/assist009-004.aspx)

22. *Consultations*, Thursday, 26 September 2013 - Vol. 43 no. 39: Interprofessional Health Federation of Quebec (Régine Laurent, Julie Martin, Michàle Boisclair, Brigitte Doyon) (http://www.consciencelaws.org/background/procedures/assist009-022.aspx)

23. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand) (http://www.consciencelaws.org/background/procedures/assist009-001.aspx)

24. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin) (http://www.consciencelaws.org/background/procedures/assist009-002.aspx)

25. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of Quebec Medical Specialists (Dr. Gaétan Barrette, Dr. Diane Francoeur, Nicole Pelletier) (http://www.consciencelaws.org/background/procedures/assist009-003.aspx)

26. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert. (http://www.consciencelaws.org/background/procedures/assist009-005.aspx)

27. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Pharmacists Association of Health Facilities of Quebec (François Paradis, Linda Vaillant) (http://www.consciencelaws.org/background/procedures/assist009-006.aspx)

28. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon) (http://www.consciencelaws.org/background/procedures/assist009-035.aspx)

29. *Consultations*, Wednesday, 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health and Social Services (Michel Gervais, Diane Lavallée) (http://www.consciencelaws.org/background/procedures/assist009-008.aspx)

30. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger) (http://www.consciencelaws.org/background/procedures/assist009-009.aspx)

31. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#121 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#121)

32. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#119 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#119)

33. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#084 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#084)

34. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#086 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#086)

35. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert), T#012 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#012)

36. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: *College of Pharmacists of Quebec* (Dianne Lamarre, Manon Lambert), T#103 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#103)

37. 37. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert), T#104 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#104)

38. 38. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#021 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#021)

39. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#106 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#106)

40. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#110 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#110)

41. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#025 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#025)

42. ARELC, Sections 33, 39(1)b (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#033)(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#039)

43. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Observatory for Aging and Society (André Ledoux, Gloria Jeliu, Denise Destrempes, Claude Tessier) (http://www.consciencelaws.org/background/procedures/assist009-025.aspx)

44. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Provincial Association of User Committees (Claude Ménard, Pierre Blain) (http://www.consciencelaws.org/background/procedures/assist009-020.aspx)

45. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams) (http://www.consciencelaws.org/background/procedures/assist009-030.aspx)

46. *Consultations*, Wednesday, 18 September 2013 - Vol. 43 no. 35: College of Social Workers & Marriage & Family Therapists of Quebec (Claude Leblond, Marielle Pauzé) (http://www.consciencelaws.org/background/procedures/assist009-007.aspx)

47. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd) (http://www.consciencelaws.org/background/procedures/assist009-036.aspx)

48. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Council for the Protection of Patients (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert) (http://www.consciencelaws.org/background/procedures/assist009-021.aspx)

49. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Quebec Bar (Johanne Brodeur, Marc Sauvé, Michel Doyon) (http://www.consciencelaws.org/background/procedures/assist009-010.aspx)

50. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Chamber of Notaries of Quebec (Jean Lambert) (http://www.consciencelaws.org/background/procedures/assist009-013.aspx)

51. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier) (http://www.consciencelaws.org/background/procedures/assist009-031.aspx)

52. *Consultations*, Tuesday 24, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Ombudsman (Raymonde Saint-Germain, Marc André Dowd, Michel Clavet) (http://www.consciencelaws.org/background/procedures/assist009-012.aspx)

53. *Consultations*,Tuesday 24 September 2013 - Vol. 43 no. 37: Physicians' Alliance for Total Refusal of Euthanasia (Dr. Catherine Ferrier, Dr Serge Daneault, Dr François Primeau) (http://www.consciencelaws.org/background/procedures/assist009-014.aspx)

54. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Coalition of Physicians for Social Justice (Dr. Paul Saba, Hélène Beaudin, Dominique Talarico) (http://www.consciencelaws.org/background/procedures/assist009-015.aspx)

55. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Quebec Palliative Care Network (Alberte Déry, Dr.Christiane Martel, Danielle Blondeau, Pierre Deschamps, Jessy Savaria, Yvan Lessard) (http://www.consciencelaws.org/background/procedures/assist009-026.aspx)

56. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 41: Quebec Society of Palliative Care Physicians (Dr. Patrick Vinay, Dr. Michelle Dallaire) (http://www.consciencelaws.org/background/procedures/assist009-028.aspx)

57. Christian Medical Dental Association, *The Christian Medical and Dental Society of Canada Response to Quebec's Bill 52 - An Act respecting end of life care*. Larry Worthen, Executive Director, September 12, 2013 (The Society was not allowed to appear before the legislative committee.) (http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_75065&process=Default&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz) (Accessed 2014-08-10)

58. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 41: Quebec Society of Palliative Care Physicians (Dr. Patrick Vinay, Dr. Michelle Dallaire) T#031 (http://www.consciencelaws.org/background/procedures/assist009-028.aspx#031)

59. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert) (http://www.consciencelaws.org/background/procedures/assist009-023.aspx)

60. *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard) (http://www.consciencelaws.org/background/procedures/assist009-024.aspx)

61. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville) (http://www.consciencelaws.org/background/procedures/assist009-029.aspx)

62. *Consultations*, Thursday, 10 October 2013 - Vol. 43 No. 46: Palliative Home Care Society of Greater Montreal (Elsie Monereau, Bérard Riverin) T#019 (http://www.consciencelaws.org/background/procedures/assist009-038.aspx#019)

63. *Consultations*, Thursday, 10 October 2013 - Vol. 43 No. 46: Palliative Home Care Society of Greater Montreal (Elsie Monereau, Bérard Riverin) T#112 (http://www.consciencelaws.org/background/procedures/assist009-038.aspx#112)

64. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Rally Against Euthanasia (Dr. Claude Morin, Dr. Marc Bergeron, Daniel Arsenault, Clément Vermette) (http://www.consciencelaws.org/background/procedures/assist009-016.aspx)

65. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity(Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot) (http://www.consciencelaws.org/background/procedures/assist009-017.aspx)

66. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Quebec Medical Association (Dr. Laurent Marcoux, Dr. Claude Roy, Mr. Norman Laberge),T#048 (http://www.consciencelaws.org/background/procedures/assist009-004.aspx#048)

67. ARELC, Section 4. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#004)

68. *Consultations*, Tuesday 24, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Ombudsman (Raymonde Saint-Germain, Marc André Dowd, Michel Clavet), T#018 (http://www.consciencelaws.org/background/procedures/assist009-012.aspx#018)

69. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Canadian Cancer Society (Suzanne Dubois, Mélanie Champagne, Marie-Anne Laramee),T#013 (http://www.consciencelaws.org/background/procedures/assist009-027.aspx#013)

70. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Rally Against Euthanasia (Dr. Claude Morin, Dr. Marc Bergeron, Daniel Arsenault, Clément Vermette) T#109 (http://www.consciencelaws.org/background/procedures/assist009-016.aspx#109)

71. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Rally Against Euthanasia (Dr. Claude Morin, Dr. Marc Bergeron, Daniel Arsenault, Clément Vermette) T#112,T#113, T#115, T#116, T#118, T#120, T#129 (http://www.consciencelaws.org/background/procedures/assist009-016.aspx#112; http://www.consciencelaws.org/background/procedures/assist009-016.aspx#113; http://www.consciencelaws.org/background/procedures/assist009-016.aspx#115; http://www.consciencelaws.org/background/procedures/assist009-016.aspx#116; http://www.consciencelaws.org/background/procedures/assist009-016.aspx#118; http://www.consciencelaws.org/background/procedures/assist009-016.aspx#120; http://www.consciencelaws.org/background/procedures/assist009-016.aspx#129)

72. *Consultations*,Tuesday 24 September 2013 - Vol. 43 no. 37: Physicians' Alliance for Total Refusal of Euthanasia (Dr. Catherine Ferrier, Dr Serge Daneault, Dr François Primeau), T#014 (http://www.consciencelaws.org/background/procedures/assist009-014.aspx#014)

73. 73. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Quebec Medical Association (Dr. Laurent Marcoux, Dr. Claude Roy, Mr. Norman Laberge),T#046 (http://www.consciencelaws.org/background/procedures/assist009-004.aspx#046)

74. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 41: Quebec Society of Palliative Care Physicians (Dr. Patrick Vinay, Dr. Michelle Dallaire), T#010 (http://www.consciencelaws.org/background/procedures/assist009-028.aspx#010)

75. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#017 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#017)

76. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#020 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#020)

77. ARELC, Section 48. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#048)

78. The International Association For The Study Of Pain. *Declaration of Montréal: declaration that access to pain management is a fundamental human right.* (http://www.iasp-pain.org/Advocacy/Content.aspx?ItemNumber=1821&navItemNumber=582) (Accessed 2014-06-20)

79. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Margaret Somerville, T#012 (http://www.consciencelaws.org/background/procedures/assist009-033.aspx#012)

80. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Margaret Somerville, T#013 (http://www.consciencelaws.org/background/procedures/assist009-033.aspx#013)

81. The International Association For The Study Of Pain. *Declaration of Montréal: declaration that access to pain management is a fundamental human right.* (http://www.iasp-pain.org/Advocacy/Content.aspx?ItemNumber=1821&navItemNumber=582) (Accessed 2014-06-20)

82. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier)T#009 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#009)

83. Chittley, Gordon, "'Gradual de-Canadianization' means Quebec has pretty much already separated." CTV News, 6 March, 2014 (http://knlive.ctvnews.ca/gradual-de-canadianization-means-quebec-has-pretty-much-already-separated-1.1716318)(Accessed 2014-06-22)

84. Parliament of Canada: *Party Standings*. (http://www.parl.gc.ca/SenatorsMembers/House/PartyStandings/standings-e.htm) (Accessed 2014-06-22)

85. Leblanc, Daniel, "Conservatives plan Quebec blitz to seize seats from NDP in 2015." *The Globe and Mail*, 21 January, 2014. (http://www.theglobeandmail.com/news/politics/conservatives-plan-quebec-blitz-to-seize-seats-from-ndp-in-2015/article16424590/) (Accessed 2014-06-22)

86. Séguin, Rhéal, “Quebec first province to adopt right-to-die legislation,” *The Globe and Mail*, 5 June, 2014. (http://www.theglobeandmail.com/news/national/quebec-first-province-to-adopt-right-to-die-legislation/article19009781/) (Accessed 2014-06-22)

87. *Carter v. Canada (Attorney General),* 2013 BCCA 435 (http://www.courts.gov.bc.ca/jdb-txt/CA/13/04/2013BCCA0435.htm)(Accessed 2014-06-22)

Redefining the Practice of Medicine

Euthanasia in Quebec

Part 2: ARELC in Detail

Sean Murphy, Administrator
Protection of Conscience Project

Revision Date: 2014-08-12

Abstract

An Act Respecting End-of-Life Care ("ARELC") is intended to legalize euthanasia by physicians in the province of Quebec. It replaces the original Bill 52, the subject of a previous commentary by the Project. ARELC purports to establish a right to euthanasia for a certain class of patients by including it under the umbrella of "end-of-life care." ALERC calls euthanasia for competent patients "medical aid in dying" (MAD). ALERC provides for but does not identify euthanasia for incompetent patients, called here Euthanasia Below the Radar (EBTR).

ARELC's definition of palliative care clearly distinguishes palliative care from MAD. In defining MAD, the statute does not say "kill," but employs a euphemism: "hastening death." Nonetheless, it is obvious that ARELC authorizes a physician to kill patients.

The MAD guidelines for euthanasia restrict it to legally competent persons at least 18 years old who are insured under the provincial Health Insurance Act. Beyond age, legal competence and residency/insurance, someone seeking euthanasia must be at "the end of life," suffering from an incurable serious illness, in an advanced state of irreversible decline and suffering from constant and unbearable physical or psychological pain. The patient need not be terminally ill and is free to refuse effective palliative treatments.

A qualifying patient must personally make a written request for MAD "in a free and informed manner." It must be signed in the presence of professional, who must also sign the request. The attending physician must confirm the eligibility of the patient and the free and informed nature of the request. He must verify the persistence of suffering and a continuing desire for euthanasia, speak to other members of the health care team and see that the patient is able to discuss the decision with others. However, the physician cannot advise family members unless the patient so wishes. Thus, a physician may kill a patient without the knowledge of the family. Finally, the attending physician must obtain a written opinion of an independent physician confirming eligibility for euthanasia.

Only physicians may administer the lethal drugs or substances, and, having done so, must remain with a patient until he dies. Physicians who provide MAD must report the fact to institutional authorities or the College of Physicians, as well as the Commission on End-of-Life Care.

A central role in the provision of euthanasia is assigned to institutional councils of physicians, dentists and pharmacists (or, in their absence,institutional directors of care). They are to adopt MAD guidelines, and then review reports from physicians who have provided the procedures to "assess the quality of the care provided." The Collège des médecins is also to receive such reports from physicians and, apparently, to establish or at least recognize "clinical standards" relative to the procedures.

In addition to the MAD protocol, ARELC permits a substitute decision-maker to order that an incompetent patient be starved and dehydrated to death. This provides an alternative form of euthanasia subject to none of the restrictions or conditions imposed by MAD guidelines: hence the term used here - "Euthanasia Below the Radar" (EBTR). Since death by starvation and dehydration would be a painful process, it is likely that, in such circumstances, continuous palliative sedation (CPS) would be used to anaesthetize the patient. This may lead to the under-reporting of the actual number of euthanasia cases and further confusion about continuous palliative sedation.

Canadian criminal law is not affected by ARELC. A physician who does what ARELC requires in the MAD protocol will have provided excellent evidence that the killing was intentional, planned and deliberate. Conforming to the Act Respecting End-of-Life Care would seem to increase the likelihood that a physician - and anyone counselling, aiding, abetting his act - could be charged and convicted for first degree murder, for which the punishment is life imprisonment without parole for 25 years.

Definitions

"Institution" [Section 3(1)]

The definition of "institution" is critical because Act Respecting End-of-Life Care (ARELC) purports to impose a duty to provide end-of-life care (which includes euthanasia) on institutions governed by the Act Respecting Health Services and Social Services (ARHS&SS) that operate local community service centres, hospital centres, and residential and long-term care centres. As a general rule, any person or partnership who carries on "activities inherent in the mission" of one of these kinds of centres is considered to be an "institution." Institutions are public if they are non-profit corporations, or if they are incorporated or are formed as a result of amalgamation or conversion under the Act Respecting Health Services and Social Services. They are private if they are unincorporated, or profit-making corporations, or non-profit corporations providing some kinds of health care for fewer than 20 patients. (Appendix A10, A11)

"Palliative care hospice" [Section 3(2)]

The definition of "palliative care hospice" is equally important because ARELC exempts palliative care hospices from having to provide euthanasia. Palliative care hospices are "community organizations" accredited by the Minister of Health and Social Services that have agreements with institutions to obtain some or all of the care needed by their clientele. "Community organization" is defined by ARHS&SS as incorporated an non-profit entity governed by a board of directors. Although community organizations receive government funding, they remain free to define their "orientations, policies and approaches." (Appendix A6)

"End-of-life care" [Section 3(3)]

ARELC speaks of "end-of-life care," which it defines as "palliative care provided to end-of-life patients and medical aid in dying."[1]

Thus, when ARELC states that "every person whose condition requires it has the right [subject to the Act] to receive end-of-life care,"[2] this must be understood to mean that the law establishes two different rights: a right to palliative care for "end-of-life patients," and a right to euthanasia that is not limited to "end-of-life patients" - a frequently used but undefined term.

"Palliative care" [Section 3(4)]

The distinction between euthanasia and palliative care is frequently (and often deliberately) blurred. Testimony from a number of experts and specialist groups before the legislative committee in the fall of 2013 repeatedly emphasized that euthanasia is not palliative care. Legal effect to this distinction is given by one of the most important additions to the final text of ARELC: a definition of palliative care:

> "palliative care" means the total and active care delivered by an interdisciplinary team to patients suffering from a disease with reserved prognosis, in order to relieve their suffering, without delaying or hastening death, maintain the best quality of life possible and provide them and their close relations the support they need;[3]

"Continuous palliative sedation" (CPS) [Section 3(5)]

The original text of Bill 52 included the novel term "terminal palliative sedation," which generated a good deal of confusion and comment during the committee hearings in the fall of 2013. It appears that the Quebec government used the term because it could be understood to mean terminating the life of the patient. The term has been replaced in ARELC by "continuous palliative sedation," (CPS) defined as "administering medications or substances to an end-of-life patient to relieve their suffering by rendering them unconscious without interruption until death ensues."[4]

When compared to professionally recommended palliative care practice, ARELC's definition of continuous palliative sedation is problematic. When CPS is properly used, the goal is not to render the patient unconscious:

> The aim or intention of CPST is the relief of suffering due to refractory and intolerable symptoms and not the sedation itself. There should be no intention to shorten life and no intention to bring about complete loss of consciousness although this latter may sometimes be necessary. The level of consciousness is lowered only as far as is necessary to relieve the suffering. Thus . . . the combination and amount of drug used to reduce the level of consciousness should be just sufficient to alleviate distress. Viewing the actual sedation as the desired outcome is inappropriate.[5]

ARELC's definition does not imply the CPS causes death. However, ARELC also requires that a patient or substitute decision maker be advised of "the irreversible nature of the sedation,"[6] so "irreversibility" remains an implied characteristic of the procedure envisioned in the law. Moreover, the reporting requirements imposed by ARELC for continuous palliative sedation are almost identical to the reporting requirements for euthanasia,[7] which seems to imply an extremely close connection between the two procedures.

Sedation is not, by its nature, irreversible, a point demonstrated by the recommended monitoring of patients and careful titration of sedation. Moreover, CPS is normally considered only when death is imminent, clinically defined as "'dying' or 'being in the last stages of life,'" typically understood to mean a projected remaining lifespan of "hours or days, or at most less than two weeks."[8]

The problematic statutory definition of CPS, the reference to "irreversibility" and the peculiar reporting requirements is likely related to the fact that ARELC authorizes two different kinds of euthanasia, and CPS may be used in conjunction with one of them (See Euthanasia Below the Radar).

"Medical aid in dying" (MAD) [Section 3(6)]

MAD was not defined in Bill 52, apparently to avoid a constitutional challenge to the law by the federal government. Nonetheless, everyone was aware that MAD meant euthanasia by physicians. The Quebec government has dispensed with the winks and nods and has defined "medical aid in dying" in ARELC:

> "medical aid in dying" means care consisting in the administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death.[9]

The law requires that a physician who determines that "medical aid in dying" (MAD) may be administered to a patient "must administer such aid personally and take care of and stay with the patient until death ensues."[10]

The statute does not say "kill" or even "end the life of the patient," but employs a euphemism: "hastening death." Nonetheless, in view of the law's requirement that the physician who administers the medication or substance must "stay with the patient until death ensues," it would be disingenuous to claim that ARELC does not authorize a physician to kill patients. We do not, after all, describe executions by lethal injection (which may use the same drugs and procedures employed in MAD) as "hastening death" or "aid in dying." (Part 4)

Eligibility for "medical aid in dying" (MAD) [Section 26]

Age, residence and health insurance (Section 26(1), (2)]

The statutory MAD guidelines for euthanasia restrict it to legally competent persons at least 18 years old who are insured under the provincial Health Insurance Act.[11] Insured persons are residents or temporary residents of Quebec who have registered for provincial health insurance coverage.[12] A Quebec resident is a Canadian citizen, permanent resident of Canada, a refugee or other category of person defined by regulation whose permanent home is in Quebec. Temporary residents of Quebec include foreign nationals authorized to work in Quebec for more than six months and their spouses and dependents, certified foreign students and their spouses and dependents and other less common categories defined by regulation.[13]

Canadians who move to Quebec from other provinces and register for Quebec health care become insured persons only after the health care coverage from the other province ceases.[14] Generally, this occurs after two or three months. Similarly, most other people who have moved to Quebec become residents or temporary residents on first day of the third month following their arrival.[15]

"At the end of life" [Section 26(3)]

In order to be eligible for MAD, patients must also be "at the end of life."[16] This requirement was added to ARELC, apparently because of concern that the original wording in Bill 52 could be construed too broadly.[17]

Illness, irreversible decline, pain [Sections 26(4), 26(5), 26(6)]

In addition to meeting the criteria of age, competency, insurance, and being "at the end of life," MAD criteria require that a patient must also "suffer from a serious and incurable illness,"[18] be in an "advanced state of irreversible decline in capability,"[19] and "experience constant and unbearable physical or psychological pain which cannot be relieved in a manner the patient deems tolerable."[20]

Stability of eligibility criteria

At first glance, the eligibility criteria for MAD seem clear and stable, so that circumstances in which conflicts of conscience may arise with respect to direct participation will be limited and predictable. However, it will be seen in Part 3 that this is not the case.

The MAD procedure (Section 29)

A qualifying patient must personally request MAD "in a free and informed manner," in writing, using a form approved by the Minister.[21] If the patient is unable to date and sign the form, it may be signed on his behalf by a competent adult who is not part of the health care team looking after the patient.[22] It must be signed in the presence of "a health and social services professional," who may be the attending physician. This professional witness must sign the form as well. The form is to be given to the attending physician if he is not the professional witness.[23]

The attending physician cannot provide euthanasia unless he first confirms eligibility of the patient using the criteria in Section 26 (above)[24] and ensures that the patient is making a free and informed decision, not a result of "external pressure,"[25] a decision that includes an awareness of "the prognosis of the illness and other therapeutic possibilities and their consequences."[26] The fact that a patient has refused effective palliative treatments is not reason to refuse euthanasia.[27]

The physician must also talk to the patient "at reasonably spaced intervals" to verify "the persistence of suffering" and a continuing desire for euthanasia,[28] ensure that the patient has the opportunity to discuss their decision with people they wish to contact,[29] and discuss the request with other members of the health care team who are in regular contact with the patient.[30] However, the physician cannot discuss the patient's request with family members unless the patient so wishes.[31] Thus, under the terms of the Act, a physician may kill a patient without the knowledge of the family.

Finally, the attending physician must obtain the written opinion of an independent physician who is not involved with the care or treatment of the patient confirming the patient's eligibility for euthanasia. Before providing the opinion, the second physician must review the patient chart and examine the patient.[32]

Only physicians may provide MAD, and, having done so, must "stay with the patient until death ensues."[33] Physicians associated with private health care facilities may provide euthanasia at a patient's home.[34]

Physicians associated with institutions who provide CPS or MAD must report the fact to the council of physicians, dentists and pharmacists (or medical director) having jurisdiction.[35] Those practising in private health facilities must report to the College of Physicians.[36] They must report all MAD cases to the Commission on End-of-Life Care within 10 days.[37]

Euthanasia Below the Radar (EBTR)

The MAD provisions are limited to legally competent patients. They include statutory restrictions, procedural guidelines and reporting requirements, and have understandably been the focus of most public and professional attention. Most people probably believe that this is the only type of euthanasia authorized by the new law.

However, ARELC also provides that substitute decision makers can order legally incompetent patients who are not dying to be starved and dehydrated to death. This practice, identified here as Euthanasia Below the Radar (EBTR), is to be distinguished from the withdrawal of food and fluids when death is imminent and they are no longer wanted or needed. EBTR was introduced into ARELC by means of a revision to the original text.

Section 6 of Bill 52 stated that a competent adult could "refuse to receive, or withdraw consent to, a life-sustaining treatment or procedure." This introduced nothing new; it merely codified an existing right. Equally important, even if refusal of treatment or care by a competent patient led to his death, the law has never considered this euthanasia or assisted suicide. However, two modifications were introduced into what is now Section 5 of ARELC.

First: the original phrase "life-sustaining treatment or procedure"" has been replaced in ARELC's by "life-sustaining care." The latter term more readily encompasses food and fluids in any form. Second: ARELC provides that life-sustaining care (i.e., including food and fluids) can be refused on behalf of or withdrawn from an incompetent patient by a substitute medical decision-maker.[38] The change permits a substitute decision-maker to direct that an incompetent patient who is neither terminally ill nor dying be starved and dehydrated to death.

The change from treatment to care and the statutory authorization of a substitute decision maker to stop the provision of food and fluids may have been prompted by a British Columbia case that made the news in late 2013. Family members went to court to stop caregivers from spoonfeeding an 82 year old legally incompetent nursing home resident when she opened her mouth to accept food. She was not terminally ill, nor was she dying, so to comply with the family wishes would have caused her death by starvation and dehydration. Among other things, the judge ruled that spoon-feeding was not "health care" within the meaning of the law, but a form of personal care. While he agreed that, under the common law, a competent adult can refuse food and fluids and thus commit suicide, he found no legal precedent to justify such a decision by a substitute decision maker in the case of an incompetent person. On the other hand, he recognized that his conclusions could be affected by public policy or statute.[39] Within the province of Quebec, the authority that the judge could not find in the law has now been supplied by Section 5 of ARELC.

Professor Jocelyn Downie of Dalhousie University supports this as an option, at least in the case of competent patients, or when authorized by an advance directive made by a patient before becoming incompetent.[40] She warned legislative committee members that euthanasia by starvation and dehydration should be clearly identified as a specific category and made subject to MAD guidelines. Otherwise, she said, "You will be setting up a situation where somebody could access [euthanasia] when they're not expected to die for five months and not meet your conditions of medical aid in dying."[41]

Professor Downie's advice was ignored. Euthanasia of legally incompetent patients by starvation and dehydration is not identified as such in ALERC. It is completely unrestricted and is not even reportable: hence the term used here: Euthanasia Below the Radar (EBTR).

However, since death by starvation and dehydration would be a painful process, it is likely that, in such circumstances, continuous palliative sedation (as defined by ARELC rather than recommended medical practice) would be used to anaesthetize the patient. This probably explains ALERC's medically problematic definition of CPS and its requirement that CPS be reported to councils of physicians, dentists and pharmacists or the Collège des médecins, but not to the Commission on End of Life Care. ALERC's handling of Below the Radar Euthanasia and CPS may lead to the under-reporting of the actual number of euthanasia cases and further confusion about the nature of continuous palliative sedation.

Institutional exemptions

Palliative care hospices may offer euthanasia, but are not required to do so. Before admitting patients, they must explain what kind of end-of-life care they offer,[42] so that patients seeking MAD services will not be inadvertently misled and may go elsewhere (Part 8)

Section 72 of the Act is a grandfather clause that concerns any institution operating a "general and specialized hospital centre" that offers only palliative care. Such institutions "may continue to offer that care exclusively" (i.e., need not provide euthanasia), as long as they notify patients of this before admitting them.[43] Véronique Hivon, when Minister of Health, explained that the section is intended to apply to a single institution - La Maison Michel Sarrazin.[44] (Part 8)

Institutional oversight

The Collège des médecins du Québec is designated to receive reports from physicians who have provided CPS or MAD, and to assess the "quality of the care provided." The Act appears to assume that the College will establish or at least recognize "clinical standards" relative to the procedures.[45] It is to report annually on the provision of the services, both on its website and to the Commission on End-of-Life Care.[46]

A central role in the provision of euthanasia is assigned to institutional councils of physicians, dentists and pharmacists (or, in their absence, institutional directors of care[47]) (Appendix A19.1). They are to adopt CPS and MAD guidelines,[48] and then review reports from physicians who have provided the procedures to "assess the quality of the care provided."[49]

Commission on End-of-Life Care

ARELC authorizes the establishment of the Commission on End-of-Life Care[50] that will consist of eleven government appointees who will hold office for up to five years.[51] They are to evaluate the implementation of the Act and provide advice to the government.[52]

The Commission is to review every physician report of euthanasia. If at least two thirds of the members present believe that a physician failed to comply with Section 29 MAD procedure, they are to notify the physician, the institution, and the Collège des médecins du Québec. As a result of concerns expressed by physicians, a requirement in Bill 52 to notify "any other authority concerned" - such as the police - has been dropped.[53]

Criminal law

Canadian criminal law is not affected by the Act. Hence, no matter what the Act purports to do, the following will remain criminal offences in Quebec even if the Act passes:

Killing

- Murder (1st degree)[54]
- Murder (2nd degree)[55]
- Manslaughter[56]
- Conspiracy to commit murder[57]
- Doing or omitting to do anything for the purpose of aiding any person to commit murder[58]
- Abetting any person to commit murder[59]
- Counselling, procuring, soliciting or inciting someone to commit murder,[60] even if the murder is not committed.[61]

Administering lethal drugs

- Administering a noxious substance[62]
- Conspiracy to administer a noxious substance[63]
- Doing or omitting to do anything for the purpose of aiding any person to administer a noxious substance[64]
- Abetting any person in the administration of a noxious substance[65]
- Counselling, procuring, soliciting or inciting someone to administer a noxious substance,[66] even if the substance is not administered[67]

Parties to criminal offences

While the Act assigns the task of providing "medical aid in dying" to physicians, the criminal law applies, not just to the act of killing the patient, but to any act or omission done for that purpose, including the making and distribution of MAD guidelines and protocols. This has implications not only for all of the health care workers and institutions expected by the Act to provide MAD, but for administrators, regulators and councils directed by the Act to regulate or manage the procedures.

First degree murder

First degree murder is defined as murder that is "planned and deliberate."[68] Since "medical aid in dying" means killing the patient, a physician who does what the Act requires under Section 29 and 30 (see above) will have provided excellent evidence that the killing was intentional, planned and deliberate. Thus, conforming to the Act Respecting End-of-Life Care would seem to increase the likelihood that a physician - and anyone counselling, aiding, abetting his act - could be charged and convicted for first degree murder, for which the punishment is life imprisonment without parole for 25 years.[69]

Notes

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. *An Act respecting end-of-life care* (Hereinafter "ARELC"), Section 3(3). (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#003(3))

2. ARELC, Section 4. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#004)

3. ARELC, Section 3(4). (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#003(4))

4. ARELC, Section 3(5). (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#003(5))

5. Dean MM, Cellarius V, Henry B, Oneschuk D, Librach Canadian Society Of Palliative Care Physicians Taskforce SL. "Framework for continuous palliative sedation therapy in Canada." *J Palliat Med*. 2012 Aug;15(8):870-9. doi: 10.1089/jpm.2011.0498. Epub 2012 Jul 2 (http://www.cspcp.ca/wp-content/uploads/2014/06/Canadian_CPST_Framework_16-June-2011.pdf) (Accessed 2014-08-10)

6. 6. ARELC, Section 24. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#024)

7. 7. The Act requires physicians to report both CPS and MAD to institutional councils of physicians, dentists and pharmacists (Section 34) (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#034) or the Collège des médecins (Section 36) (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#036) which, in turn, must report the statistics on its website and to the Commission on End of Life Care (Section 37.)

(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#037) The executive directors of institutions are to report annually to their boards the number of times CPS and MAD were administered. (Section 8) (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#008) Physicians must report every MAD case - but not CPS cases - to the Commission on End-of-Life Care. (Section 46) (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#046)

8. Dean MM, Cellarius V, Henry B, Oneschuk D, Librach Canadian Society Of Palliative Care Physicians Taskforce SL. "Framework for continuous palliative sedation therapy in Canada." *J Palliat Med.* 2012 Aug;15(8):870-9. doi: 10.1089/jpm.2011.0498. Epub 2012 Jul 2 (http://www.cspcp.ca/wp-content/uploads/2014/06/Canadian_CPST_Framework_16-June-2011.pdf) (Accessed 2014-08-10)

9. ARELC, Section 3(6). (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#03(6))

10. ARELC, Section 30. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#030)

11. ARELC, Section 26(1), (2) (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#026)

12. Health Insurance Act, Chapter A-29, Section 1(g.1). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/A_29/A29_A.html) (Accessed 2014-06-11)

13. Health Insurance Act, Chapter A-29, Section 5; Regulation respecting eligibility and registration of persons in respect of the Régie de l'assurance maladie du Québec, Section 3 (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=3&file=/A_29/A29R1_A.HTM) (Accessed 2014-06-11)

14. 14. Health Insurance Act, Chapter A-29, Section 8; (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/A_29/A29_A.html)(Accessed 2014-06-11)

15. 15. Regulation respecting eligibility and registration of persons in respect of the Régie de l'assurance maladie du Québec, Section 4 (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=3&file=/A_29/A29R1_A.HTM)(Accessed 2014-06-11)

16. 16. ARELC, Section 26(3) (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#026)

17. Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill 52* (hereinafter "*Consultations*"), Wednesday, 9 October 2013 - Vol.

43 No. 45: Quebec Association of Clinical Ethicists (Delphine Roigt, Emilia Guévin, Michel Lorange) T#144
(http://www.consciencelaws.org/background/procedures/assist009-034.aspx#144)

18. ARELC, Section 26(4)
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#026)

19. 19. ARELC, Section 26(5)
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#026)

20. ARELC, Section 26(6)
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#026)

21. 21. ARELC, Section 26
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#026)

22. ARELC, Section 27
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#027)

23. ARELC, Section 26
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#026)

24. ARELC, Section 29(1)
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#029)

25. ARELC, Section 29(1)a
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#029(1)a)

26. ARELC, Section 29(1)b
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#029(1)b)

27. ARELC, Section 6
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#006)

28. ARELC, Section 29(1)c
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#029(1)c)

29. ARELC, Section 29(2)
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#029(2))

30. ARELC, Section 29(1)d
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#029(1)d)

31. ARELC, Section 29(1)e
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#029(1)e)

32. ARELC, Section 29(3)
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#029(3))

33. ARELC, Section 30
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#030)

34. ARELC, Section 16
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#016)

35. ARELC, Sections 34, 35
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#034)
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#035)

36. ARELC, Section 36
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#036)

37. ARELC, Section 46
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#046)

38. ARELC, Section 5
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#005)

39. *Bentley v. Maplewood Seniors Care Society,* 2014 BCSC 165
(http://www.courts.gov.bc.ca/jdb-txt/SC/14/01/2014BCSC0165.htm)(Accessed 2014-06-24)

40. Consultations, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Joceyln Downie, T#061, T#085 (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#061) (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#065)

41. Consultations, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Joceyln Downie, T#078. (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#078) During the hearing, Professor Downie was referring to the process Bill 52 called "terminal palliative sedation" - a novel term applied to euthanasia by starvation and dehydration masked by deep, continuous palliative sedation.

42. ARELC, Section 13
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#013)

43. ARELC, Section 72
(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#072)

44. Note: in Bill 52, the original section number was 65. Consultations, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#030, T#032
(http://www.consciencelaws.org/background/procedures/assist009-018.aspx#030)
(http://www.consciencelaws.org/background/procedures/assist009-018.aspx#032)

45. ARELC, Section 36 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#036)

46. ARELC, Section 37 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#037)

47. ARELC, Section 35 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#035)

48. ARELC, Section 33 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#033)

49. ARELC, Section 34 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#034)

50. ARELC, Section 38 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#038)

51. ARELC, Section 39 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#039)

52. ARELC, Section 42 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#042)

53. ARELC, Section 47 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#047)

54. *Criminal Code* (R.S.C., 1985, c. C-46) (Hereinafter "*CC*"), Section 229 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-114.html); Section 231(1) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html) (Accessed 2014-07-25)

55. *CC*, Section 229 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-114.html); Section 231(7) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html) (Accessed 2014-07-25)

56. *CC*, Section 232(1) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-116.html) (Accessed 2014-07-25)

57. *CC.* Section 465. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-225.html)(Accessed 2014-07-25)

58. *CC*, Section 21(b). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

59. *CC*, Section 21(c). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html) (Accessed 2014-07-25)

60. *CC*, Section 22 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

61. *CC*, Section 464. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-224.html) (Accessed 2014-07-25)

62. *CC*, Section 245. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-119.html) (Accessed 2014-07-25)

63. *CC*, Section 465. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-225.html)(Accessed 2014-07-25)

64. *CC*, Section 21(b). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

65. *CC,* Section 21(c). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

66. *CC*, Section 22. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

67. *CC*, Section 464. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-224.html)(Accessed 2014-07-25)

68. *CC*, Section 231(2). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html)(Accessed 2014-07-25)

69. *CC*, Section 745(a). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-429.html)(Accessed 2014-07-25)

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Redefining the Practice of Medicine

Euthanasia in Quebec

Part 3: Evolution or Slippery Slope?

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

Euthanasia laws frequently include guidelines and safeguards intended to prevent abuse. Eligibility criteria are the most basic guidelines or safeguards. In considering their stability, it is important to consider not only the elasticity of existing statutory provisions, but recommendations for expansion that might ultimately result in changes to the law.

ARELC's requirement for legal competence can be sidestepped through the provision allowing substitute decision makers to order the starvation and dehydration of legally incompetent patients (Euthanasia Beneath the Radar-EBTR). Beyond this, there are strong indications that the reach of the law will be expanded to include legally incompetent patients.

The Quebec Commission on Human Rights and Youth Rights has indicated that it would consider refusal of euthanasia to the legally incompetent, uninsured persons or minors, including children, to be unlawful discrimination

No agreement was reached during legislative hearings about when a patient is "at the end of life," so this added criterion provides only an opportunity for disagreement and judicial interpretation.

A "serious and incurable illness" could conceivably include clinical depression, which could cause "unbearable psychological pain" that cannot be relieved because the patient finds the side-effects of anti-depressants intolerable. Such a patient qualify for euthanasia, and the Quebec Ombudsman recommended that the possibility of euthanasia for the mentally ill be seriously studied.

Expanding the law's reach in these directions is supported by a number of powerful and influential organizations in Quebec; a number of them recommended an incremental approach to accomplish this.

For these reasons, it is reasonable to believe that ARELC's criteria for euthanasia will be broadened by interpretation, by statutory amendments and by court rulings, so that, as time goes on, there will be more euthanasia, not less. Depending upon one's moral or ethical perspective, this can be described as a slippery slope, a process of natural evolution (for better or worse) or progressive democracy in action.

It is not necessary here to determine which of these conflicting perspectives is the most accurate. It is sufficient to observe that the expansion of the

eligibility criteria for euthanasia can be safely predicted. This is relevant to concerns about freedom of conscience because increasing the range of circumstances under which euthanasia can be provided increases the likelihood of conflicts of conscience and conscientious objection.

Introduction

Euthanasia laws frequently include guidelines and safeguards intended to prevent abuse, known in Quebec as balises ("safeguards" or "tags") to prevent dérive ("drift" or "deviation" from the standard; "abuse"). Thus, the Quebec Bar emphasized the need to "to establish standards (normes) and specific and well-defined tags (balises) to protect and reassure patients and their families,"[1] while the Quebec Ombudsman reviewed Bill 52 "to ensure that appropriate safeguards (balises) are in place and implemented in a practical way to prevent such abuses (dérives) as might occur."[2]

A number of those who appeared before the legislative committee studying Bill 52, while acknowledging the need for safeguards, expressed dissatisfaction with the bill because they believed it to be too restrictive: that it failed to make euthanasia more widely available. Their criticisms would apply equally to ARELC, the text of which, in this respect, is not substantially different from Bill 52.

In view of this pressure for expansion of access to euthanasia, it is important to consider not only the elasticity of existing statutory provisions, but recommendations for expansion that might ultimately result in changes to the law, either by statutory amendment or judicial fiat. This is relevant to concerns about freedom of conscience because increasing the range of circumstances under which euthanasia can be provided increases the likelihood of conflicts of conscience and conscientious objection.

Statutory eligibility

Eligibility criteria are the most basic guidelines or safeguards. The criteria set out in ARELC to establish eligibility for euthanasia[3] require that a patient

- be legally competent;
- be at least 18 years old;
- be insured under the provincial health insurance act;
- be "at the end of life;""suffer from a serious and incurable illness;"
- be in an "advanced state of irreversible decline in capability;"
- "experience constant and unbearable physical or psychological pain which cannot be relieved in a manner the patient deems tolerable."

This seems fairly straightforward, but appearances are deceiving.

Elastic eligibility

Competence

In the first place, the requirement for legal competence can be sidestepped through the provision allowing substitute decision makers to order the starvation and dehydration of legally incompetent patients (Euthanasia Beneath the Radar- EBTR). Beyond this, there are strong indications that the reach of the law will be expanded to include legally incompetent patients.

The provisions that make EBTR possible were not added to ARELC until after the 2013 hearings into Bill 52. Thus, a number of the submissions to the legislative committee expressed concern, based on the original wording of the bill, that incompetent persons would be denied the benefit of euthanasia. The Commission on Human Rights and Youth Rights warned that the failure to extend MAD criteria to allow physicians to kill legally incompetent patients impinged upon the patients' fundamental freedoms,[4] and that denying euthanasia to people who are legally incompetent may constitute unlawful discrimination.[5]

Most of the complaints or suggestions concerned the failure to allow euthanasia based on an advanced medical directive, particularly in the case of those who prepared a directive while legally competent but who become incompetent, usually as a result of degenerative diseases, but also by accidents. Allowing euthanasia based on advanced directives was recommended not only by the Quebec Association for the Right to Die with Dignity,[6] but by

- the Collège des médecins;[7]
- the Federation of Quebec Medical Specialists;[8]
- the College of Social Workers & Marriage & Family Therapists of Quebec;[9]
- Association of Councils of Physicians, Dentists and Pharmacists of Quebec;[10]
- the Quebec Bar;[11]
- Professor Jocelyn Downie;[12]
- the Institute for Care Planning.[13]

The Collège des médecins urged consideration of euthanasia "for all incompetent individuals," (emphasis added) which, presumably, includes those who have never been competent;[14] the Quebec human rights commissioner made the same kind of recommendation.[15]

On this point, however, the College of Social Workers & Marriage & Family Therapists was more cautious. The College felt that there was a sufficiently broad consensus to permit physicians to kill patients who had asked for euthanasia through an advanced directive. However, it did not think it advisable to amend the law to permit the killing of people who had never been competent, and who, for that reason, had never asked for euthanasia. The College believed there is not yet "a consensus of social acceptance large enough to actually impose it upon society, so "it would not be a good choice, in our view."

> We must now, I think, accept what is accepted by the population, which allows us to

> take a step and then continue to talk calmly, in a non-partisan way, about the other dimensions.[16]

Insurance

The residency/insurance requirement would seem to preclude "euthanasia tourism." However, no one who is insured in another Canadian province would be denied medical treatment in Quebec prior to becoming an "insured person" under Quebec law. Indeed: no uninsured person would be denied medical treatment. The practice in such cases is to provide the treatment and bill the patient. Someone from another province would then apply to his own province's health insurance plan for reimbursement, which would be limited to the fees payable under the other province's plan.[17]

Since the normal practice is to provide services for uninsured persons and then bill them, it is not clear what would happen if someone from another province who met all of the requirements for ARELC (apart from residency/insured status) asked for euthanasia in Quebec. The Quebec Commission on Human Rights and Youth Rights has indicated that it would consider refusal in such circumstances to be unlawful discrimination.[18]

"At the end of life"

Bill 52 made no reference to time frames for euthanasia. The Quebec Medical Association suggested that, while greater care is needed in providing euthanasia when death is not imminent, it is conceivable that some people might decide that death is imminent "at two years instead of three months." The Association foresaw that euthanasia might be provided in such circumstances within the doctor-patient relationship, and that such cases can be reviewed by the Commission on End of Life Care. Dr. Laurent Marcoux, President of the Association, said this would be an exception, but "You know, in life there are always exceptions."[19]

On the other hand, Paul Brunet of the Council for the Protection of Patients saw no reason to consider this an exception. Assuming that the patient met all of the other criteria, he asserted that the choice of timing should be up to the patient:

> What is the difference between indignity when that person decides one morning to finish, five years before his death or eight days before his death? . . . What is the difference? . . . Who are we to come and say: No, you will wait maybe your death is imminent? Who are we, who am I?[20]

A requirement was added to ARELC that patients must be at "the end of life" to qualify for euthanasia. But when is a patient "at the end of life"?

The legislative committee studying Bill 52 was unable to answer the question. A reference to death being "imminent" was considered, but rejected after legal experts cautioned that the Supreme Court had decided that a threat to do something three years in the future could be considered "imminent."[21] The same experts said that there are many ways to understand the term "end of life."[22]

It was acknowledged that it is very difficult to find a definition of end of life in medical literature,[23] and that "the notion of the end of life is a concept that is interpreted very, very different in the groups."[24] Mme Hivon, referring to the title of the bill, mused that it means being "really close" to death.[25] One group thought the "end of life" could begin up to six months in advance of death,[26] the

Order of Nurses suggested it might mean a matter of weeks or days,[27] and a legislator referred to a remark that "the end of life begins at the moment of our birth."[28]

Ultimately, the question remained unanswered, so the added condition that an applicant for euthanasia must be "at the end of life" provides only an opportunity for disagreement and judicial interpretation.

"Serious incurable illness, advanced decline, pain"

With respect to the remaining conditions, note that the patient need not be terminally ill and remains free to refuse effective palliative treatments that he deems 'intolerable' and opt, instead, for euthanasia. Moreover, most of the terms used are highly subjective; they can be variously understood and broadly construed. A "serious and incurable illness" could conceivably include clinical depression, which could cause "unbearable psychological pain" that cannot be relieved because the patient finds the side-effects of anti-depressants intolerable. Such a patient might end up in an advanced state of decline in capability, "irreversible" because of refusal to accept the (intolerable) treatment offered.

These interpretations (and others) are possible without changing a word of the statute, and one should not be too quick to dismiss them as mere fancies. For example, the Quebec Ombudsman suggested that the Commission on End of Life Care "should really very thoroughly" study the possibility of providing euthanasia for the mentally ill.[29] And Professor Margaret Somerville challenged the legislative committee members:

I'd ask you to think, if a law with it would currently be murder, first degree murder, is not being obeyed, why do you think the restriction in Bill 52 would be obeyed? So, if our physicians are not obeying the law now, when it's the most serious crime on our books, why would they obey Bill 52?[30]

An incremental approach

Recall that, in relation to euthanasia for legally incompetent persons, the College of Social Workers & Marriage & Family Therapists advocated a step-by-step approach to expanding the law, moving forward in conjunction with the social consensus on such things.

This incremental approach to legalization was also recommended by others. The Federation of General Practitioners, which also believed that the legislature should consider allowing euthanasia authorized in advance directives, nonetheless thought that this "should perhaps be in a second stage."[31] The Quebec Bar, while recommended that applications to kill patients who have never been competent to consent to euthanasia should be handled by the courts,[32] but thought it best to proceed slowly:

> So what we are saying is that for these cases, maybe take the time to see how we will enforce the law, what will be, actually, the data that will be forthcoming, appeal to the Council on End of Life Care to see . . . how we can broaden the dialogue in society, and, possibly, at a second stage, perhaps include these cases. But for the sake of equilibrium - equilibrium you sometimes mention - it will, for now, in a first step, be limited to those able to clearly and freely express their will.[33]

Former Quebec Minister of Health, Dr. Yves Bolduc, agreed. "[W]e are perhaps not ready to take the step of going directly there, but rather say: maybe do it in two stages."

> [T]here could be one day when we will take the second step, that is to say, first, to settle what is for us, what we think is perhaps a little more obvious, and, [concerning] legally incompetent people, minors, gain experience, put a system in place . . . and, secondly, there may be a reassessment of the law, then we could decide, then, whether we could not go to the next step.[34]

"Getting over taboos"

With respect to authorizing the killing of patients who have never been legally competent, Ghislain Leblond admitted "we are not ready to do that right away."[35] His co-presenter, Dr. Yvon Bureau spoke of a "duty" to those who have never been legally competent to ensure that "these people have the least amount of pain and they suffer as little as possible,"[36] but acknowledged that "society is not there" - yet - and urged that the matter be studied by the Commission on End of Life Care. Leblond was insistent:

> I think we should get over our taboos. I know that there are some great souls who will become concerned, but the fact remains that there is a category of people who are condemned to atrocious lives of hell, and parents and families who are sentenced to lives hell, and we must think as a society, if we are a community, we must get over our taboos and face up to this.[37]

In the meantime, the Quebec Ombudsman counselled patience and faith in evolution. The Ombudsman believed it important to pass the bill "even conservatively."

> And there is a social consensus that permits all that is in the bill to be accepted , I think we should move forward. And if there are still reservations that ensure that the bill could be blocked and delayed, in my opinion, it is better to start with what is a consensus , which is ensured, and let the law evolve.[38]

In what direction might the law evolve? What other "taboos" might people have to "get over"?

Euthanasia for children

Making euthanasia available to minors and children might qualify as evolution. This was recommended by the College of Social Workers & Marriage & Family Therapists of Quebec,[39] Ghislain Leblond and Dr. Yvon Bureau,[40] the Observatory for Aging and Society[41] and the Commission on Human Rights and Youth Rights.[42] The Commission was especially emphatic, putting the legislators on notice that restricting euthanasia to adults will be impossible.

> The bad news for you is that, if the bill remains as it is when passed, I guarantee you there will be a 16 year old who will go to court, then the discourse will be judicial. And if I had a penny to put on the table, it will ... your legislation, the exemption, including the prohibition for incompetent minors will be quick-fried.[43]

The transcribed phrase "incompetent minors" (les mineurs inaptes) may not have accurately captured the statement, which would make more sense as "prohibition for incompetents and minors." In any case, the Commission made it clear that preventing physicians from providing euthanasia for the uninsured, legally incompetent and minors would probably run afoul of human rights law, which imposes the criterion of "minimal impairment."

This criterion requires indeed that the measure adopted minimally affect the rights and freedoms restricted. However, a full and unconditional ban as proposed in the bill imposed on minors, persons unable to consent to care, and those who are not insured under the Health Insurance Act is difficult to justify. In addition, the distinction between people who are incompetent to consent to care and others may constitute discrimination based on disability.[44]

While recognizing that introducing such amendments might be difficult, the Commission insisted that it was "essential."

"It would be a shame," said Jacques Frémont, "after having courageously come this far, for the legislature to fail to protect the rights of highly vulnerable people."[45]

Thus, while others wait for society and the law to "evolve," the Commission on Human Rights and Youth Rights seems poised to jumpstart the process.

Or, as euthanasia opponents argue, to grease the slippery slope.

Evolution or slippery slope?

Slippery slope

The danger of a "slippery slope" is one of the perennial arguments advanced against euthanasia. Briefly: the argument asserts that if euthanasia is legalized under restricted conditions, it will be impossible, in practice, to maintain the restrictions, and more and more people will be killed in circumstances never contemplated when the law was first changed. Ultimately, it is said, people will be killed even though they might not wish to be.

Now, the transcripts of the hearings into Bill 52 certainly demonstrate that it is unrealistic to expect that ARELC's criteria for eligibility for euthanasia will be maintained. Patients and physicians can interpret them broadly even as they stand, and, in the longer term, it is obvious that powerful state institutions and influential groups in Quebec intend to see access to euthanasia expanded, moving incrementally to achieve their objectives. This suggests that concern about a "slippery slope" is not unreasonable.

Evolution

However, supporters of Bill 52/ARELC emphatically reject concerns about slippery slopes, even as they urge legislators to make euthanasia more and more available. The Quebec Association for the Right to Die, for example, told the legislative committee, "It is not a slippery slope to consider a new development, which is already predictable now."[46] The more common argument, however, is that society is evolving, and morality and ethics are evolving much faster than the law.[47] Again, Dr. Yves Bolduc:

> I have seen a lot in society, that the law lags behind ethics, and some point at the level of society we accepted things we did, they were accepted at the moral and ethical

> level, and laws had to be changed later, and I think it's this type of case that we now have.

"The proof," he said, "is that this is not the first in the world to do it, there are already four countries that do it. And then, at the medical level, there are doctors who are willing to do so, there are patients who are willing to have it."[48]

Véronique Hivon, the minister responsible for Bill 52 and ARELC, asked, rhetorically, if legislators should ignore the evolution of society, especially "the consecration of the autonomy of the individual," and let people suffer by refusing applications for euthanasia even when they cannot be relieved by palliative care.[49] While she acknowledged the fear of slippery slopes, she warned that "fear is never a good guide," saying, "I think caution is a good guide, and that's what guided me in developing the bill."[50]

The democratic process

In this regard, it is instructive to consider Mme. Hivon's rebuke of the Catholic bishops, responding to their attempt to demonstrate their concerns about a slippery slope:

> I tell you, and unlike you, democratic debate reassures me because I think that we, our role is to be in line with the demands of the people and listen to everyone without taboos. Sure it can hurt [the feelings of] people who have different values €‹€‹to hear us talk about this . . . quite freely. Should it expand? Should we consider legally incompetent people? People who say [they want physician assisted dying] when they are competent, but who become incompetent? People who are legally incompetent from birth? Minors? But I think it's a great sign of democratic health to be able to have this debate as we have had for almost four years, with such openness, where there are no taboos.[51]

In her view, the democratic process is an adequate safeguard against a slippery slope leading to uncontrolled killing.

> When we say: perhaps a second stage, it's not because, overnight, we will not adhere to the guidelines: on the contrary. It's been three years since we discussed what should be done. And then we formed €‹€‹another parliamentary committee for a month to discuss guidelines: this is because we want to make them with due care. Then, if there is democratic debate in a few years, will also, well, we, as elected officials, we must welcome that debate. . .[52]52

Conflicting perspectives

Reiterating the point made earlier, it is reasonable to believe that ARELC's criteria for euthanasia will be broadened by interpretation, by statutory amendments and by court rulings or decisions of quasi-judicial tribunals, so that, as time goes on, there will be more euthanasia, not less. Depending upon one's moral or ethical perspective, this can be described as an uncontrolled descent down a slippery slope, a gradual process of natural evolution (for better or worse) or a democratically controlled ascent to a more liberal, compassionate and enlightened society.

It is not necessary here to determine which of these conflicting perspectives is the most accurate. It is sufficient, for present purposes, to observe that, based on the submissions to the legislative committee studying Bill 52, the expansion of the eligibility criteria for euthanasia can be safely predicted. This increases the likelihood of conflicts of conscience and conscientious objection to the procedure.

Notes

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. (". . .d'édicter des normes et des balises précises et bien définies pour protéger et rassurer les usagers et leurs proches.") Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill 52* (Hereinafter "*Consultations*"), Thursday, 19 September 2013 - Vol. 43 no. 36: Quebec Bar (Johanne Brodeur, Marc Sauvé, Michel Doyon), T#006 (http://www.consciencelaws.org/background/procedures/assist009-010.aspx#006)

2. (". . . m'assurer que des balises appropriées soient prévues et mises en oeuvre de façon concrète afin d'empêcher que de telles dérives puissent survenir.") *Consultations*, Tuesday 24, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Ombudsman (Raymonde Saint-Germain, Marc André Dowd, Michel Clavet), T#011 (http://www.consciencelaws.org/background/procedures/assist009-012.aspx#011)

3. ARELC, Section 26 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#026)

4. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#010 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#010)

5. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#011 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#011)

6. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#012 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#012)

7. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#008(c) (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#008(c))

8. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of Quebec Medical Specialists (Dr. Gaétan Barrette, Dr. Diane Francoeur, Nicole Pelletier), T#111 (http://www.consciencelaws.org/background/procedures/assist009-003.aspx#111)

9. *Consultations*, Wednesday, 18 September 2013 - Vol. 43 no. 35: College of Social Workers & Marriage & Family Therapists of Quebec (Claude Leblond, Marielle Pauzé), T#016, T#092 (http://www.consciencelaws.org/background/procedures/assist009-007.aspx#016) (http://www.consciencelaws.org/background/procedures/assist009-007.aspx#092)

10. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger), T#109 (http://www.consciencelaws.org/background/procedures/assist009-009.aspx#109)

11. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Quebec Bar (Johanne Brodeur, Marc Sauvé, Michel Doyon), T#028 (http://www.consciencelaws.org/background/procedures/assist009-010.aspx#028)

12. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Joceyln Downie, T#061, T#062 (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#061) (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#062)

13. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#021, T#022, T#029 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#021) (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#022) (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#029)

14. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#009(d) (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#009(d))

15. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#010 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#010)

16. *Consultations*, Wednesday, 18 September 2013 - Vol. 43 no. 35: College of Social Workers & Marriage & Family Therapists of Quebec (Claude Leblond, Marielle Pauzé), T#092 (http://www.consciencelaws.org/background/procedures/assist009-007.aspx#092)

17. British Columbia Ministry of Health-Medical Services Plan- B.C. Residents: *Leaving British Columbia* (http://www.health.gov.bc.ca/msp/infoben/leavingbc.html)(Accessed 2014-06-11)

18. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43. *Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier) T#010,*

011, 013 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#010)
(http://www.consciencelaws.org/background/procedures/assist009-031.aspx#011)
(http://www.consciencelaws.org/background/procedures/assist009-031.aspx#013)

19. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Quebec Medical Association (Dr. Laurent Marcoux, Dr. Claude Roy, Mr. Norman Laberge),T#088
(http://www.consciencelaws.org/background/procedures/assist009-004.aspx#088)

20. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Council for the Protection of Patients (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert)T#050
(http://www.consciencelaws.org/background/procedures/assist009-021.aspx#050)

21. *Consultations*, Thursday, 10 October 2013 - Vol. 43 No. 46: Committee of Legal Experts (Jean-Pierre Ménard, Michelle Giroux) T#069, T#071
(http://www.consciencelaws.org/background/procedures/assist009-039.aspx#069)
(http://www.consciencelaws.org/background/procedures/assist009-039.aspx#071)

22. *Consultations*, Thursday, 10 October 2013 - Vol. 43 No. 46: Committee of Legal Experts (Jean-Pierre Ménard, Michelle Giroux) T#072
(http://www.consciencelaws.org/background/procedures/assist009-039.aspx#072)

23. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#051
(http://www.consciencelaws.org/background/procedures/assist009-035.aspx#051)

24. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45 Quebec Association of Clinical Ethicists (Delphine Roigt, Emilia Guévin, Michel Lorange) T#144
(http://www.consciencelaws.org/background/procedures/assist009-034.aspx#144)

25. *Consultations*, Wednesday,9 October 2013 - Vol. 43 No. 45: Dr. Annie Tremblay, Dr. Pierre Gagnon, T#036
(http://www.consciencelaws.org/background/procedures/assist009-037.aspx#036)

26. *Consultations*, Wednesday,9 October 2013 - Vol. 43 No. 45: Dr. Annie Tremblay, Dr. Pierre Gagnon, T#015
(http://www.consciencelaws.org/background/procedures/assist009-037.aspx#015)

27. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#048
(http://www.consciencelaws.org/background/procedures/assist009-035.aspx#048)

28. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45 Quebec Association of Clinical Ethicists (Delphine Roigt, Emilia Guévin, Michel Lorange) T#144
(http://www.consciencelaws.org/background/procedures/assist009-034.aspx#144)

29. 29. *Consultations*, Tuesday 24 September 2013 - Vol. 43 No. 37: Quebec Ombudsman (Raymonde Saint-Germain, Marc André Dowd, Michel Clavet), T#080 (http://www.consciencelaws.org/background/procedures/assist009-012.aspx#080)

30. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Margaret Somerville, T#064 (http://www.consciencelaws.org/background/procedures/assist009-033.aspx#064)

31. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#024 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#024)

32. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Quebec Bar (Johanne Brodeur, Marc Sauvé, Michel Doyon), T#029 (http://www.consciencelaws.org/background/procedures/assist009-010.aspx#029)

33. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Quebec Bar (Johanne Brodeur, Marc Sauvé, Michel Doyon), T#105 (http://www.consciencelaws.org/background/procedures/assist009-010.aspx#105)

34. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Quebec Bar (Johanne Brodeur, Marc Sauvé, Michel Doyon), T#041 (http://www.consciencelaws.org/background/procedures/assist009-010.aspx#041)

35. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Ghislain Leblond, Dr. Yvon Bureau, T#126 (http://www.consciencelaws.org/background/procedures/assist009-019.aspx#126)

36. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Ghislain Leblond, Dr. Yvon Bureau, T#130 (http://www.consciencelaws.org/background/procedures/assist009-019.aspx#130)

37. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Ghislain Leblond, Dr. Yvon Bureau, T#016 (http://www.consciencelaws.org/background/procedures/assist009-019.aspx#016)

38. *Consultations*, Tuesday 24 September 2013 - Vol. 43 No. 37: Quebec Ombudsman (Raymonde Saint-Germain, Marc André Dowd, Michel Clavet), T#103 (http://www.consciencelaws.org/background/procedures/assist009-012.aspx#103)

39. *Consultations*, Wednesday, 18 September 2013 - Vol. 43 no. 35: College of Social Workers & Marriage & Family Therapists of Quebec (Claude Leblond, Marielle Pauzé), T#016, T#092 (http://www.consciencelaws.org/background/procedures/assist009-007.aspx#016) (http://www.consciencelaws.org/background/procedures/assist009-007.aspx#092)

40. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Ghislain Leblond, Dr. Yvon Bureau, T#130 (http://www.consciencelaws.org/background/procedures/assist009-019.aspx#130)

41. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Observatory for Aging and Society (André Ledoux, Gloria Jeliu, Denise Destrempes, Claude Tessier)T#129, T#130 (http://www.consciencelaws.org/background/procedures/assist009-025.aspx#129) (http://www.consciencelaws.org/background/procedures/assist009-025.aspx#130)

42. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#010, T#011, T#014 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#010) (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#011) (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#014)

43. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier)T#114 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#114)

44. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#011(http://www.consciencelaws.org/background/procedures/assist009-031.aspx#011)

45. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier)T#014(http://www.consciencelaws.org/background/procedures/assist009-031.aspx#014)

46. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance),T#066 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#066)

47. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Margaret Somerville, T#080 (http://www.consciencelaws.org/background/procedures/assist009-033.aspx#080)

48. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Margaret Somerville,T#068 (http://www.consciencelaws.org/background/procedures/assist009-033.aspx#068)

49. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 No. 45: Professor Margaret Somerville, T#084 (http://www.consciencelaws.org/background/procedures/assist009-033.aspx#084)

50. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Coalition of Physicians for Social Justice (Dr. Paul Saba, Hélène Beaudin, Dominique Talarico), T#080 (http://www.consciencelaws.org/background/procedures/assist009-015.aspx#080)

51. *Consultations*, Thursday 19 September 2013 - Vol. 43 no. 36: Assembly of Catholic Bishops of Quebec (Bishop Noël Simard, Bishop Pierre Morissette),T#068

52. *Consultations*, Thursday 19 September 2013 - Vol. 43 no. 36: Assembly of Catholic Bishops of Quebec (Bishop Noël Simard, Bishop Pierre Morissette), T#070 (http://www.consciencelaws.org/background/procedures/assist009-011.aspx#070)

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Redefining the Practice of Medicine
Euthanasia in Quebec
Part 4: The Problem of Killing

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

The original text of Bill 52 did not define "medical aid dying" (MAD), but it was understood that, whatever the law actually said, it was meant to authorize physicians to kill patients who met MAD guidelines. The Minister of Health admitted that it qualified as homicide, while others acknowledged that MAD meant intentionally causing the death of a person, and that its purpose was death. Various witnesses in favour of the bill referred explicitly to lethal injection and the speed of the expected death of a patient.

Given the moral or ethical gravity involved in killing, it is not surprising to find serious disagreement about MAD among health care workers. Conflicting claims made about the extent of opposition to or support for euthanasia within health care professions are difficult to evaluate, but a review of the transcripts of the legislative committee hearings into Bill 52 is instructive.

One physician member of the committee was shocked by the assertion that there is no moral, ethical, or legal difference between withdrawing life support and lethally injecting a patient. Hospices and palliative care physicians rejected participation in euthanasia. Sharp differences of opinion among other health care workers were reported. Support for killing patients by lethal injection was likened to support for the death penalty; that is, many more agreed with the act in principle than were willing to do the actual killing. So marked was the evidence of opposition to euthanasia that doubts were raised about the possibility of implementing the law.

Since the law was passed as a result of assurances from the Quebec medical establishment that it could be implemented, a committee member who is now a minister of the Quebec government warned that they would be called to account if it is found that few physicians are willing to participate. This political pressure is likely to provide an additional incentive for the medical establishment to secure the compliance of Quebec physicians.

The introduction of euthanasia into Quebec's health care system is to be accomplished using the structures and powers established by other Quebec statutes that govern the delivery of health care in the province,

which have established a multi-layered and overlapping bureaucracy of committees, councils, commissions, boards, directors, examiners, coordinators, syndics and commissioners. Physicians and other health care providers who object to euthanasia will find their working environments increasingly controlled by a MAD matrix functioning within this system, a prominent feature of which is an emphasis on patient rights.

Everyone authorized to enact or supervise adherence to policies or standards can become a MAD functionary, using codes of ethics, protocols, guidelines, directives, etc. to normalize euthanasia. Similarly, every disciplinary and complaints procedure can be used to force participation in MAD services. Those who openly advocate refusal to provide or facilitate euthanasia can be fined from $1,500.00 to $40,000.00 per day under Quebec's *Professional Code* if they are deemed to have helped, encouraged, advised or consented to a member of a profession violating the profession's code of ethics.

Killing patients

The original text of Bill 52 did not define "medical aid dying" (MAD). Nothing in the original *Act Respecting End-of-Life Care* specified that MAD included killing a patient. Thus, on the face of it, there was no conflict with Canadian criminal law and no basis for a constitutional challenge by the federal government. Despite this, everyone knew that, whatever the law actually said, it meant euthanasia; it was meant to authorize physicians to kill patients who met MAD guidelines.

MAD = euthanasia = killing

This was obvious from the names of some of the organizations opposed to Bill 52 (Quebec Rally Against Euthanasia; Physicians Alliance for Total Refusal of Euthanasia) and from submissions to the legislative committee in the fall of 2013. Living with Dignity cited the Report of the Select Committee on Dying with Dignity[1] to demonstrate that "medical aid in dying" is equivalent to euthanasia.[2] Dr. Catherine Ferrier, a palliative care physician, told the legislators that "almost all my patients meet on the criteria to be eligible to be killed by this bill."[3] Professor Margaret Somerville warned against the corruption of medical practice by "this awful killing aspect."[4]

MAD = "homicide"

Now, since these points were made by groups or individuals opposed to the bill, it might be thought that their terminology was deliberately tendentious. Health Minister Véronique Hivon seemed annoyed that people continued to say that "medical aid in dying" meant euthanasia, which, she said, is "a very loaded word,"

> . . .because we're talking about euthanasia of animals, because we're talking about euthanasia in the Nazi regime. So, yes, it is a word very, very loaded.[5]

However, even though she insisted that "medical aid in dying" should not be considered euthanasia,[6] she admitted that it qualified as homicide.[7]

MAD = "intentionally causing death"

Further, even groups and individuals supporting the bill implicitly or explicitly acknowledged that they understood "medical aid in dying" to mean physicians killing patients. The Collège des médecins du Québec, for example, agreed that "medical aid in dying" involved "an act of intentionally causing the death of a person."[8] Professor Jocelyn Downie, who applauded the bill, noted that it clearly included "the provision of a lethal injection."[9] She recommended that patients be given a choice between assisted suicide by a self-ingested toxic drug and death by lethal injection,[10] and suggested that the bill could include euthanasia by starvation and dehydration in addition to "the lethal injection category,"[11] thus providing patients with another lethal "option."[12]

Lawyer Stéphanie Vallée, now Quebec Minister of Justice but then a Liberal member of the committee, noted that "in the context of medically assisted dying . . . the purpose is death," adding that "there is a distinction between a treatment for alleviate suffering, which is not intended to . . . administer a lethal dose, and medical assistance to die . . .which is really aimed at the death."[13]

MAD = "lethal injection"

Gloria Jeliu, representing the Observatory for Aging and Society, which did not take a position for or against euthanasia, cautioned that those who want "medical help to die" must understand "it is a lethal injection and is extremely fast. . ."

> But I guess most people, I suspect, know with certainty that the medical assistance to die is the sting, the final sting, the sting ... Doctor, give me the shot. I do not want to live. That is the definition of physician-assisted dying. It is a lethal injection of barbiturate and curare, if I remember correctly, and it causes death within minutes.[14]

Indeed, the repeated reference to killing disturbed Liberal committee member Yves Bolduc, a physician and former Quebec Minister of Health.

"[M]ost people," he said, "always talk to us about killing," adding, "Athough I do not agree. We are not in medicine to kill."[15]

However, Bolduc himself, reflecting on the results of surveys purporting to indicate physician support for euthanasia, also understood that Bill 52 was intended to authorize physicians to kill their patients:

> I think that what people said they wanted to do at the end of life, they were ready to give morphine to relieve the people, but I'm not sure they are willing to a give big dose of morphine or barbiturate, or curare to kill the person in the space of five minutes.[16]

MAD = "hastening death" = killing

Despite the absence of a formal definition of "medical aid in dying," these admissions and assertions show that the Minister of Health, legislators and those making submissions to the committee all understood MAD to mean that physicians should kill patients under the conditions specified in Bill 52. ARELC's definition of MAD simply confirms the obvious, even though it tries to conceal the obvious by using "hastening death" as a rhetorical figleaf.[17]

Disputes about killing

It is generally agreed that killing someone is a matter of considerable moral or ethical gravity, even when it is agreed that the killing is justified. But justifications offered for euthanasia are sharply disputed, so it is not surprising to find serious disagreement about MAD among health care workers. As committee member Stephanie Vallee observed, "the polarization in the debate is really about the issue of physician-assisted dying, because it resonates with all of us in our most fundamental values."[18]

Conflicting claims, dubious statistics

Conflicting claims are made about the extent of opposition to or support for euthanasia within health care professions. These are difficult to evaluate because of the variables affecting responses to surveys or polls, as well as the natural inclination of partisan groups to emphasize or interpret results in ways favourable to their causes. In addition, health care workers seem more inclined to contact groups that share their concerns rather than groups opposed to them. For example, Living with Dignity reported contacts from people opposed to euthanasia in general and family medicine,[19] while the Quebec Association for the Right to Die with Dignity claimed that "many caregivers" in the palliative care community support euthanasia,[20] but are unable to express their views.[21]

A review of the transcripts of the legislative committee hearings into Bill 52 might be criticized as merely anecdotal, but it is instructive nonetheless.

". . . a big difference . . ."

Quebec's Interprofessional Health Federation told legislators that conscientious objection to euthanasia was not an issue raised among their members.[22] On the other hand, the Order of Nurses said that it did not consider MAD to be a form of "care," but "a procedure that terminates life,"[23] while the Association of Health Facilities and Social Services anticipated that physicians, at least at the outset, would be reluctant to be the first to start the practice.[24]

Liberal committee member Dr. Yves Bolduc supported euthanasia, but was sensitive to the moral significance of killing a patient by lethal injection. Thus, he was shocked by the claim by the province's human rights commissioner that there is "no significant moral, ethical, or legal difference between unplugging a person or the fact of accelerating [death] to allow him to relieve his suffering."[25]

> Dr. Bolduc (Jean-Talon): . . . I am a doctor and I'm not a lawyer, but I must admit I was a little confused by what you are telling me. There is a big difference between injecting someone and letting him die. . . Did you have doctors who advised you, in your opinion?[26]

When assured that the commission included a physician, he mused that the opinion probably included "a value judgment."[27] In fact, the opinion included much more than that, but, for present purposes, it is enough to recognize in this exchange the existence of serious disagreement among physicians about Quebec's euthanasia project.

Hospices, palliative care, family medicine

Hospices, though not required to allow physicians to kill their patients, spoke strongly against euthanasia and expressed fears that legalizing the procedure would ultimately compromise their operations.[28] Most palliative care physicians - up to 90% - are adamantly opposed to the MAD provisions in ARELC.[29] Some have stated that they will resign if euthanasia is introduced into their units.[30] Speaking for the Quebec Palliative Care Network, Dr. Christiane Martel emphasized how legalizing euthanasia would cause profound conflicts for palliative care physicians:

> And I was at a conference a few weeks ago, 140 or 150 stakeholders in palliation asked the question: What will I do with the request for medically assisted dying? And there I saw more doctors cry than I've ever seen in my 18 years in medicine because it concerns us deeply. It is we who are there at the end of life, it is we who receive these requests , and it is a conflict with our values.[31]

The anti-euthanasia organization Living with Dignity told legislators that health care workers in general and family medicine had contacted them, and plan to agitate for exemption from legal requirements to participate in euthanasia. "There are many who are preparing to do this, warned Marc Beauchamp. "If you pass this law," he said, "you will being firing a slingshot into the medical system such as you cannot even imagine."[32]

Dr. Claude Morin, who might be taken as representative of those most strongly opposed to euthanasia, was adamant that he would not provide it, help anyone else to do it, or even offer suggestions about how the service might be provided.[33]

"It's like the death penalty."

The testimony of others appearing before the committee also suggested that health care workers and others were often profoundly disturbed by the idea of killing a patient. One of the more striking examples was an experience related by Marie-Claude Mainville of NOVA Montreal, who told the committee about a woman who asked her to lethally inject her dying mother. Mainville gave the woman a morphine syringe (actually a palliative rather than lethal dose) and said, "You do the injection."

"And she was just outraged," Mainville said, "saying: But you're not actually going to ask me to kill my mother? You are paid for it, you!"[34]

> So there is a difference between wanting it "generally" and doing it. It's like the death penalty, there are people who may be in favour, but that would certainly not be the executioner who would do the lethal injection. So we, that is our position also ... We agree with the idea not to prolong the suffering, the idea of pushing the syringe that causes death, that is another debate.[35]

Mainville, canvassing NOVA nurses, found some nurses willing to provide lethal injections and other who said they would never do so.[36]

Who will kill?

Linda Vaillant, speaking for the Pharmacists Association of Health Facilities of Quebec, told the committee that Bill 52 caused discomfort for many members of the association because "[p]eople have really made it clear they do not want them to be seen as people who help others to die."[37]

Similarly, Dr. Bolduc warned his committee colleagues not to assume that physicians who express support for euthanasia will also be willing to kill a patient.

> The real question, it will be: Yes, you agree to the medical assistance to die, if you agree that if that, are you ready to do it? It's going to be the challenge. Because there are many people who all agree that someone else should, but how many are willing to do it [themselves]?[38]

So marked was the evidence of opposition to euthanasia that Dr. Bolduc - almost alone among his committee colleagues - repeatedly raised the question of how access to euthanasia could be provided if physicians were unwilling to provide it for reasons of conscience.[39]

"If people agree to respect the conscientious objection," he observed, "it is possible that there will be nobody who is willing to do it,"[40] at least in some locations.[41]

> . . . I'm not sure that there are many physicians in Quebec who will want to do this. And when you're in a region as large as Montreal, the Laurentians where there are hundreds of thousands of people, in practice, you can always eventually find someone who will agree to do it . . . But when you are in Sainte-Anne-des-Monts, you know, a population of 12,000 or 13,000 people, Îles-de-la-Madeleine, about 12,000 people, also the area of Bonaventure thirty thousand people, I'm not sure we'll be able to find a professional who will do it. . . .But when the time comes for the injection, it cannot be done remotely and a nurse can't be asked to do it. . . the doctor will have to do it himself.[42]

At various points, Dr. Bolduc expressed grave doubts about whether or not the law could be successfully implemented. "I'm not sure we'll be able to give effect to the law," he said, adding that he hoped "that there are professionals who will have enough conviction to say, "I'll be ready to help people in situations that require it."[43]

Applying political pressure

He also expressed some annoyance at five professional organizations - the Collège des médecins, the Quebec Federation of General Practitioners, the Quebec Federation of Medical Specialists, the Quebec Association of Boards of Physicians, Dentists and Pharmacists and the Quebec Medical Association - which told the committee that "the vast majority of their members were in agreement," an assertion that he had come to question.[44]

If, after passing the law, it were found that few physicians are willing to provide the service, he warned, "then we will have to have those groups come and explain how it is that they unanimously agreed with the commission that accessibility would not be a problem," since the law was based on that assurance.[45]

> . . .this is not just a government responsibility, then, there are groups who came here and told us that it would work, then they will have responsibility . . . we will remind people: the application of the law will not just be the responsibility of the government, it will be the responsibility of all the major ... groups who came here and told us that it was a good thing to do, and who were willing to cooperate.[46]

Dr. Bolduc, now a minister in Quebec's Liberal government, is in a position to call Quebec's medical establishment to account should his predictions about the implementation of ALERC prove accurate. The prospect of being called to account is likely to provide an additional incentive for the five organizations to secure the compliance of Quebec physicians.

Implementing euthanasia

The implementation of An Act respecting end-of-life care (ARELC) and introduction of euthanasia into Quebec's health care system is to be accomplished using the structures and powers established by other Quebec statutes that govern the delivery of health care in the province, notably the Act Respecting Health Services and Social Services. This is the law that provides the administrative framework for the delivery of health care and the enforcement of health care policy. Other relevant statutes include the Professional Code and the laws specific to each of the health care professions. These laws have established a multi-layered and overlapping bureaucracy of committees, councils, commissions, boards, directors, examiners, coordinators, syndics and commissioners.

Appendix "A" identifies the key statutes and the health care structures established by them relevant to the purposes of ARELC. Appendix "B" describes statutory complaint and disciplinary procedures that could be turned against health care workers who decline to provide or facilitate euthanasia.

Physicians and other health care providers who want no part of euthanasia will find their working environments increasingly controlled by a MAD matrix functioning within this system, a prominent feature of which is an emphasis on rights[47] and the vindication of "user rights,"[48] including a purported "right" to "medical aid in dying" promised by ARELC.[49]

The MAD matrix

The Minister for Social Services and Youth Protection is empowered to issue "policy directions" that are to guide health and social service agencies and institutions in providing end-of-life care, including euthanasia.[50] As noted in Part 1, the official representatives of major professional organizations have made clear their support for euthanasia. For example, the Collège des médecins du Québec, the regulator of medical practice, believes that euthanasia can be an acceptable "medical act," consistent with a Code of Ethics requirement (i.e., that physicians ensure that "death occurs with dignity" and that "appropriate support and relief" is provided to the patient).[51]

Health care in every region in Quebec is delivered under the direction of a regional health and social service agency (Appendix A2). ARELC requires every agency to establish general rules concerning access to end-of-life care, including euthanasia, for all institutions and palliative care hospices in its jurisdiction.[52] The agencies must inform people living in their regions of how to access end-of-life services, including euthanasia, and provide information about "the rights and options of end-of-life patients."[53] In addition to regional health and social service agencies, "local health and social services networks" have been established (Appendix A5). These are intended to focus particularly on access to services, which, in this case, means euthanasia.

Almost all institutions that operate local community service centres, hospital centres or residential and long-term care centres[54] are required to offer end-of-life care (which includes euthanasia),[55]to establish clinical programmes[56] and policies concerning it,[57] and to include reference to it in their codes of ethics.[58] This includes rehabilitation centres, described in the Act Respecting Health and Social Services, which serve developmentally disabled patients.[59]

Exceptions

It was noted above that almost all institutions will be required to offer end-of-life care that includes euthanasia. One exception to the general rule is palliative care hospices, which may offer euthanasia, but are not required to do so. Before admitting patients, they must explain what kind of end-of-life care they offer.[60] (Part 8)

Section 72 of the Act concerns any institution operating a "general and specialized hospital centre" that offers only palliative care. Such institutions "may continue to offer that care exclusively" (i.e., need not provide euthanasia), as long as they notify patients of this before admitting them.[61] According to the government, this section is intended to apply only La Maison Michel Sarrazin.[62] (Part 8)

Standards and enforcement

Obviously, every individual or group that is authorized to enact or supervise adherence to policies or standards can become a MAD functionary, using codes of ethics, protocols, guidelines, directives, etc. to normalize euthanasia. Similarly, every disciplinary or complaints procedure can be used to force participation in MAD services. However, two elements of the MAD matrix warrant special notice.

First, regional and local complaints commissioners and the Health and Social Services Ombudsman are all empowered to take action on their own initiative to enforce "the rights of a user or group of users" (Appendices B3.3, B9.2), while syndics (investigators) for professional orders may lodge complaints of professional misconduct without waiting for a complaint (Appendix B10.2). Any or all of these individuals who are MAD advocates could create considerable difficulty for physicians who are unwilling to participate in or facilitate euthanasia.

Second, the Professional Code provides that anyone who "knowingly helps or, by encouragement, advice or consent" leads a member to violate the order's code of ethics can be fined not less than $1,500.00 and not more than $20,000.00 for each day the violation continues. In the case of an incorporated entity, the minimum and maximum fines are $3,000.00 to $40,000.00 per day. (Appendix B10.3) The Collège des médecins du Québec believes that its Code of Ethics supports euthanasia, and will likely become an active MAD advocate. Thus, the Physicians' Alliance for Total Refusal of Euthanasia, the Euthanasia Prevention Coalition and other groups that oppose euthanasia might face prosecution and substantial fines if they continue to help, encourage or advise physicians not to participate in the procedure.

Notes

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. "Euthanasia: An act that involves deliberately causing the death of another person to put an end to that person ' s suffering." *Report of the Select Committee on Dying with Dignity*, (March, 2012), p. 18 (http://www.consciencelaws.org/archive/documents/2012-03-quebec_death_report.pdf)

2. Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill 52* (Hereinafter "*Consultations*), Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity (Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#023 (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#023)

3. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Physicians' Alliance for Total Refusal of Euthanasia (Dr. Catherine Ferrier, Dr Serge Daneault, Dr François Primeau), T# 040 (http://www.consciencelaws.org/background/procedures/assist009-014.aspx#040)

4. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N ° 45: Professor Margaret Somerville, T#092 (http://www.consciencelaws.org/background/procedures/assist009-033.aspx#092)

5. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity (Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#039 (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#039)

6. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity (Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#040 http://www.consciencelaws.org/background/procedures/assist009-017.aspx#040

7. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity (Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#039 (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#039)

8. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#013 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#013)

9. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N ° 45: Professor Joceyln Downie, T#019 (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#019)

10. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N ° 45: Professor Joceyln Downie, T#020 (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#020)

11. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N ° 45: Professor Joceyln Downie, T#072 (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#072)

12. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N ° 45: Professor Joceyln Downie, T#085 (http://www.consciencelaws.org/background/procedures/assist009-032.aspx#085)

13. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Quebec Bar (Johanne Brodeur, Marc Sauvé, Michel Doyon), T#060 (http://www.consciencelaws.org/background/procedures/assist009-010.aspx#060)

14. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Observatory for Aging and Society (André Ledoux, Gloria Jeliu, Denise Destrempes, Claude Tessier), T#117 (http://www.consciencelaws.org/background/procedures/assist009-025.aspx#117)

15. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N ° 45: Professor Margaret Somerville, T#059 (http://www.consciencelaws.org/background/procedures/assist009-033.aspx#059)

16. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#113 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#113)

17. ARELC, Section 3(6) (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#medical_aid_in_dying)

18. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#059 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#059)

19. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity (Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#103 (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#103)

20. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#018 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#018)

21. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#037 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#037)

22. *Consultations*, Thursday, 26 September 2013 - Vol. 43 no. 39: Interprofessional Health Federation of Quebec (Régine Laurent, Julie Martin, Michàle Boisclair, Brigitte Doyon), T#110 , T#112 (http://www.consciencelaws.org/background/procedures/assist009-022.aspx#110) (http://www.consciencelaws.org/background/procedures/assist009-022.aspx#112)

23. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#099 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#099)

24. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#109 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#109)

25. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#096 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#096)

26. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#098 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx\#098)

27. *Consultations*, Friday, 4 October 2013 - Vol. 43 no. 43: Commission on Human Rights and Youth Rights (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#102 (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#102)

28. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#014 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#104); *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard), T#014, T#059 (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#014) (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#059)

29. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 41: Quebec Society of Palliative Care Physicians (Dr. Patrick Vinay, Dr. Michelle Dallaire), T#043 (http://www.consciencelaws.org/background/procedures/assist009-028.aspx#043)

30. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity (Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#102 (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#102)

31. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Quebec Palliative Care Network (Alberte Déry, Dr.Christiane Martel, Danielle Blondeau, Pierre Deschamps, Jessy Savaria, Yvan Lessard), T#064

(http://www.consciencelaws.org/background/procedures/assist009-026.aspx#064)

32. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity (Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#103 , T#104 (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#103) (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#104)

33. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Rally Against Euthanasia (Dr. Claude Morin, Dr. Marc Bergeron, Daniel Arsenault, Clément Vermette), T#101 (http://www.consciencelaws.org/background/procedures/assist009-016.aspx#101)

34. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#121 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#121)

35. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#122 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#122)

36. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#038 , T#106 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#038) (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#106)

37. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Pharmacists Association of Health Facilities of Quebec (François Paradis, Linda Vaillant), T#031 (http://www.consciencelaws.org/background/procedures/assist009-006.aspx#031)

38. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#117 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#117)

39. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#101 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#101); *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Rally Against Euthanasia (Dr. Claude Morin, Dr. Marc Bergeron, Daniel Arsenault, Clément Vermette), T#099 (http://www.consciencelaws.org/background/procedures/assist009-016.aspx#099); *Consultations*, Thursday, 26 September 2013 - Vol. 43 no. 39: Interprofessional Health Federation of Quebec (Régine Laurent, Julie Martin, Michàle Boisclair, Brigitte Doyon), T#054 , T#055, T#057 (http://www.consciencelaws.org/background/procedures/assist009-022.aspx#054) (http://www.consciencelaws.org/background/procedures/assist009-022.aspx#055) (http://www.consciencelaws.org/background/procedures/assist009-022.aspx#057); *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael

Laplante, Marie-Claude Mainville), T#110, T#116 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#110) (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#116); *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#049 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#049)

40. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin),T#103 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#103)

41. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#095 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#095)

42. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#054 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#054)

43. *Consultations*, Wednesday, 2 October 2013 Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#119 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#119)

44. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#110 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#110)

45. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#115 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#115)

46. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#116 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#116)

47. *An Act Respecting Health Services and Social Services* (R.S.Q. Chapter S-4.2) (Hereinafter "ARHS&SS") Sections 2(8), 3(2), 4-28. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-26)

48. ARHS&SS, Sections 33, 40,49, 52, 64(4), 66, 72, 74, 76.7, 76.10, 76.11(4), etc. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html)(Accessed 2014-07-26)

49. ARELC, Section 4. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#004)

50. ARELC, Section 19. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#019)

51. Collège des médecins du Québec, Physicians, Appropriate Care and the Debate on Euthanasia: A Reflection . (16 October, 2009) p. 2. For the Collège's view on the acceptability of euthanasia, see p. 3 to 7. (http://www.cmq.org/en/Public/Profil/Commun/AProposOrdre/Publications/\u126 ~/media/Files/Positions/Euthanasie%20document%20reflexion%20ANG%202009.pdf?61323) (Accessed 2014-07-26)

52. ARELC, Section 17. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#017)

53. ARELC, Section 18. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#018)

54. ARELC, Section 3(1) . (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#003)

55. ARELC, Section 7. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#007)

56. ARELC, Section 9 . (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#009)

57. ARELC, Section 8. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#008)

58. ARELC, Section 10. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#010)

59. ARHS&SS, Sections 86-87. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-26)

60. ARELC, Section 13 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#013)

61. ARELC, Section 72 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#072)

62. Note: in Bill 52, the original section number was 65. *Consultations* & hearings on Quebec Bill 52, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#030, T#032 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#030) (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#032)

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Redefining the Practice of Medicine

Euthanasia in Quebec

Part 5: An Obligation to Kill

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

Statistics from jurisdictions where euthanasia and/or assisted suicide are legal suggest that the majority of physicians do not participate directly in the procedures. Statistics in Oregon and Washington state indicate that the proportion of licensed physicians directly involved in assisted suicide is extremely small. At most, 2.31% of all Belgian physicians were directly involved in reported euthanasia cases, and the actual number could be much lower. A maximum of 9% to 12% of all Dutch physicians have been directly involved, most of them general practitioners. The current situation in Belgium and the Netherlands suggests that, for some time to come, a substantial majority of Quebec physicians will probably not lethally inject patients or provide second opinions supporting the practice.

It is anticipated that between 150 and 600 patients will be killed annually in Quebec by lethal injection or otherwise under the MAD protocol authorized by ARELC. While these estimates amount to only a small percentage of the deaths in the province each year, and while Quebec has about 8,000 physicians in general practice, there is concern that only a minority of physicians will be willing to provide euthanasia, and it may be difficult to implement ARELC.

The reason for the concern appears to be that ARELC purports to establish MAD as a legal "right" that can be exercised and enforced anywhere in the province, but physicians willing to provide the service are unlikely to be found everywhere. As a result, in some areas, if no physicians are willing to provide MAD services, patients wanting euthanasia may be unable to exercise the "right" guaranteed by the statute.

Rather than deny either patients' access to euthanasia or physicians' freedom of conscience, several mechanisms have been proposed to accommodate both. Delegation is not permitted by law, and transfer of patients will not normally be feasible. However, workable alternatives include the advance identification of willing physicians in each region, the use of electronic communication services to permit remote consultation and the establishment of mobile "flying squads" of euthanatists to provide services not otherwise available in some parts

of the province.

Euthanasia proponents deny that they intend to force physicians to personally kill patients, but the exercise of freedom of conscience by objecting physicians who refuse to kill patients can lead to unjust discrimination against them. Discriminatory screening of physicians unwilling to kill patients can be effected by denying them employment in their specialties and denying them hospital privileges. By such strategies one can truthfully affirm that physicians are not actually being forced to kill, although those unwilling to do so may be forced to change specialties, leave the profession or emigrate.

Most physicians will not kill

The accuracy of official euthanasia and assisted suicide returns is disputed, though it is usually agreed that the actual number of cases is probably higher than the reported number. However, with respect to the reported cases, the returns indicate that the majority of physicians do not participate directly in the procedures. In fact, depending on the jurisdiction, the number of physicians who actually kill patients or write prescriptions for lethal drugs or provide second opinions in support of euthanasia or assisted suicide can be very small. For reasons connected with reporting requirements, this is easier to establish in the United States than in Europe.

Demand vs. supply

Belgium

Though euthanasia has been legal in Belgium since 2002, the number of Belgian physicians who actually provide lethal injections and second opinions is apparently unknown. The reason for this appears to be that the Federal Control and Evaluation Commission for Euthanasia cannot identify the physicians who report they have performed euthanasia unless it decides that the law may have been broken.[1]

Nonetheless, the statistics produced by the Commission establish the maximum number of physicians who have been involved in reported euthanasia cases each year. By comparing this to the estimated number of licensed physicians in the country it is possible to estimate the proportion of Belgian physicians directly involved in euthanasia reported to the Commission. The percentage has been increasing steadily, but it is still quite low: euthanasia is provided by 0.62% to 2.31% of all Belgian physicians (Appendix C1). Moreover, these are maximums; the actual number of physicians directly involved could be much lower. For example, in 2013, Dr. Sarah Van Laer said publicly that she had killed 28 patients since 2002,[2] which, in Commission statistics, would be reflected as the work of 28 physicians, not one.

This may explain the anecdotal reports that most Belgian physicians will not provide euthanasia. Only about 400 of 20,000 physicians in Flanders (2%) were involved in providing second opinions in 2013; they considered themselves overburdened and underpaid.[3] Dr. Sarah Van Laer told a Belgian newspaper that there were too few physicians willing to perform euthanasia, and that this problem had been "badly underestimated." As a result, she said, she and others willing to provide the service were becoming burned out.[4]

Finally, Dr. Wim Distelmans, a Belgian physician who is a leading practitioner and advocate of euthanasia and co-chairman of the Federal Control and Evaluation Commission has complained that many physicians, hospitals and nursing homes are reluctant to provide the service. He described them as "still very prudent," adding, "There are still a lot of people suffering unbearably because they ask for euthanasia and they don't get it."[5]

Netherlands

Physicians may provide both euthanasia and assisted suicide in the Netherlands, but, here, too, the number of physicians directly involved is uncertain. As in the case of Belgium, it is impossible to determine from published statistics whether or not a subset of euthanasia practitioners is responsible for killing most of the patients.

What is clear, however, is that general practitioners in the Netherlands are overwhelming responsible for performing euthanasia, and the numbers are rising. In 2004 almost 21% of Dutch general practitioners were directly involved; by 2010 it was over 28%. In comparison, the next most active category, hospital specialists, represented less than 2% of Dutch medical specialists directly involved with euthanasia or assisted suicide. Overall, the statistics indicate that a maximum of 9% to 12% of all Dutch physicians have been directly involved in reported euthanasia cases each year (Appendix C2).

This is consistent with a report that euthanasia is usually provided by general practitioners, but many refuse to do so. It was for this reason that, in 2012, Right to Die NL formed mobile teams to provide euthanasia for patients at home.[6]

Oregon and Washington State

Published statistics in Oregon and Washington state provide a more accurate picture of the actual involvement of physicians in assisted suicide than can be had from Belgian and Dutch authorities. The proportion of licensed physicians directly involved is extremely small.

In Oregon, where assisted suicide has been legal since 1997, between 33 and 64 physicians wrote prescriptions for lethal medication each year from 2002 to 2013, a range of 0.38% to 0.62% of the state's active registered physicians (Appendix C3).

The state of Washington legalized assisted suicide in March, 2009. The number of physicians prescribing lethal medications has increased steadily from 53 to 89, from 0.21% to 0.34% of licensed physicians. The number of pharmacists dispensing lethal drugs has been more variable, rising from 2009 to 2011 and dropping thereafter. From 2009 to 2013, 23 to 46 pharmacists dispensed drugs for assisted suicide annually, representing 0.25% to 0.52% of licensed pharmacists (Appendix C4).

Implications for Quebec

While interesting, the extremely low physician participation rates in Oregon and the state of Washington pertain solely to assisted suicide, not euthanasia, and there are many other cultural, legal and political differences between Quebec and these western American states.

It is more promising to consider what would happen if developments in Quebec were to approximate those in Belgium or the Netherlands. Quebec and Belgium have some linguistic similarities, share some civil law traditions,[7] and the state in both jurisdictions is responsible for the delivery of health care. Moreover, the situation in Belgium is of particular interest in Quebec because ARELC was modelled on the Belgian euthanasia law.

If we apply the highest physician participation rate reflected in the Belgian figures (2.31%) to the number of active members registered with Quebec's College of Physicians (19,818),[8] one might predict that about 458 Quebec physicians would actually provide lethal injections and/or second opinions. Since two physicians are required for each case, the predicted number of available physicians would suffice to process 229 euthanasia requests each year: slightly more than one third the highest estimate of anticipated demand (600 cases annually).

Applying the highest Dutch physician participation rates (12% overall, 28% of general practitioners), one might predict direct involvement of 2,378 Quebec physicians overall, or 1,440 general practitioners.

Taking a different perspective, the highest Belgian and Dutch physician participation rates suggest that, more than ten years after legalization of assisted suicide and euthanasia, between 88% and 98% of physicians in Belgium and the Netherlands are not directly involved in the procedures. This estimate seems so high as to be improbable.

On the other hand, abortion - another highly controversial procedure that involves killing - has been available in Canada since 1969 and completely unrestricted since 1988. Yet, as of 2011, over 99.5% of registered physicians in British Columbia were not performing abortions; almost 25 years after the legalization of abortion, proportionately fewer physicians were performing abortions in British Columbia than were writing prescriptions for assisted suicide in neighbouring Oregon.[9] Thus, while it would be unwise to assert that 88 to 98% of Dutch and Belgian physicians are not providing euthanasia or assisted suicide, such high rates of non-provision are not without precedent.

In any case, the current situation in Belgium and the Netherlands suggests that, for some time to come, a substantial majority of Quebec physicians will probably not lethally inject patients or provide second opinions supporting the practice.

Number of MAD cases anticipated

During the committee hearings, then Minister of Health Véronique Hivon took note of the possibility that few physicians would be willing to kill patients, but emphasized that this had to be set against the expectation that only "a very small number" of patients would actually seek the service, "between 0.2% to 1.8% of deaths."[10]

Overnight, then there will not be a flood of applications from everyone wanting to get to have medical help to die, it will be in the special case where it is really not possible to relieve a person. So, in those jurisdictions that we have seen, this is often less than 1% of all deaths. So it means that it is still very exceptional, and it is good that it is like that.[11]

Similarly, committee member Hélène Daneault, comparing the populations of Quebec and Belgium, estimated that there might be 150 to 200 cases of euthanasia each year "a tiny fraction" of the 60,000 deaths annually.[12] Dr. Yves Bolduc offered a higher estimate: 300 to 600 cases annually.[13]

Number of willing physicians

Citing the Quebec Medical Association Survey that found 41% of physicians willing to provide euthanasia, Minister Hivon argued that, although many physicians might not be prepared to provide MAD, "there is still a significant number of doctors who say they are willing."[14]

Setting aside physician surveys, Dr. Yves Bolduc approached the question from a different angle. He considered his estimate of 300 to 600 anticipated MAD cases each year a relatively small number of deaths. That being the case, he concluded that only a minority of physicians would actually be involved in meeting the demand, since, "we cannot think that every doctor will have the expertise, even if he wants to."

"We can believe in the project," he explained, "but if you do it once every two years, you are perhaps better not to touch it."[15]

Why, then, was Dr. Bolduc so concerned that there might not be enough willing physicians available to implement the law?

Administrative issues

Part of the explanation might concern the administrative impact of the need to arrange for the killing of up to 600 patients each year. Michel Racicot of Living with Dignity pointed out that this is the equivalent of emptying the Drapeau-Deschambault Centre, a 223 bed long term care facility,[16] two or three times a year.[17] Adopting Dr. Bolduc's figures, about 30 hospitals would be required to provide MAD service;[18] 600 MAD cases annually would average about one every two weeks in each institution. Since the MAD protocol requires prior consultations with at least the patient and a second physician, any significant resistance by physicians or other health care workers would make this a year-round, almost daily administrative headache.

Still, there are over 8,000 physicians in general practice in Quebec.[19] If only ten per cent of that number were willing to provide MAD, it would seem that there are more than enough physicians available to lethally inject 600 patients each year. Nonetheless, Dr. Bolduc repeatedly expressed concern that it would be very difficult to implement the law. Why?

A right implies an obligation

The answer was provided, in part, by Véronique Hivon, who insisted that, in the interests of fairness, both palliative care and MAD must be made available in the state health care system, so that people who live in cities like Montreal or rural areas like Gaspé "have the same access."[20]

Beyond a general concern about equality of access, however, Dr. Bolduc repeatedly drew attention to the fact that Bill 52/ARELC purports to establish a "practically inalienable" legal right to MAD, which, in turn, imposes an obligation on all health care institutions in the province to fulfil demands for euthanasia.[21] Thus, even though only a minority of patients are expected to seek the service, the law requires that the whole health care delivery system be arranged to accommodate them.[22] Committee member Stéphanie Vallée explained:

> [The law] gives a right to every person, regardless of his place of residence in Quebec, so that if it is in the Northern Quebec, whether in Montreal, whether in MontÉrÉgie , it gives the right to anyone to have palliative care, to have [continuous] palliative sedation, to have physician-assisted dying, we must ensure that at the time of implementation, those services will be available and we will not have to run around Quebec to be able meet the demand, to be able to respond to the request of the patient.[23]

While Dr. Bolduc agreed with this in principle,[24] he feared that it would lead to serious confrontations:

> Take, for example, there were people this morning who practised at Notre Dame in palliative care, they will simply refuse out of conviction, and probably even resign from the hospital rather than be required to do that, though in the law, there is an obligation to do it.[25]

Moreover, he reminded his colleagues that genuine respect for physician freedom of conscience added another level of difficulty, "[b]ecause there are three elements: you have the right of the patient, you have the obligation of the institution and then you can also have your conscientious objection."[26]

> [If we find ourselves in places where death is relatively imminent and there is nobody in the medical team who can perform these tasks, will this not undermine the right of the patient or prevent the person who has a conscientious objection, from acting on his conscientious objection?[27]

"What will be the priority or have primacy?" he asked. "Will it be the patient's right?"

"Or," he asked, "will there be a way to force professionals to provide the service?"[28]

Accommodating conscience and killing

Rather than deny the patient's access to euthanasia or physicians' freedom of conscience, Dr. Bolduc insisted that some kind of timely mechanism must be developed to accommodate both, although he understood that this would probably take some time to accomplish.[29]

Delegation

The Quebec Association of Gerontology wondered if lethal injection might be delegated to nurses.[30] Leaving aside the question of the ethics of delegation, this would simply move the question one step further back, since a nurse might take the same position as an objecting physician. Moreover as Yves Bolduc observed,[31] ARELC states that it is the physician's task to administer the lethal substance. There is no provision for delegation.[32]

Transferring patients

If no local physicians or facilities can supply a specialized service, such as heart surgery, it is common practice to transfer patients elsewhere. However, the Alliance of Quebec Hospices noted that it is not a simple matter to transfer a terminally ill patient from one facility to another, especially after he has been in the first institution for some time,[33] and Dr. Bolduc confirmed that one would not expect a patient to be transferred to access MAD services.[34] Thus, while transferring a patient in a particular case might be practical, it would likely occur only in exceptional circumstances.

Identifying physicians in advance

In addition to recommending that regional health administrators should be personally aware of the scope of practice of professionals in their territories,[35] the Quebec College of Pharmacists suggested that access to lethal drugs for MAD and accommodation of freedom of conscience for pharmacists who object to euthanasia could be accomplished by adopting an existing practice:

> [The regional health authority] sends a request to community pharmacists to clarify the various services they offer: anticoagulation, the ACT program methadone, syringe recovery . . . There are several services. So, medical assisted dying could also be a service . . . for which we require pharmacists to indicate whether they are available . . .[36]

Similarly, the Quebec Association of Health Facilities and Social Services suggested that regional health authorities could ask physicians willing to assist with or provide MAD services to identify themselves in advance.[37] Such advance planning was also supported by the Association of Councils of Physicians, Dentists and Pharmacists of Quebec.[38] The maintenance of a registry of physicians willing to cooperate in the provision of defined services has been recommended by Holly Fernandez Lynch in *Conflicts of Conscience in Health Care: An Institutional Compromise*. She describes a register of health care providers in Texas who are willing to accept patients who want treatment or care either continued or discontinued near the end of life.[39]

Remote monitoring

While the act of killing a patient would have to be performed by a physician on the spot, Dr. Bolduc suggested that other aspects of the MAD process might be managed by using telecommunications systems and digital technology that would permit remote monitoring.[40]

For example, if a physician in Gaspé wanted to provide a lethal injection but could not find another local physician willing to provide the required second consultation, he could consult physicians in Quebec or Montreal who might be willing to support him. Michel Gervais of the Quebec Association of Health Facilities and Social Services, noting the effective use of telepsychiatry and teleradiology, thought the suggestion "very valuable and very possible."[41]

Flying squads

Committee members Yves Bolduc and Hélène Daneault suggested that "flying squads" could be established to provide MAD services around the province or in the regions as an alternative to transferring patients, which is not normally feasible.[42] The idea of such "visiting physicians" found favour with the Quebec Association for the Right to Die with Dignity,[43] but the Quebec Rally Against Euthanasia warned that, if such teams had to "crisscross Quebec by plane," money would be spent providing euthanasia rather than palliative care.[44]

Dr. Pierre Gagon thought "the idea of people coming in from outside" seemed "very artificial" and "goes a little against the principles of medicine." He cautioned the committee that the concept required "systematic evaluation."

> Well, I think there was a phenomenon much like that in Switzerland. It went very, very badly. Some mobile teams who came did very little evaluation ... They were a bit like at odds with palliative care teams. I do not know, it is very delicate. . .[45]

Forcing physicians to kill

When Dr. Bolduc asked if there was a way to force physicians to kill, he asked the question only to emphasize that, "in reality," in his view, no physician could be forced to do so.[46]

"We cannot force professionals," he said. "Despite what it looks like: The patient has rights - you cannot go and tell a professional: You'll have to do that."[47]

This seems to imply that people who are not professionals can be forced to do what they are told: that physicians are exempt from such coercion precisely because they are professional. If that is Dr. Bolduc's view, he will eventually have a very rude awakening. A number of prominent academics have been making an argument for some time that one of the essential features of medical "professionalism" means doing what one believes to be immoral, unethical or unjust.[48]

In any case, Dr. Bolduc did not offer principled reasons for his assertion that physicians cannot be forced to provide euthanasia. His argument was purely pragmatic:

> If we start with that principle, then you will destroy the bill. Society is in agreement to date, according to the polls, but if you start to force people to do things like this, if you want my opinion, you can talk because you defend a position, but I will not follow you that far, that's for sure. Most professionals do not follow you that far.[49]

His warning was addressed to the Quebec Association for the Right to Die with Dignity, which responded, that it had always said that it respected "the freedom of the professional." Speaking for the Association, Hélène Bolduc (no relation to the legislator) said that the organization had never had any intention of forcing physicians to provide euthanasia, as "there is not a doctor who would do it well if, in addition, it was not his inclination to do so, and it is not to anyone's advantage to give this impression."[50]

Discrimination for refusing to kill

The answer satisfied Dr. Bolduc, but he failed to take into account that the exercise of freedom of conscience by objecting physicians who refuse to kill patients can lead to unjust discrimination against them.

This was demonstrated during the committee hearings into Bill 52, when the Interprofessional Health

Federation of Quebec told legislators that no one is forced to work in palliative care units, "so the person who applies for this position will go knowing what is required." The Federation did not anticipate much problem being caused by conscientious objection "because when people apply to a specialized department they know what they have to do."[51]

The assumption, of course, is that providing euthanasia will become one of the duties of palliative care units, so that those wanting to practise palliative care but who are unwilling to kill patients will not apply. And if they do apply, of course, management may deny them employment, as now happens in at least one major Canadian maternity hospital that denies employment to qualified maternity nurses who have moral or religious objections to assisting with abortion, including third trimester abortions.

Discriminatory screening of physicians unwilling to kill patients can also be effected by denying them hospital privileges (Appendix B1), as explained by the Association of Councils of Physicians, Dentists and Pharmacists of Quebec:

> Let me explain, skills, when a doctor applies to a health facility, the [Council of Physicians, Dentists and Pharmacists] will ensure he has the necessary skills and will grant him a status and privileges. Privileges usually come with obligations. These obligations also allow the guidance of practice and ensure that we will practise within the framework provided by organization, yet based on the reality of practice and skill level. . . So, to grant privileges in a CSSS, it might be meaningful to this necessary and required training for the physician to practise this activity. . . [52]

By such strategies one can truthfully affirm that physicians are not actually being forced to kill, although those unwilling to do so may be forced to change specialties, leave the profession or emigrate.

Notes

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. *The Belgian Act on Euthanasia of May 28, 2002*, Section 7, 8. (http://www.ethical-perspectives.be/viewpic.php?TABLE=EP&ID=59) (Accessed 2014-07-18)

2. Cook Michael, "First-world problems 2: I'm really not into the whole 'turbo-euthanasia' thing." *Bioedge*, 27 June, 2013. (http://www.bioedge.org/index.php/bioethics/bioethics_article/10577) (Accessed 2014-07-15)

3. *HLN.be*, "Artsen die dokters bijstaan bij euthanasie overbevraagd." 24 June, 2013. (http://www.hln.be/hln/nl/33/Fit-Gezond/article/detail/1657124/2013/06/24/Artsen-die-dokters-bijstaan-bij-euthanasie-overbevraagd.dhtml) (Accessed 2014-07-15)

4. Cook Michael, "First-world problems 2: I'm really not into the whole 'turbo-euthanasia' thing." *Bioedge*, 27 June, 2013. (http://www.bioedge.org/index.php/bioethics/bioethics_article/10577) (Accessed 2014-07-15)

5. Hamilton G. "Death by doctor: Controversial physician has made his name delivering euthanasia when no one else will." *National Post*, 22 November, 2013 (http://news.nationalpost.com/2013/11/22/death-by-doctor-controversial-physician-has-made-his-name-delivering-euthanasia-when-no-one-else-will/) (Accessed 2014-07-15)

6. Jolly, D., "Push for the Right to Die Grows in the Netherlands." *New York Times*, 2 April, 2012. (http://www.nytimes.com/2012/04/03/health/push-for-the-right-to-die-grows-in-the-netherlands.html?pagewanted=all&_r=0) (Accessed 2014-07-15)

7. Société de législation comparée, European Contract Law: *Materials for the CFR* (April, 2008) (http://www.legiscompare.fr/site-web/IMG/pdf/10._CH_2_Obligation_and_duty.pdf) (Accessed 2014-07-17)

8. Collège des Médecins du Québec, *Rapport Annuel*, 2013-2014. (http://www.cmq.org/fr/Public/Profil/Commun/AProposOrdre/Publications/\u126 ~/media/Files/Rapports/Rapportannuel1314.pdf?71417) (Accessed 2014-07-17)

9. In 2011, only 50 (0.46%) of 10,842 professionally active registered physicians provided abortions in British Columbia. Norman WV, Soon JA, Maughn N, Dressler J. (2013) "Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey" (BCAPS) (2013) *PLoS ONE* 8(6): e67023. doi:10.1371/journal.pone.0067023 (http://www.plosone.org/article/info:doi/10.1371/journal.pone.0067023) (Accessed 2013-07-25); College of Physicians and Surgeons of British Columbia, 2011 *Annual Report*, p. 12 (https://www.cpsbc.ca/files/pdf/2011-annual-report.pdf) (Accessed 2014-07-12) In contrast, 0.60% of active registered Oregon physicians wrote lethal prescriptions for assisted suicide in 2011 (Appendix C3.).

10. Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill 52* (Hereinafter "*Consultations*"), Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger), T#041 (http://www.consciencelaws.org/background/procedures/assist009-009.aspx#041)

11. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#075 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#075)

12. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#108

(http://www.consciencelaws.org/background/procedures/assist009-008.aspx#108)

13. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger), T#099 (http://www.consciencelaws.org/background/procedures/assist009-009.aspx#099)

14. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#076 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#076)

15. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger), T#099 (http://www.consciencelaws.org/background/procedures/assist009-009.aspx#099)

16. Quebec Ministry of Health and Social Services, Rapport de Viste d'Évaluation de la Qualité du Milieu de Vie (2013) (http://www.santelaurentides.qc.ca/fileadmin/documents/Soins_et_services/rapports_appreciation/13-SS-00202-02_Rapport_CHSLDDrapeau_Deschambault_15_VF.pdf)(Accessed 2014-07-09)

17. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity(Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#079 (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#079)

18. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N° 45: Dr. Annie Tremblay, Dr. Pierre Gagnon, T#112 (http://www.consciencelaws.org/background/procedures/assist009-037.aspx#112)

19. Fédération des médecins omnipraticiens du Québec: Mission. (http://www.fmoq.org/fr/fmoq/mission/default.aspx) (Accessed 2014-07-10)

20. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#074 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#074)

21. Consultations, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#062 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#062)

22. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#116 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#116)

23. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger),

T#054 (http://www.consciencelaws.org/background/procedures/assist009-009.aspx#054)

24. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N° 45: Dr. Annie Tremblay, Dr. Pierre Gagnon, T#112 (http://www.consciencelaws.org/background/procedures/assist009-037.aspx#112)

25. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#116 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#116)

26. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#118 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#118)

27. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#158 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#158)

28. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin),T#103 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#103)

29. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#095; T#101 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#095)(http://www.consciencelaws.org/background/procedures/assist009-008.aspx#101); Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#118 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#118); Wednesday, 9 October 2013 - Vol. 43 N° 45: Dr. Annie Tremblay, Dr. Pierre Gagnon, T#112 (http://www.consciencelaws.org/background/procedures/assist009-037.aspx#112); Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger), T#099 (http://www.consciencelaws.org/background/procedures/assist009-009.aspx#099)

30. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#055 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#055)

31. *Consultations*, Thursday, 3 October 2013 - Vol. 43 no. 42: Quebec Association of Gerontology (Catherine Geoffroy, Nathalie Adams), T#062 (http://www.consciencelaws.org/background/procedures/assist009-030.aspx#062)

32. ARELC, Sections 3(6), 30 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#003(6))

(http://www.consciencelaws.org/background/procedures/assist009-041.aspx#030)

33. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#146 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#146)

34. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin),T#103 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#103); Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#095 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#095)

35. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert),T#050 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#050)

36. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert),T#063 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#063)

37. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#109 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#109)

38. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger), T#014 (http://www.consciencelaws.org/background/procedures/assist009-009.aspx#014)

39. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008, p. 146.

40. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#095 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#095)

41. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#103 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#103)

42. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin),T#103 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#103); Tuesday 24

September 2013 - Vol. 43 no. 37: Quebec Rally Against Euthanasia (Dr. Claude Morin, Dr. Marc Bergeron, Daniel Arsenault, Clément Vermette), T#099 (http://www.consciencelaws.org/background/procedures/assist009-016.aspx#099); *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N° 45: Dr. Annie Tremblay, Dr. Pierre Gagnon, T#148 (http://www.consciencelaws.org/background/procedures/assist009-037.aspx#148)

43. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#072 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#072)

44. *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Rally Against Euthanasia (Dr. Claude Morin, Dr. Marc Bergeron, Daniel Arsenault, Clément Vermette), T#102, T#103 (http://www.consciencelaws.org/background/procedures/assist009-016.aspx#102) (http://www.consciencelaws.org/background/procedures/assist009-016.aspx#103)

45. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N° 45: Dr. Annie Tremblay, Dr. Pierre Gagnon, T#150 (http://www.consciencelaws.org/background/procedures/assist009-037.aspx#150)

46. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin),T#103 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#103)

47. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#102 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#102)

48. See, for example, Cantor, Julie D., "Conscientious Objection Gone Awry - Restoring Selfless Professionalism in Medicine." *N Eng J Med* 360;15, 9 April, 2009; Charo, R. Alta, "The Celestial Fire of Conscience- Refusing to Deliver Medical Care." *N Eng J Med* 352:24, June 16, 2005. (http://content.nejm.org/cgi/content/full/352/24/2471) (Accessed 2008-09-13); Kolers, A. "Am I My Profession's Keeper?" *Bioethics*, Vol. 28, No. 1, 2014.

49. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#102 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#102)

50. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#107 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#107)

51. *Consultations*, Thursday, 26 September 2013 - Vol. 43 no. 39: Interprofessional Health Federation of Quebec (Régine Laurent, Julie Martin, Michàle Boisclair, Brigitte Doyon), T#058

(http://www.consciencelaws.org/background/procedures/assist009-022.aspx#058)

52. *Consultations*, Thursday, 19 September 2013 - Vol. 43 no. 36: Association of Councils of Physicians, Dentists and Pharmacists of Quebec (Dr. Martin Arata, Annick Lavoie, Annie Léger), T#017 (http://www.consciencelaws.org/background/procedures/assist009-009.aspx#017)

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Redefining the Practice of Medicine
Euthanasia in Quebec
Part 6: Participation in Killing

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

It appears that, even where euthanasia or assisted suicide is legal, the majority of physicians do not actually provide the services. However, by establishing a purported legal "right" to euthanasia, ARELC generates a demand that physicians kill their patients, despite the high probability that a majority of physicians will not do so.

Often for purely pragmatic reasons, euthanasia supporters do not usually insist that an unwilling physician should be compelled to personally kill a patient. Thus, the difficulty created by the law can be addressed by administrative measures that connect patients looking for euthanasia with the minority of physicians willing to provide it. Nonetheless, physicians who object to euthanasia for reasons of conscience will likely be expected to facilitate access to the procedure by helping the patient find a colleague willing to provide it.

However, objecting physicians not only refuse to kill patients, but also often refuse to do anything that they believe makes them morally responsible for the killing. This includes actions that indirectly support or facilitate it. Hence, it is likely that most of the attacks on freedom of conscience resulting from ARELC will be precipitated, not by a refusal to kill directly, but by this kind of refusal to participate indirectly in killing.

The *Criminal Code* demonstrates that a physician who refuses to facilitate the killing of a patient because he does not want to be a culpable participant in killing is acting well within well-established moral and legal norms reflected in our criminal law. Further, the polices of professional medical organizations that forbid physician participation in capital punishment, torture, and female genital cutting indicate that it is not unreasonable for objecting physicians to refuse to facilitate euthanasia even indirectly.

On the contrary: refusing to participate, even indirectly, in conduct believed to involve serious ethical violations or wrongdoing is not aberrant behaviour. It is the response expected of physicians by professional bodies and regulators in order to avoid physician complicity in such procedures.

A difficulty created by the law

It appears that, even where euthanasia or assisted suicide is legal, the majority of physicians do not actually provide the services, and the number of physicians who actually kill patients or write prescriptions for lethal drugs or provide second opinions in support of euthanasia can be very small. Further, often for purely pragmatic reasons, euthanasia supporters do not usually insist that an unwilling physician should be compelled to personally kill a patient.[1]

However, by establishing a purported legal "right" to euthanasia, ARELC generates a demand that physicians kill their patients in accordance with MAD guidelines, despite the high probability that a majority of physicians will not do so. One response to this difficulty - a difficulty created solely by the law - is to connect patients looking for euthanasia with the minority of physicians willing to provide it. We have seen some of the suggestions: advance identification of willing physicians in each region, the use of electronic communication services to permit remote consultation and the establishment of mobile "flying squads" of euthanatists to provide services not otherwise available in some parts of the province (Part 5).

Such systems require not only the services of physicians willing to perform MAD procedures, but of many other people who will be expected to conform to the "new normal" by providing the logistical and administrative support necessary to make them work. Of course, one would expect this kind of help to be provided by the Quebec government and by those who support euthanasia and assisted suicide, like the Association for the Right to Die with Dignity and the various groups or individuals who spoke in favour of euthanasia during the legislative committee hearings in the fall of 2013. One might also anticipate this kind of help from physicians who would be uncomfortable lethally injecting a patient, but who have no objection to it being done by someone else.

But ARELC demands more than this. By purporting to establish euthanasia as a "right," it also purports to impose obligations, the first of which is simple non-interference: an obligation not to obstruct. Unfortunately, what counts as "obstruction" is the subject of activist polemics, who are bent on transforming an obligation not to obstruct into an obligation to facilitate. This leads to a demand that physicians who object to euthanasia for reasons of conscience facilitate access to the procedure by helping the patient find a colleague willing to provide it. Note, for example, the Quebec Association for the Right to Die with Dignity assured Dr. Bolduc that it had no intention of forcing objecting physicians to kill patients themselves,[2] but no assurance was given that they would not be compelled to participate indirectly in killing, in ways like those identified by the American Medical Association in its prohibition of physician participation in executions.[3]

"The serious moral burdens of complicity"

It is here that we encounter the most common kind of conflict likely to be caused by ARELC. It is unlikely that a physician who refuses to personally kill a patient for reasons of conscience will be prosecuted by state or professional authorities, since the practical competence of such a physician would be in doubt, and coercion of that kind would be politically unwise and counterproductive.

On the other hand, physicians who object to euthanasia for reasons of conscience not only refuse to kill patients, but often refuse to do anything that they believe makes them morally responsible for the killing. This includes actions that support or facilitate it - such as encouraging or affirming a patient's desire to be killed, or helping to find someone to do it. As Holly Fernandez Lynch noted in her book, *Conflicts of Conscience in Health Care: An Institutional Compromise*, such actions impose "the serious moral burdens of complicity."[4]

It is thus likely that most of the attacks on freedom of conscience resulting from ARELC will be precipitated, not by a refusal to kill directly, but by refusal to participate indirectly in killing.

Are such refusals reasonable? If so, what might reasonably be considered to be "indirect participation"?

Answers to both questions are readily available from different sources, the first of which is Canada's *Criminal Code*. The *Criminal Code* remains in force despite ARELC, so it is both convenient and appropriate to use it to demonstrate that the concept of indirect participation is reasonable, and to illustrate what kinds of actions can be considered indirect participation in killing.

"Parties" to killing

The *Code* describes anyone who participates in a crime as a "party to an offence." Applying Code's definition of "party" to lethally injecting a patient pursuant to ARELC, "party" would include

1. the person who injects the patient,[5]
2. anyone who does or omits to do anything for the purpose of helping someone perform the lethal injection,[6]
3. anyone who encourages, instigates, promotes or arranges it,[7]
4. anyone who counsels, procures, solicits or incites someone to provide it.[8]

Within the context of ARELC, the participants in lethal injection would include (1) the injecting physician, (2) the pharmacist dispensing the drug and the nurse preparing the needle, (3) a family member or referring physician, and (4) the executive director of an institution or local authority who arranges for a willing physician to replace an objecting physician. A plan to lethally inject a patient constitutes a conspiracy among all who agree to it, each of whom (like members of an institutional ethics committee) is a participant in a conspiracy.[9]

The *Criminal Code* is concerned with criminal complicity or criminal culpability, which are narrower concepts than moral complicity or culpability. Nonetheless, it demonstrates that the concept of indirect participation is well-recognized and undisputed. A physician who refuses to facilitate the killing of a patient because he does not want to be a culpable participant in the killing is acting well within well-established moral and legal norms reflected in our criminal law.

Participation in killing

While these references to criminal law are clear and convenient, it is appropriate to supplement them by reflecting on the concept of morally significant participation in killing within the context of medical ethics.

World Medical Association

In October, 2012, the World Medical Association (WMA) reaffirmed its position that physician must not "participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions", adding that, they must not "facilitate the importation or prescription of drugs for execution" (emphasis added).[10]

The WMA did not define "participation." However, it is obvious that the statement reaffirmed was meant to include acts contributing even indirectly to an execution, and this was further emphasized by the additional proscription of "facilitating" drug importation or prescription.

American Medical Association

The policy of the American Medical Association forbids physician participation in capital punishment. We are not concerned here with the morality of capital punishment or even with the morality of physician participation in executions. What is of interest is the discussion of "participation," which is obviously intended to mean morally significant participation. The policy and supporting documents demonstrate that participation becomes morally significant to the extent to which one's actions contribute to and thus make one complicit in what follows from them. With respect to participation in executions, this includes:

> (1) an action which would directly cause the death of the condemned;
>
> (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned;
>
> (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Among the actions identified by the AMA as "participation" in executions are

- prescribing or administering tranquillizers or other drugs as part of the procedure,
- directly or indirectly monitoring vital signs,
- rendering technical advice or consulting with the executioners,
- selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel;
- attending or observing an execution, except at the request of the condemned, or in a non-professional capacity.

The attention paid to what others might consider insignificant participation is exemplified in the provision that permits physicians to certify death, providing that death has been pronounced by someone else, and by restrictions on the donation of organs by the deceased.[11]

Participation in torture

Recall that our interest here is not in the morality of capital punishment or euthanasia, but in the meaning of morally significant participation. This interest can be pursued further by considering participation in torture.

Extraordinary rendition

In the weeks following the terrorist attacks on the United States in September, 2001, Newsweek columnist Jonathon Alter argued that it was time to think about torturing terrorist suspects who might have information about plans for such horrendous crimes. He acknowledged that physical torture was "contrary to American values," but argued that torture is appropriate in some circumstances, and proposed a novel 'compromise:' that the United States turn terrorist suspects who won't talk over to "less squeamish allies,"[12] a practice known as "extraordinary rendition." The allies would then do what Americans would not, without compromising American values.

Maher Arar

Less than a year later, Canadian citizen Maher Arar, returning home from Zurich through New York, was detained, interrogated and "rendered" to Syria by U.S. authorities.[13] In Syria he was imprisoned for almost a year, "interrogated, tortured and held in degrading and inhumane conditions."[14] A commission of inquiry was appointed to investigate the actions of Canadian officials because, unlike Jonathon Alter, most Canadians did not believe that referral to "less squeamish allies" could absolve one of moral responsibility for torture.

Even though Mr. Arar's deportation to Syria was effected by the United States, and Syrian officials imprisoned and tortured him, the public and the government wanted to know whether or not Canadian officials had caused or contributed to what happened to Mr. Arar. The key issue was whether or not Canada was complicit in torture - even indirectly. The report of the Inquiry made this abundantly clear: "Canada should not inflict torture, nor should it be complicit in the infliction of torture by others."[15]

> If it is determined that there is a *credible risk* that the Canadian interactions would render Canada *complicit* in torture or *create the perception* that Canada *condones* the use of torture, then a decision should be made that *no interaction is to take place* (emphasis added).[16]

Physician participation in torture

Thus far, government officials. But the problem of complicity does not relate only to government officials. The Lancet, among others, has asked, "How complicit are doctors in the abuse of detainees?"[17] and other journal articles have explored the answer with some anxiety.[18]

The Arar Inquiry and the alarm raised about physician complicity in torture make sense only if it is agreed that facilitating an act done by someone else makes one morally responsible for it: a participant in the act, as it were: in the words of the Criminal Code, a party to it. This is the principle underlying the prohibition of physician participation in capital punishment by the World Medical

Association and American Medical Association, and it is also the basis for their prohibition of physician participation in torture.

The WMA states that a physician must not "countenance, condone or participate in the practice of torture," "provide any premises, instruments, substances or knowledge to facilitate the practice of torture" and must not even be present "during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened."[19]

The AMA states that participation in torture includes, but is not limited to, "providing or withholding any services, substances, or knowledge to facilitate the practice of torture."[20] Similarly, the Canadian Medical Association opposes physician involvement in the punishment or torture of prisoners. The CMA states that physicians "should refuse to allow their professional or research skills to be used in any way" for such purposes.[21]

Participation in female genital cutting (mutilation)

Female genital cutting (also known as female circumcision) is a ritual practice that involves excising, infibulating or mutilating the labia majora, labia minora or clitoris, usually of girls four to eight years old. It is a criminal offence in Canada, a form of aggravated assault.[22]

Consistent with the criminal law, the College of Physicians and Surgeons of Ontario prohibits physicians from performing female genital cutting, and also forbids referral for the practice: "The performance of, or referral for, FGC/M procedures by a physician will be regarded by the College as professional misconduct."[23]23

This is formal acknowledgement by a state regulatory authority that facilitating an act - in this case by referral - makes one complicit in it. Indeed, the policy makes no distinction between performance and referral; both amount to professional misconduct.

It might be argued that the College prohibition of referral merely reflects the criminal prohibition of aiding or abetting (discussed above). However, ethical misconduct is distinct from criminal law; the College was free to draw the attention of physicians to the law against female genital cutting without also declaring it to be professional misconduct.

Moreover, while the policy document cautions physicians about legal issues, it introduces the topic within the context of adverse health outcomes, and the principles that inform the policy concern the practice of medicine, the physician-patient relationship and the duty to act in the patient's best interests. This is a professional ethical framework, not a mere re-statement of the criminal law.

Finally, criminal rules of evidence require proof beyond reasonable doubt for conviction, so various factors, such as the absence of a key witness, may preclude criminal prosecution for referral for genital cutting. However, the standard of proof in disciplinary proceedings is proof on the balance of probabilities, so that charge of professional misconduct for referral may proceed even if criminal prosecution does not take place. In that case, the criminal law on parties to offences would not be applicable, though it could, as here, serve as a reference to illustrate the underlying principles. Instead a conviction for professional misconduct for referral would have to rely on the concept of morally significant participation discussed above.

Refusing to participate

It is reasonable to hold that the kind of action involved in helping a patient to access euthanasia amounts to participation in the sense intended by various medical authorities in policies that forbid physician participation in capital punishment, torture or female genital cutting. Refusing to participate, even indirectly, in conduct believed to involve serious ethical violations or wrongdoing is not aberrant behaviour. On the contrary: it is the response expected of physicians by professional bodies and regulators in order to avoid physician complicity in such procedures.

Notes:

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. For example, the Association for the Right to Die with Dignity is against forcing an unwilling physician to lethally inject a patient because it is concerned that an unwilling physician would probably not do it well. Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill 52* (Hereinafter "*Consultations*"), Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#107. (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#107) Others, like Dr. Yves Bolduc, believe that an attempt to force unwilling physicians or others to lethally inject a patient would cause of counterproductive backlash. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#102 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#102)

2. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#107. (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#107)

3. American Medical Association, Resources- Medical Ethics: Opinion 2.06 - *Capital Punishment*. (http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page?) (Accessed 2014-07-10)

4. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008, p. 229

5. *Criminal Code* (R.S.C., 1985, c. C-46) (Hereinafter "*CC*"), Section 21(a). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html) (Accessed 2014-07-17)

6. Often referred to as "aiding."*CC*, Section 21(b). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html) (Accessed 2014-07-17)

7. The *Code* uses the word "abet." *CC*, Section 21(c) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html); *R. v. Greyeyes*, [1997] 2 S.C.R. 825, at para. 26. (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1537/index.do) (Accessed 2014-07-17)

8. *CC*, Section 22 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html) (Accessed 2014-07-17)

9. *R v. Papalia* (1979) 2 S.C.R. 256 (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/4459/index.do); CC. Section 465. (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-225.html) (Accessed 2014-07-17)

10. World Medical Association, "WMA Resolution to Reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment." Adopted by the 63rd General Assembly of the World Medical Association, Bangkok, Thailand, October 2012. (http://www.wma.net/en/30publications/10policies/c23/index.html) (Accessed 2014-07-17)

11. American Medical Association, Resources- Medical Ethics: Opinion 2.06 - *Capital Punishment*. (http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page?) (Accessed 2014-07-10)

12. Alter, Jonathon, "Time to Think About Torture." *Newsweek*, 5 November, 2001, p. 45.

13. *Wikipedia*, “Maher Arar.” (http://en.wikipedia.org/wiki/Maher_Arar) (Accessed 2014-07-27)

14. Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar, *Report of the Events Relating to Maher Arar: Analysis and Recommendations*. (hereinafter, "*Arar Inquiry: Analysis and Recommendations*") p. 9. (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf)(Accessed 2008-09-08)

15. *Arar Inquiry: Analysis and Recommendations*, p. 346. (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) (Accessed 2008-09-08)

16. *Arar Inquiry: Analysis and Recommendations*, p. 199. (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) (Accessed 2008-09-08)

17. Editorial, "How complicit are doctors in the abuse of detainees?" *The Lancet*, Vol 364, August 21, 2004, p. 725-729

18. Miles, Steven H., "Abu Ghraib: its legacy for military medicine." *The Lancet*, Vol 364, August 21, 2004, p. 725-729; Lifton, Robert Jay, Doctors and Torture. N Engl J Med 351;5

19. *WMA Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*. Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006 (http://www.wma.net/en/30publications/10policies/c18/) (Accessed 2014-07-18)

20. American Medical Association Policy E.2.067: *Torture*. (http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2067.page) (Accessed 2014-07-27)

21. Canadian Medical Association Policy resolution BD80-03-99 - *Treatment of prisoners*. Status: Approved, 1979-Dec-08. Last Reviewed, 2004-Feb-28: Still relevant.

22. *CC*, Section 268(3). (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-132.html) (Accessed 2014-07-18)

23. College of Physicians and Surgeons of Ontario, Policy Statement #2-11, *Female Genital Cutting (Mutilation)*. Reviewed and updated November, 2004, September 2011. (http://www.cpso.on.ca/cpso/media/uploadedfiles/policies/policies/policyitems/female_circ.pdf)(Accessed 2014-07-18)

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Redefining the Practice of Medicine

Euthanasia in Quebec

Part 7: Refusing to Kill

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

It is important identify problems that the Act poses for those who object to euthanasia for reasons of conscience, and to consider how objecting health care workers might avoid or respond to coercion by the government and the state medical and legal establishments. The goal here is to ensure that conscientious objectors to euthanasia will be able to continue to work in health care without becoming complicit in what they consider to be wrongdoing.

Physicians may refuse to provide euthanasia if the patient is legally ineligible, and for other reasons, including conscientious objection. ARELC requires physicians who refuse to provide euthanasia for any reason other than non-eligibility to notify a designated administrator, who then becomes responsible for finding a MAD physician. The idea is to have the institution or health care system completely relieve the physician of responsibility for facilitating the procedure.

It would be preferable to end the involvement of the objecting physician with refusal, accompanied by a suggestion that the patient will have to look for assistance from other sources. This might be achieved if objecting physicians were to notify both executive directors and patients in advance that they will not provide or facilitate euthanasia.

A more sensitive problem attends the requirement that an objecting physician forward a euthanasia request form to the designated administrator, since that is more clearly connected to the ultimate killing of a patient. Since the requirement to forward the request applies only if it has been given to the physician, this might be avoided if the objecting physician made his position clear in advance, and/or refused to accept such a request. Such complications could avoided if administrators were to adopt a policy to the effect that a health care professional who witnesses and countersigns a euthanasia request to arrange for MAD services is responsible for arranging them.

The protection of conscience provision in ARELC distinguishes physicians from other health professionals, providing less protection for physicians than for others. Other health care professionals may

refuse to "take part" (participate) in killing a patient for reasons of conscience. Physicians may refuse only "to administer" euthanasia - a very specific action - which seems to suggest that they are expected to participate in other ways.

Some Quebec physicians may be unwilling to provide euthanasia while the criminal law stands, even if they do not object to the procedure. Quebec's Attorney General may be unwilling to provide the extraordinary kind of immunity sought by physicians, which exceeds what was recommended by the Select Committee on Dying with Dignity, and some physicians may be unwilling to provide euthanasia without it.

Finally, as long as euthanasia remains a criminal offence, physicians or other entities responsible for issuing or administering MAD guidelines may respond to requests for euthanasia precisely as they would respond to requests to become involved in first degree murder: with total refusal to co-operate. Even a partial and scattered response of this kind would likely be administratively troublesome.

Patients may lodge complaints against physicians who refuse to provide or facilitate euthanasia with institutions and the regulatory authority, regardless of the reasons for refusal.

When physicians refuse

From the limited perspective of protecting freedom of conscience, it is important identify problems that the Act poses for those who object to euthanasia for reasons of conscience, and to consider how objecting health care workers might avoid or respond to coercion by the government and the state medical and legal establishments.

The goal here is to ensure that conscientious objectors to euthanasia will be able to continue to work in health care without becoming complicit in what they consider to be wrongdoing. While this reflects support for freedom of conscience, not euthanasia, everyone should be interested in preventing physicians from being denied privileges, dismissed or forced to resign, which would hardly improve the delivery of health care in Quebec.

Refusing to kill generally

Refusal based on statutory eligibility (Section 30)

A physician may refuse to provide euthanasia based on his assessment of a patient's statutory eligibility. If, for example, the physician finds that the patient is under 18, or not a Quebec resident, or not suffering from an incurable illness, or not acting freely, the physician may not provide euthanasia, and must inform the patient of the reasons for his decision.[1] Nothing else is required of the physician, but, as will be seen presently, the physician's refusal is not necessarily the end of the story, though that is not apparent from ARELC.

Refusal for other reasons (Section 31)

Section 31 is a general provision that applies to anyone who refuses to provide euthanasia for reasons other than the patient not fitting the criteria for MAD service, whether or not the refusal results from conscientious objection.

> 31. A physician practising in a centre operated by an institution who refuses a request for medical aid in dying for a reason not based on section 29 must, as soon as possible, notify the executive director of the institution or any other person designated by the executive director *and forward the request form given to the physician, if that is the case*, to the executive director or designated person. The executive director of the institution or designated person must then take the necessary steps to find, as soon as possible, another physician willing to deal with the request in accordance with section 29 (emphasis added).

The remainder of the section imposes essentially the same requirement on physicians not practising in centres operated by an institution; they are to notify executive directors of a local authority or of an institution operating a local community service centre, as the case may be. As noted in the section, executive directors can appoint someone to receive all such requests.

Generally

Physicians who are not opposed to euthanasia in principle may have various reasons for refusing to provide the procedure for eligible patients. For example, they may refuse because they believe that

- they lack the skill needed to provide euthanasia;
- the drugs available are not suitable for the procedure; the institution lacks the privacy required for it;
- institutional rules concerning it are burdensome or otherwise unreasonable.

If a patient refuses to discuss the issue with family members, physicians may be unwilling to risk the consequences of killing the patient without the family's knowledge. Similarly, physicians may decline to be involved when disputes arise within families concerning euthanasia.

In such cases, the requirement under Section 31 to notify the director of professional services and forward the MAD request should not be problematic. Since these physicians do not object to euthanasia and would be willing to provide it in different circumstances, there is no reason for them to object to facilitating it.

Conscientious objection

Section 31 also applies to a physician who refuses to provide euthanasia for reasons of conscience. Consistent with the discussion in Part 8, the idea behind the section is to have the institution or health care system take over and completely relieve the physician of responsibility for facilitating the procedure.[2] Holly Fernandez Lynch recommends this as "an institutional compromise,"[3] though, as Michel Racicot of Living with Dignity observed, it denies freedom of conscience to the executive director or person designated to find a replacement physician.[4]

It is conceivable that an objecting physician might refuse to notify the executive director, inasmuch as that would set in motion a search for a MAD physician and ultimately lead to the killing of the patient. For this reason, it would be preferable to end the involvement of the objecting physician with refusal, accompanied by a suggestion that the patient will have to look for assistance from other sources. This issue could also be addressed if objecting physicians were to notify both executive directors and patients in advance that they will not provide or facilitate euthanasia. By doing so they would, arguably, fulfil the obligation imposed on the physician by ARELC, and it would enable executive directors to take whatever steps they deemed necessary to provide MAD service, while avoiding confrontations involving objecting staff and patients or family members.

A similar but more sensitive problem attends Section 31's provision (in italics above) that an objecting physician forward a euthanasia request form to the executive director. Objecting physicians who are willing to notify an executive director that they have refused or will refuse euthanasia may not be willing to transmit a request for euthanasia, since that is more clearly connected to the ultimate killing of a patient. However, the requirement to forward the request applies only if it has been given to the physician (ref. "if that is the case"). This would presumably not occur if the attending physician made clear in advance that he would have nothing to do with euthanasia; it may also be possible for an objecting physician to refuse to accept a request by a health care professional who has witnessed and countersigned it.

Such complications could avoided if administrators were to adopt a policy to the effect that a health care professional who witnesses and countersigns a euthanasia request to arrange for MAD services is responsible for arranging them. Presumably a health care professional who witnesses and countersigns a euthanasia request would have no objection to assuming that responsibility.

Refusing to kill for reasons of conscience

The original wording of the protection of conscience provision in Bill 52 did not actually recognize or authorize conscientious objection, but stated only that the law did not limit what had already been provided for in the codes of ethics of health care professionals. If there was no provision in a code of ethics to protect freedom of conscience, the original text of the law would not have provided protection.[5] During the legislative committee hearings, then Minister of Health Véronique Hivon explained that the government could not provide protection in the bill that a profession had not included in its own code of ethics.[6]

However, the Quebec Association of Clinical Ethicists recommended that the concept of conscientious objection by other health care professionals be incorporated into the bill,[7] a recommendation also made by committee member StÉphanie VallÉe.

> Just as it is super important to respect individual freedom of the patient, I think we must also ensure respect for professional individual freedom, those who will be called upon to intervene. Because it is apparent in the debate, there are professionals working in care at the end of life, who, for many personal reasons, are not comfortable with the concept of medically assisted dying. Sometimes it may be for reasons to do strictly with skill, that is to say it is not a treatment they know administer or is something with which they are uncomfortable.[8]

In fact, referring to her personal experience with palliative care homes in her riding, Ms. Vallée wanted freedom of conscience recognized for boards of directors that operate homes for "the end-of-life population."[9]

Finally, the Quebec Assembly of Catholic Bishops, which opposed the passage of the law, insisted that if it were passed, the "possibility of objection should be clearly extended to all the nursing and administrative staff of health care facilities" to ensure that they "are not subjected to any pressure and are not discriminated against."[10]

Some of these recommendations seem to have had some effect, as the revised provision in ARELC now acknowledges freedom of conscience (though not by name) and the recognition extends to all health professionals.

> 50. A physician may refuse to administer medical aid in dying because of personal convictions, and a health professional may refuse to take part in administering it for the same reason. In such a case, the physician or health professional must nevertheless ensure that continuity of care is provided to the patient, in accordance with their code of ethics and the patient's wishes. In addition, the physician must comply with the procedure established in section 31.

The Order of Nurses said that it did not consider MAD to be a form of "care," but "a procedure that terminates life."[11] Unfortunately, this position is likely to be attacked by activist insistence that "continuity of care" includes facilitating euthanasia.

Note that the section distinguishes physicians from other health professionals, providing less protection for physicians than for others. Other health care professionals may refuse to "take part" (participate) in killing a patient for reasons of conscience, which includes a broad range of conduct. Physicians, on the other hand, may refuse only "to administer" euthanasia - a very specific action - which seems to suggest that they are expected to participate in other ways. This may well be a result of the Collège des médecins *Code of Ethics*, which will be discussed in detail in Part 9.

Refusals based on criminal law

Up to this point, discussion has been limited to what might be considered predictable refusals of applications for euthanasia under ARELC. However, refusals may also be based on the continuing prohibition of euthanasia under Canadian criminal law. Moral or ethical objections might also be involved, but need not be. Indeed, physicians who have no moral objections to euthanasia might be unwilling to participate in it so long as it remains a crime. Some of these might stand by the principle of the rule of law, but others may have much more practical concerns, beginning with the extent of the immunity from prosecution promised by the Quebec government.

The question of immunity from prosecution

The government promise of immunity from criminal prosecution was based on the report of the Select Committee on Dying with Dignity. The Committee recommended that the Attorney General instruct the Director of Criminal and Penal Prosecutions "that physicians who provide medical aid in dying *in accordance with the criteria provided by law* cannot be prosecuted" (emphasis added).[12] Minister of Health Véronique Hivon promised physicians who appeared before the legislative committee that this would be done.[13]

Note that the guarantee of immunity recommended by the Select Committee and (apparently) promised by the government is restricted to cases in which physicians have complied with the MAD guidelines in ARELC. That is: the government is willing to promise that physicians who comply with ARELC will not be charged with murder or manslaughter.

However, Quebec physicians want more than this. The Federation of General Practitioners wants a guarantee of immunity from prosecution even if a physician who kills a patient does not comply with ARELC. The position of the Federation is that a physician who kills a patient in violation of MAD guidelines may face disciplinary action by the Collège des médecins, but must not face criminal prosecution. In this, the Federation is supported by the Quebec Association of Health Facilities and Social Services.[14]

It is by no means certain that the Attorney General of Quebec will go this far, because the Federation's expectation of immunity is really quite extraordinary, particularly within the context of killing people. Killing people is sometimes legally allowed; that is why the Criminal Code distinguishes between homicide that is culpable (illegal) and non-culpable (legal). Nonetheless, those who are authorized to kill people in some circumstances - the police, for example - are not guaranteed immunity from criminal prosecution if they fail to adhere to the restrictions the law imposes on the use of deadly force. On the contrary: one can imagine the public reaction if the president of a Quebec police union were to ask the Attorney General to promise that policemen who kill people in the course of their duties will not be criminally charged, even if they fail to comply with the law in so doing.

From this perspective, the nonchalance with which the Federation's request was received by the legislative committee was remarkable. How it will be received by Quebec's Attorney General when it comes to instructing the Director of Criminal and Penal Prosecutions is an open question. There is a precedent for acceding to the request, to be sure; state executioners were immune from prosecution for killing prisoners sentenced to death. But that exception ceased to exist with abolition of capital punishment, and it seems doubtful that prudent public policy would now authorize a professional class to kill, and also guarantee its members immunity from prosecution. As a result, Quebec's Attorney General may be unwilling to provide the extent of immunity sought by physicians, and at least some physicians may be unwilling to provide euthanasia without it.

Civil jeopardy

Even if Quebec physicians are satisfied with the criminal immunity offered by the government, they may decline to provide euthanasia so for fear of other legal consequences. The commission of a criminal offence - especially murder or manslaughter - provides grounds for civil action by aggrieved parties. The Attorney General may refuse to prosecute, but cannot prevent private civil actions by distressed family members who decide to sue physicians or institutions who have - according to criminal law - murdered a relative. No doubt the legal arguments in such a case would be extensive and interesting, but it would not be surprising if many physicians would prefer to avoid situations in which such arguments become necesssary.

Total refusal

As long as euthanasia remains a criminal offence, physicians concerned about the rule of law and conscientious objectors to euthanasia (the categories are not mutually exclusive) may take advantage of the additional clarity introduced by ARELC's definition of MAD. They would seem to be legally justified in responding to every request to provide or facilitate euthanasia precisely as they would respond to a request to become involved in first degree murder.

Given the provisions in criminal law dealing with aiding, abetting and counselling offences, physicians adopting this approach could, it seems, refuse to conform to any part of ARELC touching euthanasia. This strategy could be adopted not only by individuals, but by regional health agencies, councils of physicians, pharmacists and dentists or other entities responsible for issuing or administering MAD guidelines. If this response were widespread, it would completely hamstring implementation of euthanasia, though it would not affect palliative care. Even a partial and scattered response of this kind would likely be administratively troublesome, especially if those being pressured to comply with the Act respond by seeking injunctions and making complaints to the police.

Complaints about refusals

Regardless of the reason for refusal, patients may respond by making a standard request for a second opinion. However, a patient can also lodge a complaint about physician refusal, even in the case of a refusal based on statutory ineligibility. Further, the patient or his representative can seek the assistance of the institutional user committee (Appendix A21) and make a complaint about the physician to the institutional complaints commissioner (Appendices A13, B3), who would forward it to the institutional medical examiner for investigation (Appendix B3.2).

The medical examiner might investigate the complaint himself, or transmit it to the institutional council of physicians, dentists and pharmacists for investigation. (Appendix B4.1[b]) If the council concludes that discipline is warranted, it would communicate its opinion to the complainant and the institutional board of directors (Appendix B6), which can respond by reprimanding the physician, changing his status, or withdrawing, suspending or restricting his of privileges (Appendix B7.2).

If the institutional response does not satisfy a complainant, an appeal lies to the Health and Social Services Ombudsman, who is entitled to intervene (Appendix B9.3)

Alternatively (or simultaneously) a complaint of professional misconduct can be made to the Collège des médecins du Québec, which, upon conviction, can strike the physician from the register, suspend or restrict professional activities, or levy substantial fines (Appendix B10.3).

Notes

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. ARELC, Section 30. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#030)

2. Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill 52* (Hereinafter "*Consultations*"),Tuesday 24 September 2013 - Vol. 43 no. 37: Physicians' Alliance for Total Refusal of Euthanasia (Dr. Catherine Ferrier, Dr Serge Daneault, Dr François Primeau), T#038 (http://www.consciencelaws.org/background/procedures/assist009-014.aspx#038)

3. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008.

4. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Living with Dignity (Nicolas Steenhout, Dr. Marc Beauchamp, Michel Racicot), T#027 (http://www.consciencelaws.org/background/procedures/assist009-017.aspx#027)

5. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#075 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#075)

6. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N° 45: Quebec Association of Clinical Ethicists (Delphine Roigt, Emilia Guévin, Michel Lorange), T#118 (http://www.consciencelaws.org/background/procedures/assist009-034.aspx#118)

7. *Consultations*, Wednesday, 9 October 2013 - Vol. 43 N° 45: Quebec Association of Clinical Ethicists (Delphine Roigt, Emilia Guévin, Michel Lorange), T#028 (http://www.consciencelaws.org/background/procedures/assist009-034.aspx#028)

8. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#056 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#056)

9. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#057 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#057)

10. *Consultations*, Thursday 19 September 2013 - Vol. 43 no. 36: Assembly of Catholic Bishops of Quebec (Bishop Noël Simard, Bishop Pierre Morissette), T#023 (http://www.consciencelaws.org/background/procedures/assist009-011.aspx#023)

11. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#099 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#099)

12. *Select Committee Dying with Dignity Report* (March, 2012) p. 89-90. See also Recommendation 20. (http://www.dyingwithdignity.ca/database/files/library/Quebec_death_with_dignity_report.pdf) (Accessed 2013-06-13)

13. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#021 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#021)

14. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of General Practitioners of Quebec (Dr. Louis Godin, Dr. Marc-André Asselin), T#015, T#092, T#094 (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#015) (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#092) (http://www.consciencelaws.org/background/procedures/assist009-002.aspx#094); Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#017 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#017)

Redefining the Practice of Medicine

Euthanasia in Quebec

Part 8: Hospitality and Lethal Injection

Sean Murphy, Administrator
Protection of Conscience Project

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Abstract

Under the *Act Respecting End of Life Care* (ARELC) palliative care hospices may permit euthanasia under the MAD protocol on their premises, but they do not have to do so. Patients must be advised of their policy before admission. The government included another section of ARELC to provide the same exemption for La Michel Sarrazin, a private hospital. The exemptions were provided for purely pragmatic and political reasons.

The exemptions have been challenged by organizations that want hospices forced to kill patients who ask for MAD, or at least to allow physicians to come in to provide the service. Hospice representatives rejected the first demand and gave mixed responses to the second. A spokesman for the Alliance of Quebec Hospices confirmed that palliative care hospices that provide euthanasia will not be excluded from the Alliance.

A prominent hospice spokesman predicted that the pressures would increase after the passage of ARELC, and that hospices refusing to provide euthanasia would operate in an increasingly hostile climate.

A former minister of health rejected the challenges to the exemptions and insisted that the policy of hospices be respected, appealing to the principles of autonomy and freedom of choice. Consideration of freedom of conscience is irrelevant to this approach, and the description of the problem as a conflict of autonomy actually precludes a successful resolution by an appeal to the principle giving rise to it.

While the former minister of health wanted the autonomy of hospices explicitly set out in law, the only requirement in ARELC is that regional health authorities consult with institutions and palliative care hospices in their territories before making rules. Mere consultation may be insufficient to protect the integrity of hospices in the long term.

Introduction

A review of the situation of Quebec hospices provides some insight into the effect of the legalization of euthanasia on those who object to the procedure for reasons of conscience, notably the pressures that will be brought to bear on objectors by the law and public or professional opinion.

Exemptions for palliative care hospices

ARELC Section 13

Recall that palliative care hospices are "community organizations" as defined in the *Act Respecting Health Services and Social Services*. Although they receive government funding, they remain free to define their "orientations, policies and approaches." Consistent with this, section 13 of ALERC permits palliative care hospices to determine what end-of-life care they will provide, and requires them to notify patients of their practice before admitting them.[1] This means that, while they may permit MAD services on their premises, they do not have to do so. The section is extremely important for palliative care hospices because their administration and staff are normally opposed to assisted suicide and euthanasia.

It appears that pragmatic considerations underlie this provision in the law. Hospices are not formally part of the state health care system, though they are subject to state regulation and are dependent to varying degrees on public funds to provide their services. If the government were to demand that they provide euthanasia, there is a risk that they would close or lose critical members of their palliative care teams, so that, as Dr. Bolduc explained, "excellent resources that are doing excellent work" would be lost.[2] Aside from the loss of resources for patients, the government would likely have to incur additional expense to replace them.

ARELC Section 72

Section 72 of the Act is a grandfather clause that concerns any institution operating a "general and specialized hospital centre" that offers only palliative care. Such institutions "may continue to offer that care exclusively" (i.e., need not provide euthanasia), as long as they notify patients of this before admitting them.[3] Véronique Hivon, when Minister of Health, explained that the section is intended to apply only to a single institution:

> Article [72] is a clarification. The only institution affected by Article [72] is La Maison Michel Sarrazin; no other public institutions can avoid [providing physician-assisted dying]. In fact, it is the Michel Sarrazin clause to that preserves its status as the only hospice that has a status of [a public] institution. Why? Because it was the first, and does research, it is an academic institute. And we have no choice. We wanted to give it ... put it on the same footing as other hospices. So this is why there is this clause there. And [the law] cannot be applied because it is the only institution that offers only palliative care, so it's a grandfather clause, actually.[4]

Note that the term "public institution" is a category used for administrative purposes under the Act Respecting Health Services and Social Services. It does not mean state-owned. La Maison Michel Sarrazin is a private, not-for profit palliative care hospital with 15 beds. Operating for almost 30 years, it is funded largely by the Michel Sarrazin foundation and relies extensively on volunteers. From its inception, in has been the leader in the development of palliative care in Quebec; 8,000 patients have spent their last days there. The institution is adamantly opposed to euthanasia and assisted suicide.[5]

Minister Hivon's comment, "we have no choice," probably reflects the government's judgement that, in addition to the purely pragmatic considerations applicable to other palliative care hospices, to compel La Maison Michel-Sarrazin to kill its patients would have been politically disastrous. Recall the warning of Yves Bolduc against forcing physicians to lethally inject patients: "If we start with that principle, then you will destroy the bill."[6]

Exemptions challenged

Demands that hospices provide MAD

Nonetheless, the exemption for hospices, including Michel Sarrazin, was criticized by the Institute for Care Planning, which complained that hospices were not being obliged to kill their patients, and that the government had been "very timid and insufficiently firm" (très pudiques et très peu audacieux) by releasing them from this obligation.[7] The Quebec Association for the Right to Die with Dignity also criticized the government for "allowing a loophole for hospices and some institutions."[8]

In explaining its position on hospices, the Institute for Care Planning inadvertently revealed an underlying premise based on a false dichotomy that is in fundamental conflict with the philosophy of hospice and palliative care and even the provision of health care generally. Recollecting the community origins of hospices and designation as community organizations, the Institute said, "It is now difficult to regard them as community organizations."

> They are in a certain sense, when they decide to make gardens, places for accommodation for families, etc.., It is wonderful, the community participates. But with respect to care, in my opinion, their status is much more related to health and increasingly, they have obligations and constraints of approval, control and everything.[9]

In its complaint, the Institute reveals a purely functional -not to say bureaucratic and statist - view of health care, as a mere government service that is paid for and must be delivered when paid for, not - as others might see it - a personal encounter between two human beings that demands a human face, and fully human engagement. The Institute seems to have forgotten that "hospice", "hospital" and "hospitality" have the same linguistic and historical roots. But this has not been forgotten by hospices, which associate hospitality with making people welcome and comfortable rather than with lethal injections.

Consistent with the Institute's "government service" paradigm of health care, the Quebec Association for the Right to Die with Dignity asserted, "an institution such as a hospice or a health facility, which receives significant public funding should not be able to escape this new obligation to provide the range of services," including euthanasia.[10]

According to the Association, if the staff at such an institution is not willing to kill a patient who qualifies under the MAD criteria, it "has an obligation to provide means and results, namely that of putting at the disposal of those who so request a real possibility, a convenient way to get medical help to die from a professional whose ethics and empathy will be compatible with this noble goal."[11]

The Association and the Institute for Care Planning acknowledged the requirement for prior notification of patients, so that a patient might ask for admission to a hospice in good faith, uninterested in euthanasia and knowing that MAD services were unavailable there. However, they warned, subsequent developments might cause the patient to want euthanasia. The Institute argued that it would not be appropriate to transfer him to a hospital emergency room. Instead, a consultant could be brought in to provide the service. After all, the Institute asked, what does the hospice do?

"It provides a location, that's all," was the answer.[12]

"That's all" abruptly dismisses what hospice staff probably consider the most important elements of their vocation.

Suggestions that hospices allow MAD

The scenario proposed by the Association for the Right to Die with Dignity and the Institute for Care Planning was put by committee member Hélène Daneault to Lucie Wiseman, representing the Alliance of Quebec Hospices. Ms. Daneault asked if, in such circumstances, Alliance hospices would admit a "flying squad" to provide MAD.[13] The question was unanticipated. Ms. Wiseman was clearly disturbed by the question and unable to respond definitively on behalf of all the Alliance houses, or even to predict how they might respond, beyond assuring legislators that "we are human beings, above all, with compassion."[14]

In contrast, speaking for La Maison Michel Sarrazin, Dr. Michel L'Heureux was clear that euthanasia flying squads would not be allowed to operate in the facility.

> I put in parenthesis at the outset, in relation to the previous discussion with Alliance of Hospices, to make euthanasia or assisted suicide available by means of a third party like a flying squad would be no more admissible to me than doing it oneself. You know, families in the living room, in the dining room. Everyone knows in a house. And you can not maintain an image or a strong message like this and at the same time be doing things that are undermining the credibility of that message. So for me, it is inconsistent to think that we could allow people from a third party to come and do this within the walls of a house. That would have an impact on all the other patients, on the other families.[15]

Dr. L'Hereux explained that if a patient at Michel Sarrazin were to request euthanasia he would refuse the request.

"I would not have an obligation to find another doctor in another institution . . . or find a hospital ready to take the patients," he said, "because otherwise it comes in the back door, it is imposed indirectly."[16]

Nonetheless, he remained concerned: "I think I can see it coming."[17]

Suggestion that the hospice association should accept MAD

As will be seen presently, Dr. Yves Bolduc rejected suggestions that hospices should be compelled to provide euthanasia, but had a question for the Alliance of Quebec Hospices. Observing that the law permitted a hospice to offer euthanasia,[18] he asked if the Alliance would allow a hospice that provided MAD services to be called a hospice and remain a member of the Alliance: that such a hospice would not be excluded from the association.[19] Lucie Wiseman confirmed that membership would be allowed.[20] What she could not confirm - perhaps did not consider - was the possibility of a schism within the Alliance and the formation of two different hospice associations based on fundamental differences about euthanasia and the nature of hospice work.

"Environmental pressures"

The foregoing summary of key points of the discussion during the hearings into Bill 52 illustrates what Dr. Michel L'Heureux called "environmental pressures" (des pressions de l'environnement) on hospices and palliative care generated by ARELC.[21] Dr. L'Heureux predicted that the pressures would increase after the passage of the bill, and that hospices would have to navigate in an increasingly hostile social and political climate.

> Because activism does not stop the day after the bill is passed. Because activism continues, because after that, there is a will to expand, new amendments, to want to widen it and put pressure on institutions that do not offer it. This is the reality of Belgium. It is the reality of Quebec.[22]

The prediction does not seem unreasonable in view of the expansive tendencies evident during the committee hearings (See Part 3), the complaints of the Institute for Care Planning and the Association for the Right to Die with Dignity. Perhaps reflecting what he has already experienced, Dr. L'Heureux mused about being told "that what we do is not acceptable, is inhuman, that we have no sympathy,"[23] or that palliative care being offered is "futile and cruel," and, finally, the threat: "Well, if you let them die slowly like this, we will cut your funding."[24]

Such comments are characterized by the Association for the Right to Die with Dignity as "a filibuster by the palliative care network" that threatens to obstruct "smooth implementation of the continuity of care at end of life."[25] The Association alleges that "there is a law of silence squarely within the palliative care network" that prevents palliative care workers who support euthanasia from speaking up.[26]

"Autonomy" for all

Committee member Dr. Yves Bolduc was firm in his responses to complaints about the exemptions and the concerns of hospice representatives. He described his approach as one that combined idealism and pragmatism,[27] reflecting the conflicting demands of a pluralist society.[28]

"[W]e have patients who want to have a choice," he said. "We have patients who do not really want to have the choice because they are against the idea. We have professionals who say I never will, we have professionals who are willing to do it."[29]

He explicitly rejected the claim that receipt of public funding justified imposing the MAD regime on hospices,[30] and assured the Alliance of Quebec Hospices that they would have not obligation to provide euthanasia, "and this will not be linked to financing so that you are not blackmailed by the back door."[31]

In taking his stand, Dr. Bolduc appealed to autonomy and freedom of choice, the very concepts relied upon by those insisting that hospices provide MAD.

> Well, I find it sad that people who defend the autonomy of individuals, are not also able to defend the autonomy of groups that are independent of the health system, and even if there is funding that comes from the health system, such as is provided to community organizations, I want people to respect the choice of those people.[32]

Committee member Stéphanie Vallée told the Association for the Right to Die with Dignity that if, as they claimed, many people working in palliative care were willing to provide euthanasia, such people were free to persuade house management to provide it.[33] Thus, some hospices could provide euthanasia even if most did not, and the requirement for notification prior to admission made it possible for patients to choose which they preferred. Dr. Bolduc argued that the arrangement allows respect for both the autonomy of the patient and the autonomy of the hospices and their employees.[34]

"Autonomy," he said, "is good for everyone."[35]

Note, however, that consideration of freedom of conscience is irrelevant to this approach. Moreover, Dr. Bolduc's description of the problem as a conflict of autonomy actually precludes a successful resolution of the conflict by appealing to the principle giving rise to it. Dr. Iain Benson explains:

> The real issue, where there is a conflict of views between people regarding involvement with a procedure or drug, is not settled by reference to one person's "autonomy" but by reference to another principle, that of "justice" (defined as "rendering a person their due"). For it is there, in the order of justice, that competing claims must be reconciled in a manner that accords with the rule of law (including professional ethics and respect for professional disagreement), the provision of health-care and the developed understanding of a civil society.[36]

ARELC and the integrity of hospices

There is no doubt that Dr. Bolduc was sincere, but he was also realistic enough to know that, even as a former minister of health, his promises as an opposition member on a legislative committee were insufficient to provide the kind of guarantee needed by the hospices. Hence, he wanted the Alliance of Quebec Hospices to explain how arrangements respecting their autonomy could be set out in the law. Otherwise, he feared, a regulation would be made somewhere, possibly by "a lot people who want to impose on others their own opinions."[37]

In the end, the only change introduced into the Act Respecting End of Life Care that seems related to Dr. Bolduc's concern is a requirement that regional health authorities consult with institutions and palliative care hospices in their territories before determining the rules for access to end-of-life care.[38] Of course, mere consultation may be insufficient to protect the integrity of hospices in the long term.

Notes:

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. *An Act respecting end-of-life care*. (Hereinafter “ALERC”), Section 13 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#013)

2. Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill 52* (Hereinafter "Consultations"), Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#139 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#139)

3. ARELC, Section 72 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#072)

4. Note: in Bill 52, the original section number was 65. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#030, T#032
(http://www.consciencelaws.org/background/procedures/assist009-018.aspx#030)
(http://www.consciencelaws.org/background/procedures/assist009-018.aspx#032)

5. Pelchat, Pierre, "Aide médicale à mourir: la Maison Michel-Sarrazin dit non." *Le Soleil*, 12 October, 2013. (http://www.lapresse.ca/le-soleil/actualites/sante/201310/11/01-4699081-aide-medicale-a-mourir-la-maison-michel-sarrazin-dit-non.php) (Accessed 2014-07-27)

6. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#102 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#102)

7. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#011, T#121
(http://www.consciencelaws.org/background/procedures/assist009-036.aspx#011)
(http://www.consciencelaws.org/background/procedures/assist009-036.aspx#121)

8. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#018 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#018)

9. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#123 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#123)

10. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#019 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#019)

11. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#020 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#020)

12. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#123, T#124 T#125 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#123) (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#124) (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#125); *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#036 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#036)

13. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#144, T#147 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#144) (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#147)

14. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#149, T#151, T#152 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#149) (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#151) (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#152)

15. *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard), T#058 (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#058)

16. *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard), T#090 (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#090)

17. *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard), T#091 (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#091)

18. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#124 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#124)

19. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#131 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#131)

20. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#135 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#135)

21. *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard), T#091 (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#091)

22. *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard), T#059 (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#059)

23. *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard), T#091 (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#091)

24. *Consultations*, 1 October 2013 - Vol. 43 no. 40: Michel Sarrazin Home (Dr. Michel L'Heureux, Dr. M. Louis-André Richard), T#059 (http://www.consciencelaws.org/background/procedures/assist009-024.aspx#059)

25. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#018 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#018)

26. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#018, T#037 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#018) (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#037)

27. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#119 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#119)

28. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), #107 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#107); *Consultations*, Tuesday 24 September 2013 - Vol. 43 no. 37: Quebec Rally Against Euthanasia (Dr. Claude Morin, Dr. Marc Bergeron, Daniel Arsenault, Clément Vermette), T#105 (http://www.consciencelaws.org/background/procedures/assist009-016.aspx#105)

29. *Consultations*, Wednesday, 2 October 2013 - Vol. 43 no. 4: NOVA Montreal (Dr. Michael Laplante, Marie-Claude Mainville), T#106 (http://www.consciencelaws.org/background/procedures/assist009-029.aspx#106)

30. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#123 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#123)

31. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#136 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#136)

32. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 No. 44: Institute for Care Planning (Danielle Chalifoux, Denise Boulet, Louise Boyd), T#138 (http://www.consciencelaws.org/background/procedures/assist009-036.aspx#138)

33. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#058 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#058)

34. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#124 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#124)

35. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#125 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#125)

36. Benson, I.T. "'Autonomy', 'Justice' and the Legal Requirement to Accommodate the Conscience and Religious Beliefs of Professionals in Health Care." *Protection of Conscience Project* (http://www.consciencelaws.org/law/commentary/legal004.aspx)

37. *Consultations*, Tuesday, 1 October 2013 - Vol. 43 no. 40: Alliance of Quebec Hospices (Lucie Wiseman, Suzanne Fitzback, Pierre Hébert), T#125 (http://www.consciencelaws.org/background/procedures/assist009-023.aspx#125)

38. ARELC, Section 17. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#017)

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Redefining the Practice of Medicine

Euthanasia in Quebec

Part 9: Codes of Ethics and Killing

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

Refusing to participate, even indirectly, in conduct believed to involve serious ethical violations or wrongdoing is the response expected of physicians by professional bodies and regulators. It is not clear that Quebec legislators or professional regulators understand this.

A principal contributor to this lack of awareness - if not actually the source of it - is the *Code of Ethics* of the Collège des médecins, because it requires that physicians who are unwilling to provide a service for reasons of conscience help the patient obtain the service elsewhere. The President of the Collège was pleased that law will allow physicians to shift responsibility for finding someone willing to kill a patient to a health system administrator, avoiding an anticipated problem caused by the requirement for referral in the Code of Ethics. However, the law does not displace the demand for referral in the Code, and can be interpreted to support it.

The Collège des médecins *Code of Ethics* demand for referral conflicts with the generally accepted view of culpable indirect participation. Despite this, it continues to be used as a paradigm by other professions, notably pharmacy. It is thus not surprising that the College of Pharmacists also anticipates difficulty over the issue of referral. Like the Collège des médecins, the College of Pharmacists would like to avoid these problems by allowing an objecting pharmacist to shift responsibility for obtaining lethal drugs to a health systems administrator.

Nurses cannot be delegated the task of killing a patient, it is not unreasonable to believe that nurses may be asked to participate in euthanasia in other ways. Thus, there remain concerns about indirect but morally significant participation in killing. Their *Code of Ethics* imposes a duty to ensure both continuity of care and "treatment," which is to include euthanasia. However, under ARELC, an objecting nurse is required to ensure only continuity of care. This should not be interpreted to require nurses to participate in euthanasia, though they may be pressured to do so.

As a general rule, it fundamentally unjust and offensive to human

dignity to require people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It was a serious error to include this a requirement in *Code of Ethics* for Quebec physicians and pharmacists. The error became intuitively obvious to the Collège des médecins and College of Pharmacists when the subject shifted from facilitating access to birth control to facilitating the killing of patients.

A policy of mandatory referral of the kind found in the *Code of Ethics* of the Collège des médecins is not only erroneous, but dangerous. It establishes the priniciple that people can be compelled to do what they believe to be wrong - even gravely wrong - and punish them if they refuse. It purports to entrench a 'duty to do what is wrong' in medical practice, including a duty to kill or facilitate the killing of patients. To hold that the state or a profession can compel someone to commit or even to facilitate what he sees as murder is extraordinary.

Quebec's medical establishment can correct the error by removing the mandatory referral provisions of their codes of ethics that nullify freedom of conscience. This would prevent objecting physicians and pharmacists from being cited for professional misconduct for refusing to facilitate euthanasia or disciplined for refusing to facilitate other procedures to which they object for reasons of conscience, including contraception and abortion. This would almost certainly antagonize consumers who have been conditioned to expect health care workers to set aside moral convictions.

It remains to be seen whether the Quebec medical establishment will maintain the erroneous provisions, preferring to force objecting health care workers to become parties to homicide rather than risk occasionally inconveniencing people, such as the young Ontario woman and her supporters who were outraged because she had to drive around the block to obtain The Pill.

Introduction

During the legislative committee hearings into Bill 52, Dr. Yves Bolduc noted that "conscientious objection. . . goes a long way."

> We heard groups there, that do not at all agree with [physician assisted dying] . . . to such an extent that even the fact of collaborating indirectly with others goes against their consciences.

"I'm not saying that this is what we meet in the system, most of the time," he added, but he was clearly concerned about the potential for conflict.[1]

What is much less clear is whether or not he or others understood that such refusals are morally and ethically legitimate responses to indirect participation in perceived wrongdoing. As noted in Part 6, refusing to participate, even indirectly, in conduct believed to involve serious ethical violations or wrongdoing is not aberrant behaviour. On the contrary: it is the response expected of physicians by professional bodies and regulators.

A review of the transcripts of the hearings into Bill 52 discloses that this point was not grasped by any of the legislators or supporters of the bill. A principal contributor to this lack of awareness - if not actually the source of it - is the *Code of Ethics* of the Collège des médecins du Québec.

Collège des médecins *Code of Ethics*

"It is as if you did it anyway."

Dr. Charles Bernard, President and Director General of Quebec's Collège des médecins , acknowledged that, like society, members of the medical profession were not unanimous in supporting euthanasia, "[s]o it is certain that there will be a number of people who will not do this." Physicians, he said could withdraw because of religious beliefs.[2] Further, Dr. Bernard concisely stated and appeared to agree with the reasoning of physicians who refuse to refer for or facilitate morally contested procedures:

> [I]f you have a conscientious objection and it is you who must undertake to find someone who will do it, at this time, your conscientious objection is [nullified]. It is as if you did it anyway. / [Original French] Parce que, si on a une objection de conscience puis c'est nous qui doive faire la démarche pour trouver la personne qui va le faire, à ce moment-là , notre objection de conscience ne s'applique plus.[3]

Nullification of freedom of conscience

This is a striking admission. Dr. Bernardin's explanation is entirely consistent with the generally accepted view of culpable indirect participation discussed in Part 6. However, it is not consistent with the Collège des médecins *Code of Ethics*. Quebec is the only province in which the physician regulator demands that objecting physicians assist patients to obtain morally contested procedures.

The Collège's *Code of Ethics* requires that physicians who are unwilling to provide a service for reasons of conscience "offer to help the patient find another physician."[4] The gloss provided by the Collège mentions abortion and contraception and emphasizes an expectation of active assistance by the objecting physician to locate, not just another physician, but the services themselves.[5] The result is precisely what Dr. Bernard's found problematic; freedom of conscience is nullified.

Strictly speaking, the Code itself requires an offer of help, but does not specify what constitutes "help," nor does the gloss specify what is considered satisfactory assistance. In the Project's experience, physicians who wish to avoid becoming morally complicit in a procedure are usually willing to provide a patient with general information, such as the address of a registry of physicians maintained on the website of a regulatory authority. It could be argued that this suffices for compliance with the Code, and it may be that, until now, neither patients nor the Collège have consistently tried to push for more.

Intuitive recognition of the problem

Be that as it may, the presentation of the officers of the Collège des médecins du Québec on this point exposed both the problem with the Collège *Code of Ethics* and their intuitive recognition of the problem. As noted above, Dr. Bernard acknowledged that referral results in moral culpability. Thus, he was pleased with the provision in the bill (retained in ARELC)[6] that requires a physician who refuses to provide euthanasia for reasons of conscience to notify the executive director of an institution or local authority. Since the executive director becomes responsible for finding a willing physician, Dr. Bernard felt that solved the problem of complicity, at least for the objecting physician. Concerning this arrangement, he said, "We like it a lot."[7]

Sidestepping the problem

Dr. Bernard and his Collège colleague, Dr. Michelle Marchand, were pleased with the provision in the law because it sidestepped the problem they would otherwise face as a result of the requirement for referral in the *Code of Ethics*.

Dr. Marchand noted the requirement in the *Code of Ethics*, but described the provision as "an obligation to transfer" (l'obligation de transférer). An obligation to "transfer" does not necessarily involve the physician in finding a physician willing to take the patient; it can mean simply providing medical records to a physician who has been found by someone else. This is not what the Code means, and she seems to have meant referral rather than transfer, so her terminology confuses the issue. However, she, too, was pleased with the idea of collective or institutional rather than individual responsibility.

> But it is conceivable that, when implementing a practice like this early on, the transfer will be difficult. So I think it's a good idea to make it the collective responsibility of physicians and facilities to make this possible, so that the patient ultimately is not deprived of a service that should be accessible.[8]

Her explanation actually underscores the signifcance of the earlier discussion of culpable indirect participation, and the problem with the Collège des médecins *Code of Ethics*. Dr. Marchand said she expected difficulty "early on" in requiring transfer (i.e., referral, helping a patient to find a physician to provide a lethal injection), and thought this could be overcome by relieving physicians of individual responsibilty.

Why expect difficulty?

Because she knew that some physicians believe that euthanasia is gravely wrong, and, for that reason, they would refuse to facilitate it even indirectly by referral.

Why difficulty "early on"?

Because she believed that, as time goes on, more and more physicians will accept euthanasia as a legitimate practice, and will have no objection to referral if they are unwilling to do it themselves.

Relieving physicians of what individual responsibility?

The responsibility imposed by the Collège's *Code of Ethics* on an objector to help the patient find a willing colleague.

A problematic responsibility

Dr. Marchand's concern about encountering difficulty was shared by Dr. Gaétan Barrette, then representing the Federation of Medical Specialists. He emphasized that, in the case of conscientious objection, "someone in the system" should be responsible for finding a replacement, because if it were made the responsibility of the objecting physician "there will be too much opposition."[9]

Dr. Yves Bolduc was of the same opinion:

> When a doctor decides he does not practice medical assistance to die and that at this time the patient should consult another doctor or another team , I must confess that I am of the school that says we should not ask doctors to find or even participate in it because it will be too complex. And what will happen is that while people are arguing , the patient will not receive treatment.[10]

The difficulties anticipated by Collège representatives, Dr. Barrette and Dr. Bolduc arise from the conflict between the Collège des médecins *Code of Ethics* and a fundamental ethical norm that all of them intuitively recognized.

No escape from the Code

The Minister of Health understood why the Collège des médecins liked Section 31 "a lot", but, unlike Dr. Bernard and Dr. Marchand, she recognized that the concomitant obligation in the *Code of Ethics* is not affected by ARELC:

> . . .you can imagine that doctors, who had some reservations about being forced at all costs to find another doctor, are very relieved to see that they are not alone*, though, in the Code of Ethics, they have the obligation*, so they are supported by the institution. So the idea there, is to find balance. (emphasis added)[11]

Recall that, in Part 7, we noted that the protection of conscience provision in ARELC appeared to provide objecting physicians with a much narrower exemption than other health care workers. Physicians may only refuse "to administer" euthanasia - a very specific action - which seems to suggest that they are expected to participate in other ways. And ARELC states that objectors must "ensure that continuity of care is provided. . . *in accordance with their Code of Ethics*." (emphasis added)

Thus, whether or not an objecting physician conforms to Section 31 of ARELC by notifying an executive director of refusal to provide euthanasia, the Collège des médecins *Code of Ethics* can be cited to try to force them to facilitate MAD services by referral or other means, and this may actually be supported by the restricted exemption for physicians in Section 50, together with its reference to physicians' *Code of Ethics*.

It is interesting to note that this is consistent with what the Provincial Association of User Committees demanded during legislative hearings into Bill 52:

> We want to make sure that professionals who have responsibilities under the law must refer a user who wants to access terminal palliative sedation or medical assistance to die to another professional. It should ensure that, even in private practice, and I know that you have discussed, a home care professional is required to redirect user who wants these forms of care to another professional.[12]

The Quebec Association of Health Facilities and Social Services was even more direct, quoting the

Collège des médecins *Code of Ethics* in support of its demand:

> So, *the Code of Ethics of physicians, we know, that states that it is still the doctor, who must provide the patient with assistance in finding another doctor.* So we must, of course, not disempower this premise and AQUESSS believes that it would be inappropriate for the legislature to impose on the [executive director] full responsibility to find a replacement when a doctor refuses his patient medical help to die. (emphasis added)[13]

The Association complained that on objecting physician who notified the executive director that he was refusing to provide euthanasia could thereby discharge his responsibility, which, they understood, "benefits the physician who refuses to refer the matter to someone else." However, they were insistent: "Do not relieve the doctor of responsibility in this process with the client and family."[14]

This seems to be what has happened. Section 31 provides objecting physicians with an alternative to the demand in the *Code of Ethics*, and it may prove acceptable in many situations. However, if push comes to shove, Section 31 of ARELC does not displace the demand for referral in the Code, and ARELC Section 50 can be understood to support it.

Other professions

Since the Collège des médecins *Code of Ethics* conflicts significantly with the generally accepted view of culpable indirect participation discussed in Part 6, it is unfortunate that its mandatory referral provision was and continues to be used as a paradigm by other professions. Predictably, the intuitive recognition of the problem evident in the Collège presentation surfaced when the subject of freedom of conscience was raised with pharmacists.

Pharmacists

Representatives of the College of Pharmacists of Quebec told legislators that (like physicians) objecting pharmacists are required to help the patient find another pharmacist. Their *Code of Ethics* states:

> Pharmacists must, where their personal convictions may prevent them from recommending or providing pharmaceutical services that may be appropriate, so inform their patients and explain the possible consequences of not receiving the services. Pharmacists must then offer to help the patients find another pharmacist.[15]

This appears to have developed as a result of conscientious objection to "emergency oral contraception."[16] Véronique Hivon commented that this was "just like" the Collège des médecins *Code of Ethics*, but added that this did not impose an obligation "for results."[17] That is, the Code imposes an obligation to help the patient find another pharmacist, not to ensure product delivery by another pharmacist.

It does not appear that the full significance of this distinction was recognized by either representatives of College of Pharmacists of Quebec or the legislators. The difference is important because a literal reading of the Code indicates that the obligation to help find another pharmacist can be discharged by referring the patient to a telephone book or a list of pharmacies in the area. The experience of the Project is that most objectors are willing to direct the patient to this kind of publicly available information that is not specific to the provision of the morally contested service. Since the majority of pharmacists do not object to dispensing oral contraceptives, telephone listings or a local list of pharmacies probably coincides more or less exactly with a list of oral contraceptive dispensers, so that this kind of general approach would likely result in the patient getting the drug.

That is not the case, however, with euthanasia drugs. Linda Vaillant, speaking for the Pharmacists Association of Health Facilities of Quebec, told the committee that Bill 52 caused discomfort for many members of the association because "[p]eople have really made it clear they do not want them to be seen as people who help others to die."[18]

While she was representing pharmacists working in health facilities, it is not unreasonable to believe that unwillingness to being associated with euthanasia exists among pharmacists outside institutional walls. In this context, committee member Stéphanie Vallée once more recognized the problem created by establishing a purported "right" to euthanasia:

> A pharmacist, for example, by conscientious objection does not stock the required drugs . . . the only pharmacist in a community that, for some reason very, very personal, says I, I do not intend to offer that service, so I will not order the medication, what do we do? . . . I understand that you want to respect this freedom, but at the same time, we have a bill that makes ... which gives a right, access to the entire territory of certain services, including medical assistance to die. So how can we reconcile the freedom of conscience in that context and the right as provided in the bill?[19]

Unfortunately, the position of the College of Pharmacists seems likely to exacerbate this tension. It seems that, whatever the Code actually says, the College interprets it to mean that an objecting pharmacist must help to find a pharmacist willing to dispense lethal medication for the purpose of killing a patient (see the italicized section in the passage below). Leaving aside the validity of the interpretation, the College anticipates more serious problems with requests for drugs for lethal injections or toxic milkshakes than it has encountered with requests for oral contraceptives.[20]

> On the human level now, indeed, we may end up with more problematic situations. And the idea of having a system to facilitate, I would say, the inventory of pharmacists who are able to offer medical assistance to die, *without placing the pharmacist in a situation he has to run after other pharmacists,* we think it may be welcome in a case like this. But it is clear that we do not want to remove this obligation, the obligation to refer to another pharmacist, but if it occurred it would be difficult for him to do, well, a helping hand, just like what is done for doctors, could be welcome, especially considering that you want a better quality of care for these patients.(emphasis added)[21]

The "helping hand" referred to here is Section 31 of ARELC, which allows an objecting physician to turn over to health system administrator the responsibility for finding someone willing to kill a patient. The Pharmacists Association of Health Facilities of Quebec also supported the idea. "We should not force [objecting pharmacists] to look for a colleague," said François Paradis. "I think it further complicates the process."[22]

As noted in Part 5, it was to avoid such problems that the Quebec College of Pharmacists suggested that regional health authorities canvas pharmacists in advance to identify those willing to provide euthanasia drugs.[23]

Nurses

The *Code of Ethics* for Quebec nurses has no poison that recognizes freedom of conscience.[24] Since, under ARELC, only physicians may actually kill a patient, the absence of such recognition may not seem important with respect to MAD services. However, as the Quebec Order of Nurses pointed out, nurses are continuously and intimately involved with the care and treatment of patients.[25] While they cannot be delegated the task of killing a patient, it is not unreasonable to believe that nurses may be asked to participate in euthanasia in other ways: by, for example, preparing the lethal injection, or monitoring vital signs to ensure that death occurs following the administration of lethal drugs. Thus, as discussed in Part 6, there remain concerns about indirect but morally significant participation in killing.

Two provisions of the Code seem relevant to the case of a nurse who refuses to participate in certain activities for reasons of conscience. The first states, "A nurse who is providing care and treatment to a client may not abandon him or her without a serious reason."[26]

Whether or not refusing to participate in euthanasia amounts to "patient abandonment" is disputed; euthanasia and assisted suicide advocates sometimes use such rhetoric in order to compel participation in the procedures.[27]

The second provision states that nurses must "take reasonable measures to ensure the continuity of care and treatment."[28]

Nurse representatives offered the following explanation:

> . . . if a nurse is caring for a client, but has a conscientious objection in relation to a specific situation, as provided in the bill at this time she could [exercise] conscientious objection, but she should ensure that . . . there is a continuity of care so that you don't end up with a customer who does not receive care. . .[29]

In fact, this provision in their *Code of Ethics* imposes a duty to ensure not just continuity of care, but also continuity of "treatment," which, under ARELC's terms, would include killing a patient by administering lethal drugs. Here, the distinction the nurses' Code makes between care and treatment is important, because, under Section 50 of ARELC, an objecting nurse is required to ensure only continuity of care. Elsewhere, nurse representatives explained that nurses did not consider euthanasia to be "care," but "a procedure that terminates life."[30] It thus seems that ensuring continuity of care should not be interpreted to require nurses to participate in euthanasia. That does not mean that they will not be pressured to do so under the rubric of "continuity of care."

Examined emotions

Both the Collège des médecins and College of Pharmacists of Quebec anticipate problems arising from the requirements in their respective Codes of Ethics, apparently developed in response to conscientious objection to contraception and abortion, that physicians and pharmacists who refuse to provide services or procedures they believe to be wrong are obliged to help patients find someone who will provide them. Of course, if it is legitimate to force objecting physicians to help patients obtain morally contested services or procedures like abortion, then it is legitimate to force them to help patients obtain euthanasia and assisted suicide.

Nonetheless, one detects discomfort about the problem created by their codes, and relief (in the case of the Collège des médecins) that ARELC may allow them to avoid it. The intuitive awareness of the Colleges of the problems likely to arise in compelling objecting professionals to facilitate what they believe to be wrong warrants attention. So, too, is their discomfort in contemplating the application of such a policy, and relief at the prospect of avoiding it. Here we can apply a suggestion by Professor Margaret Somerville that "moral intuition" and "examined emotions" may provide valuable ethical insights by asking some questions.[31]

Whence the awareness of the problem? Why the discomfort? Why the relief?

The most probable explanation is that, as a general rule,[32] it is fundamentally unjust and offensive to human dignity to require people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It is thus a serious error to include such a requirement in a *Code of Ethics*. College representatives were aware of this because, in the words of Project advisor Jay Budziszewski, this is one of those things we can't not know, though we may not know them "with unfailing perfect clarity" or have worked out "their remotest applications."[33]

An absence of clarity or sufficient reflection may explain why this error was not apparent to College representatives with respect to contraception and abortion, but it became intuitively obvious to them when the subject shifted from facilitating access to birth control to facilitating the killing of patients. This explains why they were uncomfortable and even doubtful about the wisdom of forcing objecting physicians and pharmacists to find colleagues willing to kill patients, and why they were relieved by the prospect that they might be able to sidestep the problem.

A dangerous idea

When one works out the remote applications of the policy of mandatory referral for contraception and abortion adopted by Quebec regulatory authorities, it becomes clear that it is not only erroneous, but dangerous. It establishes the principle that a learned or privileged class, a profession or state institutions can legitimately compel people to do what they believe to be wrong - even gravely wrong - and punish them if they refuse. It purports to entrench a 'duty to do what is wrong' in medical practice, which, through ARELC, is to include a duty to kill or facilitate the killing of patients. One of the leading proponents of this view is Professor Jocelyn Downie of Dalhousie University.

Mandatory referral for abortion

In 2006 Professor Downie was one of two law professors who wrote a guest editorial in the Canadian Medical Association Journal claiming that physicians who refuse to provide abortions for reasons of conscience had an ethical and legal obligation to refer patients to someone who would. This elicited a flood of protest, and the CMA reaffirmed its position that objecting physicians were not obliged to refer for the procedure, repeating the affirmation in 2008. The negative response to the editorial from the medical profession convinced Professor Downie that policy reform by the CMA was unlikely, so she turned her attention to provincial regulatory authorities to persuade them to force the medical profession to conform to her views.[34]

Mandatory referral for assisted suicide/euthanasia

Professor Downie was also a member of the "expert panel" of the Royal Society of Canada that, five years later, recommended legalization of assisted suicide and euthanasia. The panel conceded that health care workers may object to providing euthanasia or assisted suicide, and that compelling them to do so might constitute a limitation of their "liberty or freedom of conscience and religion." For these reasons, Professor Downie and her expert colleagues recommended that health care professionals who object to euthanasia and assisted suicide should be compelled to refer patients to someone who would provide the procedures.[35]

Their explanation:

> Today's procedural solution to this problem is, in Canada as well as many other jurisdictions, that health care professionals may provide certain reproductive health services that some religious health care professionals object to on conscientious grounds, however, they do not have to provide those services, in case the provision of those services would violate their conscience. Such objecting health care professionals are required to transfer an assistance seeking person on to other health care professionals who will provide the required services in a timely manner. The underlying rationale for this procedural solution lies in this kind of reasoning: If only health care professionals are permitted to provide assistance but they are not obligated to do so, then their autonomy is not limited but the autonomy of those seeking assistance could potentially be unfairly limited. Hence the requirement on conscientious objectors to refer assistance seekers to colleagues who are prepared to oblige them.[36]

Two points warrant attention here.

The first is that the panel argued that, because it is agreed that we can compel objecting health care professionals to refer for abortion, we are justified in forcing them to refer for euthanasia.

The second and more remarkable point is that, outside of Quebec, there is, in fact, no agreement that objecting health care professionals should be compelled to refer for abortions. Given the repudiation of her views by the CMA, Professor Downie must have been aware of that. This inconvenient fact was left out, apparently to make it appear that compulsory referral for euthanasia and assisted suicide is an entirely reasonable and uncontested "procedural solution" to the "problem" caused by people who refuse to do what they believe to be wrong. Presumably this accounts for the absence of any cited reference to back up their assertion.

Two perspectives on killing patients

We have seen that, as a matter of Canadian constitutional law, ARELC does not affect Canadian criminal law. Hence, no matter what ARELC purports to do, killing patients under the conditions specified by the act would constitute first degree murder (murder that is "planned and deliberate"[37]) and anyone counselling, aiding, abetting the killing (by referral, for example) would be considered a party to the offence.[38]38

Now, it is not inconceivable (and this is the hope of the Quebec government) that a court might rule that killing a patient in accordance with ARELC is not murder under the criminal law. An undetermined number of physicians and health care workers would then begin or continue with killing patients under the terms of the law, in the belief that what they were doing was not only legal, but morally acceptable. In a sense, this would not be remarkable, because that sort of thing has happened in the past, and it is happening now, in Belgium and the Netherlands, for example.

Nonetheless, there is no doubt that most of those opposed to the bill in principle would, despite the ruling of the court, continue to consider euthanasia to be (morally) planned and deliberate murder. Having this view, it would come as no surprise if they were to refuse to kill patients or refuse to encourage or facilitate the killing of patients by counselling, referral or other means. And this would not be remarkable, because this has also happened in the past.

Normalizing mandatory participation in killing

It is at this point that one realizes the unique character of the 'duty to do what is wrong' movement, exemplified by Professor Downie and enshrined in the Collège des médecins du Québec *Code of Ethics*. Recall that, for Professor Downie and the other Royal Society panel of experts (and those who share their views) it is not sufficient to simply encourage and allow willing health care professionals to kill patients. They demand that health care professionals be compelled to participate in and facilitate the killing of patients - even if they believe it to be wrong, even if they believe it to be murder - and that they should be punished if they refuse to do so. This is quite extraordinary, even if there are precedents for it.

Killing is not surprising; even murder is not surprising. It has even been said that there is something uniquely human about murder. But to hold that the state or a profession can, in justice, compel an unwilling soul to commit or even to facilitate what he sees as murder, and justly punish or penalize him for refusing to do so - to make that claim ought to be beyond the pale. If the state or civil society or professional organizations can legitimately require people to commit or aid in the commission of murder, what can they not require?

At the crossroads

This is the ultimate problem that comes of establishing a 'duty to do what is wrong' in medical practice. It typically begins, as it began in Quebec, by forcing objecting physicians or pharmacists to help patients obtain contraceptives or abortion. These services are so popular that many people are willing to nullify freedom of conscience among health care workers so that they can have access to them on demand.

But, as illustrated by the response of the Collège des médecins and Quebec College of Pharmacists to ARELC, forcing physicians and pharmacists to facilitate the provision of contraception and abortion is a dress rehearsal for forcing them to facilitate euthanasia and assisted suicide, because both policies are supported by the same erroneous principle: that some authority can impose a duty to do what one believes to be wrong, or that the acceptance of such a duty can be made a condition membership in a profession.

Quebec's medical establishment can correct the error by removing the mandatory referral provisions of their codes of ethics that nullify freedom of conscience. This would prevent objecting physicians and pharmacists from being cited for professional misconduct for refusing to facilitate euthanasia. However, it would also prevent them from being disciplined for refusing to facilitate other procedures to which they object for reasons of conscience, including contraception and abortion. Unfortunately, correcting the error would almost certainly antagonize consumers who have been conditioned to expect health care workers to set aside moral convictions and provide or at least facilitate provision of contraception and abortion.

It remains to be seen whether or not the Quebec medical establishment will maintain the erroneous provisions, preferring to force objecting health care workers to become parties to homicide rather than risk occasionally inconveniencing people, such as the young Ontario woman and her supporters who were outraged because she had to drive around the block to obtain The Pill.[39]39

Notes:

Note: "T#" is the prefix identifying a numbered block of translation of largely French language transcripts of hearings into Bill 52 in the fall of 2013.

1. Committee on Health and Social Services of the Quebec National Assembly, *Consultations & hearings on Quebec Bill* 52 (Hereinafter "*Consultations*"), Thursday, 26 September 2013 - Vol. 43 no. 39: Interprofessional Health Federation of Quebec (Régine Laurent, Julie Martin, Michàle Boisclair, Brigitte Doyon), T#055 (http://www.consciencelaws.org/background/procedures/assist009-022.aspx#055)

2. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins du Québec (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#141(a) (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#141(a))

3. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: Collège des médecins du Québec, (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle) T#154 Marchand)(http://www.consciencelaws.org/background/procedures/assist009-001.aspx#154)

4. Collège des médecins du Québec, *Code of Ethics of Physicians*, para. 24 (http://www.cmq.org/en/Public/Profil/Commun/AProposOrdre/\u126 ~/media/Files/ReglementsANG/cmqcodedeontoan.ashx?61323) (Accessed 2013-06-23)

5. "For example, a physician who is opposed to abortion or contraception is free to limit these interventions in a manner that takes into account his or her religious or moral convictions. However, the physician must inform patients of such when they consult for these kinds of professional services and assist them in finding the services requested." Collège des médecins du Québec*, Legal, Ethical and Organizational Aspects of Medical Practice in Québec*. ALDO-Québec, 2010 Edition, p. 156. (http://www.canadianopenlibrary.ca/SwfDocs/231/231229.pdf) (Accessed 2013-06-23)

6. ARELC, Section 31. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#031)

7. *Consultations, Tuesday*, 17 September 2013 - Vol. 43 no. 34: Collège des médecins du Québec (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#154 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#154)

8. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Collège des médecins du Québec (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand), T#156 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#156)

9. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Federation of Quebec Medical Specialists (Dr. Gaétan Barrette, Dr. Diane Francoeur, Nicole Pelletier), T#076 (http://www.consciencelaws.org/background/procedures/assist009-003.aspx#076)

10. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#087 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#087)

11. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#032 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#032)

12. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Provincial Association of User Committees (Claude Ménard, Pierre Blain), T#012 (http://www.consciencelaws.org/background/procedures/assist009-020.aspx#012)

13. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#017 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#017)

14. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#038 (http://www.consciencelaws.org/background/procedures/assist009-008.aspx#038)

15. *Code of Ethics of Pharmacists* (Quebec), Section 26. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=%2F%2FP_10%2FP10R7.htm) (Accessed 2014-08-12)

16. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert),T#047 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#047)

17. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert),T#074 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#074)

18. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Pharmacists Association of Health Facilities of Quebec (François Paradis, Linda Vaillant)T#031 (http://www.consciencelaws.org/background/procedures/assist009-006.aspx#031)

19. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert),T#053 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#053)

20. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert),T#080 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#080)

21. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert),T#081 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#081)

22. *Consultations*, Tuesday, 17 September 2013 - Vol. 43 no. 34: Pharmacists Association of Health Facilities of Quebec (François Paradis, Linda Vaillant)T#020 (http://www.consciencelaws.org/background/procedures/assist009-006.aspx#020)

23. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: College of Pharmacists of Quebec (Dianne Lamarre, Manon Lambert),T#063 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#063)

24. *Code of Ethics of Nurses* (Quebec) (http://www2.publicationsduquebec.gouv.qc.ca/documents/lr/I_8/I8R9_A.htm) (Accessed 2014-07-23)

25. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#021 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#021)

26. *Code of Ethics of Nurses* (Quebec), Section 43 (http://www2.publicationsduquebec.gouv.qc.ca/documents/lr/I_8/I8R9_A.htm) (Accessed 2014-07-23)

27. For example, the testimony of Prof. Margaret Battin referred to at Paragraph 239 in *Carter v. Canada (Attorney General)* 2012 BCSC 886. Supreme Court of British Columbia, 15 June, 2012. Vancouver, British Columbia.

28. *Code of Ethics of Nurses* (Quebec), Section 44(3) (http://www2.publicationsduquebec.gouv.qc.ca/documents/lr/I_8/I8R9_A.htm) (Accessed 2014-07-23)

29. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#064 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#064)

30. *Consultations*, Tuesday, 8 October 2013 - Vol. 43 no. 44: Quebec Order of Nurses (Lucie Tremblay, Claudia Gallant, Suzanne Durand, Sylvie Truchon), T#099 (http://www.consciencelaws.org/background/procedures/assist009-035.aspx#099)

31. "Although feelings can sometimes be misleading in terms of ascertaining what is and is not acceptable conduct (as indeed can rationality, which we have sometimes found to our sorrow), we ignore feelings at our peril. We need to take into account 'examined emotions'. . ." Somerville, Margaret, *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide.* McGill-Queens University Press, 2001, p. 75-76.

32. "As a general rule," since exceptions might be imagined, as in the case of a delusional driver who refuses to stop for red lights. However, the general rule states the default position, and a serious burden of proof lies on those who want to set it aside in particular cases. Murphy S, Genuis SJ, "Freedom of Conscience in Health Care: Distinctions and Limits." *Journal of Bioethical Inquiry*, October 2013, Vol. 10 No. 3, p. 347-354 (http://rd.springer.com/article/10.1007/s11673-013-9451-x)

33. "However rude it may be these days to say so, there are some moral truths that we all really know - truths which a normal human being is unable not to know. They are a universal possession, the emblem of a rational mind, an heirloom of the family of man. That doesn't mean that we know them with unfailing perfect clarity, or that we have reasoned out their remotest implications; we don't and we haven't. Nor does it mean that we never pretend not to know them even though we do, or that we never lose our nerve when told they aren't true; we do, and we do. It doesn't even mean that we are born knowing them, that we never get mixed up about them, or

that se assent to them just a readily whether they are taught to us or not. That can't even be said of 'two plus two is four.'" Budziszewski J., *What We Can't Not Know: A Guide*. Dallas: Spence Publishing, 2003, p. 19.

34. (We decided to proceed by way of these provincial regulatory bodies rather than the CMA, in part, because of the negative reaction of the CMA to the Rodgers/Downie editorial, which made policy reform by the CMA seem unlikely.)" McLeod C, Downie J. "Let Conscience Be Their Guide? Conscientious Refusals in Health Care." *Bioethics* ISSN 0269-9702 (print); 1467-8519 (online) doi:10.1111/bioe.12075 Volume 28 Number 1 2014 pp ii–iv

35. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 101 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) (Accessed 2014-02-23)

36. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 62 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) (Accessed 2014-02-23)

37. *Criminal Code* (R.S.C., 1985, c. C-46) (Hereinafter "*CC*") Section 231(2). (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-115.html) (Accessed 2014-02-24)

38. *CC*, Section 745(a) (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-429.html); *CC*, Section 21(b) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html); CC, Section 21(c)(http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html); CC, Section 22 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html) (Accessed 2014-02-24)

39. Murphy, S. *"NO MORE CHRISTIAN DOCTORS": Crusade against NFP only physicians*. Protection of Conscience Project (http://www.consciencelaws.org/background/procedures/birth002-contents.aspx)

Protection of Conscience Project
www.consciencelaws.org

Revision Date: 2014-08-12

Redefining the Practice of Medicine
Euthanasia in Quebec
Appendix A: Health Care Delivery in Quebec

Sean Murphy, Administrator
Protection of Conscience Project

A1. Statutes

A1.1 *An Act Respecting Health Services and Social Services* provides the administrative framework for the delivery of health care in Quebec, outlines principles that inform the system and sets out the rights and obligations of various parties. It supported by *An Act respecting the Health and Social Services Ombudsman.*

A1.2 The *Professional Code* establishes the structure of professions in the province (called "orders") including the health care professions. It also establishes the Office des professions du Québec, consisting of five government appointees. Among other things, the Office has the power to supervise the professions to ensure that they conform to the requirements of the *Professional Code*.[1]

A1.3 Subject to the *Professional Code*, separate statutes govern pharmacists,[2] nurses,[3] physicians[4] and midwives.[5]

A2. Regional health and social service agencies

A2.1 A health and social services agency established by the government in each region of the province is designated as the state agency responsible for responsible for the delivery and coordination of health care in the region.[6] Every agency must establish a public health department, and may request the Minister for Social Services and Youth Protection to appoint a public health director.[7]

A3. Regional service quality and complaints commissioner

A3.1 Regional complaints commissioners are answerable to the regional health agency that appoint them but are expected to act independently to enforce "user rights" and respond diligently by investigating "user complaints."[8] They are to promote and explain the complaint process to people in the region[9] and encourage and support people in formulating complaints.[10]

A4. Regional nursing and multidisciplinary commissions

A4.1 In each region, the government has established a nursing commission.[11] A nursing commission is responsible to the board of directors of the regional health and social services agency and provides advice about nursing care, staffing and other issues.[12] The government has also established a multidisciplinary commission in each region, with analogous functions.[13]

A5. Local health and social services networks

A5.1 In addition to regional health and social service agencies, "local health and social services networks"[14] have been established "to foster a greater sense of responsibility among all the health and social service providers in the network to ensure that the people in the network's territory have continuous access to a broad range of general, specialized and superspecialized health services and social services."[15] These networks are coordinated by local authorities operating local community service centres, residential and long-term care centres or general and specialized hospital centres.[16] Local authorities have numerous responsibilities,[17] among which is working with other elements of the health care bureaucracy to "create conditions that foster accessibility, continuity and networking of general medical services, focusing in particular on accessibility."[18]

A6. Community organizations

A6.1 Incorporated non-profit community organizations governed by boards of directors may engage " in activities related to the field of health and social services,"[19] including (if authorized by the Minister) the provision of abortion.[20] Community organizations may receive subsidies from regional health and social services agencies,[21] or from the Quebec government,[22] but remain free to define their "orientations, policies and approaches."[23] Subsidized community organizations must send annual activity and financial reports to the subsidizing authorities.[24] They may also agree to be subject to the regional complaint process (see Appendix "B").[25]

A7. Accredited private resources

A7.1 Private nursing homes, private institutions that operate residential and long term care centres and community organizations may apply to the regional health and social services agency for accreditation.[26] Accreditation may be granted by the Minister only if they conform to the Minister's accreditation requirements.[27] Accreditation may be granted temporarily or for specified periods; continued accreditation depends upon continued compliance with the Act and the conditions set by the Minister.[28] Regional health and social service agencies may grant a financial allowance only to accredited persons.[29]

A8. Private homes for seniors and vulnerable clients

A8.1 A private seniors' residence is a facility for persons at least 65 years of age that provides residential accommodation and at least two services identified by regulation. Every regional health and social services agency must maintain a register of private seniors' residences in its jurisdiction.[30] All such residences are subject to regulation and inspection and require certificates of compliance in order to operate.[31]

A9. Specialized medical centres

A9.1 A specialized medical centre may be opened only by physicians. It must be governed by a board, the majority of whom must be physicians practising in the centre[32] and supervised by a medical director appointed from among them.[33] Specialized medical centres may provide "services necessary for a hip or knee replacement, a cataract extraction and intraocular lens implantation" and other specialized medical treatment authorized by the government through regulation.[34]

A10. Health care facilities

A10.1 Health care is provided in five kinds of facilities: a local community service centres, hospital centres, child and youth protection centres, residential and long-term care centres and rehabilitation centres.[35]

A11. Health care institutions

A11.1 As a general rule, any person or partnership who carries on "activities inherent in the mission" of one of these five kinds of centres is considered to be an "institution."[36] However, there are some exceptions, including persons or partnerships operating private health facilities[37] and some religious or teaching institutions that operate infirmaries for their personnel, members or followers.[38]

A11.2 Institutions are public or private.[39] Institutions are public if they are non-profit corporations, or if they are incorporated or are formed as a result of amalgamation or conversion under the *Act Respecting Health Services and Social Services.*[40]

A11.3 Private institutions are unincorporated, or profit-making corporations, or non-profit corporations providing some kinds of health care for fewer than 20 patients.[41]

A12. Institutional Boards of Directors

A12.1 Public institutions are governed by boards of directors[42] constituted[43] and functioning[44] in accordance with the Act. Each board must form governance, ethics, audit and watchdog committees[45] and appoint a local service quality and complaints commissioner.[46] Boards of directors of private institutions have the same functions and responsibilities.[47]

A12.2 Presumably under the auspices of the board of directors, every institution "must adopt a code of ethics which shall set out the rights of the users and the practices and conduct expected, with respect to the users, from the employees, the trainees, including medical residents, and the professionals practising in a centre operated by the institution" and provide a copy of it to every institutional "user" upon request.[48]

A13. Local Service Quality and Complaints Commissioners

A13.1 Local complaints commissioners are answerable to the institutional boards that appoint them but are expected to act independently to enforce "user rights" and respond diligently by investigating "user complaints."[49] They are to promote and explain the complaint process to people served by an institution[50] and encourage and support them in formulating complaints.[51]

A14. Executive Directors

A14.1 Executive directors, appointed by and responsible to boards of directors, are responsible for day-to-day operations of institutions.[52]

A15. Directors of Professional Services

A15.1 Every local authority in charge of a health and social services network and every institution operating a hospital must appoint a physician as director of professional services. Other institutions may appoint directors of professional services, but are not required to do so.[53]

A15.2 Acting under the authority of the executive director, the director of professional services coordinates the professional and scientific activities of an institution.[54] In particular, they direct and supervise clinical department heads[55] and councils of physicians, dentists and pharmacists.[56]

A16. Directors of Nursing Care

A16.1 Every local authority in charge of a health and social services network and every institution operating a hospital must appoint a nurse as director of nursing care. Alternatively, the executive director may designate a nurse to take charge of nursing. Other institutions may appoint directors of nursing care, but are not required to do so.[57] Acting under the authority of the executive director, directors of nursing care supervise and monitor nursing care.[58]

A17. Midwifery Services Coordinators

A17.1 Every institution operating a local community service centre in which midwifery is practised must appoint midwife as midwifery services coordinator. Coordinators must define standards of care, and supervise midwives and coordinate the provision of midwifery services.[59]

A18. Medical Examiners

A18.1 An institutional board of directors must appoint a Medical Examiner, either for each of the facilities it operates, or as Medical Examiner for all of them. A Director of Professional Services may be so designated. Medical Examiners are responsible to the board of directors for the investigation of complaints involving physicians, dentists or pharmacists, or a medical resident.[60]

A19. Institutional Councils

Physicians, dentists and pharmacists

A19.1 Every public institution with a centre employing at least five physicians, dentists or pharmacists must form a council of that includes all of them. Boards of directors that operate more than one institution may form a single council composed of the practitioners in all of the institutions.[61] Councils of physicians, dentists and pharmacists are, among other things, responsible for assessing and maintaining professional standards[62] and making recommendations about medical care and dental care and the use of medicines.[63]

A19.2 Councils of physicians, dentists and pharmacists can give opinions about disciplinary measures against physicians, pharmacists or dentists,[64] and make recommendations about obligations associated with privileges granted to physicians or dentists, especially with respect to participation in clinical activities.[65]

Nurses

A19.3 Every public institution with a centre employing at least five nurses must form a council of nurses that includes all of them. Boards of directors that operate more than one institution may form a single council composed of the practitioners in all of the institutions.[66] An executive committee of at least four nurses exercises the responsibilities of the council.[67] Councils of nurses are responsible for assessing and maintaining the quality of nursing care[68] and making recommendations about it.[69] A councils of nurses is also responsible for forming a committee to perform the council's functions with respect to nursing assistants.[70]

Midwives

A19.4 Every public institution that has contracted with at least five midwives must form a council of midwives consisting of all of them,[71] unless the midwives and the council of physicians, dentists and pharmacists agree that the latter should exercise the function of a council of midwives.[72] When a council of midwives is formed, an executive committee comprised of at three midwives and the executive director of the institution exercises the powers of the council.[73] These include monitoring and assessing the work of the midwives,[74] recommending standards of care[75] and "obligations to be attached to the practice of midwifery,"[76] and confirming the qualifications of midwife applicants.[77]

Other disciplines

A19.5 Multidisciplinary councils must be formed in every public institution, consisting of employees (except physicians, dentists, pharmacists and nurses) who hold college diplomas or university degrees who perform functions in their field of expertise directly related to nursing assistance, health services, social services, and research or teaching.[78] Multidisciplinary councils assessing and improving the quality of the professional activities of their members, and making recommendations concerning them.[79]

A20. Clinical Department Heads

A20.1 Every clinical department in a hospital must be headed by a physician, pharmacist, dentist or clinical biochemist.[80] Clinical department heads are primarily responsible for coordinating and supervising professional activities[81] and the allocation and use of resources in each department.[82] They may also offer opinions about the granting or maintenance of professional status and privileges and the obligations attached to them.[83]

A21. Users' Committees

A21.1 Every public and private institution must establish and provide funds for a Users' Committee, consisting of at least five members elected by users of institutional facilities[84] for terms not exceeding three years.[85] Among their responsibilities, Users' Committees are to "inform users of their rights and obligations,"[86] defend the rights and interests of users,[87] and accompany and assist users in making complaints.[88]

A22. Health and Social Services Ombudsman

A22.1 The office of Health Services Ombudsman is exercised by a Deputy Public Protector appointed under the *Public Protector Act*. The Ombudsman is to ensure that people seeking heath care are respected and that their rights are enforced.[89]

Notes:

1. *Professional Code* (R.S.Q. c C-26) Sections 3-16.8 (http://www.canlii.org/en/qc/laws/stat/rsq-c-c-26/latest/rsq-c-c-26.html) (Accessed 2014-07-27)

2. *Pharmacy Act* (R.S.Q. c-P10) (http://www.canlii.org/en/qc/laws/stat/rsq-c-p-10/latest/rsq-c-p-10.html) (Accessed 2014-07-27)

3. *Nurses Act* (R.S.Q. c I-8) (http://www.canlii.org/en/qc/laws/stat/rsq-c-i-8/latest/rsq-c-i-8.html) (Accessed 2014-07-27)

4. *Medical Act* (R.S.Q. c M-9) (http://www.canlii.org/en/qc/laws/stat/rsq-c-m-9/latest/rsq-c-m-9.html) (Accessed 2014-07-27)

5. *Midwives Act* (R.S.Q.. c S-0.1) (http://www.canlii.org/en/qc/laws/stat/rsq-c-s-0.1/latest/rsq-c-s-0.1.html) (Accessed 2014-07-27)

6. *An Act Respecting Health Services and Social Services*, (R.S.Q. Chapter S-4.2) (Hereinafter "ARHS&SS) Sections 339-342.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

7. ARHS&SS, Sections 371-372. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

8. ARHS&SS, Section 66. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

9. ARHS&SS, Section 66(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

10. ARHS&SS, Section 66(3). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

11. ARHS&SS, Section 370.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

12. ARHS&SS, Section 370.3. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

13. ARHS&SS, Sections 370.5-370.7. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

14. ARHS&SS, Section 99.2. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

15. ARHS&SS, Section 99.3. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

16. ARHS&SS, Section 99.4. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

17. ARHS&SS, Sections 99.5-99.8. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

18. ARHS&SS, Section 99.9.7. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

19. ARHS&SS, Section 334. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

20. ARHS&SS, Section 338.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

21. ARHS&SS, Section 336. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

22. ARHS&SS, Section 337. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

23. ARHS&SS, Section 335. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

24. ARHS&SS, Section 338. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

25. ARHS&SS, Sections 76.6, 76.7. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

26. ARHS&SS, Section 457. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

27. ARHS&SS, Section 456. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

28. ARHS&SS, Section 458. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

29. ARHS&SS, Section 454, 455. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

30. ARHS&SS, Section 346.0.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

31. ARHS&SS, Sections 346.0.2, 346.0.4, 346.0.8. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

32. ARHS&SS, Section 333.2. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

33. ARHS&SS, Section 333.5. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

34. ARHS&SS, Section 333.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

35. ARHS&SS, Sections 79. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

36. ARHS&SS, Sections 94. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

37. ARHS&SS, Sections 95. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

38. ARHS&SS, Sections 96. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

39. ARHS&SS, Sections 97. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

40. ARHS&SS, Sections 98. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

41. ARHS&SS, Sections 99. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

42. ARHS&SS, Sections 119-128.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

43. ARHS&SS, Sections 129-156. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

44. ARHS&SS, Sections 157-180. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

45. ARHS&SS, Sections 181-181.0.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

46. ARHS&SS, Section 30. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

47. ARHS&SS, Section 182. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

48. ARHS&SS, Section 233. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

49. ARHS&SS, Sections 31, 33. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

50. ARHS&SS, Section 33(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

51. ARHS&SS, Section 33(3). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

52. ARHS&SS, Sections 192.1-201. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

53. ARHS&SS, Section 202. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

54. ARHS&SS, Section 203. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

55. ARHS&SS, Section 204(1). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

56. ARHS&SS, Section 204(4). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

57. ARHS&SS, Section 206. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

58. ARHS&SS, Section 207-208. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

59. ARHS&SS, Section 208.1-208.3. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

60. ARHS&SS, Section 42. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-12)

61. ARHS&SS, Section 213. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

62. ARHS&SS, Section 214(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

63. ARHS&SS, Section 214(6). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

64. ARHS&SS, Section 214(5). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

65. ARHS&SS, Section 2414(7)a. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

66. ARHS&SS, Section 219. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

67. ARHS&SS, Section 224. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

68. ARHS&SS, Section 220(1). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

69. ARHS&SS, Section 220(2)-(4). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

70. ARHS&SS, Section 223. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

71. ARHS&SS, Section 225.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

72. In that case, three midwives will participate in the council of physicians, dentists and pharmacists, though they can vote only on matters concerning midwifery. ARHS&SS, Section 225.2. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

73. ARHS&SS, Section 225.6. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

74. ARHS&SS, Section 225.3(1)225.4(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

75. ARHS&SS, Section 225.3(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_

4_2/S4_2_A.html) (Accessed 2014-07-27)

76. ARHS&SS, Section 225.3(5). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

77. ARHS&SS, Section 225.3(4). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

78. ARHS&SS, Section 226. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

79. ARHS&SS, Section 227. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

80. ARHS&SS, Section 188. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

81. ARHS&SS, Sections 189(1), (5), 190(1)-(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

82. ARHS&SS, Sections 189(2)-(4), (7), 191, 192. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

83. ARHS&SS, Section 190(3). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

84. ARHS&SS, Section 209. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

85. ARHS&SS, Section 209.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

86. ARHS&SS, Section 212(1). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_

4_2/S4_2_A.html) (Accessed 2014-07-27)

87. ARHS&SS, Section 212(3). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

88. ARHS&SS, Section 212(4). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

89. *An Act Respecting the Health and Social Services Ombudsman* (R.S.Q. c P-31.1) Section 1. (http://www.canlii.org/en/qc/laws/stat/rsq-c-p-31.1/latest/rsq-c-p-31.1.html) (Accessed 2014-07-27)

Protection of Conscience Project
www.consciencelaws.org

Redefining the Practice of Medicine
Euthanasia in Quebec
Appendix B: Disciplinary and Complaint Procedures

Sean Murphy, Administrator
Protection of Conscience Project

B1. Professional privileges

Application for and renewal of privileges

B1.1 Physicians or dentists must apply for privileges to practice or to renew their privileges with the executive director of an institution. If the council of physicians, dentists and pharmacists recommends the application, the director must submit the application to the board of directors.[1] The board may grant privileges, but (except in emergencies, or to replace personnel) not without the approval of the regional health agency.[2]

B1.2 A resolution granting privileges to a physician or dentist must include, among other things, their undertaking “ to fulfil the obligations attached to the enjoyment of the privileges.”[3] The physician or dentist must provide written proof that he has read the resolution.[4]

B1.3 Pharmacists must also apply to the executive director to practise of an institution, and a similar process is followed in processing the application.[5]

B1.4 Midwives must apply to boards of directors, which, upon the recommendation of the council of midwives,[6] may contract with her for three years, the terms of the contract specifying her rights and obligations. [7]

B2. Refusal, suspension and revocation of privileges

B2.1 The board may refuse to grant privileges based on the needs of the institution, qualifications, scientific competence or conduct, and “fulfilment of the obligations attached to the enjoyment of the privileges granted.”[8]

B2.2 In emergencies, professional privileges of physicians, dentists and pharmacists can be suspended for up to ten days pending a decision by the board of directors “by the director of professional services, the chairman of the council of physicians, dentists and pharmacists, the head of the clinical department concerned or, if these persons are

Revision Date: 2014-08-12

absent or unable to act, or fail to act, the executive director."[9] The same actions can by taken in urgent situations with respect to midwives by the midwifery services coordinator, chairs of the professional council having jurisdiction, or, in their absence or as a result of their failure to act, by the executive director.[10]

B2.3 Directors of nursing may limit or suspend a nurse's right to engage in some advanced practices; in urgent cases, if they fail to act, directors of professional services or clinical department heads may do so.[11]

B3. The complaints process

B3.1 Every regional health and social services agency and every institution must appoint a service quality and complaints commissioner to investigate complaints concerning health care delivery (See Appendix "A"). The regional complaints commissioner is responsible for responding to complaints about community organizations or private facilities or seniors' residences that are regulated by the regional agency or formally associated with it by accreditation or agreement.[12] Local complaints commissioners must investigate complaints about the institutions for which they are responsible.

B3.2 Complaints commissioners may address complaints about administrative or organizational problems involving medical, dental or pharmaceutical services that do not result from the conduct of a physician, pharmacist, dentist or medical resident. Complaints about physicians, pharmacists, dentists or medical residents must be referred to the institutional Medical Examiner for investigation. The Medical Examiner also has sole jurisdiction over complaints involving the supervision or assessment of medical, dental or pharmaceutical acts.[13]

B3.3 Complaints at both levels can be dismissed by the Complaints Commissioners if they are "frivolous, vexatious or made in bad faith."[14] On the other hand, neither regional nor local complaints commissioners need wait until they receive complaints before taking action. Both may commence investigations on their own initiative "when there are reasonable grounds to believe that the rights of a user or group of users are not being enforced."[15]

B3.4 Complaints Commissioners can access most documents and communications relevant to the subject of a complaint and require anyone involved to provide information or attend meetings.[16] If they uncover apparent breaches of discipline by professionals or others, they report them to the highest responsible authority within the institution or organization in question.[17] Those authorities are then responsible for investigating the alleged breach and must keep the complaints commissioners apprised of the progress and the outcome of their investigations, including any disciplinary measures taken. That information is, in turn, communicated to complainants by the complaints commissioners.[18]

B4. Medical Examiners' investigations

B4.1 A Medical Examiner who receives a complaint concerning a physician, dentist or pharmacist, or a medical resident may dismiss the complaint if satisfied that it is "frivolous, vexatious or made in bad faith."[19] In other cases, the Examiner must,

a) investigate the complaint himself[20]

b) refer the complaint to the institutional council of physicians, dentists and pharmacists, which must form a committee to investigate it,[21]

c) in the absence of a council of physicians, dentists and pharmacists, handle the complaint as directed by government regulations[22]

d) in cases involving a medical resident, refer the complaint to the authority designated by government regulation.[23]

B4.2 If a Medical Examiner begins an investigation, he may, at any point, decide that it should be referred as indicated in (b), (c) or (d) above.[24] Investigations must be completed within 45 days.[25]

B5. Review Committees

B5.1 A review committee must be established for every local authority operating a local health and social services network (See Appendix A5) and may be established by a public institution. Review committees act as tribunals hearing appeals from the decisions of medical examiners concerning complaints that have not been referred for disciplinary investigation.[26]

B6. Council of Physicians, Dentists and Pharmacists investigations

B6.1 When a complaint is referred to the Council of Physicians, Dentists and Pharmacists by the Medical Examiner or Review Committee, the Council must form a committee to investigate the complaint in accordance with government regulations. If the committee concludes that discipline is warranted, it must communicate its opinion to the board of directors and other interested parties.[27]

B7. Disciplinary powers

B7.1 A board that receives a complaint against an employee who is a member of a professional order or against a midwife may, if the gravity of the complaint warrants, forward the complaint to the professional order.[28]

B7.2 In other cases, following procedures authorized by government regulation,[29] boards of directors can discipline physicians and dentists for "lack of qualifications, scientific incompetence, negligence, misconduct" and "non-compliance with the by-laws of the institution."[30] Discipline can take the form of reprimand, changes in status, withdrawal, suspension or restriction of privileges and compulsory refresher training. When disciplinary action is taken, the professional regulator must be notified.[31]

B7.3 Boards can use the same process to discipline pharmacists after seeking the opinion of the institutional council of physicians, dentists and pharmacists. Disciplinary measures may range from reprimand to dismissal, and, again, the professional regulator must be notified.[32]

B7.4 The board of directors may discipline midwives for "lack of qualifications, incompetence, negligence, misconduct, non-compliance with the regulations of the institution" or failure to meet contractual obligations. Discipline can include “reprimand, modification or withdrawal of one or more rights under the contract and cancellation of the contract.” The disciplinary process is similar to that for pharmacists.[33]

B8. Immunity

B8.1 No legal proceedings may be brought against Complaints Commissioners and their assistants, Medical Examiners, Review Committees, Councils of Physicians, Dentists and Pharmacists (individually or corporately), or Boards of Directors (individually or corporately) for acts or omissions done in good faith in the exercise of their responsibilities.[34]

B8.2 Except with respect to a question of jurisdiction, courts may not issue injunctions against any of the entities or persons in B8.1,[35] even “when the enactment upon which the proceedings have been based or the judgment rendered is null or of no effect”[36] or “there has been a violation of the law or an abuse of authority amounting to fraud and of such a nature as to cause a flagrant injustice.”[37]

B9. Health and Social Services Ombudsman

B9.1 People who are not satisfied with the handling of their complaints at the institutional or regional level may appeal to the Health and Social Services Ombudsman.[38]

B9.2 The Ombudsman may intervene on his own initiative if he “has reasonable grounds to believe that a natural person or a group of natural persons has been or may likely be wronged by an act or omission” of an institution or agency or their employees or resources. However, he may not assume any control over “the supervision or assessment of medical, dental or pharmaceutical acts.”[39]

B9.3 The Ombudsman intervenes by bringing to the attention of the highest authority in the institution in question “the act or omission that is the subject of the intervention and the facts or reasons warranting the intervention” and recommendations. It is expected that the institution will collaborate in resolving the issue within 30 days.[40]

B9.4 If the Ombudsman is not satisfied with the response, he may make a written report to the government and may also report the case to the National Assembly.[41]

B10. Professional Orders

B10.1 The Professional Code requires each order to adopt a code of ethics by regulation[42] and sets out the complaints and disciplinary procedures that are to be followed.[43] Every professional order has a disciplinary council[44] chaired by government appointee.[45]

B10.2 The board of directors of each order must appoint a “syndic” (the term used for an official investigator) and, if need be, assistant and corresponding syndics who will form the “office of the syndic” of the order.[46] Syndics must lodge complaints of professional misconduct with the disciplinary committee if requested to do so by the board of directors, and may do so upon their own initiative. Any other person may also lodge a complaint.[47]

B10.3 Of particular interest, anyone who “knowingly helps or, by encouragement, advice or

> consent" leads a member to violate the order's code of ethics can be fined not less than $1,500.00 and not more than $20,000.00 for each day the violation continues. In the case of an incorporated entity, the minimum and maximum fines are $3,000.00 to $40,000.00 per day.[48]

Notes:

1. *An Act Respecting Health Services and Social Services*, (R.S.Q. Chapter S-4.2) (Hereinafter "ARHS&SS) Section 237. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

2. ARHS&SS, Section 240. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

3. ARHS&SS, Section 242. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

4. ARHS&SS, Section 243. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

5. ARHS&SS, Sections 246-247. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

6. ARHS&SS, Sections 259.2. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

7. ARHS&SS, Sections 259.3, 259.5. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

8. ARHS&SS, Section 238. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

9. ARHS&SS, Sections 251. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

10. ARHS&SS, Sections 259.7. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

11. ARHS&SS, Section 207.1. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27). The activities are set out in Section 36.1 of the *Nurses Act*. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=%2F%2FI_8%2FI8_A.htm) (Accessed 2014-07-27)

12. ARHS&SS, Section 60. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) Accessed 2013-06-20

13. ARHS&SS, Section 45. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

14. ARHS&SS, Sections 35, 68. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

15. ARHS&SS, Sections 33(7), 66(7). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

16. ARHS&SS, Sectionss 36, 69. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

17. ARHS&SS, Section 33(5). 66(5)(http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

18. ARHS&SS, Sections 37, 70. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

19. ARHS&SS, Section 44(4). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

20. ARHS&SS, Sections 46(1), 47. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

21. ARHS&SS, Section 46(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

22. ARHS&SS, Section 46(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

23. ARHS&SS, Section 46(3). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

24. ARHS&SS, Section 48. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

25. ARHS&SS, Section 47. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

26. ARHS&SS, Sections 51-59. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

27. ARHS&SS, Section 58. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

28. ARHS&SS, Sections 39, 59. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

29. ARHS&SS, Section 506. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

30. ARHS&SS, Section 249. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

31. ARHS&SS, Sections 39, 249. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

32. ARHS&SS, Section 250. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

33. ARHS&SS, Section 259.6. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) (Accessed 2014-07-27)

34. ARHS&SS, Section 75. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) Accessed 2013-06-18

35. ARHS&SS, Section 76. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html) Accessed 2013-06-18

36. *Code of Civil Procedure* (R.S.Q. c C-25) Section 846(2). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/C_25/C25_A.HTM) (Accessed 2014-07-27)

37. *Code of Civil Procedure* (R.S.Q. c C-25) Section 846(4). (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/C_25/C25_A.HTM) (Accessed 2014-07-27)

38. *An Act respecting the Health and Social Services Ombudsman* (R.S.Q. c P-31.1) (Hereinafter "HSSO") Section 8. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/P_31_1/P31_1_A.html) (Accessed 2014-07-27)

39. HSSO, Section 20 (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/P_31_1/P31_1_A.html) (Accessed 2014-07-27)

40. HSSO, Sections 21, 24, 25. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/P_31_1/P31_1_A.html) (Accessed 2014-07-27)

41. HSSO, Section 26. (http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/P_31_1/P31_1_A.html) (Accessed 2014-07-27)

42. *Professional Code* (R.S.Q. c C-26) (Hereinafter “Prof. Code”)Section 87. (http://www.canlii.org/en/qc/laws/stat/rsq-c-c-26/latest/rsq-c-c-26.html) (Accessed 2014-07-27)

43. Prof. Code, Section 116-182. (http://www.canlii.org/en/qc/laws/stat/rsq-c-c-26/latest/rsq-c-c-26.html) (Accessed 2014-07-27)

44. Prof. Code, Section 116. (http://www.canlii.org/en/qc/laws/stat/rsq-c-c-26/latest/rsq-c-c-26.html) (Accessed 2014-07-27)

45. Prof. Code, Section 117-118. (http://www.canlii.org/en/qc/laws/stat/rsq-c-c-26/latest/rsq-c-c-26.html) (Accessed 2014-07-27)

46. Prof. Code, Section 121 . (http://www.canlii.org/en/qc/laws/stat/rsq-c-c-26/latest/rsq-c-c-26.html) (Accessed 2014-07-27)

47. Prof. Code, Section 128 . (http://www.canlii.org/en/qc/laws/stat/rsq-c-c-26/latest/rsq-c-c-26.html) (Accessed 2014-07-27)

48. Prof. Code, Sections 188, 188.2.1. (http://www.canlii.org/en/qc/laws/stat/rsq-c-c-26/latest/rsq-c-c-26.html) (Accessed 2014-07-27)

Protection of Conscience Project
www.consciencelaws.org

Redefining the Practice of Medicine
Euthanasia in Quebec
Appendix C: Statistics

Sean Murphy, Administrator
Protection of Conscience Project

C1. Belgium

The Belgian Act on Euthanasia of May 28th, 2002

Euthanasia was legalized in Belgium in 2002. The following statistics refer only to reported euthanasia cases.

Note that there is no way to determine from the statistics provided how many times a physician acted as a consultant in different euthanasia cases throughout the year. A single physician involved in three cases will appear here as three physicians. Thus, the statistics here indicate the maximum number of physicians involved in reported cases each year, not the actual number of physicians participating.

		1st. Consultant				2nd Consultant		Totals		
Year	**Deaths**	**A**	**B**	**C**	**D**	**E**	**F**	**1st**	**2nd**	**1st & 2nd**
2002-03	259	51	84	124	0	15	7	259	22	281
2004	349	53	143	147	6	10	14	349	24	373
2005	393	42	166	183	2	18	9	393	27	420
2006	429	43	190	195	1	15	11	429	26	455
2007	495	43	238	211	3	19	9	495	28	523
2008	704	71	326	307	0	38	11	704	49	753
2009	822	85	420	315	2	41	26	822	67	889
2010	953	97	475	381	0	55	25	953	80	1033
2011	1133	109	575	449	0	78	36	1133	114	1247

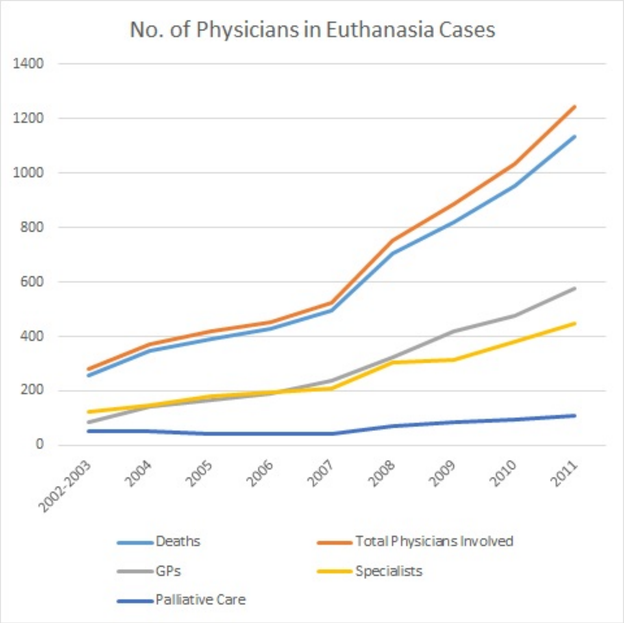
A: Palliative Care | B: General Practitioners | C: Specialists | D: Unspecified
E: Psychiatrist | F: Specialist

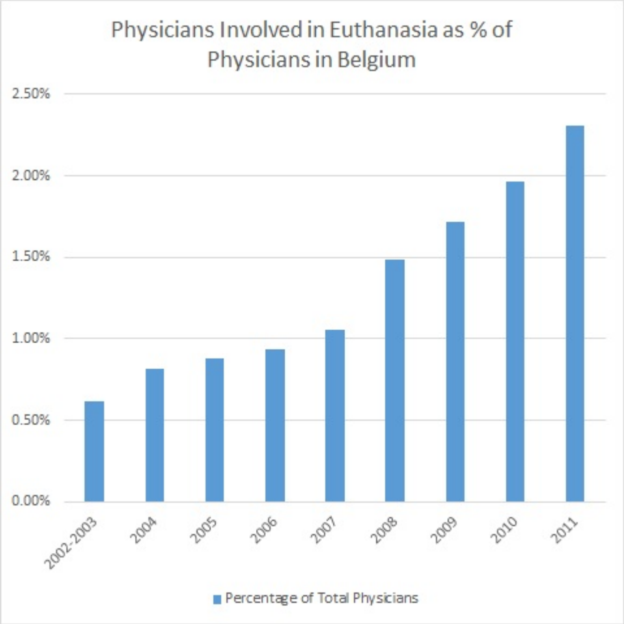
Sources: Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie Annual Reports

7120 Tofino St., Powell River, British Columbia, Canada V8A 1G3
Tel: 604-485-9765 E-mail: protection@consciencelaws.org

Year	Deaths	Physicians Involved	Physicians/ 100,000	Population	Est. Total No. Physicians	% of Total
2002-03	259	281	437.3	10,355,844	45,286	0.62%
2004	349	373	441.3	10,396,421	45,879	0.81%
2005	393	420	458.4	10,445,852	47,884	0.88%
2006	429	455	462.7	10,511,382	48,636	0.94%
2007	495	523	469	10,584,534	49,641	1.05%
2008	704	753	474.7	10,666,866	50,636	1.49%
2009	822	889	480.9	10,753,080	51,712	1.72%
2010	953	1033	485.5	10,839,905	52,628	1.96%
2011	1133	1247	491.1	11,000,638	54,024	2.31%

Sources: Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie Annual Reports; Eurostat: Licensed Physicians Per 100,000 Inhabitants; Eurostat: Population on 1 January- Belgium





C2. Netherlands

Termination of Life on Request and Assisted Suicide (Review Procedures) Act

Euthanasia and assisted suicide were legalized in the Netherlands in 2002. The following statistics refer only to reported euthanasia and assisted suicide cases.

Note that there is no way to determine from the statistics provided how many times a physician acted as a consultant in different euthanasia cases throughout the year. A single physician involved in three cases will appear here as three physicians. Thus, the statistics here indicate the maximum number of physicians involved in reported cases each year, not the actual number of physicians participating.

	Euthanasia & A. Suicide Deaths				**Attending Physician**				
Year	**Total**	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**Total**
2002	1,882								
2003	1,815	1,626	148	41					
2004	1,886	1,714	141	31	1,646	188	52	0	1,886
2005	1,933	1,765	143	25	1,697	170	66	0	1,933
2006	1,923	1,765	132	26	1,692	151	80	0	1,923
2007	2,120	1,923	167	30	1,886	157	76	1	2,120
2008	2,331	2,146	152	33	2,083	152	91	5	2,331
2009	2,636	2,443	156	37	2,356	184	87	10	2,637
2010	3,136	2,910	182	44	2,819	193	115	9	3,136
2011	3,695	3,446	196	53	3,329	212	139	15	3,695
2012	4,188	3,965	185	38	3,777	171	166	74	4,188
A: Euthanasia | B: Assisted Suicide | C: Combined Euthanasia & Assisted Suicide **D: General Practitioner | E: Hospital Specialist | F: Geriatrician* | G: Other** ***Includes physicians working in nursing homes.**									
Sources: Regional Euthanasia Review Committees Annual Reports.									

		Total in Netherlands per Category			**Percentage of Totals, Categories & Overall No. Physicians**				
Year	**Deaths**	**A**	**B**	**C**	**D**	**E**	**E**	**G**	**% Overall**
2004	1,886	7,960	11,275	19,235	20.68%	1.67%	0.46%	0.00%	9.81%
2005	1,933	8,165	12,305	20,470	20.78%	1.38%	0.54%	0.00%	9.44%

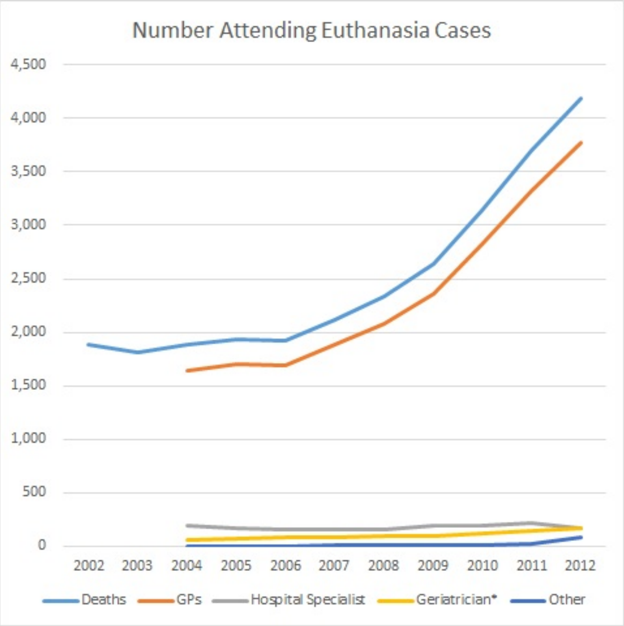
		Total in Netherlands per Category			Percentage of Totals, Categories & Overall No. Physicians				
Year	**Deaths**	**A**	**B**	**C**	**D**	**E**	**E**	**G**	**% Overall**
2006	1,923	8,450	12,850	21,300	20.02%	1.18%	0.62%	0.00%	9.03%
2007	2,120	9,130	14,080	23,210	20.66%	1.12%	0.54%	0.01%	9.13%
2008	2,331	9,350	14,485	23,835	22.28%	1.05%	0.63%	0.03%	9.78%
2009	2,636	9,660	15,020	24,680	24.39%	1.23%	0.58%	0.07%	10.68%
2010	3,136	9,960	16,055	26,015	28.30%	1.20%	0.72%	0.06%	12.05%

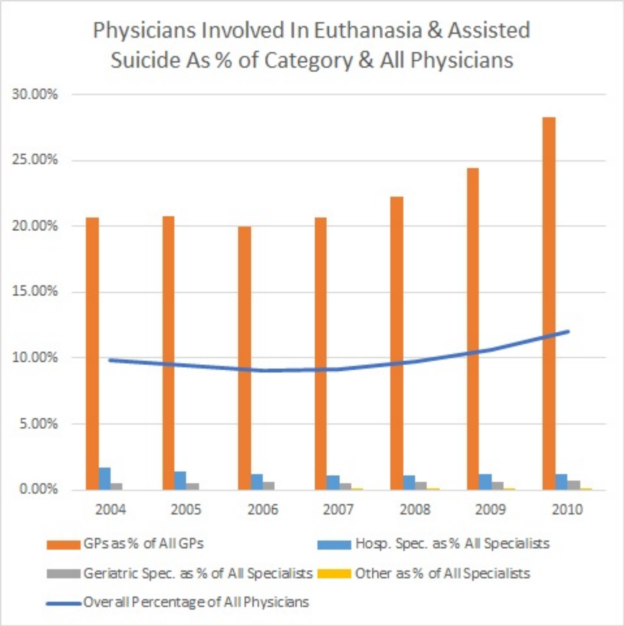
A: General Practitioners | B: Medical Specialists | C: Physicians

D: % of General Practitioners | E: % Hospital Specialists | F: % Geriatricians | G: % Other

Note: percentages of hospital and geriatric specialists and "other" is relative to the total number of medical specialists. Overall percentage is in relation to the total number of physicians.

Sources: Regional Euthanasia Review Committees Annual Reports; Statistics Netherlands: Health, lifestyle, health care use and supply, causes of death; from 1900. Subjects: Care Supply, Health Professions. (Accessed 2014-07-16)





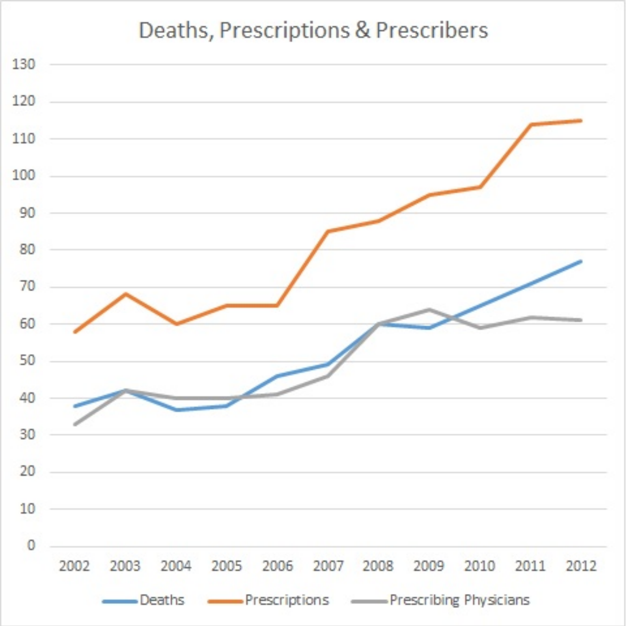
C3. Oregon

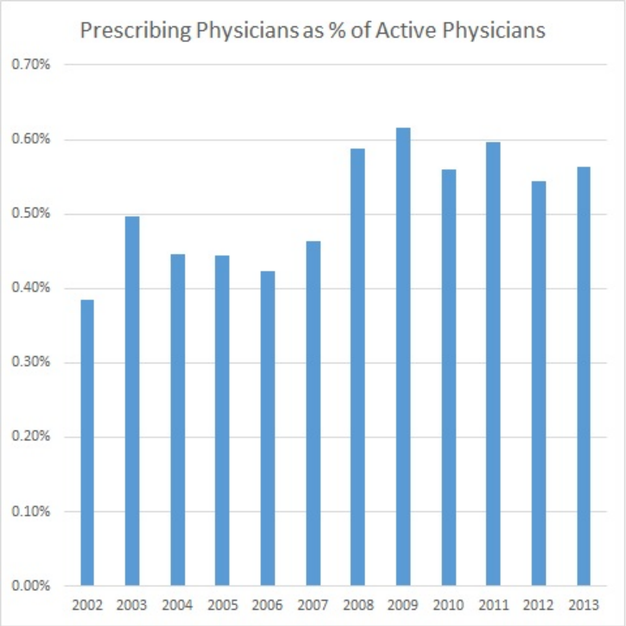
Death With Dignity Act: Physician Prescribers

Physician assisted suicide was legalized in Oregon in 1997.

Year	Deaths	Prescriptions	Prescribing Physicians	Active MDs	% of Active MDs
2002	38	58	33	8,596	0.38%
2003	42	68	42	8,469	0.50%
2004	37	60	40	8,986	0.45%
2005	38	65	40	8,997	0.44%
2006	46	65	41	9,691	0.42%
2007	49	85	46	9,915	0.46%
2008	60	88	60	10,211	0.59%
2009	59	95	64	10,389	0.62%
2010	65	97	59	10,546	0.56%
2011	71	114	62	10,389	0.60%
2012	77	115	61	11,203	0.54%
2013	71	122	62	11005,	0.56%

Sources: Oregon Public Health Division, 2013 Death with Dignity Act Report: Prescription History; Oregon Medical Board Reports.





C4. Washington State

Death With Dignity Act: Physician Prescribers, Pharmacist Dispensers

Physician assisted suicide was legalized in the state of Washington in 2009.

Year	**Deaths**	**A**	**B**	**C**	**D**	**E**	**% Licensed MDs**	**%Licensed Pharmacists**
2009	36	63	53	29	24,670	8,216	0.21%	0.35%
2010	51	87	68	40	25,135	8,556	0.27%	0.47%
2011	70	103	80	46	25,783	8,861	0.31%	0.52%
2012	83	121	87	30	26,167	8,983	0.33%	0.33%
2013	119	173	89	23	26,536	9,289	0.34%	0.25%
A: Drugs Dispensed | B: Prescribing Physicians | C: Dispensing Pharmacists | **D: Licensed Mds | E: Licensed Pharmacists**								
Sources: Washington State Department of Health, Death With dignity Act Reports; Washington State Department of Health, Health Systems Quality Assurance, Health Professions Discipline and Regulatory Activities (2009-2011 Biennial Report); Washington State Department of Health, Health Systems Quality Assurance Division, 2011-2013 Uniform Disciplinary Act Biennial Report.