



Protection of Conscience Project

www.consciencelaws.org

ADVISORY BOARD

Dr. Shahid Athar, MD
*Clinical Associate Professor
of Medicine & Endocrinology,
Indiana School of Medicine,
Indianapolis, Indiana, USA*

J. Budziszewski, PhD
*Professor, Departments of
Government & Philosophy,
University of Texas,
(Austin) USA*

Abdulaziz Sachedina, PhD
*Dept. of Religious Studies,
University of Virginia,
Charlottesville, Virginia, USA*

Roger Trigg, MA, DPhil
*Academic Director,
Centre for the Study
of Religion in Public Life,
Kellogg College,
University of Oxford,
United Kingdom*

Lynn D. Wardle, JD
*Professor of Law,
J. Reuben Clark Law School,
Brigham Young University,
Salt Lake City, Utah, USA*

PROJECT TEAM

Human Rights Specialist
Rocco Mimmo, LLB, LLM
*Ambrose Centre for Religious
Liberty, Sydney, Australia*

Administrator
Sean Murphy

Commentary: CMA draft framework for physician assisted suicide, euthanasia (August, 2015)

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

The Canadian Medical Association (CMA) draft framework, *Principles Based Approach to Assisted Dying in Canada* presumes that physicians have an obligation to kill patients or help them commit suicide in the circumstances described by the Supreme Court of Canada in *Carter v. Canada*. It claims that objecting physicians are obliged to support physicians who do so, and to facilitate their work. By presuming these contested obligations as normative, the framework imposes a structure for response and discussion that is prejudicial to objecting physicians.

CMA officials define “participation” in the draft framework to mean only providing a lethal injection or writing a lethal prescription, although this is not stated in the document. Referral is not counted as “participation,” and the draft framework appears to reflect the view that referral is the preferred method for reconciling conflicts between patients seeking euthanasia or assisted suicide and physicians unwilling to be involved with homicide or suicide. This introduces a fundamental structural bias in framing the CMA approach to accommodating freedom of conscience and religion.

The bias in favour of mandatory referral becomes particularly evident in Schedule B, which considers only compulsory referral as a means of reconciling freedom of conscience and access to services. Further, the structural bias is reflected and reinforced by numerous erroneous and substantially misleading statements.

What support might be offered to physicians unwilling to provide or *facilitate* euthanasia and assisted suicide is conditional upon their referring the patient to a third party, but the formulation in the draft framework is insufficiently clear and has been compromised by revisions to fundamental principles. An acceptable policy will not require objecting physicians to become part of a chain of causation culminating in a morally contested procedure.

Despite the bias apparent in the draft framework, it should be possible to reconcile respect for the fundamental freedoms of physicians and demands for access to morally contested services. This can be done within the framework proposed by the CMA in the manner suggested in this commentary.

Pub: 2015 Aug 22
Updated: 2022 Oct 12

Table of Contents

I.	Introduction.....	1
II.	Overview	1
III.	Principles Based Approach to Assisted Dying in Canada.....	1
III.1	Highlights of the decision from the physician perspective.....	1
III.2	Strategic Questions	2
III.2.1	Strategic Question 3	2
III.2.2	Additional strategic questions.....	2
IV.	Schedule A: Draft Principles-Based Recommendations	3
IV.1	Foundational Principles	3
IV.1.1	Caveat added.....	3
IV.1.2	2: Equity	3
IV.1.3	3: Respect for physician values.....	4
IV.1.3	5: Clarity	4
IV.1.4	9: Solidarity	4
IV.2	Recommendations - 1. Patient qualifications.....	5
IV.2.1	1.2: Capacity.....	5
IV.2.2	1.4: Informed decision	5
IV.3	Recommendations - 2. Process map	6
IV.3.1	Stages 1 & 2	6
	Making room for conscience.....	6
IV.3.2	Stage 3: After undertaking medical aid in dying.....	7
IV.4	Recommendations - 5. Moral opposition.....	7
IV.4.1	5.2 Conscientious objection by a physician	7
	Direct access to the euthanasia/assisted suicide pathway.....	8
V.	Schedule B: Legislative Criteria Across Jurisdictions	9
VI.1	Q3: Reconcile refusal and equitable access?	9
V.2	Netherlands: misleading and biased	9
V.3	Luxembourg: incomplete and confusing.....	10
V.4	Belgium: confusing.....	11
V.5	Oregon: erroneous, misleading, confusing and biased	12
V.6	Washington: erroneous, misleading, confusing and biased	13
V.7	Vermont: misleading and biased.....	14
V.8	Senate Bill 225: misleading and biased	15
V.9	<i>Carter</i> decision - trial level: seriously misleading and biased	15
V.10	<i>Carter</i> SCC decision: misleading and biased	16
VI.	Project Summary	19

VII. Project Recommendations 20

APPENDIX “A” 25
CMA Draft Framework. 25

I. Introduction

- I.1 On 6 February, 2015, the Supreme Court of Canada ordered the legalization of physician-assisted suicide and euthanasia in Canada, effective in February, 2016.¹ The one year suspension of the ruling provided the federal and provincial governments time to make legislative and regulatory changes necessary to implement the ruling. The federal government later announced that no new legislation would be proposed before the federal election in October. A panel was appointed in July to conduct consultations and report to the federal government about options for a legislative response.²
- I.2 The Canadian Medical Association (CMA) had been preparing for legalization of physician assisted suicide and euthanasia since 2014. In the months following the ruling, CMA officials and the Board of Directors finalized draft guidelines ("draft framework") on the subject and published them in June.
- I.3 An internal CMA on-line consultation concerning the draft framework ran from 8 June to 20 July, 2015. The draft framework was revised to take feedback into account. The results of the consultation are to be reported at the CMA General Council on 25 August. The Board of Directors will also present the revised framework for consideration.

II. Overview

- II.1 The draft framework is divided into three main sections: *Principles Based Approach*, *Schedule A* and *Schedule B*.
- II.2 The CMA draft framework revised for the 2015 Annual General Council is reproduced in Appendix "A" .
- II.3 The on-line version of this commentary and Appendix "A" can be accessed at:
<http://www.consciencelaws.org/ethics/ethics090-001.aspx>

III. Principles Based Approach to Assisted Dying in Canada

III.1 Highlights of the decision from the physician perspective

- III.1.1 The draft states:

The category of patients described by the Court as eligible for medical aid in dying is arguably not narrow. Patients do not have to suffer from a terminal illness. Rather, in the words of the decision, they "must be competent adults who clearly consent to the termination of life, and have a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual" (para. 127).

III.1.2 This significantly understates the problem by leaving out a important caveat included by the Court.

“Irremediable” . . . does not require the patient to undertake treatments that are not acceptable to the individual (para. 127).

VIII.1.3 Thus, any illness, disease or disability becomes "irremediable" if the patient considers even successful treatments "not acceptable."

III.2 Strategic Questions

III.2.1 Strategic Question 3

III.2.1.1 The draft framework includes four strategic questions to focus discussion. Strategic Question 3 raises the issue of physician freedom of conscience within the context of patient access to physician-assisted suicide and euthanasia.

For those physicians who refuse to participate in assisted dying for reasons of conscience, how do we reconcile this refusal with their obligation to ensure equitable access? What mechanisms can physicians employ to ensure this access? (Emphasis added)

III.2.1.2 Dr. Jeff Blackmer, moderating the on-line consultation, explained that, for the purposes of the consultation on the framework, “participate” means only *providing* the lethal injection or prescription.³

III.2.1.3 This is a narrower definition of “participate” than is customary, since “participate” is normally understood to mean taking part in, which may encompass indirect forms of action that contribute to an outcome - such as referral.

III.2.1.4 However, the peculiar definition of “participation” used in the framework can only be found in one comment by Dr. Blackmer in one strand of the on-line CMA physician dialogue. Most people reading the draft framework would be unaware of it.

III.2.1.5 Once the narrow definition supplied by Dr. Blackmer is understood, it follows that the strategic question is actually addressed only to refusal to directly perform the lethal act, not a refusal to facilitate it by others means.

III.2.1.6 The question also presumes an obligation that is contested. Physicians who, for reasons of conscience, refuse to kill patients or help them commit suicide do not recognize any obligation to facilitate killing by others. Hence, the question subtly imposes a framework for response and discussion that is prejudicial to objecting physicians.

III.2.2 Additional strategic questions

III.2.2.1 In addition to the four strategic questions included in the draft framework, two more strategic questions will be asked of delegates when they are presented with the document:

1. Are the elements contained in the proposed draft framework the correct ones?
 - a. If not, which ones should be discarded?

b. Are there elements which should be added?

2. To what extent should the CMA advocate on behalf of its members to promote the adoption of this framework by federal and provincial legislatures and regulatory bodies?

III.2.2.2 These questions are found in a separate document provided for the Council.⁴ It is not clear whether these questions are meant to supplement or to displace the four questions in the draft framework.

III.2.2.3 If they become the focus of the discussion, it seems unlikely that it will be possible for delegates to critique any particular aspect of the framework, apart from suggesting additions or deletions of whole sections.

III.2.2.4 Further, it appears that delegates will not actually be asked to approve the framework. Approval will be presumed, since any answer to the second question presumes that the framework is acceptable, the only issue being the extent to which it should be promoted.

IV. Schedule A: Draft Principles-Based Recommendations

IV.1 Foundational Principles

IV.1.1 Caveat added

IV.1.1.1 An additional sentence was added to the revised framework in introduction the strategic questions:

Proposing foundational principles is a starting point for ethical reflection, and their application requires further reflection and interpretation when conflicts arise.

IV.1.1.2 This caveat warns that all of the principles, no matter how carefully they might seem to be worded, are subject to interpretation. Thus, objecting physicians cannot be confident that any of the principles will be interpreted in their favour should a conflict arise.

IV.1.2 2: Equity

IV.1.2.1 The principle as stated:

To the extent possible, all those who meet the criteria for medical aid in dying should have access to this intervention. Physicians will work with relevant parties to support increased resources and access to high quality palliative care, and medical aid in dying. There should be no undue delay to accessing medical aid in dying, either from a clinical, system or facility perspective. (Emphasis added)

IV.1.2.2 Physicians who, for reasons of conscience, object to killing patients or helping them to commit suicide cannot be expected to work to support euthanasia and assisted suicide. This principle makes an authoritarian demand based on a contested premise (VIII.3.6).

IV.1.2.3 The term “undue delay” is undefined, but it would seem from what follows later in the draft that nothing less than 22 days can be considered an “undue delay.”(VIII.8.1.3)

IV.1.3 3: Respect for physician values

IV.1.3.1 The principle as stated:

Physicians can follow their conscience when deciding whether or not to provide medical aid in dying without discrimination. This must not result in undue delay for the patient to access these services. No one should be compelled to provide assistance in dying. (Emphasis added)

IV.1.3.2 The title of the principle is not “Respect for the fundamental freedoms of physicians,” thus avoiding reference to the constitutional priority of freedoms of conscience and religion and the legal obligation to accommodate them.

IV.1.3.3 The principle is limited to defending physicians who refuse to *provide* euthanasia and assisted suicide. No support is offered to physicians who refuse to facilitate euthanasia or assisted suicide by referral or other means. This is consistent with the narrow definition of participation used in the document (III.2.1.2-III.2.1.5).

IV.1.3.4 The phrase "without discrimination" is ambiguous. It is not clear if it means that physicians who follow their consciences should not be discriminated against, or if it means that, in deciding whether or not to provide euthanasia or assisted suicide, physicians must not engage in illicit discrimination.

IV.1.3.5 The term “undue delay” is undefined, but it would seem from what follows later in the draft that nothing less than 22 days can be considered an “undue delay.”(IV.3.1.3)

IV.1.3.6 The interpretation of this passage is likely to be affected by the revision made to the principle “solidarity.” (IV.1.4)

IV.1.3 5: Clarity

IV.1.3.1 The principle as stated:

All Canadians must be clear on the requirements for qualification for medical aid in dying. There should be no "grey areas" in any legislation or regulations.

IV.1.3.2 This is unrealistic because it is impossible, given the broad terms of the *Carter* ruling and the even broader CMA policy on assisted suicide and euthanasia (III.1).

IV.1.4 9: Solidarity

IV.1.4.1 The original text of this principle was revised by striking out “accompanied” and adding two phrases (here identified by square brackets:

Patients should be ~~accompanied~~ [supported and not abandoned] by physicians and health care providers, [sensitive to issues of culture and background] throughout the dying process regardless of the decisions they make with respect to assisted dying.

IV.1.4.2 The addition of the reference to non-abandonment is highly significant, for two reasons.

IV.1.4.3 First: activists frequently hurl accusations of patient abandonment at objecting physicians

who refuse to facilitate morally contested procedures by referral or other means. Hence, this principle can be used as a key to interpreting the recommended policy concerning conscientious objection by physicians.

- IV.1.4.4 Second: the original reference to “accompanying” the patient in solidarity originated in the supportive approach taken in palliative care. It did not develop as simply another aspect of the duty of non-abandonment. For example, a publication of the Canadian Cancer Society describes palliative care as “a human solidarity pact,” and quotes a palliative care nurse: “Palliative care firstly involves accompanying patients through all the symptoms and stages of their disease.”⁵
- IV.1.4.5 The revision changes what seems to have originated as a reference to the supportive approach characteristic of palliative care to a statement intended to compel health care workers to be closely associated with assisted suicide and euthanasia.

IV.2 Recommendations - 1. Patient qualifications

IV.2.1 1.2: Capacity

IV.2.1.1 As stated:

If either or both the attending physician or the consulting physician determines that the patient is incapable, the patient must be referred for further capacity assessment. (Emphasis added)

IV.2.1.2 If *either* the attending or consulting physician determines that the patient is incapable, a further consultation would seem called for to resolve the question. Presumably the final decision would rest upon a diagnosis agreed upon by two physicians.

IV.2.1.3 However, if *both* the attending and consulting physician conclude that the patient lacks capacity, there would seem to be no reason to seek further opinions, unless the goal is to find someone willing to certify capacity so that euthanasia or assisted suicide can be provided, and to act upon a certification of capacity by only one physician despite the existence of two contrary opinions.

IV.2.1.4 This recommendation is indicative of a euthanasia/assisted suicide activist mindset.

IV.2.2 1.4: Informed decision

IV.2.2.1 As stated:

The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication and alternatives, including comfort care, palliative and hospice care, and pain and symptom control. (Emphasis added)

IV.2.2.2 In fact, death is *not* always certain.⁶ Physicians willing to perform euthanasia as well as to assist in suicide should disclose and discuss options available in the event that a lethal injection or prescribed drug does not kill the patient.

- IV.2.2.3 Physicians willing to prescribe lethal drugs but unwilling to provide euthanasia by lethal injection should consider what they may be expected to do if a prescribed drug incapacitates but does not kill a patient.

IV.3 Recommendations - 2. Process map

IV.3.1 Stages 1 & 2

- IV.3.1.1 The draft framework recommends that patients make a series of requests for euthanasia or assisted suicide that are to be documented by the attending physician. It appears that this is meant to ensure that a patient has a firm and settled intention to be killed or to commit suicide.
- IV.3.1.2 Three requests are required by the draft: two oral, and one written, in the form required by the appropriate authority.
- IV.3.1.3 After the first oral request, the patient must wait at least 15 days before making the second oral request. The written request cannot be made until at least 7 more days have elapsed, for a total of at least 22 days.
- IV.3.1.4 Only when the physician receives a written request following the two preceding oral requests is he obliged to begin to act upon it, within 48 hours or as soon as is practicable.
- IV.3.1.5 The draft includes an important qualification:
6. In cases of terminal illness where time is of the essence, CMA recommends that shorter timelines be considered.
- IV.3.1.6 It is not clear why time is of the essence in terminal illness unless there is a concern that the patient may die of natural causes before a physician can provide euthanasia or assisted suicide. This statement is indicative of a pro-euthanasia mindset.

Making room for conscience

- IV.3.1.7 It appears that the attending physician must document the requests and opportunities to rescind the requests in the patient chart, but is not obliged to process a request until a written request is received.
- IV.3.1.8 It would be possible for an objecting physician to have the necessary exploratory conversations with a patient in conjunction with the first and second oral requests. During that period, an objecting physician could make clear that, if the patient wishes to proceed, the patient must direct a written request to another physician.
- IV.3.1.9 Should the patient direct the written request to another physician, the new physician would request the transfer of the patient chart. The transferred chart would include the records of the oral requests, so no repetition of the oral requests would be required. The objecting physician could ensure continuity of other aspects of care until the transfer occurred.
- IV.3.1.10 The Project has not encountered objecting physicians who find patient-initiated file

transfer problematic.

IV.3.1.11 Patient-initiated file transfer is the norm in other jurisdictions in such circumstances.

IV.3.2 Stage 3: After undertaking medical aid in dying

IV.3.2.1 Stage 1 of the process is called “Requesting medical aid in dying.” Stage 2, which is called, “Before undertaking medical aid in dying,” includes all of the steps up to and including documentation of everything that has been done preliminary to the lethal act.

IV.3.2.2 Thus, the context of the single recommendation under this head indicates that “undertaking” means administering the lethal substance or providing the lethal substance for the patient to ingest.

12. The attending physician, or a physician delegated by the attending physician, must take care of the patient until the patient's death. (Emphasis added)

IV.3.2.3 The wording of the title of this subsection in the draft (“undertaking . . .”) demonstrates an awareness of the moral gravity of the act of killing someone or helping someone to commit suicide.

IV.3.2.4 In order to minimize conflicts of conscience among other physicians and health care workers, the physician responsible for the decision to provide euthanasia or assisted suicide should personally administer the lethal medication, or be present when it is ingested, and remain with the patient until death ensues.

IV.4 Recommendations - 5. Moral opposition

IV.4.1 5.2 Conscientious objection by a physician

IV.4.1.1 As stated:

Physicians are not obligated to fulfill requests for medical aid in dying. There should be no discrimination against a physician for their refusal to participate in medical aid in dying. In order to reconcile physicians' conscientious objection with patient access to care, a system should be developed whereby referral occurs by the physician to a third party that will provide assistance and information. (Emphasis added)

IV.4.1.2 “Fulfill” presumably means only performing the lethal act or providing the lethal prescription, and “participate” has the same meaning (III.2.1.2). Thus, this policy supports only refusal to *perform* the lethal act, not a refusal to facilitate it by others means.

IV.4.1.3 The support offered here to physicians unwilling to provide or facilitate euthanasia and assisted suicide is conditional upon their referring the patient to a third party.

IV.4.1.4 Physicians who object to referral will find this acceptable only if they can be satisfied that directing the patient to the third party will not constitute morally significant participation in or causal facilitation of euthanasia or assisted suicide. The formulation in the draft

- framework is insufficiently clear on this point.
- IV.4.1.5 On the other hand, the Project has not encountered objections to the routine transfer of patient records when the transfer is initiated by the patient or the patient's delegate. This approach has been ignored in the draft framework.
- IV.4.1.6 The distinction between referral and transfer of care highlights another point: the meaning of "referral." The term can be used in a narrow, technical sense to mean a formal arrangement for consultation with another physician. However, as it is frequently used by those demanding that physicians "refer for abortion" or "refer for euthanasia," it often means only providing contact information for a provider or directing the patient to someone who will provide the service. Both forms of "referral" would be unacceptable to physicians who consider such assistance to involved complicity in wrongdoing.
- IV.4.1.7 It would be less confusing to restrict the use of the term "referral" to its technical sense, and then distinguish between physician-initiated and patient-initiated transfers of care or records. These three options are well understood by physicians and can easily be explained to patients.
- IV.4.1.8 To these three options one can add two more: providing contact information for a provider, and suggesting sources of information about services and/or providers.
- IV.4.1.9 Of the five options, the experience of the Project is that three - referral (formal), physician-initiated file transfer and providing contact information for service providers - are likely to be unacceptable to many objecting physicians.
- IV.4.1.10 On the other hand, two are likely to be acceptable to the widest range of objecting physicians:
- patient-initiated transfer of care/records (discussed in IV.4.1.5)
 - directing the patient to one or more generic sources of information that can be used to find out how to access morally contested services.

Direct access to the euthanasia/assisted suicide pathway

- IV.4.1.11 While a physician will have to be consulted in order to verify the conditions set in *Carter* and to perform the lethal act or provide the lethal prescription, there is no need for patients to enter the euthanasia and assisted suicide pathway through gates kept by physicians: certainly not exclusively through them.
- IV.4.1.12 Patients can directly access or take steps to obtain other morally contested procedures like abortion and contraception by contacting other providers or seeking assistance from other community groups or institutions. The availability of these services is widely advertised by the provinces, health authorities and activist groups. This kind of arrangement avoids conflicts between physicians and patients, protecting the integrity of objecting physicians while providing patients with a way to access the services they want. This is what CMA President Dr. Chris Simpson proposed in March, 2015.⁷
- IV.4.1.13 Since, under the terms of the *Carter* ruling, eligible patients must be competent adults

who have the capacity to consent to euthanasia or assisted suicide, there is no reason to think that eligible patients would be unable to open a gate of their choosing to enter the euthanasia and assisted suicide pathway.

- IV.4.1.14 Further: it is likely that eligible patients with physical disabilities that would prevent them from opening the gate would probably have a care aide or personal assistant who might be willing to do so on their behalf.
- IV.4.1.15 The draft framework is deficient in that it fails to consider direct access models or other methods of accommodating physician freedom of conscience and religion. It focuses, instead, on an approach that increases patient dependency upon physicians and on referral.

V. Schedule B: Legislative Criteria Across Jurisdictions

VI.1 Q3: Reconcile refusal and equitable access?

- V.1.1 Schedule B considers the accommodation of freedom of conscience in the case of objecting physicians in jurisdictions where euthanasia and/or assisted suicide are legal, and with reference to the *Carter* case and a private bill that has been proposed in the Canadian Senate (S-225). The jurisdictions are listed in a table, together with Bill S-225 and the trial and Supreme Court of Canada rulings in *Carter*.
- V.1.2 Note that Schedule B considers only one possible method of reconciling freedom of conscience and access to services: compelling a physician who refuses to kill a patient or assist in suicide to refer the patient to someone who will. This effectively excludes other approaches and introduces a fundamental structural bias in favour of mandatory referral.
- V.1.3 Two questions are proposed with respect to each jurisdiction, Bill S-225 and *Carter*: “Is there a duty to refer to another physician?” and “Is participation mandatory?” The answers offered are “Yes - No - Silent.” In each case, the table purports to provide evidence supportive of the answer.
- V.1.4 Since “participation” is not defined, readers will be unaware that CMA officials understand the term to mean only directly administering a lethal drug or providing the lethal prescription. This is confusing, since the word normally has a broader meaning and a broader meaning is implied in the Supreme Court of Canada ruling in *Carter*.
- V.1.5 A review of the answers given to the two questions and what is offered by way of “evidence” demonstrates that Schedule B is incomplete, erroneous and substantially misleading. Consistent with the underlying structural bias, all of the erroneous and misleading statements are supportive of mandatory referral.

V.2 Netherlands: misleading and biased

- V.2.1 Schedule B states that the law in the Netherlands is “silent” with respect to a duty to refer to another physician and “silent” as to whether or not it is mandatory for physicians to participate in euthanasia or assisted suicide.

- V.2.2 Consensual homicide and assisted suicide continue to be prohibited by the *Penal Code* in the Netherlands. The Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* does not actually authorize either physician- assisted suicide or euthanasia, but provides a defence to criminal charges for physicians who adhere to its requirements.⁸ In this respect, it is analogous to the provisions of the Canadian *Criminal Code* on therapeutic abortion from 1969 to 1988, and to the exemptions offered in the *Carter* decision.
- V.2.3 One of the requirements of the Dutch law is that the physician must believe that the patient’s request is “well-considered.” Another is that the physician must believe that the patient’s suffering is “lasting and unbearable.” A physician who did not actually believe one or both of these things and who killed a patient or helped a patient commit suicide or aided or abetted either act would have no defence to a charge of murder or assisted suicide.
- V.2.4 Physicians who object to euthanasia and assisted suicide for reasons of conscience usually do not believe that a request for either can be “well-considered.” Moreover, they may not believe that a patient’s suffering is “lasting and unbearable,” particularly if the suffering can be relieved. On both points, the available defence requires actual belief; doubt is insufficient to provide a defence to a criminal charge.
- V.2.5 Since the legal prohibition of homicide and assisted suicide is not displaced in such circumstances, there can be no obligation on the part of objecting physicians to provide or refer for euthanasia or physician-assisted suicide. They have no obligation to commit or cooperate in the commission of a criminal offence. The Royal Dutch Medical Association makes this clear:
- Physicians are never lawfully required to fulfil a request for euthanasia. If, for whatever reason, they object to euthanasia they are not required to cooperate.⁹
- V.2.6 Schedule B is misleading with respect to the situation in the Netherlands. Contrary to the impression created by its assertion that the law is “silent,” there is no duty to participate in or refer for euthanasia or assisted suicide in the Netherlands. This reflects and reinforces the underlying structural bias in favour of mandatory referral (V.1.2).
- V.3 Luxembourg: incomplete and confusing**
- V.3.1 Schedule B states that physicians in Luxembourg are not required to perform euthanasia or assisted suicide. This is correct.
- V.3.2 In the original draft framework used for consultation, Schedule B also stated that physicians who refused to provide euthanasia or assisted suicide in Luxembourg did “not really” have a duty to refer patients to another physician. This was a biased response that would likely have led readers to believe that there was a duty almost equivalent to a duty to refer. The draft framework revised for the General Council corrects this.
- V.3.3 Schedule B paraphrases the legal requirement that a physician who refuses to perform

- euthanasia or assisted suicide must notify a patient of his refusal and the reasons for it. This is unrelated to referral, but the statement is found in the column labelled "Evidence" (pertaining to a duty to refer).
- V.3.4 The following passage from the same section of the paraphrased law has been left out of Schedule B:
- The doctor who refuses to respond to a request for euthanasia or assisted suicide shall be obliged, on the request of the patient or of the person of trust, to send the patient's medical file to the doctor appointed by the latter or by the person of trust.¹⁰
- V.3.5 This is not a referral to another physician, but a patient-initiated transfer of medical records. Physicians in Luxembourg have no duty to refer: no duty to help the patient find someone to provide euthanasia or assisted suicide.
- V.3.6 The outline of the law in Luxembourg provided in Schedule B is incomplete, since it leaves out part of the law dealing with conscientious objection. It is confusing, because information not related to referral is found in the column concerning "evidence" for referral (an artifact of the original biased response, "not really"). It should have been moved to the "Other" column. This reflects the underlying structural bias of the Schedule (V.1.2).
- V.4 Belgium: confusing**
- V.4.1 Schedule B states that physicians in Belgium are not required to perform euthanasia. This is correct.
- V.4.2 In the original draft framework used for consultation, Schedule B also stated that physicians who refused to provide euthanasia or assisted suicide in Belgium did "not really" have a duty to refer patients to another physician. This was a biased response that would likely have led readers to believe that there was a duty almost equivalent to a duty to refer. The draft framework revised for the General Council corrects this.
- V.4.3 Schedule B paraphrases the legal requirement that a physician who refuses to perform euthanasia or assisted suicide must notify a patient of his refusal and the reasons for it, and, at the request of the patient, transfer the medical file to another physician.
- V.4.4 The obligation to notify the patient and transfer records upon request are identical to those found in the law in Luxembourg. What is described here is a patient-initiated transfer of medical records. This has nothing to do with referral, but the statement is found in the column identified as evidence related to the answer to the question about referral. Physicians in Belgium have no duty to refer: no duty to help the patient find someone to provide euthanasia.
- V.4.5 Moreover, consensual homicide continues to be prohibited in Belgium. Like the law in the Netherlands, the Belgian *Act on Euthanasia of May 28, 2002*, does not actually authorize euthanasia, but provides a defence to criminal charges for physicians who

- adhere to its requirements.¹¹ In this respect, it is analogous to the provisions of the Canadian *Criminal Code* on therapeutic abortion from 1969 to 1988 and to the provisions of the *Carter* decision.
- V.4.6 One of the requirements of the Belgian law is that the physician must ensure that the patient's request is "well-considered." Another is that the physician must ensure that the patient is in "a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated." A physician who did not actually ensure all of these things and who killed a patient or aided or abetted homicide would have no defence to a charge of murder.
- V.4.7 Physicians who object to euthanasia for reasons of conscience usually do not think that they can ensure that a request for it is "well-considered." Moreover, they are unlikely to think that a patient's condition can be described as "medically futile," and may well believe that suffering can be alleviated. On both points, the available defence requires a firm conclusion; doubt is insufficient to provide a defence to a criminal charge.
- V.4.8 Since there is a legal prohibition of homicide is not displaced in such circumstances, there can be no obligation on the part of objecting physicians to provide or refer for euthanasia.
- V.4.9 The outline of the law in Belgium is confusing, because information not related to referral is found in the column concerning "evidence" for referral (an artifact of the original biased response, "not really"). It should have been moved to the "Other" column. This reflects the underlying structural bias of the Schedule (V.1.2).
- V.5 Oregon: erroneous, misleading, confusing and biased**
- V.5.1 Schedule B indicates that health care providers in Oregon are not required to participate in assisted suicide. This is correct.
- V.5.2 In the original draft framework used for consultation, Schedule B also stated that physicians who refused to provide euthanasia or assisted suicide in Oregon did "not really" have a duty to refer patients to another physician. This was a biased response that would likely have led readers to believe that there was a duty almost equivalent to a duty to refer. The draft framework revised for the General Council corrects this.
- V.5.3 Schedule B paraphrases the legal requirement that a physician who is unable or unwilling to provide assisted suicide must, at the request of the patient, transfer the medical file to another physician. This is a patient-initiated transfer of medical records like that required in Luxembourg and Belgium. This has nothing to do with referral, but the statement is found in the column labelled "Evidence" (pertaining to a duty to refer). Physicians in Oregon have no duty to refer: no duty to help the patient find someone to provide assisted suicide.
- V.5.4 Schedule B also notes:
- Participation in physician-assisted death does not include providing a patient with a referral to another physician.

- V.5.5 This is erroneous and misleading. The definition of "participation" to which this statement refers applies only to the section of the Oregon *Death with Dignity Act* that allows health care facilities to prohibit "participation" in assisted suicide on their premises. In that particular situation - when a physician *wants* to refer a patient for assisted suicide - "participation" does not include referral. Thus, the health care facility may prohibit the provision of a lethal drug on its premises, but may not prohibit a referral *by a willing physician* to an external source.¹²
- V.5.6 The special definition of "participation" to exclude referral in this particular situation confirms that the term would normally be understood to include referral; the special definition would otherwise be unnecessary.
- V.5.7 The outline of the law in Oregon provided in Schedule B is erroneous because its explanation of the Oregon *Death with Dignity Act* is mistaken. It is misleading because the mistaken explanation of what constitutes "participation" suggests that an objecting physician may be forced to refer a patient to a physician who will provide a lethal prescription. It is confusing, because information not related to referral is found in the column concerning "evidence" for referral (an artifact of the original biased response, "not really"). It should have been moved to the "Other" column. All of this reflects and reinforces the underlying structural bias of the Schedule (V.1.2).
- V.6 Washington: erroneous, misleading, confusing and biased**
- V.6.1 Schedule B indicates that (health care) providers in Washington are not required to participate in assisted suicide. This is correct.
- V.6.2 In the original draft framework used for consultation, Schedule B also stated that physicians who refused to provide euthanasia or assisted suicide in Washington did "not really" have a duty to refer patients to another physician. This was a biased response that would likely have led readers to believe that there was a duty almost equivalent to a duty to refer. The draft framework revised for the General Council corrects this.
- V.6.3 Schedule B references the legal requirement that a physician who is unable or unwilling to provide assisted suicide must, at the request of the patient, transfer the medical file to another physician. This is a patient-initiated transfer of medical records like that required in Luxembourg, Belgium and Oregon. This has nothing to do with referral, but the statement is found in the column labelled "Evidence" (pertaining to a duty to refer). Physicians in Washington have no duty to refer: no duty to help the patient find someone to provide assisted suicide.
- V.6.4 Schedule B also notes:
- Participation in physician-assisted death does not include providing a patient with a referral to another physician.
- V.6.5 This is erroneous and misleading. The definition of "participation" to which this statement refers applies only to the section of the Washington *Death with Dignity Act* that allows health care facilities to prohibit "participation" in assisted suicide on their

- premises. In that particular situation - when a physician *wants* to refer a patient for assisted suicide - "participation" does not include referral. Thus, the health care facility may prohibit the provision of a lethal drug on its premises, but may not prohibit a referral *by a willing physician* to an external source.¹³
- V.6.6 The special definition of "participation" to exclude referral in this particular situation confirms that the term would normally be understood to include referral; the special definition would otherwise be unnecessary.
- V.6.7 The outline of the law in Washington provided in Schedule B is erroneous because its explanation of the Washington *Death with Dignity Act* is mistaken. It is misleading because the mistaken explanation of what constitutes "participation" suggests that an objecting physician may be forced to refer a patient to a physician who will provide a lethal prescription. It is confusing, because information not related to referral is found in the column concerning "evidence" for referral (an artifact of the original biased response, "not really"). It should have been moved to the "Other" column. All of this reflects and reinforces the underlying structural bias in favour of mandatory referral (V.1.2).
- V.7 Vermont: misleading and biased**
- V.7.1 Schedule B indicates that no persons in Vermont are required to participate in assisted suicide. This is correct.
- V.7.2 However, Schedule B also states that the law in Vermont is "silent" as to whether or not physicians who refuse to provide assisted suicide have a duty to refer patients to another physician.
- V.7.3 Vermont's *Patient Choice and Control at the End of Life Act* is not silent on the subject of referral. It imposes a duty of referral *only* on physicians who *wish to provide* assisted suicide.¹⁴ The statute does *not* impose a duty of referral on physicians who *refuse* to participate in assisted suicide.
- V.7.4 Instead, the statute states that "a physician, pharmacist, *nurses or other person* shall *not* be under *any* duty, *by law*, or contract, to *participate* in the provision of a lethal dose of medication to a patient." [§ 5285(a). Emphasis added] Note particularly that the statute nullifies any duty that might be said to exist at common law or through the operation of another statute.
- V.7.5 Since, in Vermont, only physicians can prescribe a lethal dose of medication and only physicians or pharmacists can dispense it, the extension of protection to nurses or other persons indicates that the term "participate" is used in the statute in its normal sense, to encompass other acts that may contribute to the provision of lethal medication, such as referral.
- V.7.6 The outline of the law in Vermont provided in Schedule B ignores the meaning of "participate" as indicated by its use in the statute. It is misleading because the assertion that the law is "silent" with respect to a duty to refer suggests that a duty might exist, despite the statutory provision to the contrary. This reflects and reinforces the underlying

structural bias in favour of mandatory referral (V.1.2).

V.8 Senate Bill 225: misleading and biased

- V.8.1 Schedule B states that Senate Bill 225 is “silent” with respect to a duty to refer to another physician and “silent” as to whether or not it is mandatory for physicians to participate in euthanasia or assisted suicide. This misconstrues the meaning of “silence” in a bill of this kind.
- V.8.2 The bill could require physicians to provide euthanasia or assisted suicide only by including an explicit provision to that effect. Contrary to the impression created by Schedule B, the “silence” of the bill means that participation is *not* required. The correct answer to the question, “Is participation mandatory?” is “no.” This is confirmed by the sponsor of the bill, Senator Nancy Ruth. “No doctor is coerced to do this,” she said. “This is about choice. The choice of doctors who want to assist in it.”¹⁵
- V.8.3 Similarly, the bill could require objecting physicians to refer patients for euthanasia or assisted suicide only by including an explicit provision to that effect. Contrary to the impression created by Schedule B, the “silence” of the bill means that it does *not* require referral. The correct answer to the question, “Is there a duty to refer to another physician?” is “no.”
- V.8.4 Further: Bill S-225 defines “assist” to mean “to provide the person with the knowledge or means to commit suicide, or to perform an act with the intent to cause the person’s death.” Consistent with this, an “assisting physician” is one “who provides assistance” to a patient seeking euthanasia or physician-assisted suicide.
- V.8.5 Thus, Bill S-225 indicates that indirectly facilitating suicide *even by providing information* for that purpose is equivalent to more direct forms of assistance, like providing a lethal prescription. Further, it implies that both providing information to facilitate suicide and actually killing someone are of comparable legal or moral significance.
- V.8.6 This is exactly the position taken by many physicians and health care workers who refuse to facilitate assisted suicide or euthanasia by referral. Bill S-225 supports their reasoning. This point is more relevant to the purpose of Schedule B than the bill’s so-called “silence.”
- V.8.7 Schedule B is misleading with respect to Senate Bill 225 because it misconstrues its lack of reference to either referral or participation. This reflects and reinforces the underlying structural bias in favour of mandatory referral (V.1.2).

V.9 Carter decision - trial level: seriously misleading and biased

- V.9.1 With respect to the Carter decision in the trial court, Schedule B does not answer the questions, “Is there a duty to refer to another physician?” and, “Is participation mandatory?” The table cells are left blank.
- V.9.2 However, as “evidence” related to a duty to refer, Schedule B offers the following:

Trial level - quotes from Royal Society of Canada Report "...if unwilling should refer the individual... to another professional."

V.9.3 The inclusion of this out-of-context statement is likely to cause readers to believe that the trial judge favoured the views of the Royal Society panel on referral. This is false.

V.9.4 The introduction of the Royal Society report was one of the contested issues. The trial judge admitted it as evidence over the objections of Canada. In discussing the feasibility of safeguards, she quoted its recommendations for "the core elements of a permissive regime" which included the reference to referral (under Justice Smith's sub-heading "Features of the provider"):

Health care professionals should be permitted to provide assistance with suicide or voluntary euthanasia. They must not be obligated to provide such assistance but, if unwilling, should refer the individual making the request to another professional who is willing to consider it.¹⁶

V.9.5 However, Madame Justice Smith stated that she was not relying upon the report in relation to any "contentious matters, such as the efficacy of safeguards."¹⁷ In fact, she used the report (and other evidence) to illustrate a *lack* of social consensus concerning euthanasia and assisted suicide.¹⁸

V.9.6 Further, Madame Justice Smith noted that physicians would not be required to "participate" in a theoretical assisted suicide/euthanasia regulatory model proposed by the plaintiffs.¹⁹

V.9.7 Finally, since the plaintiffs did not assert that physicians should be compelled to "perform euthanasia" or "assist in suicide," the judge explicitly left the issue aside in her ruling.²⁰

V.9.8 The single reference to the *Carter* trial judgement provided in Schedule B is seriously misleading because it is likely to cause readers to believe that the trial judge favoured the view that mandatory referral should be imposed on objecting physicians. This reflects and reinforces the underlying structural bias of the Schedule (V.1.2).

V.10 ***Carter* SCC decision: misleading and biased**

V.10.1 Schedule B indicates that the *Carter* ruling does not require physicians to participate in euthanasia or assisted suicide. This is correct.

V.10.2 Schedule B paraphrases and quotes part of the *Carter* ruling. The Schedule B version and original text are here reproduced side by side:

Schedule B (emphasis added)	<i>Carter</i> , paragraph 132 (emphasis added)
Nothing in the declaration of invalidity would compel physicians to <u>provide</u> assistance in dying... "we note...that a physician's decision to <u>participate</u> in assisted dying is a	In our view, nothing in the declaration of invalidity which we propose to issue would compel <u>physicians</u> to <u>provide</u> assistance in dying. The declaration simply renders the criminal prohibition

matter of conscience...	invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note - as did Beetz J. in addressing the topic of physician <u>participation</u> in abortion in <i>R. v. Morgentaler</i> -- that a physician's decision to <u>participate</u> in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the <i>Charter</i> rights of patients and physicians will need to be reconciled
-------------------------	---

- V.10.3 The first point to note is that the meaning assigned to “participate” in the draft framework (participate = provide) is inconsistent with *Carter*, which implies a distinction between “providing” and “participating” by using both terms. The distinction will be considered in more detail presently (V.10.7).
- V.10.4 Note further that the passage refers to “physicians” (plural), not “a physician” (singular). This indicates that the ruling does not, in the Court’s view, create any obligation on the part of physicians (individually or collectively) to *provide* assisted suicide or euthanasia.
- V.10.5 Schedule B also states that the *Carter* decision in the Supreme Court of Canada is “silent” as to whether or not physicians who refuse to provide assisted suicide or euthanasia have a duty to refer patients to another physician. This is correct. However, Schedule B adds the following comment as “evidence” relevant to a duty to refer.
- In making their observation (see quote to the right), the court said that the rights of patients and physicians will need to be reconciled.
- V.10.6 This is not “evidence” related to a duty to refer, since compulsory referral is hardly the only means by which reconciliation might be attempted.
- V.10.7 Here we return to *Carter*’s reference to *participation* in relation to the comments of Mr. Justice Beetz in *R. v. Morgentaler*. These provide guidance not only with respect to referral, but also for developing a correct approach to the accommodation of physician freedom of conscience and religion vis-à-vis patient access to services.
- V.10.8 In the passage from *R. v. Morgentaler* cited in *Carter*, ‘patient access’ to abortion was the very issue being considered by Mr. Justice Beetz. He observed that the requirements of the *Criminal Code* seriously limited the number of hospitals eligible to perform abortions and caused “an absence or a serious lack of therapeutic abortion facilities in many parts of the country” so that “a significant proportion of Canada's population is not served by

hospitals in which therapeutic abortions can lawfully be performed.”

The lack of hospitals with therapeutic abortion committees is made more serious by the refusal of certain hospital boards to appoint therapeutic abortion committees in hospitals which would otherwise qualify under the *Criminal Code*.²¹

V.10.9 Mr. Justice Beetz thus squarely faced the fact that refusal of some hospitals to establish therapeutic abortion committees contributed to what he characterized as a serious lack of access to abortion. Nonetheless, he did not suggest that hospitals should be compelled to establish committees. On the contrary:

Nothing in the *Criminal Code* obliges the board of an eligible hospital to appoint therapeutic abortion committees. Indeed, a board is entitled to refuse . . . in a hospital that would otherwise qualify to perform abortions, and boards often do so in Canada. Given that the decision to appoint a committee is, in part, one of conscience, and, in some cases, one which affects religious beliefs, *a law cannot force a board to appoint a committee any more than it could force a physician to perform an abortion.* (p. 95-96)(Emphasis added)

V.10.10 Therapeutic abortion committees did not *provide* abortions. In fact, members of therapeutic abortion committees were prohibited from doing so.²² The committees *facilitated* abortions by authorizing them. The refusal of boards to approve the formation of such committees was a refusal to become part of (participate in) a chain of causation culminating in abortion, even if not every case brought to a committee resulted in abortion.

V.10.11 Mr. Justice Beetz, while distinguishing between appointing a committee and performing an abortion, nonetheless considered both acts to involve judgements of conscience and religious belief, and the legal suppression of one to be the equivalent of the legal suppression of the other.

V.10.12 Thus, it can be argued that Mr. Justice Beetz’ comments, affirmed by *Carter*, are authority for the proposition that the law is precluded from suppressing freedom of conscience by forcing individuals or institutions to provide morally contested procedures or to participate indirectly in them by referral or other forms of causal facilitation.

V.10.13 This conclusion is reinforced by the closing observation made Mr. Justice Beetz in the passage cited in *Carter*.

The defect in the law is not that it does not force boards to appoint committees, but that it grants exclusive authority to those boards to make such appointments.
(P. 96)

V.10.14 This also indicates how physician freedom of conscience and patient access to services should be reconciled. Lack of access to abortion was, in Mr. Justice Beetz view, caused by “the administrative structure put in place by Parliament” (p. 121). The problem being structural, a structural solution was appropriate. It was not to be resolved by suppressing

or even restricting the fundamental freedoms of physicians or health care facilities opposed to abortion for reasons of conscience or religion.

- V.10.15 Euthanasia activists often understand "reconciliation" to mean forcing physicians unwilling to kill patients or assist in suicide help them to find a colleague willing to do so. This is the paradigm that informs Schedule B's approach to addressing 'physician refusal' and 'patient access' (V.1.2). The comments made in Carter reflect and reinforce that perspective. This is misleading and biased.

VI. Project Summary

- VI.1 The CMA draft framework, *Principles Based Approach to Assisted Dying in Canada*, demonstrates a euthanasia/assisted suicide activist mindset. This is implied in its understatement of the breadth of the Carter eligibility criteria (III.1) and its unrealistic assertion that there should be "no grey areas" in legislation or regulation (IV.1.3). It is markedly evident in the recommendation that if two physicians conclude that a patient is incapable of consenting to euthanasia or suicide, another opinion should be sought (IV.2.1.3) and in its concern to shorten timelines in the case of terminal illness, apparently because patients may die before a physician can lethally inject them or provide lethal prescriptions (IV.3.1.5 - IV.3.1.6).
- VI.2 Consistent with an activist mindset, the framework presumes that physicians have an obligation to kill patients or help them commit suicide in the circumstances described by the Supreme Court of Canada in *Carter v. Canada*. It claims that objecting physicians are obliged to support physicians who do so, and to facilitate their work. These obligations are rejected by physicians who, for reasons of conscience, refuse to kill patients or help them commit suicide. By presuming these contested obligations as normative, the framework imposes a framework for response and discussion that is prejudicial to objecting physicians (III.2.1.6).
- VI.3 CMA officials define "participation" in the draft framework to mean only providing a lethal injection or writing a lethal prescription. Referral and other forms of indirect facilitation are not counted as "participation" (III.2.1.5). Thus, the relevant foundational principle offers support only for physicians who refuse to actually perform euthanasia or assisted suicide (IV.1.2.1), and the recommendation concerning conscientious objection addresses only refusal to directly perform a lethal act, not a refusal to facilitate it by others means (IV.4.1.1).
- VI.4 What support might be offered to physicians unwilling to provide or *facilitate* euthanasia and assisted suicide is conditional upon their referring the patient to a third party, but the formulation in the draft framework is insufficiently clear to determine whether or not what is proposed will sufficiently protect freedom of conscience (IV.4.1.4 - IV.4.1.5).
- VI.5 Moreover, the recommendation concerning conscientious objection has been further compromised by an added caveat concerning fundamental principles (IV.1.1) and by the introduction of reference to "abandonment" under "solidarity" (IV.1.4). It will be acceptable only if it can be phrased to ensure that directing the patient to the third party

- will not constitute morally significant participation in or causal facilitation of euthanasia or assisted suicide.
- VI.6 The draft framework appears to reflect the view that referral is the preferred method for reconciling conflicts between patients seeking euthanasia or assisted suicide and physicians unwilling to be involved with homicide or suicide. This introduces a fundamental structural bias in framing the CMA approach to accommodating freedom of conscience and religion, which likely explains why it fails to consider direct access models or other methods of accommodation.
- VI.7 The bias in favour of mandatory referral becomes particularly evident in Schedule B, which considers only compulsory referral as a means of reconciling freedom of conscience and access to services. Further, the structural bias is reflected and reinforced by numerous erroneous and substantially misleading statements (V.2 - V.10).
- VI.8 All of this is consistent with an activist mindset that places the highest priority on making euthanasia and assisted suicide readily available, and, to that end, is willing to suppress or subordinate fundamental freedoms of conscience and religion. That appears to explain why the title of the principle dealing with physician freedom of conscience has been designed to minimize the constitutional priority of freedoms of conscience and religion and the legal obligation to accommodate them (IV.1.2.2).

VII. Project Recommendations

- VII.1 Despite the bias apparent in the draft framework, it should be possible to reconcile respect for the fundamental freedoms of physicians and demands for access to morally contested services. This might be done within the framework proposed in the "Process map for decision-making" through the practice of disclosure and patient-initiated transfers of care, supplemented by structural and administrative arrangements facilitating direct access by patients to the euthanasia/assisted suicide pathway. Such solutions would be consistent with the approach taken by Mr. Justice Beetz in *Morgentaler*, which was unanimously affirmed in the *Carter* ruling.
- VII.2 In conjunction with the reconciliation suggested in VII.1, physicians unwilling to provide a procedure for reasons of conscience or religion could respond to patient demands for access to services by choosing one of the following five alternatives. The choice would depend upon the physicians' evaluation of their moral or ethical responsibilities in each case. None of the options should be imposed by state or professional authorities:
- a) by providing a formal referral; or
 - b) by arranging for a transfer of care to another physician; or
 - c) by providing contact information for someone who is able to provide the service or procedure; or
 - d) by providing contact information for an agency or organization that facilitates the service or procedure; or

e) by providing non-directive, non-selective information that will facilitate patient contact with other physicians, health care workers or sources of information about the services being sought by the patient.

- VII.3 The provision of information sufficient to satisfy the requirement of informed medical decision-making is presumed. However, in the case of (a) or (b), it may be acceptable to leave this responsibility to the physician providing the procedure or taking over the care of the patient.
- VII.4 Particularly in view of the bias evident in the document and the caveat added concerning the interpretation of fundamental principles, the wording of (e) must be sufficiently clear *in itself* to prevent it from being understood to require objecting physicians to become part of (participate in) a chain of causation culminating in a morally contested procedure. In addition, the original wording of the principle "solidarity" should be restored and reference to "abandonment" removed.

Notes

1. *Carter v. Canada (Attorney General)*, 2015 SCC 5, online: <<https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>>.
2. Department of Justice Canada. Government of Canada establishes external panel on options for a legislative response to *Carter v. Canada*: panel to consult with stakeholders and all Canadians; 2015 Jul 17 [cited 2022 Oct 10]. Available from: <https://www.globenewswire.com/en/news-release/2015/07/17/1165062/0/en/Government-of-Canada-Establishes-External-Panel-on-Options-for-a-Legislative-Response-to-Carter-v-Canada.html>
3. A Canadian approach to physician assisted dying: a CMA member dialogue (CMA on-line consultation). Blackmer J. Reply ca. 2015 July 05, re: Principles based approach to assisted dying.
4. Canadian Medical Association. 2015 CMA General Council, Strategic questions and issues for discussion: strategic session 2 - principles-based approach to assisted dying in Canada (Tuesday 25 August 2015 – 9 to 10:30 am) [Internet] Ottawa: CMA; 2015 Aug [cited 2015 Aug 22]. Available from: <https://www.consciencelaws.org/archive/documents/cma-cmaj/strategic-questions-issues-ss2-e.pdf>
5. Canadian Cancer Society. Palliative Care: Caring for Life [Internet] Montreal: CCC; c2014 [cited 2022 Oct 10]. Available from: <https://web.archive.org/web/20151120142013/https://www.cancer.ca/~media/cancer.ca/QC/get-involved/take-action/Advocacy/Palliative-care-2015.pdf>
6. Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, Willems DL, van der Maas PJ, van der wal G., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands." *N Engl J Med* 2000; 342:551-556 February 24, 2000.

7. Kirkey S. Unacceptable to force doctors to participate in assisted dying against their conscience: CMA head. National Post [Internet]. 2015 Mar 15 [cited 2022 Oct 10]. Available from:
<https://nationalpost.com/news/canada/unacceptable-to-force-doctors-to-participate-in-assisted-dying-against-their-conscience-cma-head>
8. The Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act. Ethical Perspectives [Internet] 2002 [cited 2022 Oct 10] 9(2-3):176-181. Available from:
https://ethical-perspectives.be/page.php?FILE=ep_issue&ID=58
9. Royal Dutch Medical Association (KNMG). Euthanasia in the Netherlands [Internet] Utrecht: KNMG; c2015 [cited 2022 Oct 10]. Available from:
<https://web.archive.org/web/20150201193050/http://knmg.artsennet.nl/Dossiers-9/Dossiers-thematrefoord/Levenseinde/Euthanasia-in-the-Netherlands-1.htm>
10. Grand Duchy of Luxembourg, Ministry of Health, Ministry of Social Security. Euthanasia and Assisted Suicide: Law of 16 March, 2009 - 25 Questions, 25 Answers[Internet]. Luxembourg: Ministries of Health/Social Security; 2010 Jun [cited 2022 Oct 11]; Appendix 1: Law of 16 March, 2009 on euthanasia and assisted suicide. Available from:
<https://sante.public.lu/dam-assets/fr/publications/e/euthanasie-assistance-suicide-questions-reponses-fr-de-pt-en/euthanasie-assistance-suicide-questions-en.pdf>
11. Kidd D (Trans). Belgian Act on Euthanasia of May 28, 2002. Ethical Perspectives [Internet] 2002 [cited 2022 Oct 11] 9(2-3):182-188. Available from:
<http://eol.law.dal.ca/wp-content/uploads/2015/06/Euthanasia-Act.pdf>
12. *Death with Dignity Act*, Vol 3 Or RS tit 13 c10 §127.885-sect;4.01, 5(d)(B)iii (2021). Available from:
<https://law.justia.com/codes/oregon/2021/volume-03/chapter-127/section-127-885/>
13. *Death with Dignity Act*, Wash RC tit 70 c70.245 §70.190(2)d(ii)C (2021). Available from:
<http://app.leg.wa.gov/rcw/default.aspx?cite=70.245.190>
14. *Patient Choice at the End of Life*, Vt S tit 18 c113 §5283.a(7). Available from:
<http://legislature.vermont.gov/statutes/fullchapter/18/113>
15. Murphy S. CBC interviewer fails to ask tough questions [Internet]. Powell River, BC: Protection of Conscience Project 2015 Jan 6; [cited 2022 Oct 11]. Available from:
<https://news.consciencelaws.org/?p=5480>
16. *Carter v. Canada (Attorney General)* 2012 BCSC 886 (CanLII) at para 866e, online:
<<https://www.canlii.org/en/bc/bcsc/doc/2012/2012bcsc886/2012bcsc886.html>>.
17. *Ibid* at para 120-129.

18. *Ibid* at para 290-292, 343-348.
19. *Ibid* at para 881.
20. *Ibid* at para 311.
21. *R. v. Morgentaler* [1988] 1 SCR 30 at p 95, online:
<<http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do>>.
22. *Criminal Code*, RSC 1985, c C-46, s 287(4)a, online:
<<https://laws-lois.justice.gc.ca/eng/acts/C-46/section-287-20030101.html>>.

APPENDIX “A”
CMA Draft Framework