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To kill — or not to kill? That is the question.

An answer for a Dying With Dignity clinical advisor

Sean Murphy, Administrator
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> I just can't understand why as learned as you are, you tenaciously use the verb KILL to refer to MAD. You cannot ignore that this verb requires a non-consenting victim. It makes of you a malicious pro-lifer who does not mind lying. MAD must be requested !
>
> Camus wrote: «To misname things amount to adding to the world's misery»...in La Pléiade, Oeuvres complètes p. 908.

This message was left for the Project Administrator by a member of the Clinicians' Advisory Council of Dying With Dignity Canada (DWD) after he/she had downloaded several papers from the Administrator's Academia web page.

The downloaded papers do not challenge the legalization of euthanasia and assisted suicide (EAS). The substantive morality of the procedures and their legalization is outside the scope of Project advocacy. The papers simply defend practitioners unwilling to be parties to killing their patients by providing or facilitating EAS services.

Unfortunately, the DWD clinical advisor was exasperated by the description of euthanasia and assisted suicide as "killing." This, he/she exclaims, is a malicious lie that adds to the world's misery.

Such a *cri de cœur* calls for a thoughtful discussion of the question it raises.

Does providing euthanasia and assisted suicide entail killing — or does it not?

In answering the question, we first consider what EAS practitioners actually do when they provide the service.

Euthanasia and assisted suicide practice in Canada

Euthanasia is achieved by deliberate intravenous administration of drugs intended to induce coma, cause respiratory arrest and death by anoxia (asphyxiation).[1]

Practitioner assisted suicide (very rare in Canada) entails deliberate oral self-administration of a combination of prescribed drugs intended to cause death by the same means. EAS practitioners prescribe the drugs and teach patients how to ingest them so as to ensure that death ensues as quickly as possible.[2]

Both procedures are designed to cause the patient's death, but assisted suicide is not as reliably fatal as euthanasia. If the self-administered dose seems

ineffective after a certain time, EAS practitioners are advised to administer lethal drugs intravenously "to ensure death as an outcome."[3] They consider the procedures unsuccessful if the patient does not die.[2,3,4] While patients may eventually die from an underlying condition, they will not die at the appointed time unless lethal drugs are administered.

Dr. Marcel Boisvert, now one of DWD Canada's clinical advisors,[5] understands this. Arguing for legalization of euthanasia in 2010, he wrote, "When we stand up to leave after spending an hour at a dying patient's side, we need to remember that, in that day, the patient faces another 23 hours of this existence and is already anticipating the suffering that the next day will bring."[6]

Unless the physician causes the death of the patient before standing up to leave.

And that is the point. Administering a drug that causes the death of a patient kills the patient.

The meaning of "kill"

To "kill" is to cause death — period.

Doing something intended to cause death and that does cause death is killing, and consent does not enter into the definition.[7]

For example, Michael Wade Nance, a convicted murderer in Georgia, has asked to be executed by firing squad rather than lethal injection.[8] If his request is granted, he will be killed with bullets instead of drugs, but his consent to be shot by firing squad will not convert his execution into something other than killing.

Likewise, in *Carter v. Canada (Attorney General)* the Supreme Court of Canada ruled that people should be allowed to consent to having death inflicted upon them in some circumstances, but it did not change the meaning of "killing," and it left intact the definitions of homicide and suicide.[9] It is essential to understand these terms because they correspond to the two forms of "medical aid in dying" — euthanasia and assisted suicide.[10]

Homicide and suicide

To commit homicide is to directly or indirectly cause the death of a human being:[11] that is, to kill a human being.[12] There are two kinds of homicide. "Culpable" homicide (eg., a contract killing) is blameworthy and punishable as a criminal offence; non-culpable homicide (eg. killing in self-defence) is not blameworthy and not an offence.[13]

The *Carter* decision and subsequent *Criminal Code* amendments created a new category of non-culpable homicide: directly killing a patient by euthanasia[14,15] That is why practitioners who kill patients by lethal injection in accordance with the law commit homicide, but do not commit murder. Consent by the patient killed is relevant to the distinction between culpable and non-culpable homicide, but (*contra* the exasperated DWD clinical advisor) not to a distinction between killing and not killing.[16,17]

"Suicide" means wilfully causing one's own death — killing oneself.[18,19] Since the definition of "medical assistance in dying" includes helping patients to kill themselves,[20] the *Criminal Code* was amended to permit practitioner assisted suicide. In effect, there are now culpable and non-culpable

forms of assisted suicide, though consent by the patient assisted is not relevant to this distinction.

Carter and killing

To repeat: the Supreme Court did not rule that inflicting death by lethal injection is not killing, nor that helping patients to cause their own deaths is not helping them to kill themselves. It decided that medical practitioners should be allowed to commit homicide and assist with suicide in certain circumstances: that is, to kill patients and to help them kill themselves. This was acknowledged in later remarks by Mr. Justice Moldaver, one of the nine judges who wrote the *Carter* decision.

> Here we are saying that a doctor can actually take an active part in injecting someone, for example, and killing them. . . I see a difference between that and saying, "Okay, we're going to stop the life support, and let the patient die the, the natural death."[21]

Catholic Archbishop Thomas Cardinal Collins of Toronto, speaking against euthanasia and assisted suicide, said the same thing about two weeks later:

> Death comes to us all, and so patients are fully justified in refusing burdensome and disproportionate treatment that only prolongs the inevitable process of dying. But there is an absolute difference between dying and being killed.[22]

Justice Moldaver and Cardinal Collins agreed that patients are killed by "medical assistance in dying." They disagreed about whether or not killing patients could be justified. The *Carter* decision indicates that Justice Moldaver believed that it could. But, knowing the decision he had approved would allow practitioners to "purposefully and deliberately take someone's life with impunity,"[23] he was especially candid about the importance of safeguards.

> When Parliament authorizes someone to kill somebody, they might want judicial approval first. . . They might want to put in measures that ensure so far as possible that we are not killing people who really ought not to be killed.[24]

Justice Moldaver's comments confirm the preceding analysis and the answer to complaint by the DWD clinical advisor. The term "killing" correctly describes "medical assistance in dying" (euthanasia and assisted suicide). The DWD advisor is mistaken in believing lack of consent is an essential element in the act of killing, and his/her assertion that the Project "*tenaciously* uses the verb kill" is overstated. Its use of the term is merely accurate and consistent.

However, while the DWD advisor's confusion about the meaning of killing probably explains much of his/her annoyance, something else may be irritating him/her. Even though it is accurate to say that EAS practitioners kill their patients, he/she may believe it is uncharitable, unnecessary and inflammatory to persistently draw attention to the fact. After all, euthanasia and assisted suicide within the parameters set by *Carter* are legal and publicly funded. Observing that these procedures kill patients cannot possibly affect that, but may adversely affect collegial relations among health care practitioners.

"Killing" in public and professional discourse

The term "killing" cannot be avoided in public and professional disputes about morally contested procedures that involve killing because the disputes typically arise from disagreement about the acceptability of killing. Moreover, the disagreement is almost never about the act of killing *per se*, but about justification for killing.[7] For example, vegetarians who oppose killing animals for food do not oppose killing plants for food; they consider killing animals unjustified *because* X, but killing plants justified *because* Y.

Further, disagreements about justification for killing may involve a number of considerations. One might oppose capital punishment because one believes it is wrong to kill a human being except as unintended consequence of self-defence, or because of the risk of wrongful conviction, or because one believes it is dangerous to authorize the state to kill people, or because one believes methods of execution are inhumane, or for all of these reasons.

Finally, even if one decides (as the Supreme Court did in *Carter*) that killing human beings need not be limited to cases of self-defence, that the kind of homicide contemplated is justifiable, the method of killing humane, and the risks of permitting it acceptable, other issues remain. Four are particularly relevant to ongoing controversies in the health care sector about euthanasia, assisted suicide and freedom of conscience.

First, it appears that most medical practitioners have an aversion to killing people. This cannot be ignored by EAS advocates, especially if they are concerned (as they ought to be) about the welfare of EAS practitioners.

Second, overcoming practitioners' reluctance to kill by transforming killing from a harm to a benefit has created serious problems for objecting physicians and subverts a critical safeguard for vulnerable patients identified by EAS advocates before legalization.

Third, participating in homicide and suicide may be considered incompatible with other obligations and relationships, even if one considers killing or helping to kill people otherwise justified.

Fourth, the imposition of a state-enforced obligation to participate in or facilitate homicide or suicide would violate the fundamental freedoms of those opposed to doing so, but it also has wider civil liberties implications.

Considering each of these issues at somewhat greater length will help to explain why it is not only reasonable but sometimes essential for the Project to use words like "kill" and "homicide" when advocating the protection of freedom of conscience in health care.

Aversion to killing

A number of EAS practitioners have emphasized how much personal satisfaction they get from providing the service, describing it as "very rewarding"[25] and extolling death by lethal infusion as "dignified,"[26] "peaceful"[27] and "really, really beautiful."[28] Some Belgian EAS practitioners have made similar comments.[29] However, the attitudes and inclinations of committed EAS practitioners are not necessarily characteristic of physicians generally. One must also consider the very different reactions of physicians who provided euthanasia and later regretted it.

By February, 2017, eight months after legalization, 24 Ontario practitioners who had volunteered to provide euthanasia/assisted suicide had permanently withdrawn; 30 had suspended participation. The CMA's Dr. Jeff Blackmer acknowledged that this was occurring "at a systemic level." He said some were firmly convinced of the value of the work, but others "go through one experience and it's just overwhelming, it's too difficult, and those are the ones who say,'take my name off the list. I can't do any more.'"[30]

Within the first year of legalization, Toronto oncological psychiatrist Dr. Madeliene Li saw physicians accustomed to treating dying patients break down after providing euthanasia.

"We are actively ending a life," she said. "And it's very new to us."[28]

These difficulties are consistent with reports from Belgium and the Netherlands.[31],[32],[33],[34] Dutch EAS practitioners are given a day off with pay after each lethal infusion so that they can "take care of themselves emotionally."[35]

The difficulties may also explain why, even where euthanasia or assisted suicide have been legal for years, only a minority of practitioners — sometimes a very small minority — personally provide the services. 13 years after legalization less than 14% of Belgian physicians were providing the service.[36] 12 years after formal legalization in the Netherlands the proportion of all physicians providing euthanasia was still less than 10%.[37] Less than 1% of all physicians prescribe assisted suicide drugs in Washington state[38] and Oregon,[39] though assisted suicide has been legal in those jurisdictions for nine and almost 20 years respectively. These are maximum estimates; actual numbers could be much lower, because one practitioner may be responsible for a number of cases.[40]

Thus, even before considering the position of those who object to euthanasia and assisted suicide for reasons of conscience, it seems that, while some practitioners are willing to kill another human being and can do so without suffering any apparent adverse effects, a much larger number cannot do so without experiencing considerable stress, and a certain number are unable to kill or continue killing.

It is unrealistic to discuss problems of access to EAS services, recruitment of EAS practitioners or a purported "problem" of conscientious objection while ignoring stress experienced by practitioners who kill another human being[41],[42] and what appears to be a frequent if not general aversion to the practice among health care personnel.[43]

Overcoming aversion to killing

Ironically, Joseph Arvay, chief counsel for the *Carter* appellants, lauded physician's unwillingness to harm their patients as an outstanding virtue that made them ideal euthanasia practitioners.

"[I]t is an irrefutable truth," he told the Supreme Court of Canada, "that all doctors believe it is their professional and ethical duty to do no harm."

> Which means, in almost every case, that they will want to help their patients live, not die. It is for the very reason that we advocate only physician assisted dying and not any kind of assisted dying because we know physicians will be reluctant gatekeepers, and only agree to it as a last resort.[44]

The logic of this argument depends upon the premise that killing is harmful, so that physicians would

be willing to kill their patients only if the alternative were worse than death. But Hamlet's question — "To be or not to be?" — is a not a medical question or even an ethical question. It is a metaphysical or philosophical question, the answer to which is preliminary to ethical reflection, and, in practice, entirely subjective. Thus, the claim that the ethic of "do no harm" makes physicians the best people to whom to entrust killing their patients was a recipe for continuing conflict between patients and physicians and within health care professions.

Physicians' unwillingness to kill, extolled by EAS advocates before *Carter* as a critical safeguard for vulnerable patients, is now seen as an impediment to euthanasia and assisted suicide. More important, the procedures are now widely accepted as medical treatment and health care. For example, the Canadian Medical Association (CMA) classifies them as "*therapeutic* service[s]"[45] and "legally permissible *medical* service[s]."[46]

The practical effect of this is to make participation in killing patients normative for health care practitioners, and this has had a significant adverse impact on objecting physicians. Writing in the *World Medical Journal*, seven Canadian physicians note that refusing to provide or arrange for euthanasia and assisted suicide services for legally eligible patients has become "an exception requiring justification or excuse." Hence, discussion in Canada is now largely about "whether or under what circumstances physicians and institutions should be allowed to refuse to provide or collaborate in homicide and suicide."

"For refusing to collaborate in killing our patients," they write, "many of us now risk discipline and expulsion from the medical profession," are accused of human rights violations and "even called bigots."[47]

And while EAS supporters argue that euthanasia and assisted suicide really do benefit patients and should be considered acceptable therapeutic services or medical treatment, this demolishes Joseph Arvay's argument that the ethic "do no harm" provides an effective safeguard for vulnerable patients. As noted above, that argument depends upon the premise that killing is harmful. But if killing is beneficial, and (*per* Dr. Boisvert) "providing access to euthanasia has been shown to be an effective way of warding off suffering and extending life,"[6] the "do not harm" ethic cannot possibly function as safeguard to ensure that "we are not killing people who really ought not to be killed."[24]

This final observation is relevant to the discussion of protecting practitioners who refuse to collaborate in killing patients. It demonstrates that their refusal is consistent with an ethic lauded by EAS advocates before legalization, and should not be dismissed as failing to address the interests of vulnerable patients.

Conflicting obligations and relationships

Even if one agrees that euthanasia and assisted suicide are acceptable and beneficial, it does not follow that the services must or should be provided by health care practitioners. Thomas Cavanaugh, for example, offers a succinct argument that the act of killing is wholly incompatible with fundamental ethical obligations that define the profession of medicine. Thus, when medical techniques are used for killing, those responsible should not call upon physicians to kill. Citing capital punishment as an example, he suggests "the training of competent, but not medical, executioners."[48] The same position is taken by the World Medical Association.[49,50]

In contrast, Joseph Arvay argued in the Supreme Court that "physician-assisted dying" — killing patients and helping them to kill themselves — is not only "medical treatment," but "at the core of health care,"[51] a position not contradicted or even qualified by the Canadian Medical Association in its intervention in the appeal. Instead, it told the Court that the first principles of medical ethics support both physicians who provide and those who refuse to provide euthanasia and assisted suicide , and that each response is "defensible on the basis of established medical ethical considerations and compassion."[52]

> It is acknowledged that just moral and ethical arguments form the basis of arguments that both support and deny assisted death. The CMA accepts that, in the face of such diverse opinion, based on individuals' consciences, it would not be appropriate for it to seek to impose or advocate for a single standard for the medical profession.[53]

However, after its intervention, but before the Supreme Court of Canada ruled, the Canadian Medical Association did effectively establish a single standard by approving euthanasia and assisted suicide as end of life care and promising to support patient access to the services.[54] Further, within months of the *Carter* decision, the CMA leadership appears to have thought that killing patients and helping them kill themselves is an *ethical* obligation binding the Canadian medical profession as a whole,[55] even though the Supreme Court had not made it a *legal* obligation.[56]

For example, in developing a policy framework on euthanasia and assisted suicide in 2015, the CMA leadership asked delegates at the annual General Council how the refusal of physicians to "participate" in the services could be reconciled "with their *obligation to ensure equitable access*"[57] — an obligation repudiated by objecting physicians.

Subsequent CMA statements and remarks by CMA officials reflect a different view, rejecting the idea that "the profession as a whole" should be responsible for connecting patients with EAS practitioners[58] and placing the obligation to ensure access on the federal government,[56] society[59] and health systems[46] rather than the medical profession. However, by defining euthanasia and assisted suicide as therapeutic and medical services the CMA has made it very difficult to argue that the medical professionals have no collective or individual obligation to provide them. As the *World Medical Journal* article cited above observes, this has left objecting Canadian practitioners in the position of having to justify their refusal to participate in killing their patients.

Freedom of conscience vs. authoritarianism

We have seen that protecting the exercise of freedom of conscience by objecting physicians is consistent with the goal of ensuring that (*per* Justice Moldaver) "[physicians] are not killing [patients] who really ought not to be killed." And it should be obvious that the imposition of a state-enforced obligation to participate in or facilitate homicide or suicide would violate the fundamental freedoms of those opposed to doing so.

More than this, however, it should be obvious that if the state can force unwilling people to kill or help to arrange for the killing of other people there would seem to be nothing that the state cannot demand of its citizens. This would promote the development of dangerous forms of authoritarian and totalitarian government: ultimately more effective and deep-rooted, perhaps, within a democratic framework than they ever have been in dictatorial regimes.

But that is not obvious if it is forbidden to call euthanasia and assisted suicide "killing," and obligatory to describe them as medical services.

Hence, in reading the judgement of the Ontario Court of Appeal in *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario* it is not obvious that the judges have authorized the state to compel unwilling people to become parties to killing other people, and punish them if they refuse. That is because the Court uncritically accepted the premise that euthanasia and assisted suicide are health care, so the words "kill"and "homicide"never appear.[60] The learned judges understood the case before them to be about the problem of physicians who refuse to provide medical procedures, not about whether a constitutional guarantee of freedom of conscience ought to prevent the state from forcing unwilling citizens to be parties to homicide.

Camus meets Orwell

The Project will continue to refer to killing, homicide and helping people to kill themselves when discussing euthanasia, assisted suicide and "medical assistance in dying." That does not violate Camus' injunction by misnaming the procedures, and using the terms is often necessary to provide an adequate defence of freedom of conscience.

It does not follow that the terms must always be used, even by objecting practitioners. Many objecting practitioners will, quite properly, prefer "medical assistance in dying" when attempting to engage respectfully and thoughtfully with patients, colleagues and others who are more familiar or comfortable with the legal designation. However, when objectors resist pressure to acquiesce, affirm, support, or collaborate in the procedures, they are entitled to explain that they are averse to killing patients, argue that killing is not medical treatment and violates medical ethics, and insist that they refuse to be parties to "killing people who really ought not to be killed."

And EAS practitioners and supporters are free to disagree and produce evidence to the contrary.

But should influential people or persons in authority attempt to suppress the words needed by Supreme Court judges and objecting practitioners to express their meaning, those interested in the protection of fundamental freedoms would do well remember not just Camus, but Orwell.

Discussing the principles of Newspeak, a language "devised to meet the ideological needs of Ingsoc, or English Socialism"in the blighted world he imagined in *Nineteen Eighty-Four*, Orwell wrote:

> The purpose of Newspeak was not only to provide a medium of expression for the world-view and mental habits proper to the devotees of Ingsoc, but to make all other modes of thought impossible. It was intended that when Newspeak had been adopted once and for all. . . a heretical thought — that is, a thought diverging from the principles of Ingsoc — should be literally unthinkable, at least so far as thought is dependent on words. . .[61]

Make it impossible even to think of medical assistance in dying as anything other than a medical procedure, make it impossible even to think that it involves killing, and "barriers" and "impediments" to access to EAS services will certainly disappear.

And so will freedom of conscience, religion, thought, opinion, belief and expression.

Notes

1. *Medical Aid in Dying: 11/2015 Practice Guidelines* (Montreal: Collège des médecins du Québec, 2015) at 42–48,

2. Harty C, Chaput AJ, Buna D, Trouton K, Naik VN. The Oral MAiD Option in Canada, Part 2: Processes for Providing — Review and Recommendations [Internet]. Canadian Association of MAiD Assessors and Providers; 2018 Apr 18 [cited 2020 Jan 19]. 17p. Available from: https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Process.pdf.

3. Harty C, Chaput AJ, Buna D, Trouton K, & Naik VN. The Oral MAiD Option in Canada, Part 1: Medication Protocols [Internet]. Canadian Association of MAiD Assessors and Providers; 2018 Apr 18 [cited 2020 Jan 21]. 27 p. at 6. Available from: https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf.

4. Bakewell, F, Naik VN. Complications with Medical Assistance in Dying (MAID) in the Community in Canada: Review and Recommendations [Internet]. Canadian Association of MAiD Assessors and Providers; 2019 Mar 28 [cited 2020 Jan 19] 13p. Available from: https://camapcanada.ca/wp-content/uploads/2019/05/Failed-MAID-in-Community-FINAL-CAMAP-Revised.pdf.

5. Dying With Dignity Canada: Clinicians Advisory Council | Dr. Marcel Boisvert [Internet]. Dying With Dignity Canada; 2019 [cited 2020 Jan 20]. Available from: https://www.dyingwithdignity.ca/dr_marcel_boisvert.

6. Boisvert M. Should physicians be open to euthanasia? YES [Internet]. Canadian Family Physician. 2010 Apr [cited 2020 Jan 20]; 56 (4): 320-322. Available from: https://www.cfp.ca/content/56/4/320.full.

7. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 7th ed. New York: Oxford University Press; 2013. 459 p. at 175.

8. Adone D. A Georgia death row inmate has asked to be executed by firing squad [Internet]. CNN; 2020 Jan 11 [cited 2020 Jan 20]. Available from: https://www.cnn.com/2020/01/11/us/georgia-inmate-firing-squad/index.html.

9. Carter v. Canada (Attorney General), 2015 SCC 5 [Internet]. Ottawa: Supreme Court of Canada; 2020 Jan 21 [cited 2020 Jan 21]. Available from: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do.

10. The Department of Justice lawyer told a parliamentary committee considering amendments to the *Criminal Code* that they would have to consider "an exemption for conduct that is otherwise criminal, namely, the crimes of aiding suicide and murder, which correspond to the two different types of physician-assisted dying." Parliament of Canada: Special Joint Committee on Physician Assisted Dying, Meeting No. 2 (18 January, 2016): Department of Justice - Joanne

Klineberg (Edited Video) [Internet]. Powell River, BC: Protection of Conscience Project; 2017 Feb 16 [cited 2020 Jan 21]. 0:0:0 to 0:0:31. Available from: https://www.youtube.com/watch?v=YEShYqC4INY&feature=emb_logo.

11. Criminal Code, s 222(1) [Internet]. Ottawa: Minister of Justice; 2020 Jan 08 [cited 2020 Jan 21]. Available from: https://laws-lois.justice.gc.ca/PDF/C-46.pdf#enID0EZSEK.

12. The Criminal Code uses the term in eight sections but does not define it. The Supreme Court of Canada routinely assumes that "killing" means "causing death." See, for example, R v. Droste [1984] 1 S.C.R. 208 R. v. Nette, [2001] 3 S.C.R. 488, 2001 SCC 78.

13. Criminal Code, s 222(2) and (3) [Internet]. Ottawa: Minister of Justice; 2020 Jan 08 [cited 2020 Jan 21]. Available from; https://laws-lois.justice.gc.ca/PDF/C-46.pdf#enID0EZSEK.

14. Criminal Code, s 227(1) and (2) [Internet]. Ottawa: Minister of Justice; 2020 Jan 08 [cited 2020 Jan 21]. Available from; https://laws-lois.justice.gc.ca/PDF/C-46.pdf#page=341.

15. Criminal Code, s 241.1(a) [Internet]. Ottawa: Minister of Justice; 2020 Jan 08 [cited 2020 Jan 21]. Available from: https://laws-lois.justice.gc.ca/PDF/C-46.pdf#page=349.

16. "No person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given." Criminal Code, s 14 [Internet]. Ottawa: Minister of Justice; 2020 Jan 08 [cited 2020 Jan 21]. Available from: https://laws-lois.justice.gc.ca/PDF/C-46.pdf#page=103.

17. In *Carter*, the Supreme Court of Canada struck down section 14 to the extent that it prohibits euthanasia and assisted suicide on the terms specified by the Court. Parliament re-enacted the section, but the limitation set by the Supreme Court remains in effect. Thus, section 14 does not mean exactly what it says.

18. Edwin S. Shneidman, a "father of contemporary suicidology," noted that the word "suicide" came into the English language only in the 17th century, prior to which the act was described by terms like 'self-destruction," "self-killing" and "self-slaughter." Shneidman ES. Suicide. Encyclopaedia Britannica. Chicago: Encyclopaedia Britannica Inc; 1973.

19. Blackstone called it "self-murder." Blackstone W. Commentaries on the Laws of England. 12th ed. Vol. IV, Of Public Wrongs. London: A. Strahan and W. Woodfall; 1795.443 p at 188-189.

20. Criminal Code s 241.1(b) [Internet]. Ottawa: Minister of Justice; 2020 Jan 08 [cited 2020 Jan 21]. Available from: https://laws-lois.justice.gc.ca/PDF/C-46.pdf#page=349.

21. Supreme Court of Canada, 35591, Lee Carter, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave). Webcast of the Hearing on 2016-01-16 [Internet]. Supreme Court of Canada; 2018 Jan 22 [cited 2020 Jan 21] 1:13:07 to 1:13-30.

https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2016%2f2016-01-11--35591&date=2016-01-11&fp=n&audio=n

22. Parliament of Canada: Special Joint Committee on Physician Assisted Dying, Meeting No. 11 (3 January, 2016): Coalition for HealthCARE and Conscience. Archbishop Thomas Cardinal Collins (Edited Video) [Internet]. Powell River, BC: Protection of Conscience Project; 2017 Feb 20 [cited 2020 Jan 21]; 0:1:50 to 0:2:10. Available from: https://www.youtube.com/watch?time_continue=36&v=F7Oml3_VmQ8&feature=emb_logo

23. Supreme Court of Canada, 35591, Lee Carter, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave). Webcast of the Hearing on 2016-01-16 [Internet]. Supreme Court of Canada; 2018 Jan 22 [cited 2020 Jan 21] 1:25:40 to 1:25:45. https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2016%2f2016-01-11--35591&date=2016-01-11&fp=n&audio=n

24. Supreme Court of Canada, 35591, Lee Carter, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave). Webcast of the Hearing on 2016-01-16 [Internet]. Supreme Court of Canada; 2018 Jan 22 [cited 2020 Jan 21] 1:15:36 to 1:16:03. https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2016%2f2016-01-11--35591&date=2016-01-11&fp=n&audio=n

25. Davie E. Doctors raise alarm about long delays in getting paid for medically assisted deaths [Internet] CBC News; 2017 Jul 4 [cited 2020 Jan 23]. Available from: http://www.cbc.ca/news/canada/nova-scotia/doctors-raise-alarm-about-long-delays-in-getting-paid-for-medically-assisted-deaths-1.4189468.

26. Lupton A. Meet 1 of only 2 London doctors willing to help their patients die [Internet]. CBC News; 2017 Jul 4 [cited 2020 Jan 23]. Available from: http://www.cbc.ca/news/canada/london/doctor-anderson-medically-assisted-dying-1.4186223.

27. Gulli C. Assisted death is the new pro-choice: When does life—and a doctor's duty—begin and end? Assisted dying is dredging up the big questions of the abortion debate, for better or worse [Internet]. Macleans; 2016 May 28 [cited 2020 Jan 23]. Available from http://www.macleans.ca/society/health/assisted-death-is-the-new-pro-choice/.

28. Hune-Brown N. How to End a Life [Internet]. Toronto Life; 2017 May 23 [cited 2020 Jan 23]. Available from: https://torontolife.com/city/life/doctors-assist-suicide-like-end-life/.

29. Bernheim JL, Distelmans W, Mullie A, Ashby MA. Questions and Answers on the Belgian Model of Integral End-of-Life Care: Experiment? Prototype?: "Eu-Euthanasia": The Close Historical, and Evidently Synergistic, Relationship Between Palliative Care and Euthanasia in Belgium: An Interview With a Doctor Involved in the Early Development of Both and Two of His Successors. J Bioethical Inquiry [Internet]. 2014 Aug 16 [cited 2020 Jan 23];11:507-529. doi:10.1007/s11673-014-9554-z. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4263821/pdf/11673_2014_Article_9554.pdf.

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