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Canadian/Royal Dutch Medical Association Proposed Change to WMA Policies
Euthanasia and Assisted Suicide

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Abstract

For decades, the World Medical Association (WMA) has held that euthanasia and physician assisted suicide are unethical and must be condemned by the medical profession, notwithstanding acceptance of the practices in some jurisdictions.

In 2015, the Canadian Medical Association (CMA) and Royal Dutch Medical Association (RDMA) argued that the World Medical Association should change this policy. The following year they submitted a proposal to the WMA Council setting out the changes they wished to see. After discussion, the proposal was withdrawn with a view to encouraging discussion of the subject among national associations. Four conferences subsequently held in WMA regions in Asia-Oceania, Latin America, Africa and Europe demonstrated overwhelming opposition to euthanasia and assisted suicide, and no appetite for the procedures outside Europe and the European diaspora. The subject is to be considered again at the 2018 WMA ethics conference in Iceland.

The CMA/RDMA have reintroduced the proposal with some revisions. It will be considered at the WMA Medical Ethics Committee meeting in October, 2018. As it is likely that the CMA and RDMA will continue to lobby for a change in WMA policy on euthanasia and assisted suicide, an associate WMA member asked the Protection of Conscience Project to review and comment on the CMA/RDMA proposals.

The Project does not take a position on the acceptability of euthanasia or assisted suicide. From the perspective of the Project, legalization of euthanasia or assisted suicide or a change of WMA policy against the procedures is of concern only to the extent that legalization or change threatens to disadvantage or punish physicians who refuse to do what they believe to be wrong.

The proposal's opening disclaimer of non-support for euthanasia and assisted suicide is meaningless rhetoric contradicted by other elements of the proposal. In particular, it recommends that physicians or other health care providers should perform euthanasia and assisted suicide where they are legal. If accepted, the C/RDMA proposal would be fully effective in encouraging legalization of euthanasia and assisted suicide and physician participation in both practices. Further, the proposal posits a right to euthanasia and

assisted suicide that is unrestricted with respect to eligibility criteria and other conditions under which they might be provided. For example, it does not limit provision of the procedures to terminal illness, does not preclude the procedures as a response to mental illness, disability, or chronic medical conditions, and does not require access to palliative care as a prerequisite. It does not limit provision of the services to adults: adolescents, children and infants are not excluded.

Legalization in accordance with the C/RDMA proposal would thus expose the overwhelming majority the world's physicians represented by WMA members to demands that could generate serious conflicts of conscience and ultimately place those unwilling to provide or cooperate in providing the services in serious professional jeopardy.

The protection of conscience provisions are unclear and fail to adequately consider the issue of complicity. They do not afford sufficient protection for objecting physicians, especially in light of the increased probability of conflict due to the virtually unrestricted scope of the proposal. The provisions are not well-grounded and internally inconsistent. Finally, they are contradicted by RDMA, thus bringing into question the credibility of the proposal as a whole.

Notwithstanding warnings that the WMA will "lose credibility or become "irrelevant" if it does not act quickly to change its policies, the duty to exercise due diligence is especially important when the power of the state is likely to be invoked against physicians who refuse to be parties to homicide and suicide. This has been demonstrated clearly in Canada, where the CMA acted precipitously and without adequate reflection or foresight in reversing its policy against euthanasia and assisted suicide.

The WMA should not change its policy on euthanasia and physician assisted suicide without first establishing a sound and robust policy to protect physician freedom of conscience. This cannot be accomplished within the narrow perspective afforded by controversies about particular morally contested procedures. The Project recommends, instead, a general, stand-alone policy on freedom of conscience based upon a broad and principled approach that recognizes that freedom of conscience serves the fundamental good and dignity of the physician as a human person, not merely professional autonomy or independence.

TABLE OF CONTENTS

Abstract 1

I. BACKGROUND 1
- I.1 The World Medical Association 1
- I.2 WMA policy on euthanasia and physician assisted suicide 1
- I.3 Minimum standard for changing WMA ethics policies 2
- I.5 Timeline for change 3
  - I.5.1 Standard policy change 3
  - I.5.2 Changing bylaws to effect policy change 4
- I.6 Changing policy in other national associations. 4

II. PROPOSALS FOR CHANGE 7
- II.1 Oslo: April, 2015 7
  - Policy revision survey 7
  - Ethics Committee meeting: reaffirm policies 7
  - Council meeting: physician assisted suicide policy discussed, reaffirmed 7
  - CMA implies withdrawal from WMA over physician assisted suicide 9
- II.2 Moscow: October, 2015 9
- II.3 Buenos Aires: April, 2016 10
- II.4 Taipei (October, 2016) 11

III. REGIONAL WMA CONFERENCES 13
- III.1 Summary 13
- III.2 Latin America: Rio De Janeiro (March, 2017) 13
- III.3 Oceania and Asia: Tokyo (September, 2017) 14
- III.4 Europe: Vatican City (November, 2017) 15
  - Overview 15
  - Canadian Medical Association representation 16
  - Euthanasia and assisted suicide 17
  - Protection of conscience 20
  - Euthanasia and the Nazi regime 20
- III.5 Africa: Abuja (February, 2018). 22

IV. MEETINGS AND NEW PROPOSALS 33
- IV.1 MEC and Council meetings (April, 2017) 33
- IV.2 MEC and Council meetings (October, 2017) 33
- IV.3 Canada and Netherlands on "assisted dying" in WM Journal (October, 2017) 33
  - Euthanasia in the Netherlands. 34
  - The Work of the Canadian Medical Association 35
- IV.4 MEC and Council meetings (April, 2018) 37
- IV.5 New proposal re: "Policy Consistency" (3 July, 2018) 37
- IV.6 CMA & RDMA introduce revised EAS proposal 38
  - Minor revisions 38
  - Rhetorical revisions 38
  - Rhetorical and substantive revisions. 39

Substantive revisions 39

V. 2018 WMA ETHICS CONFERENCE, ICELAND 45
V.1 Organizers 45
V.2 Programme 45
Wednesday 3. Oct. 45
Thursday 4. Oct. 46

VI. CONTENTS OF THE CMA/RDMA PROPOSAL 51
VI.1 Introduction 51
VI.2 Related WMA policies 51
VI.3 Preamble 51
VI.3.1 Irrelevant or uncontroversial assertions 51
VI.3.2 Rights claims 51
VI.3.3 Assertion of need 52
VI.3.4 Conflict between euthanasia/assisted suicide and medical practice 53
VI.3.5 Palliative care not a prerequisite for euthanasia/assisted suicide 54
VI.4 Recommendations 54
VI.4.3 The WMA does not support/does not condemn 54
VI.4.4 Physician freedom of conscience 56
VI.4.5 Palliative care 56

VII. ANALYSIS OF THE CMA/RDMA PROPOSAL 61
VII.1 Overview 61
VII.2 Foundational statement 61
VII.2.1 Rhetorical disclaimer 61
VII.2.2 Foundational statement applied to capital punishment 62
VII.2.3 Foundational statement applied to female genital mutilation . . 62
VII.2.4 Virtually unlimited and evolving criteria 63
VII.3 Palliative care 63
VII.4 Physician freedom of conscience 64
VII.4.1 Referral, participation and complicity 64
VII.4.2 The obligation to ensure access 65
VII.4.3 Commitment to euthanasia/assisted suicide, not conscience 65
VII.5 Arguments 66
VII.5.1 Introduction 66
VII.5.2 Rights claims 66
VII.5.3 Patient priority 67
VII.5.4 Moral/ethical uncertainty 67
VII.5.5 Pragmatism 68
VII.5.6 Lack of consensus 69
VII.5.7 Non-proliferation 69
VII.5.8 Proportional rarity 70
VII.5.9 Diversity and culture 71
VII.6 Conclusions 72
VII.6.1 Foundational statement, palliative care, protection of conscience 72

VII.6.2 Arguments 73

VIII. STRATEGY AND TACTICS 77
VIII.1 Strategy for change 77
VIII.2 Tactics 77
VIII.2.1 Incrementalism 77
VIII.2.2 From suicide to euthanasia 78
VIII.2.3 From “The WMA does not support” to physicians should perform 79
VIII.2.4 From “last resort” to optional treatment 79
VIII.3 The need for due diligence 79

IX. PROJECT RESPONSE. 85
IX.1 Preliminaries 85
IX.2 The issue 85
IX.3 Relevant considerations 85
IX.3.1 Most physicians refuse 85
IX.3.2 Physician obligation to provide or facilitate medical treatment 85
IX.3.3 Rights claims. 86
IX.3.4 Likelihood of conflict 86
IX.4 Response to the issue 87

X. PROJECT RECOMMENDATION 89
X.1 Conscience in the medical profession. 89
X.2 A broad and principled approach 89
X.3 Avoiding authoritarian "neutrality". 90
X.4 A stand-alone general protection of conscience policy. 90

APPENDIX "A" 93
WMA GENERAL ASSEMBLY AND POLICY DEVELOPMENT 93
Introduction 93
A1. General Assembly 93
General Assembly documents. 93
General Assembly rules of procedure 93
Voting in the General Assembly. 93
Delegate registration 94
A2. Policy Development 94
Submitting ideas for policy development 96
Accessing on-line WMA working documents, procedural guides, etc. 96
Joining committees 96

APPENDIX "B" 97
CMA APPROVAL OF EUTHANASIA AND ASSISTED SUICIDE. 97
B1. Canadian Medical Association (CMA) General Council (August, 2013) . . . 97
B2. CMA Board decides to shape the debate and the law. 97
The decision 97
Shaping the debate and the law: in brief. 98

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B3. CMA Board revises euthanasia and assisted suicide policy (December, 2013) 99
CMA studies euthanasia & assisted suicide (January-June, 2014) 99
CMA announces plan to intervene in Carter v. Canada (April, 2014) 100
B4. CMA applies for intervener status in Carter v. Canada (June, 2014) 101
B5. CMA Board resolution on euthanasia and assisted suicide (June-July, 2014) 102
B6. CMA General Council (August, 2014) 104
Briefing materials 104
Adoption of resolution on freedom of conscience (19 August, 2014) 105
B7. CMA officials comment (August-September, 2014) 106
B8. CMA intervention in *Carter v. Canada* 108
B9. CMA Board approves euthanasia and assisted suicide (December, 2014) 110
Policy against euthanasia and assisted suicide reversed 110
B10. Effects of the policy change 111
A blank cheque for the Supreme Court 111
A professional obligation to kill 111
A limit on refusing to kill 112
Other foreseeable unforeseen consequences 112
Physician freedom of conscience 114
B11. Postscript 114

APPENDIX "C" 123
2016 and 2018 CMA/RDMA PROPOSALS COMPARED 123

I. BACKGROUND

I.1 The World Medical Association

I.1.1 The World Medical Association (WMA) is comprised of 115 national medical associations (constituent members)[1] that are "broadly representative of the physicians in their countries," which are "not subject to, or controlled by, any office or agency of government."[2]

I.1.2 In addition, individual physicians may become associate members. The associate members form a group analogous to a national association. They may vote in an Annual Associate Members Meeting and, through their chosen representatives, participate (but apparently not vote) in the WMA General Assembly.[2] The associate members' group may also be consulted by standing committees and the WMA executive about policy development.

I.1.3 The WMA is organized in six regions: Africa, Asia, Europe, Latin America, North America and the Pacific.[3] Its working languages are English, Spanish and French.

I.1.4 The WMA Council is the executive of the organization, the members of which are elected every two years by the WMA General Assembly. Members of the Council are drawn from the six WMA regions.[3] The Council meets twice yearly, in the spring and in autumn. After the Council meeting in autumn, delegations from all constituent members assemble in the General Assembly, "the supreme decision-making body of the WMA."[4]

I.1.5 The WMA has three standing committees: Medical Ethics, Finance and Planning, and Socio-Medical Affairs.[3]

I.1.6 The Secretary General of the WMA is the chief executive officer of the organization and the head of the Secretariat, full time administrators in Ferney-Volataire France.[3]

I.1.7 The WMA General Assembly is the governing body of the Association, responsible for approving permanent WMA policy. It meets annually in the fall. The power of national associations is determined by the number of their members. Each association is permitted one vote for every 10,000 members, but must be present at the Assembly to vote; proxy votes are not allowed.[5] (See Appendix "A" for more information on the General Assembly and policy development.)

I.2 WMA policy on euthanasia and physician assisted suicide

I.2.1 The WMA issued a Declaration on Euthanasia in 1987, reaffirming it in 2005 and 2015:

> Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.[6]

I.2.2 The WMA Resolution on Euthanasia, originally adopted in 2002, was reaffirmed with a minor revision in 2013.[7] The Declaration and Resolution are now identical.

I.2.3 The WMA Statement on Physician Assisted Suicide was made in 1992 and reaffirmed in 2005 and 2015:

> Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical is a basic right of the patient, and the physician does not act unethically even if respecting such a wish results in the death of the patient.[8]

I.3 Minimum standard for changing WMA ethics policies

I.3.1 In order to ensure that its ethical policies reflect a consensus among its members, the WMA insists that new or revised ethics policies must be accepted by a vote of at least 75% in the General Assembly.[9]

I.3.2 This is a WMA bylaw[10] that can be changed by a 2/3 majority vote in the General Assembly, subject to the following conditions:

> The amendment must be received by the General Secretariat at least three months before the meeting at which it will be considered (apparently the Council meeting), though the Council may waive the limit.The amendment must be translated into the three WMA official languages and distributed to delegates before the (Council) meeting.The Council will transmit the amendment to the General Assembly with a recommendation for approval, non-approval or amendment.[11]

I.4 Advocacy for change

I.4.1 The Collectif des Médecins Contre L'Euthanasie (Physcians' Alliance Against Euthanasia), a Canadian physicians' organization, responding to Dr. Blackmer's tweets from the Vatican, criticized CMA attempts to change WMA policy:

> Why has Dr. Blackmer not taken a more balanced approach, which would truly reflect the unease felt by Canadian doctors about euthanasia, and show greater respect for physicians in other countries, whose views and circumstances are often very different from our own? How in short, can any spokesperson of the CMA legitimately presume to leverage the unwilling acquiescence of Canadian doctors, confronted with an unpleasant legal reality, into a positive mandate to promote the ethics of euthanasia on the international stage ?[12]

I.4.2 Notwithstanding such criticism, the efforts of the CMA and RDMA to change WMA policy (III.4.11), are understandable. Both associations and their members who provide or facilitate euthanasia or assisted suicide are currently denounced by WMA policy for unethical conduct. However, both associations believe that euthanasia and physician assisted suicide can be provided by physicians without contradicting the norms of medical ethics. Dr. Blackmer, responding to the Collectif, explains:

> [W]e support the rights of our members to decide whether or not to participate, based on their moral conscience and the parameters set forth in law and regulation. This is the position we use to advocate at the WMA and elsewhere. . .

> . . . It is up to individual physicians in Canada to decide whether or not they will provide this service, and many who opt not to will do so because they do not believe it is ethical, for religious reasons or otherwise.
>
> Given that the CMA supports fully the rights of physicians who do elect to participate, we would not then turn around and condemn them as being unethical when they do so. This is the official position of the CMA. It was arrived at as part of an open and transparent process and debate. It is the position we will continue to promote in Canada and internationally.
>
> The WMA has a policy that condemns any physician who participates in assisted dying as being, by definition, unethical. For obvious reasons, the CMA finds this position extremely problematic, since it labels hundreds of Canadian physicians as being unethical for participating in a legal activity with the support of their medical organizations.[13]

I.4.3 From the CMA/RDMA perspective, the WMA is mistaken in opposing the procedures and opposing physician participation. In these circumstances, their continued lobbying is to be expected, as they believe that WMA policy is unjust. They will likely be joined by other national medical associations that adopt similar positions. It is also likely that the CMA will repeat its threat to quit the WMA if the WMA does not withdraw its condemnation of euthanasia and assisted suicide; it is not inconceivable that the RDMA might do the same.

I.4.4 The tactic could be used to force change by threatening to split the WMA and deprive it of income and support from influential quarters. At this stage, such threats are likely tactical bluffs. The CMA derives considerable prestige and influence from its position as a founding member of the WMA in addition to beneficent, humanitarian and professional motivations for involvement. As long as it believes that it can succeed in changing WMA policy, it is doubtful that it would sacrifice all of these advantages and interests by quitting the organization.

I.5 Timeline for change

I.5.1 Standard policy change

I.5.1.1 Standard WMA procedures appear to preclude any change to WMA policy on euthanasia and assisted suicide at the General Assembly in the fall of 2018 (Appendix "A"). However, that does not prevent a motion being proposed to give some kind of direction to the Executive Council on the subject.

I.5.1.2 The CMA/RDMA proposal introduced in Buenos Aires in April, 2016 was withdrawn during the Council meeting, so it was not scrutinized by national associations (II.3). It was revised and reintroduced in July, 2018 and is scheduled for discussion at the Medical Ethics Committee meeting on 3 October, 2018.[14] Unless the meeting is rescheduled, it will precede the major ethics conference presentations on euthanasia and assisted suicide on 4 October (V.2). Hence, a decision by the Ethics Committee concerning the proposal will not be informed by the proceedings at the ethics

conference.

I.5.1.3 The Council and General Assembly will meet following the ethics conference. It seems likely that the CMA and RDMA their supporters will argue that the proposal should be circulated to national associations for comment, so that the document and feedback could be considered by the Medical Ethics Committee and Council at their regular meetings in April, 2019. Approval by the Council at that stage would mean that a change in policy could be debated was early as October at the 2019 WMA General Assembly in Tbilisi, Georgia.

I.5.1.4 A new proposal by a nominally unaffiliated group of associate members (IV.5) is arguably an ethics policy because it would allow exceptions to WMA ethics policies. It has yet to be approved by associate members. It if is approved in October, 2018, it is unlikely to be considered by the Medical Ethics Committee and Council before the spring of 2019. If it continues through the development process, it seems unlikely the proposal would reach the General Assembly before the fall of 2020.

I.5.2 Changing bylaws to effect policy change

I.5.2.1 Under current rules, the euthanasia and assisted suicide policies cannot be changed unless the change is approved by a vote of at least 75% in the annual General Assembly (I.3). Constituent members may have more than one vote, corresponding to the size of their associations: one vote per 10,000 members, but must be present to vote (I.1.7). Nonetheless, the results of the regional meetings indicate that the CMA and RDMA will find it very difficult to reverse the existing consensus against euthanasia and assisted suicide, which is essentially what would be necessary if their proposal (or a revised version of it) is to be approved.

I.5.2.2 If the consensus cannot be reversed, it remains possible to change the standard by which consensus is established. For example, it could be argued that new policies should be approved by a lesser percentage or simple majority; revisions to existing policies should be approved by a lesser percentage or simple majority; existing policies should be revoked if, upon challenge, they are not sustained by a vote of at least 75% (i.e., they no longer meet the standard of consensus).

I.5.2.3 Changes to the standard by which consensus on ethical policy is established can only be made by amending WMA bylaws (I.3.2). It is possible that such a change might be discussed formally or informally during the ethics conference in Iceland, and an amendment submitted to Council in time for the 2019 General Assembly. In that case, one would expect submission of the CMA/RDMA proposal to be delayed until 2020, as attempting to change both the bylaw and the euthanasia/assisted suicide policy at the same Assembly would be more likely to be identified as a coordinated tactic, potentially provoking opposition that could defeat both measures.

I.6 Changing policy in other national associations

I.6.1 While it is possible that the CMA and RDMA could attempt to change the WMA consensus standard in order to secure a change of euthanasia/assisted suicide policy, doing so would require more time, energy and resources and would have to overcome resistance within the WMA. Further, there is no guarantee of success.

I.6.2 Rather than continuing to work solely within the WMA structure, the CMA and RDMA could attempt to change euthanasia and assisted suicide policy within other national associations, especially those with larger memberships that have more votes at the General Assembly. This could be done in parallel with lobbying within the WMA and would complement and support it, since it would secure votes needed to make the WMA policy change. Moreover, it may be easier to change policy in national associations, which may not be impeded by obstacles like a 75% level of approval for changes to ethics policies.

I.6.3 The most promising targets for this approach would be associations in Europe and the European diaspora where there is an appetite for euthanasia and assisted suicide, especially in Australia, New Zealand and the United States. All of the elements of the strategy described above could be applied to lobbying within national associations.

I.6.4 There are strong public lobbies in Australia, New Zealand and the United States in favour of legalization. The Royal New Zealand College of General Practitioners has already adopted an approach to legalization of euthanasia and assisted suicide similar to the CMA/RDMA proposal.[15] Since Vermont, Washington, Oregon, California Washington D.C. and Colorado have legalized assisted suicide, the American Medical Association (AMA) is increasingly susceptible to an appeal to lack of consensus as a reason to change its policy. Moreover, it appears that the majority of the AMA House of Delegates is now in favour of assisted suicide, and may be prepared to reverse AMA policy against the procedure next year.[16]16

I.6.5 CMA and RDMA officials can do some lobbying at the executive level of other national organizations, at least informally. However, it would be more appropriate and more productive to support members of other national associations in their internal lobbying. For example, CMA members of the Canadian Association of MAID Assessors and Providers could connect with like-minded members in other national associations, and members of other national associations could invite CMA officials to make presentations at meetings, including national association assemblies.

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II. PROPOSALS FOR CHANGE

II.1 Oslo: April, 2015

Policy revision survey

II.1.1 On 5 February, 2015, the WMA Secretariat sent a memo to members seeking their opinions about the need to revise policies adopted or last revised in 2005, including the policies on euthanasia and assisted suicide. 18 national associations replied, though not all with respect to every policy. Of the 18 respondent associations, 15 recommended reaffirmation of the euthanasia policy and 14 recommended reaffirmation of the assisted suicide policy. Only the Netherlands, Taiwan and Canada recommended changes.[1]

II.1.2 Unsurprisingly, the Royal Dutch Medical Association (RDMA) recommended major revision of both euthanasia and assisted suicide policies. The Taiwan Medical Association (TMA) recommended major revision of the euthanasia policy, but reaffirmation of the Statement on Physician Assisted Suicide (though it later affirmed both policies: III.3.4). The Canadian Medical Association (CMA) recommended reaffirmation of the Declaration on Euthanasia, but a major revision of the physician assisted suicide policy, suggesting that the WMA "may wish to adopt a more nuanced approach to this issue."[1]

Ethics Committee meeting: reaffirm policies

II.1.3 Dr. Jeff Blackmer of the CMA was present at the meeting of the WMA Medical Ethics Committee in Oslo on 17 April, 2015. The CMA was not a member of the Committee; Dr. Blackmer was there by virtue of his position as a WMA facilitator.[2] However, during discussion of the survey results, the CMA (presumably Blackmer) "offered to write an alternative paper addressing these complex issues," (i.e., euthanasia and assisted suicide). In fact, CMA officials were hardly in a position to be offering expert advice on euthanasia and assisted suicide to the WMA, given its own undeveloped and unstable position on the issues at the time (B10.10-18). The offer was not accepted, nor was it recorded in the minutes of the meeting because "the CMA, not being a member of the MEC, could not submit a motion and such proposal had not been moved by a committee member."[3] Consistent with the results of the survey, the Committee recommended that the Declaration on Euthanasia and the Statement on Physician Assisted Suicide be reaffirmed.[2]

Council meeting: physician assisted suicide policy discussed, reaffirmed

II.1.4 38 national associations were represented at the WMA Council meeting the next day. The Canadian delegation consisted of seven members, including Dr. Blackmer and past CMA President Dr. Louis Francescutti. There were two Royal Dutch Medical Association representatives and three from Taiwan. The Canadian delegation was among the four largest; Japan, Norway and the USA each fielded nine representatives.[4]

II.1.5 The Declaration on Euthanasia was reaffirmed.[5] However, the Royal Dutch Medical Association representative, Professor van der Gaag, selected the policy on assisted suicide for individual consideration. Noting that there had been "increased public

discussion" of the subject and policy changes allowing it in some circumstances, he argued that it was important for physicians "to engage in discussion of the issue rather than simply reaffirming the WMA Statement." Responding to contrary remarks from a German representative, he said that, even where physician assisted suicide was legal, "very few people make use of the option."[6]

II.1.6 Dr. Francescutti of the CMA warned that "by ignoring public opinion physicians would not serve their patients well."

> He described impending legal changes in Canada prompted by public pressure to allow physician-assisted suicide, which led the CMA to rule that, regardless of the new expected legislation, physicians should be allowed to follow their conscience. He also commented on the need for good palliative care.[6]

II.1.7 A Polish representative spoke against assisted suicide, but WMA President, Dr. Xavier Deau (France), while observing that physicians have a duty to preserve life and accompany dying patients (good palliative care being essential), countered that "physicians are answerable only to their own conscience and should not be blind and deaf to the wishes of patients." He added, "The WMA should adjust policies in accordance with the progression of ideas in society, failing which it will lose credibility."[7]

II.1.8 Prof. Montgomery (Germany) suggested that the Statement on Physician Assisted Suicide be reaffirmed, and that the RDMA develop a paper on the subject for future discussion. Dr. Blackmer (CMA) "expressed his disappointment at the reluctance to discuss this issue," offering to support the RDMA in preparing the paper.[7]

II.1.9 Dr. Pälve (Finland) commented that public attitudes favourable to assisted suicide had generated discussion in Finland, but physicians remained unwilling to carry it out. Dr. Yokokura (Japan), noting that "dying with dignity" had been discussed at length in Japan, emphasized the importance of discussion "to identify a clear way forward." Similarly, Dr. Jorge (Brazil) stressed the WMA's role in finding "consensus and an international voice for the medical profession," welcomed the discussion prompted by the RDMA, and suggested changing WMA procedures to facilitate such developments.[7]

II.1.10 This was opposed by Dr. Dearden (Britain), who noted that national associations had already agreed to reaffirm the statements, which, he argued, "should reflect the international physician community, rather than changes occurring in a few countries." He observed that it would be contrary to WMA procedures for Council to solicit papers at that stage, and moved that the Council should reaffirm the statement as recommended by the Medical Ethics Committee.[7]

II.1.11 Dr. Blackmer argued that only 16 of 111 members had responded to the survey, and that some members of the Medical Ethics Committee who recommended reaffirming the statement "may simply have gone along with the suggestion of the Secretariat."[7,8] He added that decisions that seemed clear had, in the past, sometimes been amended following discussion. Dr. Dearden repeated his motion, pointing out that it did not exclude members from developing new papers.[7]

II.1.12 Past WMA President Dr. Johnson cautioned participants about the need to adhere to

established procedures to retain the confidence of WMA members. Dr. Mungherera (Uganda) reminded Council that many African countries had the death penalty, and warned that it might be undesirable to revisit policies at the behest of individual national associations when ethical standards have already been established by the WMA.[7]

II.1.13 Prof. van der Gaag (Netherlands) referred to the CMA's offer during the Medical Ethics Committee meeting to prepare an alternative paper, but the Secretary General explained that the offer was not considered part of the discussion, since the CMA was not a member of the Ethics Committee (II.I.3).[9]

II.1.14 Council then reaffirmed the Statement on Physician Assisted Suicide and approved the Ethics Committee report, but Dr. Bernard, the CMA representative, protested that the policy review process "excluded discussion." He asked for a review of procedures by the WMA Executive Committee.[10]

CMA implies withdrawal from WMA over physician assisted suicide

II.1.15 Near the end of the Council session, Dr. Blackmer spoke at length to express his disenchantment with the WMA.[11] He noted that the CMA was undergoing a major review of its operations, and that he was now questioning the value of its continued commitment to participation in the WMA. He complained that "considerations of geographical balance" had prevented the election of a CMA candidate as Chair of the Socio-Medical Affairs Committee.[12]

> Dr. Blackmer stated that his comments were not connected with the loss of the election, but rather deep concern about other, more important issues, such as a failure to focus on substantive issues of concern to the physicians of the world. He described the discussion on the topic of physician-assisted suicide as showing that the organisation is unwilling to discuss difficult issues or take into account the views of other countries or the public. He stated that, "if we cannot discuss controversial issues with an open mind, the WMA is not serving its members or patients and risks becoming irrelevant or obstructive."
>
> Dr. Blackmer described the past few days as disappointing and shared the view of his delegation that fundamental changes are needed within the WMA.[11]

II.1.16 In closing, Dr. Blackmer said that the CMA delegation would report on the Council meeting to the CMA Executive and Board and solicit the opinions of CMA members "on how their dues should be used with respect to international engagement and global membership." He promised to update the Council on this point at the next meeting in Moscow.[11] His remarks clearly implied that the Canadian Medical Association might withdraw from the WMA because of its unwillingness to reconsider its position on physician assisted suicide.

II.2 Moscow: October, 2015

II.2.1 At the Medical Ethics Committee meeting, the Secretary General said, "An international discussion is taking place on end of life care and euthanasia and the WMA should also enter this debate." He added that the WMA would organize a session on the subject at the Bioethics, Medical Ethics and Health Law Conference in

Naples the following month. Although not a member of the Committee, and not listed among the participants, Dr. Jeff Blackmer reported that the CMA and RDMA were preparing a paper on "end of life care and assisted dying" and would present it in 2016.[13]

II.2.2 The report of the Medical Ethics Committee, including the above information, was accepted by the Council without comment. There is no record that Dr. Blackmer provided an update on the CMA position vis-á-vis membership in the WMA, although he may well have discussed it privately with others while in Moscow.[14]

II.3 Buenos Aires: April, 2016

II.3.1 In February, 2016, Canada and the Netherlands submitted a paper to the WMA Secretariat proposing reconsideration of WMA positions on both euthanasia and assisted suicide, summarized as follows:

> Several jurisdictions in Europe, North America and South America have legalized certain forms of assisted dying under specific conditions. In these cases, such legalization has been a result of extensive legislative processes, court decisions and debate in society. In all of these locales, some physicians have agreed to provide euthanasia or assistance in dying out of compassion for their patients, in order to alleviate intractable and hopeless suffering.
>
> It is suggested that the WMA should no longer condemn physicians who want to follow their own conscience in deciding whether or not to participate in these activities, within the bounds of the legislation, in those jurisdictions where euthanasia and/or physician assisted dying are legalized.[15]

II.3.2 The second paragraph of the summary is noteworthy because it is very similar to the resolution proposed by the CMA executive and adopted by the CMA General Assembly in August, 2015. On the basis of this resolution (which was described as a neutral position), the CMA executive later affirmed both euthanasia and assisted suicide as legitimate forms of medical treatment (Appendix "B"). The substance of the CMA/RDMA proposal will be considered in Part V.

II.3.3 The document was presented by the RDMA to the Medical Ethics Committee at its meeting in Buenos Aires in April. A CMA representative (not identified in the record) explained the background and development of the proposal. The Committee discussed the proposal and recommended that it be circulated for comment by national associations.[16]

II.3.4 Dr. Jeff Blackmer and Dr. Louis Francescutti were part of the Canadian delegation at the Council meeting the following day. In introducing the subject, the RDMA admitted that it was "very controversial" and suggested that the circulation of the CMA-RDMA proposal be delayed for at least a year "to allow for additional open discussion and exchange of information and ideas, possibly through workshops organized as part of WMA meetings and regionally by NMAs."[17]

II.3.5 During discussion, the Council considered how such workshops or meetings might be organized. It was suggested that the CMA-RMDA proposal be circulated to national associations to inform discussion at meetings and workshops, and a suggestion that a

working group should be formed to address it. It was agreed that the matter be referred to the Executive Committee to develop plans responsive to the ideas proposed during the Council meeting. The RDMA and CMA withdrew the proposal, so it was not circulated to national associations.[17]

II.4 Taipei (October, 2016)

II.4.1 The Secretary General reported in October on the plans made by the Executive Committee concerning the policies on euthanasia and physician assisted suicide; the latter is referred to in the Medical Ethics Committee report as "physician assisted dying." He reported that a first workshop would be hosted by the Brazilian Medical Association for the Latin America region, and that it was hoped that the African and Asian regions would organize similar gatherings.[18] The subject was not discussed at the October Council meeting, but Prof. Rutger Jan van der Gaag (RDMA) told the Council that the Junior Doctors Network held a meeting on end-of-life care that was "very respectful and dignified," the format of which might be used at the regional meetings.[19]19

Notes

1. World Medical Association. MEC 200/Policy Review/Apr2015: Classification of 2005 Policies on Medical Ethics.

2. World Medical Association. MEC 200/Report/Apr2015: Report of the Medical Ethics Committee, 17 April, 2013, p. 1.

3. World Medical Association. Council 200/Minutes/Apr2015: Minutes of the 200th Council Session, 16 and 18 April, 2015 [Council Minutes (18 April 2015)] p. 9.

4. Council Minutes (18 April 2015), p. 19, 21

5. Council Minutes (18 April 2015), p. 7, section 8.1.3.2.

6. Council Minutes (18 April 2015), p. 7, section 8.1.6.

7. Council Minutes (18 April 2015), p. 8, section 8.1.6.

8. The minutes state, "Dr Blackmer pointed out that only 16 out of 111 members had responded and suggested that some may simply have gone along with the suggestion of the Secretariat." Since the reference to 16 out of 111 members pertains to the circulation of the survey, and the Secretariat did not make any suggestions in requesting feedback, "some" must refer to members of the Medical Ethics Committee, since the Secretariat did suggest reaffirmation to the Committee.

9. Council Minutes (18 April 2015), p. 9, section 8.1.6.

10. Council Minutes (18 April 2015), p. 9, section 8.1.5.

11. Council Minutes (18 April 2015), p. 17-18, section 10.7.

12. One of the three committees responsible for WMA operations; the other two are the Medical Ethics Committee and the Finance and Planning Committee. An American had been elected Council chair, which apparently prevented the election of someone else from North American as Chair of the Socio-Medical Affairs Committee.

13. World Medical Association. MEC 201/Report/Oct2015: Report of the Medical Ethics Committee (14 October, 2015), p. 2.

14. World Medical Association. Council 201/Minutes/Oct2015: Minutes of the 201st Council Session, 14 and 16 October, 2015.

15. World Medical Association. MEC 203/Euthanasia-Physician Assisted Dying/Apr2016: Proposed WMA Reconsideration of the Statement on Euthanasia and Physician Assisted Dying (February, 2016).

16. World Medical Association. MEC 203/Report/Apr2016, Report of the Medical Ethics Committee (29 April, 2016), p. 3.

17. World Medical Association. Council 203/Minutes/Apr2016, Minutes of the 203rd Council Session (28 and 30 April, 2016), p. 6-7.

18. World, Medical Association. MEC 204/Report/Oct2016: Report of the Medical Ethics Committee (19 October, 2016), p. 2

19. World Medical Association. Council 204/Minutes/Oct2016: Minutes of the 204th Council Session (19 and 21 October, 2016), p. 13.

III. REGIONAL WMA CONFERENCES

III.1 Summary

III.1.1 National associations gathered regionally to discuss end-of-life issues in 2017 and 2018. Conferences in three of the four WMA world regions (Latin America, Asia-Oceania and Africa) unanimously opposed euthanasia and physician assisted suicide, and the majority of participants in the European conference held in the Vatican were also opposed to the practices.

III.1.2 It is obvious that a general appetite for euthanasia and assisted suicide is confined to North America, western Europe, Australia and New Zealand, and that the overwhelming majority of national associations favour retaining the WMA prohibition of physician participation in the practices.

III.1.3 WMA public documentation of the conferences is notably weighted in favour of the European gathering, and many speakers used slides in English during their presentations. In addition, live-tweeting by Dr. Jeff Blackmer of the Canadian Medical Association supplemented the official record. For these reasons, the Vatican conference is described here in much greater detail than the other regional conferences. However, the reader should note that only the papal message and opening address by the President of the Pontifical Academy for Life were made available as full-text documents. Thus, individual presentations can only be described in outline, and some inferences are necessary to make sense of some of them.

III.2 Latin America: Rio De Janeiro (March, 2017)

III.2.1 The Brazilian Medical Association hosted the Latin American Meeting on End-of-Life Ethical dilemmas and provided a report summarizing participant conclusions. In brief, the participants emphasized the need for access to palliative care and rejected euthanasia and assisted suicide. Their view was that those at the end of life need do not need help to "precipitate death," nor to prolong suffering by "therapeutic obstinacy", but should be relieved by palliative care until death arrives.[1]

III.2.2 The summary made the important point that the participants understood the social debate about legalizing euthanasia to concern "exceptional" cases that cannot be managed adequately by "quality medical care." It is doubtful that some prominent cases of legal euthanasia in Canada,[2] Belgium[3] or the Netherlands[4] would have met this criterion, though they were obviously acceptable to the national medical associations in those countries.

III.2.3 The summary stated that human life always has dignity, although people live in conditions contrary to human dignity, caused by decisions and behaviours that fail to respect it. Since death occurs at a certain moment in life, it can neither be dignified nor undignified in itself, though the conditions of life preceding it may be either.[5]

III.2.4 The participants did not believe that respect for patient autonomy was sufficient to guarantee the freedom and dignity of the person, who may be unable to manifest his will freely in certain situations. Thus, they said, patient dignity must be defended against the interventions of third parties, and sometimes even against patients' own

decisions.[6]

III.2.5 Euthanasia and assisted suicide would, in their view, adversely affect medical ethics and undermine the trust in the physician-patient relationship. They were concerned that legalizing euthanasia would send a "social message" to severely disabled patients and other vulnerable patients that they should request euthanasia so as not to burden their families and society.[6]

III.2.6 The Latin American Associations stated that requests for euthanasia would be reduced by improving professional training in pain relief and palliative care. They expressed concern that legalizing euthanasia would discourage health professionals and researchers from responding in non-lethal ways to patients with incurable conditions, which requires considerable dedication of time and human resources. They also referred to the risk of the "slippery slope," exemplified by the Netherlands, where euthanasia has been provided to people who have not requested it or have not met legal requirements.[6]

III.2.7 The participants emphasized that those who choose to practise medicine dedicate themselves to saving the lives of their patients and eliminating as much suffering as possible, and cannot simultaneously dedicate themselve to ending a patient's life. Hence, they said, euthanasia should never be a medical activity ("La eutanasia en ningún caso debe ser una actividad médica."). On this point, the English translation of the document is not just erroneous, but states the opposite.[6]

III.3 Oceania and Asia: Tokyo (September, 2017)

III.3.1 The General Assembly of the Confederation of Medical Associations in Asia and Oceania (CMAAO) met in Tokyo in September, 2017.[7] WMA Secretary General Otmar Kloiber, German Medical Association President Prof. Dr. Frank Ulrich Montgomery, International Manager Dr. Ramin Parsa-Parsi and the immediate past American Medical Association President Dr. Andrew Gurman were present for the symposium on end-of-life questions.[8]

III.3.2 Preceding the conference, a survey was sent to all 21 national associations with five groups of questions centred on the following topics: (1) euthanasia and physician-assisted suicide, (2) advance directives, (3) withholding or withdrawing life-sustaining treatment, (4) palliative care and end-of-life care and (5) substitute decision making for incompetent adults.[9]

III.3.3 19 associations replied. During the conference, 17 associations presented reports elaborating or modifying their survey answers. Only Macau and Sri Lanka did not respond. New Zealand and Cambodia did not attend the conference, but submitted detailed answers.[10]

III.3.4 The summary states that all participants opposed euthanasia and physician assisted suicide, and, except in New Zealand and Australia, there is no appetite for discussion of the procedures in civil society. On the other hand, all participants supported advance directives and advance care planning for terminally ill patients.[11] Taiwan, which was one of only three associations to recommend a change in WMA policy (a major revision of the euthanasia policy: II.1.2) was a participant in the symposium, so it appears that either the major revision it had in mind was consistent with the

conclusions of the symposium, or that the discussion caused it to change its position.

III.3.5 Japanese Medical Association's legal advisor, Professor Tatsuo Kuroyanagi, was responsible for the report of the symposium.[12] He erroneously implied that both euthanasia and physician assisted suicide are legal in Switzerland and the United States, and also erroneously stated that Canadian legislation approves only physician assisted suicide.[10]

III.3.6 In personal comments included in the report, he noted the wide variety and strong influence of religious beliefs throughout the region. He also observed that "family and community bonds are extremely firm in the island regions in Oceania such as Indonesia, Philippines, Malaysia and the countries/jurisdictions in the Southeast Asian region such as Pakistan, India, Bangladesh, Myanmar, Thailand, and Cambodia," and that these areas have not assimilated the western concept of self-determination.[13]

III.3.7 Prof. Kuroyanagi also drew attention to confusion caused by terms like "active" and "passive" euthanasia, as well as difficulty that could arise from failing to distinguish between physician assisted suicide and "a criminal type of murder at the victim's request," which he suggested might be called "physician-assisted dying." He did not explain why consensual homicide should be called "physician-assisted dying" rather than euthanasia.[12]

III.3.8 In October, the Secretary General provided the WMA Medical Ethics Committee with an oral report of the symposium. According to the Ethics Committee minutes, he said that none of the national associations attending the meeting had a policy supporting euthanasia and assisted suicide.[14] While correct, this did not reflect the stronger position later reported by Prof. Kuroyanagi: that all associations opposed the procedures (III.3.4).

III.4 Europe: Vatican City (November, 2017)

Overview

III.4.1 A two-day WMA European Region Conference on End-of-Life Questions organized by the WMA, the German Medical Association and the Pontifical Academy for Life was held in Vatican City on 16 and 17 November 2017.[15] According to the report on the conference, about 150 participants attended. The author of the report of the conference is not identified; it is said to have been based on an article by Nigel Duncan in the World Medical Association Journal.[16]

III.4.2 During a plenary panel discussion at the conclusion of the conference, six speakers debated whether or not WMA policies on euthanasia and assisted suicide should be changed. Five of the six panelists had made presentations at the conference; one (Dr. Matilde Leonardi) had chaired the morning sessions on the first day.[17] Based on their earlier presentations, it appears that Professor Dr. Urban Wiesing (Germany), Dr. René Héman (Netherlands) and Dr. Yvonne Gilli (Switzerland) advocated for change. Presentations of Prof. Dr. Stephan Sahm (Germany) and Prof. Dr Frank Ulrich Montgomery (Germany) indicate that they represented the "no change" position during the panel discussion. They were likley supported by panelist Dr. Leonardi (Italy), a corresponding member of the Pontifical Academy for Life.

III.4.3 Throughout the conference, advocates for change emphasized "patient self-determination, dignity and compassion," insisting that their intention "was to protect physicians in their own countries who are acting within the law, not to change or influence policies in other countries."[17]

III.4.4 Those opposed rejected both procedures "as being diametrically opposed to the ethical principles of medicine." Opponents voiced concerns that legalization "could lead to misuse or abuse," generate social pressures on the elderly and those with chronic illness to end their lives, and undermine the trust essential to the physician-patient relationship.[17]

III.4.5 The majority of participants rejected any change to existing WMA policies against euthanasia and physician assisted suicide, but all supported "high-quality, accessible palliative care" and rejected the use of the procedures as cost-saving measures.[17]

Canadian Medical Association representation

III.4.6 The CMA's Dr. Jeff Blackmer, attending the conference, tweeted the reason for his presence:

> **Dr. Blackmer:** At a meeting on #EOL care and #euthanasia at #TheVatican organized by @medwma. @CMA_Docs pleased to represent Canadian physicians here. Current WMA policy states physicians who participate are unethical. We are working with others to try and change this.[18]

III.4.7 While he acknowledged that Vatican officials as "very gracious hosts,"[19] he commented, "It's like having a human-rights discussion in North Korea. It's not a neutral environment."[20]

III.4.8 Dr. Blackmer was not a speaker, he participated in discussions and defended the participation of Canadian physicians in euthanasia and assisted suicide.[21]21 He tweeted his comments on the presentations and some of his exchanges with speakers and conference participants.

III.4.9 Some Twitter respondents applauded the CMA's presence. Dr. Blackmer retweeted praise from Meredith Vanstone: "Changing and shifting values- @CMA_Docs are responding to Canadian patient needs and requests, doing important work for those who express this wish."[22] He also retweeted "Kudos" from Jocelyn Downie,[23] with whom he shared his personal experience of the proceedings:

> **Dr. Blackmer:** Would love for you to be able to observe the dialogue @jgdownie. It is a terrific exercise in attempting to exert control over your own inner dialogue.[24]

III.4.10 Professor Jocelyn Downie of Dalhousie University[25] is perhaps the foremost advocate for euthanasia and assisted suicide in Canada. She contributed substantially to the legal strategy that resulted in the Supreme Court decision ordering legalization of the procedures.[26] She favours coercion of objecting health care workers and institutions to compel them to collaborate in euthanasia and assisted suicide by referral,[27,28] as well as forcing both private and public institutions to permit the procedures on their premises.[29] She has been awarded the Order of Canada for her work in this field.[30] It appears that Dr. Blackmer has since deleted this reply to her from his Twitter feed.

III.4.11 The reaction to the CMA presence by Canadian physician Dr. Martin Owen, Vice-President of the Canadian Federation of Catholic Physicians' Societies, was markedly different.

> **Dr. Martin Owen:** How can the CMA go from "officially opposed" to euthanasia to "international advocate" in such a short time?[31]
>
> **Dr. Blackmer:** Please don't become one of those mis-stating facts. We are not advocating for euthanasia. We are asking the WMA to stop condemning our CMA members who participate - or physicians anywhere where it is a legal act - as acting unethically.[32]
>
> **Dr. Owen:** Legality does not change ethics. The WMA is within their rights to maintain their position.[33]
>
> **Dr. Blackmer:** BTW - please add the following disclaimer to all my future tweets: When I say I am representing Canadian physicians, I mean as an official representative of the CMA, based on CMA policy. Clearly I don't represent the actual views of ALL Canadian docs. That would be #impossible.[34]
>
> **Dr. Owen:** Despite the disclaimer that he doesn't represent the opinions of all Canadian doctors the official presence of the @CMA_Docs with the intention of changing WMA policy speaks volumes.[35]
>
> **Dr. Blackmer:** Let me make something crystal clear. The CMA supports the right of all its members to decide whether or not to participate in #euthanasia. We have spent 1000's of hours protecting conscience rights. And we will advocate for our members who elect to participate in a legal act.[36]

Euthanasia and assisted suicide

III.4.12 Dr. Frank Montgomery (President, German Medical Association) spoke out strongly against euthanasia,[37] eliciting a protest tweet from Dr. Blackmer.

> **Dr. Blackmer:** Dr. Montgomery from Germany says "In countries with #euthanasia, families apply pressure to pt's to end their lives" and "Assisted dying has nothing to do with #compassion. It is a misguided interpretation of compassion." This is not our experience in Canada.[38]

III.4.13 WMA President Elect Dr. Leonid Eidelman of Israel also opposed euthanasia,[39] and, in Dr. Blackmer's view, also made claims uninformed by experience. Dr. Blackmer's tweets resulted in a short Twitter conversation with some Canadian physicians.

> **Dr. Blackmer:** Dr. Eidelman from Israel argues strenuously against #euthanasia. Says doctors who participate do so with no more serious thought than prescribing antibiotics. This has not been my experience in #Canada where physicians really struggle with the decision making process.[40]
>
> **Dr. Lesley Barron:** The idea that drs providing #MAID don't take the decision seriously is quite offensive really.[41]
>
> **Dr. Blackmer:** I agree. I told him that. I asked him for his evidence - or

whether he had ever spoken to anyone who had assisted in a death. He had no evidence and had not done so. He declined to retract his statement though. He is President Elect of the WMA.[42]

Dr. Barron: Not a good approach for a medical leader.[43]

Dr. Ron George: Disparaging comment to MDs everywhere struggling with difficult decisions with the persons they provide care.[44]

III.4.14 Dr. Barron, a surgeon, has publicly and forcefully argued that physicians who object to euthanasia and assisted suicide should be compelled to facilitate the procedures by referral.[45] Dr. George is an award winning member of the Faculty of Medicine, Dalhousie University in Halifax.[46]

III.4.15 Dr. Stephan Sahm of Germany denounced euthanasia and assisted suicide as morally unjustifiable and a danger to patients.[47] He, too, made allegations concerning Canadian physicians for which he had no evidence.

Dr. Blackmer: Dr. Sahm, referencing Canadian physicians, says they might struggle with #euthanasia initially, but then they get used to it and it doesn't trouble them anymore. He hasn't spoken to any Canadian physicians.[48] When I challenged him to produce any evidence to support his claims he could not.

Then he decided that maybe physicians do continue to struggle and that this is also an argument against euthanasia. Sigh.[49]

Joel Kirsh: With a sample size of n=0, every outcome is in the confidence limits. Could re-title slide "Flaws and fallacies in the evaluation of #assisteddying."[50]

Dr. Blackmer: There were a number of slides that might be seen to fall into that category.[51]

III.4.16 Dr. Gunnar Eckerdal (Sweden) spoke largely from the perspective of palliative medicine about medication, feeding and terminal sedation. He rejected euthanasia and assisted suicide because, he said, they were unsafe and unresponsive to the actual needs of patients. His concluding slide, which concerned mistaken patient assessments,[52] appears to have been challenged by Dr. Blackmer.

Dr. Blackmer: A speaker said that 1% of pt's at his hospital are misdiagnosed but (he guessed) 20% of #euthanasia pt's are misdiagnosed. When I challenged him on his math, an Italian doctor yelled at me and accused me of saying it's ok that some euthanasia pt's are misdiagnosed.[53]

III.4.17 Finland's Dr. Heikki Pälve explained that a bill to legalize euthanasia was before the Finnish parliament, but polls showed that it was supported by only 17 percent of specialists in end-of-life care. Dr. Pälve said that the Finnish medical association supports physician participation in public debates on the subject, but opposes physician participation in the procedures. He also asserted "that the slippery slope argument was a fact, and a very undesirable one."[54] Professor Ilora Baroness Finlay discussed the portrayal of euthanasia and physician assisted suicide in public discourse, challenging the purported need for legalization and involvement of

physicians in light of the actual health needs of most of the world's population.[55]

III.4.18 In her presentation on assisted suicide in Switzerland, Dr. Yvonne Gilli presumed but did not argue for the acceptability of assisted suicide.[56] Only one speaker explicitly argued for the acceptability euthanasia and assisted suicide. Dr. René Héman, Chairman of the Royal Dutch Medical Association (RDMA) defended the practice of euthanasia in the Netherlands, basing his position on "principles of respect for a patient's autonomy and on compassion." He claimed that, while it is never good to deliberately end someone's life, it is sometimes worse not to do so.[57]

> **Dr. Blackmer:** Dr. Heman from #Holland says that "Euthanasia can be accepted as an expression of #compassion and #mercy". This is consistent with our experience in #Canada. Also references importance of #autonomy and respect for the views of others.[58]

III.4.19 Representatives of the Catholic Church or Catholic perspectives,[59,60,61,62] Islam,[63] Judaism,[64] and Orthodox Christianity[65] all opposed euthanasia and physician assisted suicide. However, Professor Urban Wiesing (Institute for Ethics and History of Medicine, University of Tuebingen,Germany) countered that there is no ethical or Christian consensus on end-of-life issues, noting support for assisted suicide and "killing on demand" (euthanasia) by the majority of Christians in industrialized countries.[66]

III.4.20 Professor Wiesing cited former Archbishop of Canterbury Lord Carey and Desmond Tutu as euthanasia/assisted suicide supporters from the Anglican tradition, and tendentiously identified Hans Kung as a supportive Catholic theologian.[67] A slide referring to criticism of Pope Francis by former European Union President Herman Van Rompuy indicates that Professor Wiesing drew attention to the provision of euthanasia for mental illness by the Belgian province of the Brothers of Charity, a Catholic religious order.[68] In short, he held that ethical or moral pluralism is the norm, and that it is necessary to preserve that pluralism by means of political solutions that do not forbid euthanasia or assisted suicide on the basis of one of many different convictions. On the other hand, he asserted that there is a consensus that no one should choose assisted suicide prematurely, as a result of pressure, or because of the lack of medical treatment or palliative care.[66] Dr. Blackmer took note:

> **Dr. Blackmer:** Dr. Wiesing from Germany uses a human rights based approach to #euthanasia. Even in Christian Ethics there is no consensus. Empirical evidence shows no #slipperyslope or decrease in #palliativecare. Personal #EOL decisions not in scope of state responsibility.[69]

III.4.21 Professor Wiesing, though he referred to "killing on demand" and occasionally to euthanasia, referred exclusively to physician assisted suicide when he offered the findings of what he called "empirical ethics." These demonstrated, he said, that where the procedure is legal, there is no "slippery slope," no decrease in palliative care, no social discrimination (against vulnerable patient groups) and no loss of trust in physicians. Perhaps it was Professor Wiesing's reference to empirical evidence that led to a memorable question from one of the participants, tweeted by Dr. Blackmer.

> **Dr. Blackmer:** My favorite question so far from the meeting on #EOL and #euthanasia at #TheVatican, from a physician representing Catholic doctors:

> "What evidence do you have that death ends suffering?" Can't wait to see THAT clinical trial application.[70]

Protection of conscience

III.4.22 Dr. Héman, defending Dutch euthanasia practices, explained that Dutch law still prohibits euthanasia as a general rule, allowing exemption from prosecution if certain criteria are met. Hence, the law does not recognize a right to be assisted by others in suicide, nor a right to euthanasia, nor does it oblige physicians to perform euthanasia.[57]

III.4.23 Speaking of Swiss practice, Dr. Gilli stated, "No physician can be ordered to assist suicide," adding that it is important to "resist any pressure on physicians to assist or perform assisted suicide" and to resist interpreting human rights to include a right to "unlimited self-determination" concerning one's time of death within the context of end-of-life-care.[56]

III.4.24 Dr. Eidelman appears to have adopted an unusual position, opposing physician participation in euthanasia and assisted suicide, but also (apparently) opposing conscientious objection by physicians.[39] Referring to a *New England Journal of Medicine* article, he appears to have asserted that "Health care professionals are not conscripts, and in a freely chosen profession, conscientious objection cannot override patient care," and that physicians are obliged to "provide, perform or refer."[71] He appears to believe that physicians are protected against involvement in euthanasia and assisted suicide by "the standards of the profession," which preclude such practices. This is clearly erroneous and unrealistic, as demonstrated by the CMA's acceptance of euthanasia and assisted suicide as legitimate treatments.

III.4.25 Professor Chris Gastmans from KU Leuven in Belgium was the only speaker who addressed freedom of conscience for health care workers, though exclusively within the context of conscientious objection.[72] His presentation was purely descriptive, identifying three categories of responses to conscientious objection: non-conventional compatibilism (the Project position), conventional compatibilism (arguably the CMA's position) and conventional incompatibilism (Julian Savulescu et al). He identified three points of agreement among those holding these disparate views:

- the patient should have adequate notice of the objection;
- disclosure should occur when a patient is taken on;
- objecting physicians should cooperate in a transfer of care.

Gastmans suggested that those opposed to conscientious objection were primarily concerned about its negative effect on patient autonomy, while those supporting it were concerned that making it illegal would cause some people not to enter health care, and that one cannot provide good care while acting against one's conscience.

Euthanasia and the Nazi regime

III.4.26 Other speakers addressed a variety of topics: the medical decision-making process,[73] assisted nutrition and hydration and terminal sedation,[74] equitable access to health care and patient centred practice,[75] suffering,[61,62,65] burdensome or disproportionate treatments,[76] public discourse in bioethics[77] and the meaning of the term

"euthanasia."[78,79]

III.4.27 A particular controversy about the meaning and significance of the term "euthanasia" was noted by Pofessor Druml,[76] summed up in a reference in one of her slides to a paper by Andrej Michalsen and Konrad Reinhart: "Euthanasia": a confusing term, abused under the Nazi regime and misused in present end-of-life debate. The thesis of the authors is that "[t]he term 'euthanasia' was so abused during the Nazi regime as a camouflage word for murder of selected subpopulations with the willing participation of physicians, we believe that, regardless of the benevolent goals of current euthanasia practices, for historical reasons the term 'euthanasia' must not be used with regards to current end-of-life care.[80]

III.4.28 It does not appear that the subject was pursued in depth by Professor Druml or addressed by other speakers, but it became the focus of a sharp quarrel precipitated by an exchange at lunch between Dr. Blackmer and another physician.

> **Dr. Blackmer**: At lunch break today a physician who shall remain unnamed struck up a conversation with me by telling me why the situation with #euthanasia in #Canada today is so similar to what happened in Nazi Germany. With great self control I managed not to euthanize him on the spot.[81]

III.4.29 A Twitter respondent congratulated Dr. Blackmer on his response.

> **Joel Kirsh:** Admirable restraint. Godwin's Law meets (?willfully?) misapplied definitions/comparison. What happened in the #Shoah was not #assisteddying. Sad that such is the level of discourse, even at a meeting of the presumably informed.[82]

> **Dr. Blackmer:** Incredibly, the German and Israeli Medical Associations made the very same comparison about two years ago. The GMA has since clearly stated that the two are completely unrelated.[83]

III.4.30 Dr. Martin Owen took exception to Dr. Blackmer's jocular reference to euthanizing a colleague, and a series of sharp exchanges followed.

> **Dr. Martin Owen:** It appears that @CMA_Docs has become unable to tolerate differences of opinion.[84]

> **Dr. Blackmer:** That is profoundly disappointing @mdmartinowen. Different opinions are one thing. Comparing voluntary, patient-requested euthanasia to Nazi Germany is quite another. All are entitled to views - but some cross a line and need to be called on it.[85]

> **Dr. Owen:** Agreed. Your comments about euthanizing your colleague for their opinion crossed the line.[86]

> **Dr. Blackmer:** You and your colleagues were so pleased when the CMA advocated strongly for the right to conscientious objection. It is profoundly unfortunate that you will not allow us to advocate for other Canadian physicians whose views differ from yours without comparing them to Nazis.[87]

> **Dr. Owen:** Please do not mischaracterize my comment. It was a strategy of the

Nazi regime to promote euthanasia. Please provide evidence to the contrary. You were the one desiring to euthanize your colleague for their opinion...that's not supportive of #freedomofconscience.[88]

Dr. Owen: Actually, euthanasia of "undesirables" was a key strategy of Nazi Germany, and its acceptance by the medical profession paved the way for future atrocities. Ironically, it was physicians in the Netherlands who opposed euthanasia.[89]

Dr. Blackmer: Really, @mdmartinowen? You really want to make any sort of comparison between the current situation in Canada and what happened in #Nazi #Germany? There are not enough characters in the whole world to tell you why this is so wrong and disappointing.[90]

Dr. Blackmer: I've decided, as a general principle, to block anyone on Twitter who in any way compares Canadian physicians who participate in #euthanasia to #Nazis. Just so there are no surprises, misunderstandings or hurt feelings.[91]

III.5 Africa: Abuja (February, 2018)

III.5.1 National Medical Associations from Nigeria, Zambia, Kenya, South Africa, Cote D'Ivoire and Botswana met in Abuja, Nigeria for two days in February, 2018. WMA Secretary General Dr. Otmar Kloiber and some invited dignitaries attended the meeting.

III.5.2 The national associations observed that most African countries suffer from a high poverty rate and "poor access to affordable, equitable and quality health care." They advocated the general strengthening of African health care systems: universal health care and increased state financing of health care and insurance, including coverage for chronic medical conditions and palliative care.

III.5.3 They noted that palliative care is generally accepted, but there there is poor access to it and little awareness of end-of-life issues among African populations and medical/health professionals. On the other hand, "[i]n African culture, tradition and religion, life is held sacred and families never abandon their loved ones at the end of life."

III.5.4 Finally, the African national associations stated that they were "unanimously opposed to euthanasia and physician assisted suicide in any form."[92]

Notes

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5. Latin America, p. 1.

6. Latin America, p. 2.

7. World Medical Association. MEC 209/End of Life Japan/Apr2018: Report of the Symposium on End-of-Life Questions in Japan 2017 (April, 2018) [Asia-Oceania].

8. Asia-Oceania, p. 3.

9. Asia-Oceania, p. 2-3.

10. Asia-Oceania, p. 2.

11. Asia-Oceania, p. 4.

12. Asia-Oceania, p. 5.

13. Asia-Oceania, p. 4-5.

14. World Medical Association. MEC 207/Report/Oct2017: Report of the Medical Ethics Committee (11 October, 2017) p. 5.

15. WMA European Region Meeting on End-of-Life Questions (16-17 November, 2017) Aula Vecchia del Sinodo, Vatican [Internet]. World Medical Association [Cited 2018 Sep 28] [WMA Vatican Programme]. Available at: https://www.wma.net/wp-content/uploads/2017/05/Vatican_Final-program-booklet-for-printer.pdf.

16. World Medical Association. MEC 209/End of Life Europe (Rev/Apr2018): Report on the WMA European Region Conference on End-of-Life Questions 2017 [Europe] p. 3.

17. WMA Vatican Programme, p. 7.

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21. Europe, p. 2.

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24. Blackmer J. Tweet Jeff Blackmer@jblackmerMD [Internet]. Twitter; 2017 Nov 17. [Cited 2017 Nov 26]. Since deleted.

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26. In 2007 and 2008 she developed a legal strategy designed to reverse the leading Supreme Court of Canada decision against euthanasia and assisted suicide *[Rodriguez v. British Columbia (Attorney General)*] and began to look for a test case. A two day conference titled "Ethical, Legal, and Social Perspectives on Physician Assisted Suicide" was held at Carelton University in 2007. Professor Downie presented "Rodriguez Revisited: Canadian Assisted Suicide Law and Policy in 2007." Conference on Physician Assisted Suicide at Carleton [Internet]. Carleton University: Carleton Newsroom; 2007 Mar 12 [Cited 2018 Sep28]. Available from: https://newsroom.carleton.ca/archives/2007/03/12/conference-on-physician-assisted-suicide-at-carleton/. It does not appear that Prof. Downie's presentation was published. A detailed account of it was written by Alex Schadenberg of the Euthanasia Prevention Coalition, who was present when it was delivered. (See Schadenberg A. Dalhousie law professor seeks to re-visit Rodriguez court decision. Euthanasia Prevention Coalition.) See also Downie J, Bern S. Rodriguez Redux. Health Law Journal 2008; 16:27-64 [Internet]. [Cited 2018 Sep 28]. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2081875

27. Downie was a member of a panel that recommended objecting health care workers be compelled to refef for euthanasia and assisted suicide. Schuklenk U et al. Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making [Internet]. Royal Society of Canada; 2011 [Cited 2018 Sep 28]. Available from: http://consciencelaws.org/archive/documents/2011-11-Royal%20Society%20of%20Canada.pdf.

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29. Downie was a member of an advisory group that recommended that all public and private institutions must allow euthanasia or assisted suicide on their premises, or arrange for it to be done elsewhere. Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report (30 November, 2015) [Internet]. Recommendation 37: p. 46-47 [Cited 2018 Sep 28]. Available from: http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf.

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33. Owen M. Tweet Martin Owen @mdmartinowen [Internet]. Twitter; 2017 Nov 19 at 6:23 am) [Cited 2018 Sep 28]. Available at: https://twitter.com/mdmartinowen/status/932268154641727490?

34. Blackmer J. Tweet Jeff Blackmer@jblackmerMD [Internet]. Twitter; 2017 Nov 18 at 12:56 pm) [Cited 2018 Sep 28]. Available at: https://twitter.com/jblackmerMD/status/932004711216988160

35. Owen M. Tweet Martin Owen @mdmartinowen [Internet]. Twitter; 2017 Nov 18 at 6:59 pm) [Cited 2018 Sep 28]. Available at: https://twitter.com/mdmartinowen/status/932095956203356160.

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49. Blackmer J. Tweet Jeff Blackmer@jblackmerMD [Internet]. Twitter; (2017 Nov 17 at 12:20 am) [Cited 2018 Sep 28]. Available at: https://twitter.com/jblackmerMD/status/931451956383703041

50. Kirsh J. Tweet Joel Kirsh @joelakirsh [Internet]. Twitter; 2017 Nov 17 at 4:34 am [Cited 2018 Sep 28]. Available at: https://twitter.com/joelakirsh/status/931515977031852033.

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58. Blackmer J. Tweet Jeff Blackmer@jblackmerMD [Internet]. Twitter; 2017 Nov 16 at 12:18 am [Cited 2018 Sep 28]. Available at: https://twitter.com/jblackmerMD/status/931089000814739459.

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64. It appears that Dr. Riccardo De Signi, Chief Rabbi of Rome, did not provide a copy of his presentation. Dr. Jeff Blackmer tweeted a summary. "Dr. De Segni, Chief Rabbi of Rome and practicing [sic] physician. 'Thou shalt not kill' must apply to #EOL and #Euthanasia as well. 'It is an offence to God. Doctors do not have a right to change God's will.'" Blackmer J. Tweet Jeff Blackmer@jblackmerMD [Internet]. Twitter; 2017 Nov 16 at 2:07 am [Cited 2018 Sep 28]. Available from: https://twitter.com/jblackmerMD/status/931116483949801472?. See also Europe, p. 2.

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http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19791215_christi-ecclesia_en.html.

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https://twitter.com/mdmartinowen/status/932267645180637184.

89. Owen M. Tweet Martin Owen @mdmartinowen [Internet]. Twitter; 2017 Nov 18 at 6:48 pm) [Cited 2018 Sep 28]. Available at: https://twitter.com/mdmartinowen/status/932093180484317184?

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IV. MEETINGS AND NEW PROPOSALS

IV.1 MEC and Council meetings (April, 2017)

IV.1.1 The Committee was advised of plans for the conferences Tokyo in September and in Vatican City in November. It was also advised that a three day WMA Ethics Conference would be held in conjunction with the WMA General Assembly in Reykjavik, Iceland. The conference is to be open to the public. At this stage, plans called for the second day of the Ethics Conference to replace the usual scientific session of the General Assembly. Denmark, Canada, Netherlands, Turkey, Kuwait, Brazil, CPME, Japan, Spain, South Africa, Belgium, and the Chair of Medical Ethics Committee volunteered to assist in developing topics for the conference.[1]

IV.1.2 Dr. Miguel Roberto Jorge of Brazil reported of that the conclusions of the Latin American conference held the previous month had been endorsed by 14 national associations. The Royal Dutch Medical Association (RDMA) claimed that some of the conclusions in the report did not accurately reflect the situation in the Netherlands. This presumably refers to mention of "the phenomenon of the 'slippery slope' that has led in the Netherlands to its application in people who had not requested it or did not meet the legal requirements." The Belgian Medical Association stated that its regulations were similar to the Dutch laws, but Belgium was not mentioned in the report.[2]

IV.2 MEC and Council meetings (October, 2017)

IV.2.1 In an oral report to the Medical Ethics Committee, the Secretary General described the end-of-life conference held the previous month in Tokyo. He said that, with the exception of Australia and New Zealand, "the appetite for discussing euthanasia and physician assisted suicide in the Asia region is very low," and that no medical association in the area supports the procedures.[3] (The written report of the conference that would be received later states that "all participants opposed euthanasia and physician assisted suicide", apart from Zealand and Australia, there is "*no* appetite" for discussion of the procedures in the region (III.3.4) - emphasis added).

IV.2.2 At the Council meeting in October, only a brief and oblique reference was made to the organization of the regional end-of-life conferences.[4]

IV.3 Canada and Netherlands on "assisted dying" in WM Journal (October, 2017)

IV.3.1 The October issue of the *World Medical Journal* included two lengthy articles on euthanasia and assisted suicide, one by Dr. Jeff Blackmer about the CMA's approach to legalization of the procedures,[5] and the other by two RDMA bioethicists, explaining and defending Dutch law and practice.[6] Notwithstanding disclaimers in both articles, they were written to support the campaign by Canada and the Netherlands to change WMA policy, so it is important to attend not only to what they emphasize, but what they leave out.

Euthanasia in the Netherlands

IV.3.2 The Dutch bioethicists wrote in response to two previous articles which, arguing for maintaining WMA opposition to euthanasia and assisted suicide, had criticized the Dutch system.[7,8] The authors did not aim "to convince others or settle the debate" but to correct "misconceptions" and to present alternative views worth considering. Only points relevant to physician freedom of conscience are considered here. Note that the term "euthanasia," as used by the authors, includes assisted suicide.

IV.3.3 De Jong and van Dijt emphasize that euthanasia remains a criminal offence if the criteria set out in the law are not satisfied, that patients seeking it have no right to require physicians to assist, and that physicians are "never obliged" to do so. For these reasons they claim that euthanasia is neither a "therapeutic intervention" nor "regular medical care,"[9] and contrary assertions do not reflect "the reality of the situation in the Netherlands."

IV.3.4 If all of this were really the case, it would be most gratifying from the perspective of the protection of physician freedom of conscience, for there would then seem to be no reason to insist that physicians should be involved in euthanasia and assisted suicide, no justification for attempting to ensure their participation or collaboration, and no reason for the WMA to change its policy. In point of fact, however, the RDMA does consider euthanasia and assisted suicide to be therapeutic medical acts, though not, as the authors correctly state, part of "regular" or "standard" care.

> A request for euthanasia is one of the most intrusive and onerous demands that a patient can make of a physician. Most physicians find it difficult to perform euthanasia or assisted suicide. This is all the more true if that wish is not prompted by a terminal illness.[10]

IV.3.5 Nonetheless, the RDMA acknowledges (as the authors do not) that the Dutch widely (though incorrectly) believe that they have a right to euthanasia and assisted suicide from physicians, describing this as "a common misconception."[10] It also acknowledges (as the authors do not) "burdensome" and "increasingly vocal" public pressure to provide euthanasia to those with dementia and psychiatric conditions and to "seniors who feel they have 'completed life,'" in response to which the RDMA insists that "euthanasia is an exceptional medical procedure that inherently entails a dilemma for the physician," and that "plenty of physicians" are "unwilling or morally indisposed" to participate.[11]

> Patients have the right to request euthanasia, but physicians are not obligated to grant their request: fundamental objections to euthanasia and assisted suicide must be respected. After all, euthanasia and assisted suicide are anything but ordinary medical procedures.[12]

IV.3.6 Despite this, the RDMA demands that physicians unwilling to kill patients or help them commit suicide or assisted suicide must help them find a colleague willing to do so. "Though there is no legal obligation to refer patients," it states, "there is a moral and professional duty to provide patients with timely assistance in finding a physician (for example, within the clinic) who does not have fundamental objections to euthanasia and assisted suicide."[12]

IV.3.7 While the authors agree that physicians may be morally obliged to provide euthanasia,[13] many objecting physicians emphatically reject the claim that physicians have a "moral duty" to facilitate homicide and suicide under any circumstances, especially in the absence of a legal requirement to that effect. That the RDMA demands such collaboration, a critical point left out by the authors, is surely relevant to any reconsideration of WMA policy on euthanasia and assisted suicide. It is also relevant to evaluating the protection of conscience provision in the CMA/RDMA proposal, which is contradicted by RDMA policy on this point (VI.4.4.3, VII.4.3.4).

IV.3.8 While it is true that euthanasia remains a criminal offence if the criteria set out in the law are not satisfied, this simply reflects the fact that it is not feasible to entirely abolish the law against deliberate homicide; legalization of euthanasia entails making an exception. On this point, Canadian legislation is identical; non-consensual homicide and assisted suicide remain criminal offences unless performed by a physician in accordance with legal criteria,[14] in which case they are considered therapeutic medical interventions.[15,16] That is the basis for demands by some euthanasia advocates and regulators that Canadian physicians must provide or facilitate the procedures by referral.

IV.3.9 On the other hand, the authors identify an important substantive requirement of Dutch euthanasia law, but fail to appreciate its relevance to physician freedom of conscience. Dutch law requires that the attending physician - not just the patient - must be satisfied that the patient's suffering is unbearable, with no prospect of improvement, and that there is "no alternative" to euthanasia or assisted suicide;[17] the RDMA insists that euthanasia must be literally a "last resort."[9] These essential requirements for legality not being met, it would be a criminal offence to facilitate euthanasia or assisted suicide by referral. In most cases, objecting physicians would probably not agree that a patient's suffering cannot be ameliorated, or that there is no alternative to euthanasia. Thus, it would likely be impossible to successfully prosecute an objecting physician for refusing to refer patients.

The Work of the Canadian Medical Association

IV.3.10 It is instructive to compare Dr. Blackmer's journal article with details of the events as they unfolded (Appendix "B"), filling in some details he omits and drawing attention to points he does not develop.

IV.3.11 Dr. Blackmer describes the CMA Board of Directors decision to actively shape the debate and law on euthanasia and assisted suicide. His article discusses the CMA's internal and external consultation process, the passage of a key policy resolution, its intervention in the *Carter* case, and its activities following the decision and subsequent legislation. He suggests that the WMA and other national associations should learn from the CMA's example. In his view, there is no point in arguing about the morality of euthanasia and assisted suicide because "no one is likely to change their views on this." Rather, he says, it is better to unite the medical profession in its approach to the procedures if they are legalized.

IV.3.12 According to the *Journal* article, the CMA's public consultation disclosed general agreement that access to palliative and hospice care was important and that a national strategy was needed to advance that goal, but that the public was divided on whether

or not euthanasia or assisted suicide should be legalized. The article highlights agreement on the need for "strict protocols and safeguards" if the law were changed, but does not make clear that this could only have been supported by those uncertain about or in favour of legalization. It also omits the finding that the potential impact of legalization on the medical profession "should be carefully considered and studied further." (B3.3)

IV.3.13 The meetings with physicians confirmed the need for advance care planning and palliative care. They also demonstrated that euthanasia and assisted suicide were "no longer taboo subjects," that physicians were ready to discuss the subject and even "lead the conversation", and what Dr. Blackmer describes as the essential intractability of opinions about euthanasia and assisted suicide: "No amount of argument or evidence was likely to change anyone's mind."

IV.3.14 That is Dr. Blackmer's view: the report itself referred only to the intractability of certain medical conditions, not physician opinions.[18] Dr. Blackmer correctly states that it found "the profession. . .divided on the issue of assisted death," but omits the fact that the great majority of physicians - over 70% - were opposed to the procedures and a change in CMA policy (B3.4).

IV.3.15 Dr. Blackmer highlights the policy resolution adopted by the CMA's Annual General Council, which is especially significant because it is very similar to the first of three WMA policy changes recommended by Canada and the Netherlands.

> The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide.

IV.3.16 This is discussed in more detail in Part VI and VII and Appendix "B." For the present, it is important to note that this did not lead the CMA to adopt a neutral position on assisted suicide and euthanasia. The Board of Directors, having convinced the delegates at the Annual General Council to approve an ostensibly neutral resolution (B5.8, B6.), later reversed CMA policy against the procedures, formally approving both (subject to legal constraints) as forms of "end of life care." Moreover, the policy committed the Association to support euthanasia and assisted suicide as end-of-life care not only for competent adults, but for any patient group and for any reason approved by the courts or legislatures, including minors, the incompetent or the mentally ill (B9).[19]

IV.3.17 Legalization of euthanasia and assisted suicide has had serious adverse consequences for objecting physicians (B10.5-9) that are not mentioned in his *Journal* article. He does not, for example, acknowledge that, as a direct consequence of the reversal of CMA policy and legalization of the procedures, objecting physicians have had to lobby the CMA for support and make "tearful pleas at several CMA General Council meetings, asking their non-objecting colleagues to support them and to defend their rights."[20]

IV.3.18 Dr. Blackmer states that, after the Supreme Court of Canada ruling in *Carter*, "the CMA was tasked with formulating a suggested legislative and regulatory approach to these complex issues." What actually happened is that the federal government did

nothing for almost five months, then called (and lost) an election, leaving the CMA and other stakeholders scrambling to develop policies without any direction as to what changes would be made to the criminal law. The result was a policy and regulatory maelstrom that lasted several months. The Board of Directors, having concentrated on shaping the debate and changing CMA policy, was quite unprepared to mount a cogent, articulate and persuasive defence of physician freedom of conscience. (B10.19)

IV.4 MEC and Council meetings (April, 2018)

IV.4.1 The Medical Ethics Committee received four written reports concerning the regional end-of-life conferences, supplemented by oral reports from the Nigerian and German Medical Associations. The Secretary General stated that the regional conferences were to lead to "an international discussion" at the WMA Ethics Conference in Iceland in October. This was the first indication in the minutes of the Medical Ethics Committee that euthanasia and assisted suicide would be on the agenda of the Ethics Conference.[21]

IV.4.2 It must have been clear to the Committee that virtually all national associations that had participated in the regional conferences were opposed to euthanasia and physician assisted suicide, and were presumably satisfied with existing WMA policies. Moreover, while there was public interest in New Zealand and Australia in legalizing the procedures, the national medical associations in both countries remained opposed to physician participation.

IV.4.3 The minutes disclose only that there was "further debate" about the subject. According to the World Medical Journal, there was a brief discussion about the fact that current WMA policy states that euthanasia is unethical, but it has been legalized in some countries. The discussion must have highlighted the difference between the ethical position of the WMA and that of constituent medical associations like the CMA and RDMA. The committee was told "there would be ample time to discuss this matter further at the medical ethics conference in Reykjavik."[22]

IV.4.4 The *Journal* added another detail not recorded in the minutes. The CMA and RDMA stated that they would be returning in October with a revised proposal on euthanasia and assisted suicide "to see if they could accommodate all the divergent views among members."[22]

IV.5 New proposal re: "Policy Consistency" (3 July, 2018)

IV.5.1 In the first week of July, five associate members submitted a policy proposal to be considered at the meeting of associate members at the WMA General Assembly in October in Iceland. The proposal is relevant to discussion at the April Medical Ethics Committee meeting about inconsistency between WMA policy on euthanasia and that of some of its constituent members (VI.4.3). One of the five sponsors of the new proposal is a Canadian medical resident who appears to have closely followed and frequently signalled approval of Dr. Blackmer's tweets from the conference in the Vatican (III.4.6 to III.4.21; III.4.28 to III.4.30).

IV.5.2 In the preamble, the proposal states that it is important that WMA and constituent member policies should, as far as possible, be consistent with one another. It notes

that, while WMA policy development includes a review of national policies, a review of WMA policy is less likely to happen during policy development by national associations. The document proposes that policy development by national associations should always include formal systematic consultation of WMA policies.

VI.5.3 However, the proposal identifies "ethical policy" as "a special case where consistency is most important and in some circumstances may not be possible." Hence, while national medical association policy "should be specific and consistent with World Medical Association Ethical Policy," the sponsors argue that WMA ethical policies should accommodate "national and culture differences."

> When an NMA has an ethical opinion that is not consistent with WMA policy, but is consistent with the law in its country and is clearly generated by benevolence toward patients, WMA may allow for national and cultural differences in formulating its own ethical policies.

IV.5.4 Euthanasia and assisted suicide are always described by EAS advocates as expressions of benevolence or beneficence (within the present context it is assumed the terms are interchangeable). Thus, if accepted, the policy would force the WMA to "allow for" physician participation in euthanasia and assisted suicide and even to allow for the coercion of objecting physicians (VII.5.9).

IV.6 CMA & RDMA introduce revised EAS proposal

IV.6.1 At the end of July the CMA and RDMA reintroduced the proposal they had withdrawn previously, with revisions (Appendix "C"). While they had stated that the revisions were intended to "accommodate divergent views" among WMA constituent members (IV.4.4), the only divergent views accommodated were those of the CMA, RDMA and other EAS supporters, which diverge from the overwhelming majority of medical associations around the world. The revisions are outlined below. The revised proposal will be considered in detail in Part VI.

Minor revisions

IV.6.2 Many of the revisions are minor. For example, "assisted suicide" in the original is now "assisted death;" those seeking the services were "patients" in the original but are "persons" in the revised version. Some, like the definitions of euthanasia and "assisted death," are clarifications.[23] A new section about the need to support for patients at the end of life is unremarkable.[24] The remaining changes are rhetorical, rhetorical and substantive or substantive.

Rhetorical revisions

IV.6.3 There is special emphasis in the revised proposal on democracy - "democratic processes" and "extensive democratic legislative processes" - and redoubled emphasis on legislation, court decisions and public debate.[25]

IV.6.4 The most obvious rhetorical change reflects an attempt to minimize the overwhelming opposition to euthanasia and assisted suicide in the medical profession worldwide, amply demonstrated by the results of the regional conferences. The admission that "the majority of physicians" find the procedures to be irreconcilable with medical ethics has been struck out entirely, replaced with the statement that "many physicians"

merely recognize a conflict.[26]

IV.6.5 A new paragraph emphasizes a 'diversity' of responses to this conflict. While it may reflect the associate members' proposal introduced earlier in the same month (IV.5), it is identical to a statement about abortion introduced into the revised *Declaration of Oslo* that will be considered by the General Assembly in October:[27]

> Diverse responses to resolve this dilemma reflect the diverse cultural, legal, traditional, and regional standards of medical care throughout the world.[28]

Rhetorical and substantive revisions

IV.6.6 With respect to physician freedom of conscience, the wording of the original proposal was very similar to the resolution used by the CMA Board of Directors as the basis for reversing CMA policy against euthanasia and assisted suicide (B5, B6, B7, B9). A new paragraph has been added, a slightly modified passage also taken from the revised Declaration of Oslo.

> Attitudes toward euthanasia and physician assisted death are evolving and are a matter of individual conviction and conscience that should be respected.[29]

At first glance, this seems only to lend more weight to the emphasis on freedom of conscience.

IV.6.7 However, this is also a substantive change. If attitudes toward euthanasia and assisted suicide continue to evolve, so will the criteria for the procedures. All evidence to date demonstrates that the evolution is exclusively in the direction of expanded access, which generally speaking, entails increasingly controversial criteria. If, as this statement requires, the WMA must respect all attitudes toward euthanasia and assisted suicide no matter how they evolve, the statement commits the WMA to accept euthanasia and assisted suicide for any reason acceptable in law.

Substantive revisions

IV.6.8 With respect to EAS providers, the original proposal stated that they were motivated by "compassion for their patients." They are now said to be responding to "the immediate needs of their patients."[30] The change implies an objectively verifiable need to be killed or helped to commit suicide, so that by approving the policy the WMA would acknowlede such a need.

IV.6.9 Palliative care was first said to be part of "part of good and appropriate medical care," but in the revised proposal this is only the case when it is "available." The implication may be that actual access to palliative care need not be a precondition for the provision of euthanasia and assisted suicide.[31] Consistent with this, the original statement that euthanasia and assisted suicide "should never" be substitutes for palliative care has been revised to read that they "should not" be.[32]

IV.6.10 Originally, the CMA and RDMA proposed only that the WMA affirm that it does not condemn EAS providers, but now wants the Association to state, in addition, that they are not acting unethically.[33]

IV.6.11 A new provision in the proposal states that euthanasia and assisted suicide should be provided by competent physicians or health care providers.[34] If the WMA approves

this proposal, it will not only reverse its policy against the procedures, but affirm that, where the procedures are legal, physicians have an ethical obligation to kill their patients or help them commit suicide.

IV.6.12 The revised proposal narrows the protection offered to objecting physicians. The CMA and RDMA first stated that objecting physicians should not be forced to refer patients to other physicians. They now state that physicians should not be forced to refer "to another physician in order to provide assistance in dying" (emphasis added). This does not preclude compulsory referral to physicians who will provide required consultations preliminary to lethal injection by someone else, nor does it preclude compulsory referral to euthanasia delivery coordinators.[35]

IV.6.13 Finally, in 2016, the CMA and RDMA insisted that euthanasia and assisted suicide "should be seen as a last resort for those whose intractable and hopeless suffering cannot be alleviated through any other ordinary means." This restriction has been struck out completely,[36]36 indicating that the ultimate goal of the CMA and RDMA is the WMA's unconditional approval of euthanasia and assisted suicide as legitimate forms of medical treatment.

Notes

1. World Medical Association. MEC 206/Report/Apr2017: Report of the Medical Ethics Committee (20-21 April, 2017).

2. World Medical Association. Council 206/Minutes/Apr2017: Minutes of the 206th Council Session (20, 22 April, 2017) p.4.

3. World Medical Association. MEC 207/Report/Oct2017: Report of the Medical Ethics Committee (11 October, 2017)3.10 Regional meetings on End-of-Life Question (EoL workshop) p. 4-5.

4. World Medical Association. Council 207/Minutes/Oct2017: Minutes of the 207th Council Session (11 and 13 October, 2011) p.2.

5. Blackmer J. Assisted Dying and the Work of the Canadian Medical Association. World Medical J [Internet]. 2017 Oct [Cited 2018 Sep 29] ; 63(3):6-9 [Blackmer-WMJ] Available from: https://lab.arstubiedriba.lv/WMJ/vol63/october-2017/#page=8.

6. de Jong A, van Dijt G. Euthanasia in the Netherlands: balancing autonomy and compassion. World Medical J [Internet]. 2017 Oct [Cited 2018 Sep 29]; 63(3)10-15 [de Jong-van Digt] Available from:
https://lab.arstubiedriba.lv/WMJ/vol63/october-2017/#page=12.

7. Requena P. Why Should the World Medical Association not Change its Policy towards Euthanasia? World Medical J [Internet]. 2016 Oct [Cited 2018 Sep 29]; 62(3) 99-102. Available from: https://www.wma.net/wp-content/uploads/2017/03/wmj201603.pdf

8. Keown J. Voluntary Euthanasia and Physician-assisted Suicide: Should the WMA Drop its Opposition? World Medical J [Internet]. 2016 Oct [Cited 2018 Sep 29]; 62(3) 103-107. Available from: https://www.wma.net/wp-content/uploads/2017/03/wmj201603.pdf

9. Similarly, Herman Nys, writing in 2001: "In the Netherlands the majority of health-care lawyers believe that euthanasia is not a 'normal medical act', although it must be administered by a physician. There is no medical indication for euthanasia and there exists no professional medical standard for its permissibility. Whether euthanasia is to be allowed or not is a matter for society, not for the medical profession. The same is true of, say, non-therapeutic abortion. Moreover, if euthanasia were a normal medical act, the physician should in principle administer it. Nobody is of that opinion in the Netherlands." Nys H. Euthanasia in the low countries: a comparative analysis of the law regarding euthanasia in Belgium and the Netherlands. Ethical Perspect [Internet]. 2002 [Cited 2018 Sep 29]; 9(2):73-85. Available from: http://www.ethical-perspectives.be/page.php?FILE=ep_detail&ID=33&TID=51.

10. Royal Dutch Medical Association [Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG)]. The Role of the Physician in the Voluntary Termination of Life [Internet]. Utrecht, Netherlands:KNMG; 2011 Jun 23 [Cited 2018 Sep 29] [RDMA-Role of the Physician] p. 6. Available from: https://www.knmg.nl/web/file?uuid=b55c1fae-0ab6-47cb-a979-1970e6f60ae6&owner=5c945405-d6ca-4deb-aa16-7af2088aa173&contentid=262.

11. RDMA-Role of the Physician, p. 6-7.

12. RDMA-Role of the Physician, p. 33.

13. ". . . the principle of compassion may require physicians to grant such a request for euthanasia." de Jong-van Digt, p. 15.

14. Criminal Code. RSC 1985, c. C-46, s. 227, 241(2) to (5.1) [Internet] [Cited 2018 Sep 29]. Available from: http://laws-lois.justice.gc.ca/eng/acts/C-46/FullText.html.

15. Doctor-assisted suicide a therapeutic service, says Canadian Medical Association. CBC News [Internet]. 2016 Feb 6 [Cited 2018 Sep 29]. Available from: http://www.cbc.ca/news/health/doctor-assisted-suicide-a-therapeutic-service-says-canadian-medical-association-1.2947779.

16. The Canadian Medical Association describes euthanasia and physician assisted suicide as "legally permissible medical service[s]." Canadian Medical Association. Medical Assistance in Dying [Internet]. 2017 May [Cited 2018 Sep 29] [CMA-MAID 2017]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/cma_policy_medical_assistance_in_dying_pd17-03-e.pdf.

17. Dutch law on Termination of life on request and assisted suicide (complete text) [Internet]. The World Federation of Right to Die Societies. Termination of Life on Request and Assisted Suicide (Review Procedures) Act [Cited 2018 Sep 29] s.1(b) and (d). Available from: https://www.worldrtd.net/dutch-law-termination-life-request-and-assisted-suicide-complete-text.

18. Canadian Medical Association. End-of-Life Care: A National Dialogue. CMA Member Consultation Report [Internet] 2014 Jul [Cited 2018 Sep 29][CMA Member Consultation] p.

8. Available from:
https://www.cma.ca/Assets/assets-library/document/en/advocacy/Englishreportfinal.pdf.

19. When the CMA revised the policy in 2017, it reintroduced the distinction between euthanasia and physician assisted suicide and other forms of end-of-life care. CMA-MAID 2017.

20. Blackmer J. Letter from Dr. Jeff Blackmer, Vice President, Medical Professionalism, Canadian Medical Association, to Physicians' Alliance Against Euthanasia [Internet]. Collectif des Médecins Contre L'Euthanasie; 2018 Apr 30 [Cited 2018 Sep28]. Available from: https://collectifmedecins.org/en/dr-blackmer-blog-response/.

21. World Medical Association. MEC 209/Report/Apr2018: Report of the Medical Ethics Committee (27 April, 2018)

22. Medical Ethics Committee, End of Life Questions. World Medical J [Internet]. 2018 Aug [Cited 2018 Sep 29]; 64(2):8-9. Available from: https://www.wma.net/wp-content/uploads/2018/09/WMJ_2_2018.pdf.

23. World Medical Association. MEC 210/Euthanasia and PAD/Oct2018: Proposed WMA Reconsideration of the Statement, Resolution and Declaration on Euthanasia and Physician Assisted Dying [2018C/RDMA] §2. See also Appendix "C": Comparison of 2016 and 2018 CMA/RDMA proposals [Appendix "C"] Ref. E, F.

24. 2018C/RDMA §13 (Appendix "C,"Ref. U)

25. 2018C/RDMA §1, 9 (Appendix "C," Ref. C, N)

26. Compare MEC 203/Euthanasia-Physician Assisted Dying/Apr2016: MEC 203/Euthanasia-Physician Assisted Dying/Apr2016: Proposed WMA Reconsideration of the Statement on Euthanasia and Physician Assisted Dying [2016 CDMA] §7 with 2018C/RDMA §8 (Appendix "C," Ref. K).

27. World Medical Association. MEC 209/ Therapeutic Abortion REV4/Apr2018: Proposed WMA Statement on Medically-Indicated Termination of Pregnancy [AbortionRev4] paragraph 3.

28. 2018C/RDMA §8 (Appendix "C," Ref. L)

29. 2018 C/RDMA, §8 (Appendix "C," Ref. P); compare Abortion Rev4, paragraph 2.

30. Compare 2016C/RDMA §1, with 2018C/RDMA §2 (Appendix "C," Ref. C)

31. Compare 2016C/RDMA §5, with 2018C/RDMA §6 (Appendix "C," Ref. H)

32. Compare 2016C/RDMA §10, with 2018C/RDMA §12 (Appendix "C," Ref. T)

33. Compare 2016C/RDMA§8, with 2018C/RDMA §9 (Appendix "C," Ref. O)

34. 2018C/RDMA §11 (Appendix "C," Ref. S)

35. Compare 2016C/RDMA §9, with 2018C/RDMA §10 (Appendix "C," Ref. Q)

36. 2016C/RDMA §10 (Appendix "C," Ref. T)

V. 2018 WMA ETHICS CONFERENCE, ICELAND

V.1 Organizers

V.1.1 An eight member international committee is responsible for organizing the programme for the conference, assisted by WMA Secretary General Dr. Otmar Kloiber and Dr. Julia Tainijoki-Seyer from the WMA Secretariat.[1]

V.1.2 Dr. Jeff Blackmer of the CMA is one of the organizers.[1] Of the remaining seven, five (Jeppe Berggreen Høj,[2] Mohammad Almutairi,[3] Miguel R. Jorge,[4] Annabel Seebohm[5] and Ramin Parsa-Parsi[6]) do not appear to have been significantly involved on either side of the euthanasia or assisted suicide controversy, and two (Heidi Stensmyren and Andreas Rudkøbing) have indicated some opposition to the procedures.

V.1.3 Dr. Stensmyren, President of the Swedish Medical Association, is a specialist in anaesthesiology and intensive care.[7] Her Twitter feed suggests opposition to euthanasia and physician assisted suicide[8] and perhaps some reservations about the course being taken by the CMA.[9] In a debate in January, 2018, she spoke against the procedures.[10]

V.1.4 Dr. Andreas Rudkøbing is President of the Danish Medical Association, which strongly opposes euthanasia and asissted suicide.[11]

V.2 Programme

V.2.1 Sessions that are or may be relevant to euthanasia and assisted suicide will be held on the second and third day of the conference (3 and 4 October, 2018), as follows:[12]

Wednesday 3. Oct.

08:30-09:00

- Plenary Presentation: Ethics of Palliative Medicine
  - Speaker: Kirsty Boyd

09:00-10:30

- WMA Associate Members symposium
  - Chair: Joseph Heyman
- Palliative Care
  - Speakers:
    - Kirsty Boyd, Edinburgh, UK
    - Salem Al Kandar, Kuwait
    - Arna Einarsdóttir MD, Reykjavik, Iceland

11:00-12:30

- Hard Choices in Medicine
  - Speakers
    - Miguel Jorge, Brazilian Medical Association
    - Greg Koski, International Federation of Associations of Pharmaceutical Physicians and Pharmaceutical Medicine (IFAPP)
    - Guðmundur Heiðar Frímannsson, (PhD ethics), professor of philosophy at the School of Humanities and Social Sciences

University of Akurey

- Free oral presentations
  - 4) Euthanasia on grounds of 'tired of living'
    - Gert van DIjk, Krista Tromp (Royal Dutch Medical Association)

15:30-17:00

- Person Centered Medicine
  - Speakers
    - Robert Cloninger: Well being and burn
    - Juan Mezzich, Professor, New York, US: Person centred medicine, general concepts
    - Jim Appleyard: Person centered medicine; the core of professionalism in medical education
    - Ihsan Salloum: The methods of Person centred medicine in research

Thursday 4. Oct

08:30-10:00

- Plenum Presentations: Euthanasia and physician assisted suicide
  - Speaker: Ilora Finlay, Baroness, Cardiff, UK

10:30-12:00

- Euthanasia and physician assisted suicide: Reports from the WMA regional meetings on end of life issues
  - Speakers:
    - Frank Montgomery German Medical Association
    - Osahon Enabulele Nigerian Medical Association
    - Tatsuo Kuroyanagi Japan Medical Association
    - Miguel Jorges Brazilian Medical Association

13:30-15:00

- Good conduct of physicians
  - Speakers:
    - Ramin Parsa, German Medical Association
    - Urban Wiesing, Professor, Tübingen, Germany
    - Runolfur Palsson Professor, Reykjavik, Iceland
- Euthanasia and physician assisted suicide
  - Speakers:
    - Antina de Jong, Royal Dutch Medical Association
    - Jeff Blackmer, Canadian Medical Association
    - Kati Myllimäki: Finnish Medical Association

V.2.2 Euthanasia and assisted suicide are scheduled topics for the last day of the conference. Reports from the regional meetings will be delivered in the morning; these will argue against a change in WMA policy. CMA and RDMA representatives argue for a change in policy in the afternoon. The representative from the Finnish Medical Association will probably speak to the importance of continuing discussion of the subject within the profession, and continuing engagement of the profession with the public. Those advocating for a change of policy have the benefit of hearing their

opponents before addressing the conference, and the advantage of speaking last.

Þriðjudagsfyrirlestur: Á dauðans tími að vera óviss? 21 February, 2015

http://www.listak.is/is/moya/news/thridjudagsfyrirlestur-gudmundur-heidar-frimannsson-a-dauda ns-timi-ad-vera-oviss-

Andspænis dauðanum (Faced with Death) 10 March, 2016

http://hugvis.hi.is/andspaenis_daudanum

Notes

1. World Medical Association. Medical Ethics Conference, Reykjavík, 2-4 October, 2018 [Internet] Organizers [Cited 2018 Sep 29]. Available from: https://icelandtravel.artegis.com/lw/CustomContent?T=1&custom=1571&navid=16916&eve nt=12406.

2. Jeppe Berggreen Høj: Danish Medical Association Secretariat (Accessed 2018-06-02).

3. Mohammad Almutairi was head of Kuwait Medical Association. Chairman, Supreme Council of the Arab Medical Union in July, 2017. KMA Chief Honoured. KMA Chief Honoured. Arab Times [Internet]. 2017 Jul 9 [Cited 2018 Sep 29].Available from: https://www.pressreader.com/kuwait/arab-times/20170709/281711204682401.

4. Miguel R. Jorge is an Associate Professor of Psychiatry and Academic Director of the Federal University of São Paulo Medical School, where he got a Masters of Science (M.Sc.) and a Philosophical Doctor (Ph.D.) degree in Pscyhopharmacology, and a Full Professorship in Clinical Psychiatry. Prof. Jorge currently is Director of International Affairs of the Brazilian Medical Association and has had some important positions in other health organizations such as President of the Brazilian Association of Psychiatry, Regional Vice-President of the World Federation for Mental Health, and President of the Diagnosis and Classification Section of the Latin American Psychiatric World Medical Association. Medical Ethics Conference, Reykjavík, 2-4 October, 2018 [Internet]. Keynote Speakers [Cited 2018 Sep 29]. Available at: https://icelandtravel.artegis.com/lw/CustomContent?T=1&custom=1571&navid=16915&eve nt=12406.

5. Annabel Seebohm: Secretary General, Comité Permanent des Médecins Européens (CPME). Formerly Head of the Brussels Office and Legal Advisor of the Bundesärztekammer/German Medical Association. From 2007 to 2016 she was Legal Advisor of the World Medical Association. Ms Seebohm studied law at the University of Bonn, undertook her judicial service training in Hamburg and holds a Master's Degree from the University of Auckland, New Zealand. CPME welcomes its new Secretary General [Internet]. World Medical Association; 2016 Apr [Cited 2018 Sep 29]. Available from: https://www.cpme.eu/cpme-welcomes-its-new-secretary-general-2/. World Medical Association: Officials: Secretaries, Editors, Press Officers and Legal Advisors [Internet]. [Cited 2018 Sep 29]. Available from: https://www.wma.net/who-we-are/history/officials/.

6. "Ramin Parsa-Parsi is the Head of the Department for International Affairs at the German Medical Association (GMA) in Berlin, Germany. Prior to joining the GMA, Dr Parsa -Parsi

worked with Harvard Medical International in Boston, USA, as the Director of Health Policy. He is a member of the Council of the World Medical Association (WMA) and chaired international workgroups for the 2013 revision of the WMA Declaration of Helsinki and the 2017 revision of the Declaration of Geneva. World Medical Association." WMA European Region Meeting on End-of-Life Questions (16-17 November, 2017) Aula Vecchia del Sinodo, Vatican [Internet]. World Medical Association [Cited 2018 Sep 28] [WMA Vatican Programme] p. 13. Available at: https://www.wma.net/wp-content/uploads/2017/05/Vatican_Final-program-booklet-for-printer.pdf.

7. "Dr Heidi Stensmyren is president of the Swedish Medical Association (SMA) since 2014. She also chairs the SMAs delegation of negotiating salaries and collective agreements for physicians on the Swedish labour market. Dr Stensmyren is council member of the WMA since 2015 and chairs the Medical Ethics Committee since 2017. She works as a specialist in Anesthesiology and Intensive care at Danderyd University Hospital, and holds an M.D. from the University of Würzburg. Dr Stensmyren has been involved as expert in several Swedish government committees such as the Organ Donation Committee, between 2013 -2015 and the Profits in Welfare inquiry, 2015 -2017. She was president of the Swedish junior Doctors between 2007 -2009, chair in the Organ Donation Council between 2012 -2015 and president of the Stockholm Medical Association between 2013 -2014. She has a specific passion for ethics and leadership issues." World Medical Association. WMA Vatican Programme, p. 13.

8. "Euthanasia to mental ill and people with autism....physicians on the slippery slope." Stensmyren H. Tweet Heidi Stensmyren @HeidiStensmyren [Internet]. Twitter; 2016 Oct 22 at 10:35 pm) [Cited 2018 Sep 29]. Available from: https://twitter.com/HeidiStensmyren/status/789701755730694144? Commenting on "Europe's morality crisis: Euthanizing the mentally ill." Washington Post.

9. "@CMA_Docs facilitate discussions in challenging questions such as assisted dying situations with lack of or little praxis." Stensmyren H. Tweet Heidi Stensmyren @HeidiStensmyren [Internet]. Twitter; 2017 Aug 23 at 4:35 am [Cited 2018 Sep 29]. Available from: https://twitter.com/HeidiStensmyren/status/900335668953583616. Commenting on slide showing 83% of responses in favour of euthanasia/assisted suicide for incompetent patients authorized by advance directives.

10. [Caution:machine assisted translation] "The Medical Association, however, says no to physician-assisted suicide. Heidi Stensmyren stated among other things that the task of healthcare is to cure, alleviate and comfort the sick person. In addition, she stated that the reasons why people choose death aid are not always medical, but they can be about losing their context, being alone, or experiencing a burden on their close relatives. 'The one who is ill and seeking medical care should never have to think about whether one's life is worth continuing or not, and the Oregon model, like all humanitarian aid models, has shortcomings. Not least, half of those who apply for assisted suicide do so because they feel relatives and society burdened and we must not have this. If people are looking for medical care, they should be very confident that it is health care they get and not death,' said Heidi Stensmyren. She pointed out, however, that the question is very difficult and has many different levels." Andersson J. Heidi Stensmyren i SVT:s Aktuellt – håller fast vid nej till dödshjälp. Läkartidningen [Internet] 2018;115:EYZP; 2018 Jan 3 [Cited 2018 Sep 29]. Available from:

http://lakartidningen.se/Aktuellt/Nyheter/2018/01/Heidi-Stensmyren-haller-fast-vid-nej-till-dodshjalp/.

11. [Caution: machine assisted translation] "'There is great support and understanding of the Medical Association's policy on euthansia when I discuss it with colleagues. It is remarkable how few doctors I have met are for euthanasia if they work daily with life-threatening sick and dying people - for example, I have not met a single physician in palliation who is a supporter,'[Rudkjøbing] says." Funch M. Læger siger massivt nej til aktiv dødshjælp. Kristeligt Dagblad [Internet]. 2017 Jun 01 [Cited 2018 Sep 29]. Available from: https://www.kristeligt-dagblad.dk/danmark/laeger-siger-massivt-nej-til-aktiv-doedshjaelp.

12. World Medical Association. Medical Ethics Conference, Reykjavík, 2-4 October, 2018 [Internet] Program [Cited 2018 Sep 29]. The direct conference programme link takes one to a log-in page. However, the programme can be accessed from the navigation menu on the conference Welcome Page available from https://icelandtravel.artegis.com/event/wma2018.

VI. CONTENTS OF THE CMA/RDMA PROPOSAL

VI.1 Introduction

VI.1.1 The focus of this review is the 2018 proposal by the CMA and RDMA (2018C/RDMA),[1] but a comparison with the original proposal (2016C/RDMA)[2] is sometimes necessary to fully grasp the implications of the most recent document. Three parts of the proposal that warrant attention are outlined below, with some preliminary observations. Detailed analysis follows in Part VII.

VI.2 Related WMA policies

VI.2.1 The CMA and RDMA state that the only WMA policies related to their proposal are the *WMA Resolution on Euthanasia*, the *WMA Declaration on Euthanasia*, and the *WMA Statement on Physician Assisted Suicide*, which their proposal would replace.

VI.2.2 However, existing WMA policies against euthanasia and assisted suicide are cited and emphatically applied in the *WMA Declaration of Venice on Terminal Illness*[3] and the *WMA Declaration on End-of-Life Medical Care*.[4] It appears that the CMA and RDMA overlooked these declarations in drawing up their proposal.

VI.2.3 If the WMA accepts the C/RDMA proposal it will also have to revise these declarations, either by deleting all references to euthanasia and assisted suicide, or by identifying them as services physicians may wish to provide where they are legal.

VI.3 Preamble

VI.3.1 Irrelevant or uncontroversial assertions

VI.3.1.1 The CMA and RDMA note that the progress of modern medicine has generated difficult questions about the usefulness and appropriateness of medical interventions (2018C/RDMA §5). This is irrelevant. Problems caused by therapeutic obstinacy — unwanted, disproportionate, futile or overly aggressive medical treatments — can be solved without recourse to euthanasia or assisted suicide, and the solutions do not impose any obvious burdens upon physician freedom of conscience.

VI.3.1.2 The first two sentences of 2018C/RDMA §7 do not invite or support the conclusion that the WMA should change its policy against euthanasia or assisted suicide, nor do they impose any burdens upon physician freedom of conscience:

> Appropriate end-of-life care should routinely respect and promote patient autonomy and shared decision-making, and be respectful of the values of the patient and his or her family.
>
> Physicians must also focus on quality of care, and on the choices that can be made together with their patients as they near their end of lives.

VI.3.2 Rights claims

VI.3.2.1 The sole justification offered in the Preamble for changing WMA policy against physician participation in euthanasia and assisted suicide is found in the last sentence of C/DMA2018 §7:

> Patients *must* be free to decide for themselves what treatments they want and the manner and circumstances of their death and may not be forced to die in ways they would not wish. (Emphasis added)

VI.3.2.2 There is no dispute that patients have at least a legal right to refuse treatment that they do not want. While they are free to decide what treatments they want, it does not follow that they have a right to have treatments they want, but the distinction is elided in the statement, and it is not clear that it is recognized. In any case, these are essentially autonomy-based rights claims ("must'): that patients have a right to choose (and perhaps access) any treatment they *do* want, a right to determine the manner and circumstances of their death, and, finally, a right not to die "in ways they would not wish" - from natural causes, for example.

VI.3.2.3 These rights claims are contested and have serious implications for physician freedom of conscience, as Dr. Blackmer and then CMA President Dr. Louis Hugo Francescutti admitted when they announced the CMA's intention to intervene in the *Carter* case:

> [W]e must recognize that decisions taken at the end of life are not made in a vacuum. They affect family members, loved ones, caregivers, healthcare providers … and even physicians. One person's right is another person's obligation, and sometimes great burden. And in this case, *a patient's right to assisted dying becomes the physician's obligation to take that patient's life*. (Emphasis added)[5]

VI.3.3 Assertion of need

VI.3.3.1 The Preamble notes that in jursidictions that have legalized physician assisted suicide and/or euthanasia, "some physicians" provide the services "to help meet the immediate needs of their patients, in order to alleviate intractable and hopeless suffering." (2018C/RDMA §1) The original proposal (2016C/RDMA §2) said nothing of "needs," noting only that EAS practitioners were motiviated by "compassion."

VI.3.3.2 The change implies an objectively verifiable need to be killed or helped to commit suicide to address pain or suffering. By approving the policy the WMA would acknowledge such a need, and, implicitly, a corresponding obligation on the part of physicians.

VI.3.3.3 Those opposed to euthanasia and assisted suicide would contest the assertion that euthanasia or assisted suicide are actually requested and provided only to "alleviate intractable and hopeless suffering," though that is what the participants in the Latin American regional meeting believed the discussion was about (III.2.2) Some prominent cases suggest that the range of what is said to constitute "intractable and hopeless suffering" is extraordinarily broad.[6,7,8]

VI.3.3.4 In any case, it will be seen presently that the CMA and RDMA do not hold that euthanasia and assisted suicide should be provided only in cases of intractable and hopeless suffering, so the reference to intractable and hopeless suffering in the preamble is actually of no consequence.

VI.3.4 Conflict between euthanasia/assisted suicide and medical practice

VI.3.4.1 The Preamble acknowledges that euthanasia and assisted suicide challenge (it does not say contradict) the traditional concepts (it does not say ethics) of the medical profession, and that the practices are not part of the "traditional role" of physicians (2018C/RDMA §8).

VI.3.4.2 Even in countries where there is an appetite for euthanasia and assisted suicide and the procedures are legal, the majority of physicians who cannot reconcile the procedures with their ethical commitments is a very large majority indeed. In Belgium, only about 1% of all physicians participated in euthanasia in the first year; for the next three years only about 2% were involved. 13 years after legalization less than 14% of Belgian physicians were providing the service.[9] The Netherlands began with much higher rates once euthanasia was formally legalized, but twelve years later the proportion of all physicians providing euthanasia was still less than 10%.[10] Less than 1% of all physicians prescribe assisted suicide drugs in Oregon[11] and Washington state,[12] 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.[13] Four or five euthanasia cases per year is apparently considered a responsible maximum for a euthanasia practitioner in the Netherlands.[14] Applying the Netherlands rule of thumb, the 551 Ontario patients who died by euthanasia or assisted suicide in the first year of practice[15] could have been adequately serviced by roughly 110 to 137 practitioners willing to personally administer the lethal drugs - or about 0.4% of active Ontario physicians.[16]

VI.3.4.3 These statistics are approximations, but, combined with the results of the WMA regional conferences, they amply demonstrate that the overwhelming majority of physicians worldwide do not wish to be involved in euthanasia and assisted suicide. It is thus noteworthy that the 2016 admission that "the majority of physicians" find the procedures to be irreconcilable with medical ethics (2016C/RDMA §7) has been struck out entirely, replaced in 2018 with the statement that "many physicians" merely recognize the conflict (2018C/RDMA §8).

VI.3.4.4 Arguments concerning coerced referral for abortion can be retooled and applied to euthanasia, and disputes concerning compulsory referral for euthanasia reflect long-running disputes about compulsory referral for abortion. The connection is demonstrated by the importation of two passages from the current revision of the *Declaration of Oslo* into the C/RDMA proposal. The first concerns ethical conflict about abortion and euthanasia/assisted suicide (IV.6.5):

MEC 209/Therapeutic Abortion REV4/Apr2018	MEC 210/Euthanasia and PAD/Oct2018
3. A circumstance where the patient may be harmed by carrying the pregnancy to term presents a conflict between the life of the foetus and the health of the pregnant woman. Diverse responses to resolve this dilemma reflect the diverse cultural, legal, traditional, and regional standards of medical care throughout the world.	8. . . . euthanasia and physician assisted death for many physicians present a conflict between respecting human life and alleviating suffering. Diverse responses to resolve this dilemma reflect the diverse cultural, legal, traditional, and regional standards of medical care throughout the world.

VI.2.4.5 In fact, as the regional meetings demonstrated, the responses are not diverse but sharply dichotomous. The CMA and RDMA hold what is actually an outlying minority position.

VI.3.5 Palliative care not a prerequisite for euthanasia/assisted suicide

VI.3.5.1 A comparison of the 2016 and 2018 documents is especially instructive in relation to palliative care. Originally said to be part of "part of good and appropriate medical care" (2016C/RMDA §5), in the revised proposal this is only so when it is "available" (2018C/RMDA §6). The implication may be that actual access to palliative care need not be a precondition for the provision of euthanasia and assisted suicide, a conclusion consistent with the proposal's recommendations.

VI.4 Recommendations

VI.4.1 The *WMA Statement on Physician Assisted Suicide* declares that euthanasia and assisted suicide are unethical, "must be condemned by the medical profession," and that physicians providing the services act unethically. Thus, according to current WMA policy, the CMA and RDMA have not only failed in their professional duty to condemn the practices, but are acting unethically by supporting euthanasia/assisted suicide providers. The CMA wants the WMA to reverse its position.[17]

VI.4.2 To accomplish this, the CMA and RDMA recommend that the WMA make four policy statements.

VI.4.3 The WMA does not support/does not condemn

VI.4.3.1 2018C/RDMA §9 is the first and principal policy statement. The core element is very similar to the resolution used by the CMA Board of Directors as the basis for reversing CMA policy against euthanasia and assisted suicide. The final sentence in 2018C/RDMA §9 has been taken from the current draft revision of the *Declaration of Oslo*.[18] Editorial changes and additions to the 2016 proposal in all of the extracts below are indicated by yellow highlight and red text respectively.

Sources	2018C/RDMA Proposal for WMA
	9. There are several jurisdictions in the world that through extensive democratic legislative processes, court decisions and public debate have legalized certain forms of euthanasia and assisted death under specific conditions.
The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide.**[CMA Board Resolution (2014)]**	The WMA does not support **or sanction** euthanasia or physician assisted death, but **also** does not condemn **or label as unethical** those physicians who follow their own conscience in deciding whether or not to participate in these activities, within the bounds of applicable legislation, in those jurisdictions where euthanasia and/or physician assisted death are legalized **and follow a person's voluntary and well-considered request.**
2. Termination of pregnancy is a medical matter between the patient and the physician. Attitudes toward termination of pregnancy are a matter of individual conviction and conscience that should be respected. **[MEC 209/Therapeutic Abortion REV4/Apr2018]**	**Attitudes toward euthanasia and physician assisted death are evolving and are a matter of individual conviction and conscience that should be respected.**

VI.4.3.2 Comparing the CMA Board Resolution and C/RDMA statements, two differences are apparent.

- The CMA resolution was silent on the Association's position on euthanasia and assisted suicide.
  - The C/RDMA proposal clearly states that the WMA does not support or sanction the procedures (though this is contradicted later).
- The CMA resolution affirmed support for the right of physicians to exercise freedom of conscience.
  - The C/RDMA proposal states only that the WMA "does not condemn or label as unethical" physicians who follow their consciences concerning the procedures, and advocates respect for freedom of conscience.

VI.4.3.3 Since the overwhelming majority of WMA members would likely oppose any policy implying their support for the euthanasia or assisted suicide, the explicit declaration to the contrary could be expected to mollify them and minimize opposition to the C/RDMA proposal.

VI.4.4 Physician freedom of conscience

VI.4.41 The second recommended policy statement directly addresses physician refusal to participate in euthanasia and assisted suicide.

> **10.** No physician should be forced to participate in euthanasia or assisted death against their personal moral beliefs. Equally, no physician should be forced to refer a patient to another physician **in order to provide assistance in dying**.

VI.4.4.2 The first sentence is essential and sound, though "personal" is superfluous. At this point, demands that physicians must personally provide euthanasia or assisted suicide are only beginning to be made and are still rare.[19,20] The distinction made between participation and referral is problematic, as is the narrowing of protection to cases involving direct referral for the procedures. These points are addressed in the detailed analysis in Part VII.

VI.4.4.3 C/RDMA 2018 §11, the third policy statement, seeks to resolve conflicts between patient demands for services and physician freedom of conscience, including refusal to refer. It implies that the state or some other entity is responsible for ensuring access to euthanasia and assisted suicide.

> **11.** Jurisdictions that legalize euthanasia or physician assisted death must provide mechanisms that will ensure access for those persons who meet the appropriate requirements. Physicians, individually or collectively, must not be made responsible for ensuring access. **Where the law allows euthanasia and physician assisted death to be performed, the procedure should be performed by a competent physician or other health care provider.**

VI.4.4.4 However, to state that physicians or health care workers should provide euthanasia and assisted suicide where they are legal flatly contradicts the earlier statement that the WMA "does not support or sanction" euthanasia or assisted suicide (2018C/RDMA §9).

VI.4.5 Palliative care

VI.4.5.1 A slight change in the preamble may indicate that the CMA and RDMA do not believe that access to palliative care should be a precondition for the provision of euthanasia and assisted suicide. (VI.3.13) Changes in the fourth policy statement that deals directly with palliative care seem consistent with that conclusion.

> 12. WMA also calls on all members to work to ensure access to high quality palliative care services for those in need. Euthanasia and physician assisted suicide should not be used as a substitute for palliative care. ~~but should be seen as a last resort for those whose intractable and hopeless suffering cannot be alleviated through any other ordinary means.~~

VI.4.5.2 The first change is subtle. The 2016 proposal stated that euthanasia and assisted suicide "should never" be substitutes for palliative care, but the 2018 proposal states they "should not" be (2018C/RDMA s12).

VI.4.5.3 The second change is important but invisible to readers who do not have the 2016 proposal. A key 2016 passage has been struck from the 2018 version (§12 above).

VI.4.5.4 The deletion of the restriction resolves an internal contradiction. The CMA and RDMA would have the WMA affirm that patients have a right to the treatment they want, the right to determine the manner and circumstances of their death, and the right not to be forced to die "in ways they would not wish" (VI.3.2). However, if one accepts these rights claims, to insist that euthanasia and assisted suicide can be provided only as a last resort, only in the face of intractable and hopeless suffering would seem to be an unacceptable and paternalistic denial of those rights. Striking out the requirement resolves the contradiction and reinforces the claims.

Notes

1. World Medical Association. MEC 203/Euthanasia-Physician Assisted Dying/Apr2016: Proposed WMA Reconsideration of the Statement on Euthanasia and Physician Assisted Dying [2016 CDMA].

2. World Medical Association. MEC 210/Euthanasia and PAD/Oct2018: Proposed WMA Reconsideration of the Statement on Euthanasia and Physician Assisted Dying [2018 CDMA].

3. World Medical Association. Declaration of Venice on Terminal Illness [Internet]. 2006 Oct [Cited 2018 Sep 29]. Available from: https://www.wma.net/policies-post/wma-declaration-of-venice-on-terminal-illness/.

4. World Medical Association. Declaration on End-of-Life Medical Care [Internet] 2011 Oct [Cited 2018 Sep 29]. Available from: https://www.wma.net/policies-post/wma-declaration-on-end-of-life-medical-care/.

5. Blackmer J Francescutti LH. Canadian Medical Association Perspectives on End-of-Life in Canada. HealthcarePapers 2014 April; 14(1):17-20.doi:10.12927/hcpap.2014.23966

6. Grant K. Medically assisted death allows couple married almost 73 years to die together. The Globe and Mail [Internet]. 2018 Apr 1 [Cited 2018 Sep 28]. Available at: https://www.theglobeandmail.com/canada/article-medically-assisted-death-allows-couple-married-almost-73-years-to-die/.

7. Waterfield B. Euthanasia twins 'had nothing to live for.' The Telegraph [Internet] 2013 Jan 14 [Cited 2018 Sep 28]. Available at: https://www.telegraph.co.uk/news/worldnews/europe/belgium/9801251/Euthanasia-twins-had-nothing-to-live-for.html.

8. Cook M. Dutch couple choose euthanasia together [Internet]. BioEdge; 2017 Aug 19 [Cited 2018 Sep 28]. Available at: https://www.bioedge.org/bioethics/dutch-couple-choose-euthanasia-together/12396?

9. Murphy S. Euthanasia reported in Belgium: statistics compiled from the Commission Fédérale de Contrôle et d' Évaluation de l'Euthanasie Bi-annual Reports [Internet]. Protection of Conscience Project; 2017 Aug [Cited 2018 Sep 29]. Available from: http://www.consciencelaws.org/background/procedures/assist018.aspx.

10. Murphy S. Euthanasia reported in Netherlands: statistics compiled from the Regional Euthanasia Review Committees' Annual Reports [Internet]. Protection of Conscience Project; 2017 Aug [Cited 2018 Sep 29]. Available from: http://www.consciencelaws.org/background/procedures/assist019.aspx.

11. Murphy S. Assisted suicide reported in Oregon, U.S.A.: statistics compiled from the Oregon Public Health Division annual Death with Dignity Act reports [Internet]. Protection of Conscience Project; 2017 Aug [Cited 2018 Sep 29]. Available from: http://www.consciencelaws.org/background/procedures/assist020.aspx

12. Murphy S. Assisted suicide reported in Washington State, U.S.A.: statistics compiled from the Washington State Dept. of Health annual Death with Dignity Act reports [Internet]. Protection of Conscience Project; 2017 Aug [Cited 2018 Sep 29]. Available from: http://www.consciencelaws.org/background/procedures/assist021.aspx

13. For example, by August, 2017, Dr. Lonny Shavelson of California was responsible for the deaths of 48 patients pursuant to the state's assisted suicide statute. See Nutik Zitter J. Should I Help My Patients Die? The New York Times [Internet]. 2017 Aug 5 [Cited 2018 Sep 29]. Available from: https://www.nytimes.com/2017/08/05/opinion/sunday/dying-doctors-palliative-medicine.html

14. Hune-Brown N. How to End a Life. Toronto Life [Internet]. 2017 May 23 [Cited 2018 Sep 29]. Available from: https://torontolife.com/city/life/doctors-assist-suicide-like-end-life/

15. First and second half year totals =189+362=551. See Health Canada. Interim update on medical assistance in dying in Canada June 17 to December 31, 2016 [Internet]. Ottawa: Health Canada, 2017 [Updated 2017 May 31; cited 2018 Sep 29]. Table 3.2: Profile of Medical Assistance in Dying by Jurisdiction/Region. Available from: https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html#t3b.

16. There were about 29,500 MDs in active practice in the province. See College of Physicians and Surgeons of Ontario. 2016 Annual Report [Internet]. Toronto: 2016 [Cited 2018 Sep 29] p. 7 Available from: https://view.joomag.com/annual-report-2016/0566350001504028906?short.

17. Blackmer J. Tweet Jeff Blackmer@jblackmerMD [Internet]. Twitter; 2017 Nov 15 at 11:29 pm [Cited 2018 Sep 28]. Available from: https://twitter.com/jblackmerMD/status/931076735227125760?

18. World Medical Association. MEC 209/ Therapeutic Abortion REV4/Apr2018: Proposed WMA Statement on Medically-Indicated Termination of Pregnancy (April, 2018).

19. Savulescu J, Schuklenk U. Doctors have no right to refuse medical assistance in dying, abortion or contraception. Bioethics Bioethics [Internet] 2017 [Cited 2018 Sep 29] ;31(3):162-170. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/bioe.12288.

20. Attaran A. The Limits of Conscientious and Religious Objection to Physician-Assisted Dying after the Supreme Court's Decision in Carter v Canada. Health L Can 2016; 36(3)

86-98.

VII. ANALYSIS OF THE CMA/RDMA PROPOSAL

VII.1 Overview

VII.1.1 The CMA/RDMA proposal would replace existing WMA policies against euthanasia and physician assisted suicide. The principal elements of the recommended policy are a foundational statement, a protection of conscience provision and statements on palliative care.

VII.1.2 The assertion in the foundational statement that "[t]he WMA does not support or sanction" the procedures is meaningless rhetoric. The document actually requires the WMA to affirm that physicians should provide euthanasia and assisted suicide in the document if they are legalized.

VII.1.3 Statements about palliative care are superficially unremarkable. However, the recommendations do not require access to or the unsuccessful application of palliative care as a prerequisite for euthanasia or assisted suicide. Euthanasia and assisted suicide are not to be considered exceptional treatments of last resort.

VII.1.4 The provision concerning physician freedom of conscience does not adequately address the issue of complicity or moral responsibility, is unclear with respect to the meaning of participation, and provides inadequate protection for those who refuse to collaborate in providing or facilitating access to the procedures. The recommendation that physicians should provide euthanasia and assisted suicide undermines an assertion that they should not be made responsible for ensuring access to the procedures. The provision does not reflect a developed understanding of the subject and is actually contradicted by the RDMA.

VII.1.5 A number of arguments advanced in support of the proposal are addressed following discussion of the principal elements of the policy. These can be contested on their own terms, or are persuasive only to the extent that one accepts the contested assumptions underlying them.

VII.2 Foundational statement

VII.2.1 Rhetorical disclaimer

VII.2.1.1 The core element in the foundational statement appears in the penultimate sentence in 2018C/RDMA §9 (VI.4.13), italicized below:

> 9. . . .*The WMA* <u>*does not support or sanction euthanasia or physician assisted death*</u>*, but also does not condemn or label as unethical those physicians who follow their own conscience in deciding whether or not to participate in these activities, within the bounds of applicable legislation, in those jurisdictions where euthanasia and/or physician assisted death are legalized and follow a person's voluntary and well-considered request.*
> (Emphasis added.)

Attitudes toward euthanasia and physician assisted death are evolving and are a matter of individual conviction and conscience that should be

respected.

VII.2.1.2 The opening disclaimer (underlined) has merely rhetorical force. It is contradicted by 2018C/RDMA 11, which states that euthanasia and physician assisted suicide should be performed by competent physicians or health care providers where the procedures are legal.

VII.2.1.3 The practical significance of the C/RDMA proposal can be assessed by applying its recommendations to the *WMA Resolution on Physician Participation in Capital Punishment* and the *WMA Statement on Female Genital Mutilation*.

VII.2.2 Foundational statement applied to capital punishment

VII.2.2.1 The WMA Resolution on Physician Participation in Capital Punishment states:

> RESOLVED, that it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions.
>
> The World Medical Association
>
> REQUESTS firmly its constituent members to advise all physicians that any participation in capital punishment as stated above is unethical.
>
> URGES its constituent members to lobby actively national governments and legislators against any participation of physicians in capital punishment.[1]

VII.2.2.2 Rewritten according to the C/RDMA proposal:

> The WMA does not support or sanction capital punishment, but WMA does not condemn or label as unethical physicians who follow their own conscience in deciding whether or not to participate in capital punishment, within the bounds of the legislation, in those jurisdictions where capital punishment is legal. **[Following C/RDMA2018 §9]**
>
> . . . where the law allows capital punishment to be performed by lethal injection, the procedure should be performed by a competent physician or other health care provider. **[Folllowing C/RDMA2018 §11]**

VII.2.3 Foundational statement applied to female genital mutilation

VII.2.3.1 The resolution on capital punishment does not address the ethics of execution, but only physician participation. A closer parallel to policies on euthanasia and assisted suicide is provided by the *WMA Statement on Female Genital Mutilation*,[2] which condemns both the practice and physician participation. Once more applying recommendations from the CMA and RDMA:

> The WMA does not support or sanction female genital mutilation, but WMA does not condemn or label as unethical physicians who

follow their own conscience in deciding whether or not to participate in female genital mutilation, within the bounds of the legislation, in those jurisdictions where female genital mutilation is legal. **[Following C/RDMA2018 §9]**

. . . where the law allows female genital mutilation, the procedure should be performed by a competent physician or other health care provider. **[Following C/RDMA2018 §11]**

VII.2.3.2 These comparisons demonstrate that the foundational statement's assertion that the WMA "does not support or sanction" euthanasia or assisted suicide is meaningless, while the withdrawal of disapproval would be fully effective in encouraging legalization of euthanasia and assisted suicide and physician participation in both practices. Taken as a whole, were the WMA to accept the proposal it would affirm that the procedures are consistent with medical ethics if provided in response to a "voluntary and well considered request."

VII.2.4 Virtually unlimited and evolving criteria

VII.2.4.1 According to the proposal, apart from legality, voluntariness and sufficient reflection are sufficient to justify the provision of euthanasia and assisted suicide. It imposes no other conditions or restrictions on the procedures. It does not require that requests be contemporaneous with provision of the services, so it permits euthanasia and assisted suicide for incompetent patients (including dementia patients, stroke victims, etc.) based upon voluntary and well considered requests made in an advance directive drawn up before they became incompetent. Acceptance of the proposal by the WMA would support euthanasia and assisted suicide in such cases, and for non-terminal chronic conditions or disabilities, for adolescents, children and infants, and for forms of mental illness or psychological disorders that do not compromise medical decision making capacity.

VII.2.4.2 Consistent with this, 2018C/RDMA §9 also commits the WMA to unconditional respect for evolving attitudes toward euthanasia and assisted suicide. As attitudes evolve, so do criteria for the procedures. All evidence to date demonstrates that the evolution is exclusively in the direction of expanded access. and the context of the recommendation suggests that this is the meaning intended. Thus, the unconditional commitment to respect evolving attitudes translates into an unconditional commitment to support euthanasia and assisted suicide for any reason and under any circumstances deemed sufficient in law.

VII.3 Palliative care

VII.3.1 The foundational statement is complemented by superficially unremarkable statements about palliative care. However, the revisions warrant attention. The proposal states that palliative care is part of good medical care "when it is available" - a qualification added in 2018 (VI.3.5) The 2016 proposal stated that euthanasia and assisted suicide should *never* be substitutes for palliative care (2016C/RDMA §10); this has been softened to "not." Finally, the single restrictive element in the 2016 proposal has been deleted (struck out below):

12. The WMA also calls on all members to work to ensure access

> to high quality palliative care services for those in need. Euthanasia and physician assisted death should not be a substitute for palliative care. ~~but should be seen as a last resort for those whose intractable and hopeless suffering cannot be alleviated through any other ordinary means.~~

VII.3.2 By striking out the restriction, the CMA and RDMA demonstrate that they do not believe that euthanasia and assisted suicide should be last resorts in alleviating otherwise uncontrollable suffering, and do not want such a restriction imposed by the WMA.

VII.3.3 The revisions support the view that access to effective palliative care is not a prerequisite for euthanasia and assisted suicide. When palliative care is not available (and it is not available in most parts of the world, including most parts of Canada), euthanasia and assisted suicide are not substitutes, but the only treatments available. When palliative care is available, the removal of the "last resort" restriction makes clear that euthanasia and assisted suicide remain options, not substitutes. WMA acceptance of the proposal would thus support the provision of euthanasia and assisted suicide as ordinary forms of medical treatment.

VII.4 Physician freedom of conscience

VII.4.1 Referral, participation and complicity

VII.4.1.1 The main protection of conscience provision has been revised to reduce the scope of protection for referral (red text below), and it distinguishes between participation and referral (underlined below).

> **10.** No physician should be forced to participate in euthanasia or assisted death against their personal moral beliefs. Equally, no physician should be forced to refer a patient to another physician **in order to provide assistance in dying**.

VII.4.1.2 The CMA and RDMA recommend that physicians should be protected only from being forced to refer directly to someone willing to provide euthanasia or assisted suicide. This seems to imply that only direct referral to an EAS provider is a matter of concern (since no other kind of referral is mentioned) and that even direct referral does not constitute participation.

VII.4.1.3 In any case, the provision does not preclude compulsory referral to physicians for consultations preliminary to lethal injection by someone else, nor does it preclude compulsory referral to service delivery coordinators whose main function is to ensure access to euthanasia and assisted suicide. Many objecting physicians consider such referrals to be unacceptable. The provision does not protect them.

VII.4.1.4 Leaving aside the uncertainty about what the CMA and RDMA intend by the distinction between referral and participation, the provision does not adequately address the issue of complicity or moral responsibility, which is the basis for concern about referral and other forms of facilitation or participation, such as the falsification of death certificates.[3]

VII.4.2 The obligation to ensure access

VII.4.2.1 The proposal requires the WMA to affirm that physicians or health care provider should perform euthanasia and assisted suicide where the procedures are legal. On the other hand, it states, "Physicians, individually or collectively, must not be made responsible for ensuring access," and insists that the state "must provide mechanisms that will ensure access" to the services (2018C/RDMA §11, VI.4.4.3).

VII.4.2.2 Insistence that physicians must not be made individually or collectively responsible for ensuring access is most welcome, but it is easier said than done, especially within the recommended policy framework.

VII.4.2.3 Physicians are generally understood to have an obligation to provide or ensure access to medical treatment when it is required. In accepting the proposal, the WMA would recognize euthanasia and assisted suicide as medical treatments that should be provided by physicians. It would thus be difficult for the WMA to insist that physicians do not have an individual or collective obligation to provide them, and the state may not be receptive to their arguments. The CMA initially accepted such an obligation when it declared euthanasia and assisted suicide to be forms of end-of-life-care, and this has had serious adverse consequences for objecting physicians in Canada.[4],[5]

VII.4.3 Commitment to euthanasia/assisted suicide, not conscience

VII.4.3.1 The protection of conscience provisions of the proposal are not underwritten by WMA policies about freedom of conscience and do not reflect a developed understanding of the subject. The only explicit reference to conscience occurs in a recommendation to unconditionally respect evolving attitudes toward euthanasia and assisted suicide (VII.2.2.2). The context suggests that this is intended to maximize expansion of the services, not safeguard physician freedom of conscience.

VII.4.3.2 The broader the criteria for euthanasia and assisted suicide, the more likely conflicts of conscience are likely to occur. Since the proposal imposes virtually no restrictions on the criteria or circumstances under which euthanasia and assisted suicide may be provided, it maximizes the likelihood of conflict.

VII.4.3.3 Moreover, in practice, the protection of conscience provisions will face significant opposition. For example, the recommendations about referral and responsibility for access have been rejected by Canada's largest medical regulator:

> The College of Physicians and Surgeons of Ontario took the position that physicians who object to physician-assisted dying requests have a positive obligation to make an effective referral. An effective referral, as described by the Ontario College, is a referral made in good faith to a non-objecting available and accessible physician, other health care professional, or agency. The College noted that the medical community has an obligation to ensure access and that conscientious objection should not create barriers.[6]

VII.4.3.4 This is, in fact, the position of the RDMA. Absolutely contradicting the recommendation it purports to support, the RDMA demands that Dutch physicians unwilling to kill patients or help them commit suicide or assisted suicide have "a

moral and professional duty" to help them find a colleague willing to do so - even though Dutch law does not require it (IV.3.6, IV.3.7). This demonstrates that the RDMA is primarily committed to ensuring access to euthanasia and assisted suicide, even at the expense of physician freedom of conscience. The contradiction brings the credibility of the entire proposal into question.

VII.4.3.5 To sum up, the protection of conscience provisions in the proposal are unclear about the relationship between participation and referral. They fail to adequately consider the issue of complicity, and thus do not afford sufficient protection for objecting physicians, especially in light of the increased probability of conflict due to the virtually unrestricted scope of the proposal. The recommendation that physicians should not be responsible for ensuring access to euthanasia and assisted suicide is at odds with the recommendation that they should provide the services. The provisions are not well-grounded; certainly the rationale supporting them is unarticulated. They are actually rejected by one of the co-authors of the proposal.

VII.5 Arguments

VII.5.1 Introduction

VII.5.1.1 Having established what the proposal actually entails, it is necessary to consider the arguments offered to convince the WMA to accept it. With the exception of rights claims, these are not found in the document but have been advanced elsewhere.

VII.5.1.2 The analysis here is not concerned with the morality or acceptability of euthanasia and assisted suicide. Such questions are outside the scope of the Project's interests. The point here is to demonstrate that the arguments fail on their own terms, or are persuasive only to the extent that one accepts the contested assumptions underlying them.

VII.5.2 Rights claims

Argument

VII.5.2.1 The sole justification offered for the change is that patients "must be free to decide for themselves what treatments they want and the manner and circumstances of their death and may not be forced to die in ways they would not wish"(VI.3.2). On this view, refusal to provide or help to arrange for euthanasia or assisted suicide is a denial of human rights and perhaps constitutional rights — precisely the view of many EAS supporters in Canada.

Response

VII.5.2.2 This justification, proposed as self-evident, actually consists of contested autonomy based rights claims that have grave implications for physicians, inasmuch as they can be understood to imply a professional obligation to kill (VI.3.5, B10.5). If the WMA accepts the C/RDMA proposal it would affirm these contested rights claims, disenfranchise those who hold contrary views, and provide significant support for coercive legislation and policies.

VII.5.3 Patient priority

Argument

VII.5.3.1 Patient priority, autonomy, and the importance of compassion for patients are widely understood to be central to medical practice. The CMA's Dr. Francescutti alluded to this when he warned the WMA Council that they "would not serve their patients well" by refusing to heed public opinion about assisted suicide. (II.1.6; see also Dr. Blackmer, II.1.15)

VII.5.3.2 Physicians who, for reasons of conscience, refuse to provide or refer patients for euthanasia and assisted suicide are callous, selfish, disrespectful, judgemental and unprofessional.

Response

VII.5.3.3 Even if one accepts principles of patient priority, autonomy and the importance of compassion, these can be understood in different ways. It does not follow that one must conclude that euthanasia and assisted suicide are morally/ethically acceptable.

VII.5.3.4 Physicians who object to euthanasia and assisted suicide for reasons of conscience reasonably refuse to anything that would entail unacceptable moral complicity, including support, encouragement or referral. In this they act no differently than colleagues confronted with demands to participate in or facilitate what they believe to be wrong, such as executions by lethal injection or female genital mutilation.

VII.5.4 Moral/ethical uncertainty

Argument

VII.5.4.1 Physicians who do not object to euthanasia and assisted suicide may be uncomfortable providing them. Others may be uncertain about the ethics of the procedures. These physicians may wish to resolve their discomfort or uncertainty in favour of patients clearly seeking the services and physicians willing to provide them.

VII.5.4.2 Other physicians who consider euthanasia and assisted suicide are immoral may also believe that they can avoid unacceptable complicity in the procedures by referring patients to a willing colleague. Alternatively, they may be doubtful about the ethics of referral.

VII.5.5.3 All of these physicians would be willing to refer patients to colleagues who seem to be motivated by compassion and other patient-centred principles traditionally associated with medical practice.

VII.5.4.4 Current WMA policy is unfair not only because it condemns physicians who provide euthanasia, but because it impedes physicians who do not object to connecting willing patients with willing colleagues. Adopting the proposal would simply nullify the condemnation and allow physicians to do what many are willing to do.

Response

VII.5.4.5 The argument depends either on the moral/ethical acceptability of euthanasia and assisted suicide or upon moral/ethical uncertainty about the procedures. However, those who reject euthanasia and assisted suicide for reasons of conscience can produce

cogent arguments to support their position, and the disagreement or uncertainty of others is not evidence that their position is doubtful.

VII.5.4.6 Like individual physicians (VII.5.3.4) if the WMA finds euthanasia and assisted suicide ethically unacceptable, it acts consistently and reasonably — not unfairly — if it maintains a policy against the procedures and refuses to do anything that would entail unacceptable moral complicity, including support or encouragement.

VII.5.5 Pragmatism

Argument

VII.5.5.1 Positions for and against euthanasia and assisted suicide, when firmly held and rationally defended, usually rest upon different interpretations or concepts of rights, patient priority, autonomy, compassion, beneficence, non-maleficence, justice, solidarity, respect or reverence for human life and other principles. In the absence of agreement about underlying principles and concepts, disputes about the morality of euthanasia and assisted suicide are difficult or impossible to resolve to everyone's satisfaction. Dr. Blackmer calls this the problem of intractability (IV.3.13-14).

VII.5.5.2 "[T]he way forward," he says, "is not to engage in further debate on the rightness or wrongness of assisted dying,"[7] but, as CMA President Dr. Chris Simpson put it, to "[move] away from a yes-no dichotomy, as to whether assisted dying should be legalized toward a more balanced and nuanced discussion."[8] (See also II.1.2)

Response

VII.5.5.3 While urging the WMA to take this path forward, Dr. Blackmer does not say where the path leads. Dr. Simpson suggests it leads to "a more balanced and nuanced discussion," but does not say what the discussion is about. The answer is found in an editorial in the Canadian Medical Association Journal: Physician-assisted death: time to move beyond Yes or No. "Whether or not physicians individually or collectively agree with physician-assisted death," wrote the authors, "[it is time for the "yes" or "no" debate to give way to a constructive dialogue about policies and guidelines for legal physician-assisted death," including such things as eligibility, consent, equitable access, effective methods, and the obligations of conscientious objectors.[9]

VII.5.5.4 In other words, the CMA and RDMA want moral and ethical debate about physician participation in euthanasia and assisted suicide to end, and practical discussion about how physicians should provide the services to begin. Contrary moral/ethical beliefs are simply ignored. Dr. Blackmer's "way forward" is to nullify continued opposition on moral/ethical grounds. Dr. Simpson provides balance and nuance to the "yes" or "no" debate by eliminating the "no." This exemplifies what Project Advisor Jay Budziszewski calls "bad faith authoritarianism . . . a dishonest way of advancing a moral view by pretending to have no moral view."[10]

VII.5.5.5 In this case, "unreflective" is arguably more fitting than "dishonest." Certainly, without reference to ethics of some sort, the WMA cannot follow Dr. Blackmer's advice to decide how to respond to legalization of physician assisted suicide and euthanasia. The CMA did not set ethics aside when it purported to unite the Canadian medical profession behind the view that euthanasia and physician assisted suicide can be legitimate forms of medical treatment (B9.) - hardly an ethically neutral viewpoint.

Later the CMA did, indeed, delete references to ethical and even medical criteria from its policy on euthanasia and assisted suicide,[11] but this means only that the CMA has chosen the law as its ethical standard, not that it has dispensed with ethics altogether.

VII.5.6 Lack of consensus

Argument

VII.5.6.1 To secure approval of the resolution upon which it based the reversal of CMA policy against euthanasia and assisted suicide, the CMA executive stressed the lack of agreement among Canadian physicians with respect to the procedures (B2.4, B5.6).

VII.5.6.2 At the European regional end-of-life conference, Dr. Blackmer took note of Professor Urban Wiesing's assertion that there is no consensus on the ethics of physician assisted suicide and euthanasia (III.4.20). Dr. Blackmer has since cited lack of consensus in suggesting that objecting physicians should support the right of colleagues to provide euthanasia and assisted suicide.[12] (Prof. Weising will be speaking at the WMA ethics conference in Iceland on Good conduct of physicians.)

VII.5.6.3 The Preamble of the CMA/RDMA proposal notes that physicians in some countries are legally providing the services (VI.3.3.1), obviously because they do not agree with the WMA position.

Response

VII.5.6.4 The claim that current WMA policy does not reflect a consensus and should be replaced by the proposed C/RDMA policy is untenable for three reasons.

VII.5.6.5 First: even if there were no consensus in favour of current WMA policy against euthanasia and assisted suicide, there is no consensus in favour of the proposed C/RDMA policy supporting the procedures. If lack of consensus is fatal to one, it is equally fatal to the other.

VII.5.6.6 Second: as the four regional meetings on end-of-life care demonstrated, there is a consensus within the WMA that euthanasia and assisted suicide are morally/the four regional meetings on end-of-life care demonstrated, there is a consensus within the WMA that euthanasia and assisted suicide are morally or at least ethically unacceptable ethically unacceptable (III.1.2). The CMA and RDMA can argue, at best, that some physicians in some countries disagree with WMA. The mere existence of disagreement does not disturb the consensus and does not warrant a change of policy.

VII.5.6.7 Finally: WMA ethics policies are based, not on lack of consensus, but upon a consensus identified by 75% approval (I.3). The CMA and RDMA may eventually succeed in gaining that level of support for their proposal, but, in the meantime, an appeal to a purported lack of consensus is specious.

VII.5.7 Non-proliferation

Argument

VII.5.7.1 The CMA and RDMA claim that they are not attempting to change the policies or practices of other national associations, but only protecting their own members (III.4.3, III.4.11).

VII.5.7.2 The proposal is presented as a kind of neutral option that does not require the WMA to support euthanasia or physician assisted suicide, does not involve significant change, and would affect only physicians legally providing the services by relieving them of accusations of unethical conduct.

Response

VII.5.7.3 The argument that changing WMA policy would have not significant influence on the policies of national associations would make sense only if WMA policies actually have no significant influence. Surely, however, they do, and are meant to, and that is why the CMA and RDMA are going to great lengths to convince the WMA to accept euthanasia and assisted suicide They cannot reasonably believe that the WMA condemnation of euthanasia and assisted suicide carries weight only in Canada and the Netherlands.

VII.5.7.4 As comparisons with analogous changes to WMA policies on female genital mutilation and capital punishment indicate (VII.2.2, VII.2.3) what is sought by the CMA and RDMA is a major change that would have repercussions in other national associations, just as a similar shift in CMA policy in Canada was widely seen as a "sea change" with tremendous implications (B7.11).

VII.5.7.5 The C/RDMA proposal is not ethically neutral. Notwithstanding the opening disclaimer, which is a bare and inefficacious rhetorical assertion, it would have the WMA formally adopt the position that euthanasia and assisted suicide are consistent with medical ethics and, where legal, should be provided by physicians or health care providers (VI.4.4.3, VII.3.2.2).

VII.5.7.6 The change in position signified by the foundational statement would have worldwide implications because it would entail a meaningful ethical shift by an international opinion leader. It could reasonably be expected to influence physicians, other healthcare workers, the public and lawmakers around the world in favour of euthanasia and assisted suicide. Moreover, the completely unrestricted nature of the foundational statement would encourage legalization and practice of euthanasia and assisted suicide on the broadest possible terms (VII.2.4) .

VII.5.8 Proportional rarity

Argument

VII.5.8.1 Only a minority of physicians — sometimes a very small minority — are involved in euthanasia and assisted suicide even where they are legal (VI.3.4.2), and euthanasia and assisted suicide deaths account for a small percentage of deaths from all causes. In Quebec, for example, 98.9% of all deaths in 2017 were not the result of euthanasia or physician assisted suicide.[13]

VII.5.8.2 The CMA/RDMA have suggested that euthanasia and assisted suicide are and will remain exceptional practices (II.1.5), provided in extreme circumstances (VI.3.3.1). From the perspective of those doubtful about the wisdom of changing WMA policy, this seems reassuring.

Response

VII.5.8.3 While Quebec statistics are correct, it is also true that the number of 2017 euthanasia

deaths in Quebec would have emptied about one quarter of the beds in Johannesburg's Chris Hani Barargwanath Hospital, the third largest hospital in the world,[14] and was more than ten times the number of non-medical homicides reported in the province the previous year.[13] Whether all of this is good news or bad news from a public policy, social, medical or political perspective depends upon one's ethical/moral view of euthanasia — which the CMA says should be set aside (VII.5.5).

VII.5.8.4 Regardless of the significance one attaches to such statistics, two points must be noted. First, since everyone dies, every physician in general practice and many in other specialities may be confronted with a demand for euthanasia or assisted suicide. Hence, legalization of the procedures does not impact only the physicians directly involved, but the entire medical profession, especially entire fields of practice like oncology and palliative care, as well as medical education and other health care professions. Second, since relatively few physicians are directly involved in the practices, legalization leads to demands that physicians and others must collaborate in providing the services in order to ensure patient access, even if doing so violates their moral, ethical or religious beliefs (IV.3.6, B10.19).

VII.5.9 Diversity and culture

Argument

VII.5.9.1 A new policy proposal drawn up by a nominally unrelated group of associate members recommends that WMA ethical policies should accommodate national association ethical policies that are "clearly generated by benevolence toward patients."

VII.5.9.2 Euthanasia and assisted suicide are always justified as expressions of benevolence, so the WMA should "allow for" physician participation in euthanasia and assisted suicide in Canada, the Netherlands and other countries.

VII.5.9.3 Similarly, drawing from the current draft revision of the Declaration of Oslo, the C/RDMA proposal asserts that, as is the case with abortion, the willingness of some physicians to provide euthanasia and assisted suicide is simply reflects the world's diversity of views, implying that they should be accommodated (VI.3.4.4).

Response

VII.5.9.4 Concerning the new proposal, a valid exception to an accepted ethical rule or principle is made on the grounds that it does not apply in a given situation, as when it is impossible to respect the principle of informed consent because an unconscious patient urgently requires life-saving treatment. Alternatively, but controversially, exceptions are defended by appealing to other ethical principles as having priority in particular cases.

VII.5.9.5 However, the proposal appeals to a single principle - benevolence - as fully and unconditionally sufficient to justify physician participation in any legal procedure, including euthanasia and assisted suicide. This is arbitrary. Surely if benevolence is itself sufficient to justify an exception, there is no reason to think that non-maleficence, autonomy, justice, solidarity, etc. would not be, either individually or in combination. If WMA ethical standards can be ignored or nullified solely by an appeal to benevolence, they can be ignored or nullified on other grounds.

VII.5.9.6 Further, the concept of benevolence is elastic. It is cited not only to justify physician participation in euthanasia and assisted suicide, but to justify their participation in executions[15],[16] and the amputation of healthy limbs.[17],[18] Especially in isolation, other principles are equally malleable: a particular view of justice is offered to support the fair innings argument, for example.[19] A national association policy requiring objecting physicians to collaborate in euthanasia or assisted suicide could be defended as a form of benevolence toward patients.

VII.5.9.7 In addition, no reason is offered to justify a preference for accommodating "national and cultural differences" rather than supporting WMA ethical standards. Nationality and culture do not necessarily produce superior ethical judgement, even if they influence ethical perspectives. Hence, if it becomes necessary to address or resolve a conflict between WMA and national association ethical policy, nationality and culture are irrelevant.

VII.5.9.8 Here it is important to note that the proposal is not about enforcing WMA ethical policies, but about formulating them. For example, the WMA maintains its policy against euthanasia and assisted suicide, but has made no attempt to enforce it by expelling a non-compliant constituent member. The continuing membership of non-compliant national associations may reflect either uncertainty about the best course of action or deliberate and prudential toleration of a perceived error. In either case, the underlying ethical differences remain unresolved.

VII.5.9.9 What is proposed, instead, is evasion of engagement on the ethical issues in dispute. Instead, based on the prejudicial assumption that the non-compliant association's ethical policy is more probably correct, the policy requires the WMA to reformulate its policy to make it consistent with that of the non-compliant national association. This is essentially a refined version of the argument for pragmatism.

VII.5.9.10 Ironically, the sponsors of the proposal argue that national associations should develop policies consistent with WMA policies. There is no reason for them to do so if the default position is that WMA ethical policies must be modified to accommodate those of national associations.

VII.5.9.11 The reference to diversity in the C/RDMA proposal seems intended to obscure the fact that responses in the global medical community to euthanasia and assisted suicide are not diverse but sharply dichotomous, EAS practitioners and supporters holding what is actually an outlying minority position.

VII.6 Conclusions

VII.6.1 Foundational statement, palliative care, protection of conscience

VII.6.1.1 The sole justification offered for the proposal rests upon contested rights claims.

VII.6.1.2 The opening disclaimer of non-support for euthanasia and assisted suicide is meaningless rhetoric contradicted by other elements of the proposal. The C/RDMA proposal, if accepted, would be fully effective in encouraging legalization of euthanasia and assisted suicide and physician participation in both practices.

VII.6.1.3 Were the WMA to accept the proposal it would affirm that the procedures are consistent with medical ethics and would commit the WMA to accepting the

legalization and practice of euthanasia and assisted suicide on the broadest possible terms: for adolescents, children, and infants, for non-terminal chronic conditions or disabilities, and for mental illness and dementia.

VII.6.1.4 Were the WMA to accept the proposal, it would affirm that access to effective palliative care is not a prerequisite for euthanasia and assisted suicide, and that euthanasia and assisted suicide are ordinary interventions that may be provided where palliative care is not available, or optional interventions where it is.

VII.6.1.5 Were the WMA to accept the proposal, the change in WMA policy could reasonably be expected to cause physicians, other healthcare workers, the public and lawmakers around the world to favour legalizing the procedures.

VII.6.1.6 Were the WMA to accept the proposal, it would cede responsibility for establishing ethical and legal criteria for euthanasia and assisted suicide to national legislatures and courts.

VII.6.1.7 The protection of conscience provisions are unclear and fail to adequately consider the issue of complicity. They do not afford sufficient protection for objecting physicians, especially in light of the increased probability of conflict due to the virtually unrestricted scope of the proposal. The provisions are not well-grounded and internally inconsistent. Finally, they are contradicted by RDMA, thus bringing into question the credibility of the proposal as a whole.

VII.6.2 Arguments

VII.6.2.1 **Rights claims**: The rights claims are treated as self-evident, but are not. If the WMA accepts the C/RDMA proposal it would affirm contested rights claims, disenfranchise those who hold contrary views, and provide significant support for coercive legislation and policies.

VII.6.2.2 **Patient priority**: Even if one accepts principles of patient priority, autonomy and the importance of compassion, these can be understood in different ways. It does not follow that one must conclude that euthanasia and assisted suicide are morally/ethically acceptable and that the WMA should change its policy.

VII.6.2.3 **Moral/ethical uncertainty**: Disagreement or uncertainty of others is not evidence that the WMA position is doubtful. If the WMA finds euthanasia and assisted suicide ethically unacceptable, it acts consistently and reasonably in maintaining a policy against the procedures.

VII.6.2.4 **Pragmatism**: The appeal to pragmatism enables the authoritarian suppression of opposition to euthanasia and assisted suicide. The WMA cannot decide how to respond to legalization of physician assisted suicide and euthanasia without reference to ethics of some sort.

VII.6.2.5 **Lack of consensus**: The claim that current WMA policy should be changed because it does not reflect a consensus is specious. Regional meetings on end-of-life care demonstrated a clear consensus that euthanasia and assisted suicide are morally/ethically unacceptable. Some physicians in some countries disagree, but this does not disturb the consensus and does not warrant a change of policy.

VII.6.2.6 **Non-proliferation**: WMA acceptance of the proposal would not be inconsequential. It would entail a meaningful ethical shift by an international opinion leader that would have worldwide implications. It could reasonably be expected to influence opinion around the world in favour of euthanasia and assisted suicide, and to encourage legalization and practice of euthanasia and assisted suicide on the broadest possible terms.

VII.6.2.7 **Proportional rarity**: Evaluation of the significance of the rate of euthanasia and assisted suicide depends upon a moral/ethical framework. Moreover, since everyone dies, legalization of the euthanasia and assisted suicide would not impact only the physicians directly involved, but the entire medical profession. Since relatively few physicians are directly involved in the practices legalization leads to demands for collaboration by others even if collaboration violates their moral, ethical or religious beliefs.

VII.6.2.8 **Diversity and culture**: The proposal to make exceptions to WMA ethics policies depends solely on an arbitrary appeal to support national or cultural concepts of benevolence. This is already an elastic concept that could support the suppression of conscientious objection by physicians. The proposal evades engagement on disputed ethical issues and relies on a prejudicial assumption in favour of a non-compliant association. This effectively subverts the ostensible purpose of the proposal.

Notes

1. World Medical Association. Resolution on Physician Participation in Capital Punishment [Internet]. 2008 Oct [Cited 2018 Sep 29]. Available from: https://www.wma.net/policies-post/wma-resolution-on-physician-participation-in-capital-punishment/.

2. World Medical Association. Statement on Female Genital Mutilation [Internet]. 2016 Oct [Cited 2018 Sep 29]. Available from: https://www.wma.net/policies-post/wma-statement-on-female-genital-mutilation/.

3. Murphy S. A bureaucracy of medical deception. Quebec physicians told to falsify euthanasia death certificates: Regulators support coverup of euthanasia from families [Internet]. Protection of Conscience Project; 2015 Nov 17 [Cited 2018 Sep 29]. Available from: http://www.consciencelaws.org/background/procedures/assist012.aspx.

4. Murphy S. Canadian Medical Association and euthanasia and assisted suicide in Canada: Critical review of CMA approach to changes in policy and law. Part I: Preliminaries to Carter - A professional obligation to kill [Internet]. Protection of Conscience Project; 2018 Sep 26; cited 2018 Sep 28]. Available from: http://www.consciencelaws.org/background/procedures/assist029-01.aspx#A_professional_obligation_to_kill.

5. See text accompany notes 50 to 53 in Murphy S. Canadian Medical Association and euthanasia and assisted suicide in Canada: Critical review of CMA approach to changes in policy and law. Part II: CMA on freedom of conscience after *Carter* [Internet]. Protection of Conscience Project; 2018 Sep 26 [Cited 2018 Sep 29]. Available from:

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11. Canadian Medical Association. Medical Assistance in Dying [Internet]. 2017 May [Cited 2018 Sep 29]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/cma_policy_medical_assistance_in_dying_pd17-03-e.pdf.

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VIII. STRATEGY AND TACTICS

VIII.1 Strategy for change

VIII.1.1 The core element of the foundational statement is a passage very similar to a 2014 CMA Board of Directors' resolution (VI.4.3). The resolution was introduced as a neutral statement that left CMA policy against euthanasia untouched; CMA officials minimized its significance. Only later did the CMA president admit that approval of the resolution was a "sea change." The Board used the resolution as the basis for reversing CMA policy and approving euthanasia and assisted suicide as end of life care (B5, B6, B7, B9).

VIII.1.2 It appears that a very similar strategy is being followed by the CMA and RDMA at the World Medical Association. The C/RDMA proposal appears to be a Trojan horse intended to reverse WMA policy and secure its support for euthanasia and assisted suicide, notwithstanding its claim that "[t]he WMA does not support or sanction" the procedures (VII.2).

VIII.1.3 In 2014 the CMA Board of Directors knew that the overwhelming majority of Canadian physicians would refuse to participate in euthanasia or assisted suicide, just as the WMA knows that most of the world's physicians will refuse. The fundamental conflict presented by imposing an obligation to kill upon unwilling physicians was foreseeable and was foreseen by CMA officials, just as it can be foreseen now. Attacks upon physician freedom of conscience, particularly with respect to referral, were predictable; they are now occurring in Canada and demonstrated by the RDMA policy on referral (VII.4.3.4).[1]

VIII.1.4 The CMA Board failed to consider physician freedom of conscience in relation to assisted suicide and euthanasia except the extent that it could be used to further its policy goals. As a result, after the *Carter* ruling, CMA officials were unprepared to mount a cogent, articulate and persuasive defence of physician freedom of conscience, especially in relation to referral. They discovered that state authorities and the public were often unreceptive and even hostile to physicians unwilling to arrange for patients to be killed by someone else. As a result, Canadian physicians who object to euthanasia and assisted suicide have been placed at a significant disadvantage.[1]

VIII.1.5 The risk now is that the WMA or national medical associations might follow the CMA's lead by precipitously approving the C/RDMA proposal or some similar policy document without adequately considering the consequences, with the same unfortunate results.

VIII.2 Tactics

VIII.2.1 Incrementalism

VIII.2.1.1 CMA/RDMA strategy includes a number of these: working out of the public eye,[2] manipulation of consultation processes,[3] discounting adverse majorities,[4] emphasis on the ideal or exceptional[5,6] while minimizing or excluding reference to troubling cases.[7,8] and omission of relevant information.[9,10,11],[12],[13]

VIII.2.1.2 In addition, almost from the first, the CMA and RDMA have been careful to advance

incrementally in attempting to change WMA policy. This warrants close attention because the significance of a current proposal is likely to be missed if preceding statements and proposals are not considered.

VIII.2.1.3 C/RDMA policy development demonstrates incrementally significant progressions from suicide to euthanasia, from non-support of physician participation in euthanasia and assisted suicide to a recommendation that they perform the procedures, and the transformation of euthanasia and assisted suicide from treatments of last resort to ordinary treatment options.

VIII.2.2 From suicide to euthanasia

VIII.2.2.1 At the time of the consultation request, both euthanasia and assisted suicide were legal in the Netherlands and supported by the RDMA, and both had been approved by the CMA and authorized by the Supreme Court of Canada. However, while the RDMA recommended major revisions of both policies in their response to the Secretariat request, the CMA recommended a "more nuanced approach" only to assisted suicide, recommending no change to the euthanasia policy (II.1.2).

VIII.2.2.2 By the time of the Council meeting in April, 2015, it appears that the CMA and RDMA had agreed to work together and adopt the incremental approach indicated in the CMA's consultation response. Thus, when the RDMA representative introduced the subject at the Council meeting, he did not raise it in relation to euthanasia policy (which was also on the agenda) but confined his attention to assisted suicide (II.1.5).

VIII.2.2.3 Restricting the presentation to suicide made good sense. A 2014 CMA poll had indicated that more physicians (27%) were willing to participate in assisted suicide than in euthanasia (20%).[14] By the April meeting in Oslo, Dr. Blackmer realized that physicians were "profoundly more uneasy" about euthanasia than assisted suicide.[15]

VIII.2.2.4 Given the higher physician discomfort known to be associated with direct lethal infusion of patients, the CMA and RDMA were prudent to begin with assisted suicide, something known to be less distressing to practitioners. Moreover, speaking of assisted suicide, the RDMA representative was able to offer further comfort to the uneasy: that, where physician assisted suicide is allowed, "very few people make use of the option." (II.1.5) He could well have been referring to the Netherlands, where assisted suicide is legal, and very few people do, in fact, make use of the option. What he left out was that very few in the Netherlands opt for assisted suicide because virtually all opt for euthanasia (over 96% in 2016).[16] The same pattern is evident in Canada.[17]

VIII.2.2.5 Similarly, Professor Urban Wiesing, speaking two years later at the European regional meeting at the Vatican, claimed that many patients approved for assisted suicide - up to 80% - do not actually go on to commit suicide.[18] This is questionable. While it is true that some patients prescribed lethal medication do not actually commit suicide, 80% seems either highly selective or grossly inaccurate.[19] Euthanasia is different; in Quebec, for example, only 5% to 6% of patients approved for euthanasia in 2016 and 2017 later withdrew their requests.[20]

VIII.2.2.6 The CMA and RDMA began by pressing for a review of the policy on assisted suicide, but when they submitted their first proposal in 2016 it proposed changes to

both euthanasia and assisted suicide policies There is no record of their explanation for the change, but it is not surprising.

VIII.2.2.7 The trial court decision in *Carter v Canada (Attorney General)*[21] demonstrates that accepting assisted suicide provides the basis for accepting euthanasia. Beginning with the premise that suicide can be a rational, moral and beneficial act, the judge found that assisted suicide in such cases would also be rational, moral and beneficial. If the person seeking suicide in such circumstances is unable to perform the lethal act even with assistance, euthanasia in response to a request from that person would seem to be moral. Thus, beginning with the premise that suicide can be moral and beneficial, the judge concluded that assisted suicide and euthanasia can be moral and beneficial.[22] Further, it is likely that euthanasia will be wanted at least as a backup for failed assisted suicide, just as abortion is wanted as a backup for failed contraception; this is reflected in professional guidelines in the Netherlands.[23]

VIII.2.2.8 This reasoning is evident in the approach of one of Canada's most active EAS practitioners. In 2016 she predicted that the EAS death rate in Canada would be closer to that of the Netherlands than Oregon because both euthanasia and assisted suicide are permitted in Canada. Her explanation was that the availability of euthanasia makes it possible for patients to avoid "cruel choices" forced upon them in assisted-suicide only regimes, where they must commit suicide sooner rather than later, before they lose the ability to self-administer lethal medication.[24]

VIII.2.3 From "The WMA does not support" to physicians should perform

VIII.2.3.1 The 2016 disclaimer "The WMA does not support euthanasia or physician assisted *suicide*" was somewhat broadened and softened in 2018 to "The WMA does not support or sanction physician assisted *death*." (Emphasis added)

VIII.2.3.2 However, a new paragraph added to the 2018 proposal would have the WMA affirm, that euthanasia and physician assisted suicide should be performed by competent physicians or health care providers where the procedures are legal.

VIII.2.4 From "last resort" to optional treatment

VIII.2.4.1 The 2016 proposal stated that euthanasia and assisted suicide "should be seen as a last resort for those whose intractable and hopeless suffering cannot be alleviated through any other ordinary means." This restriction has been dropped in the 2018 proposal.

VIII.2.4.2 Had the WMA approved the 2016 proposal it would have included this restrictive cautionary note. If it accepts the 2018 proposal its affirmation will be unrestricted, effectively authorizing euthanasia and assisted suicide as optional treatments where palliative care is available, and as acceptable treatments when it is not (VII.3.3). In either case, comparing the 2016 and 2018 proposals demonstrates that, over the course of two years, the CMA and RDMA have transformed euthanasia and assisted suicide from interventions of last resort to ordinary medical treatments.

VIII.3 The need for due diligence

VIII.3.1 The WMA has been warned that it will "lose credibility, become "irrelevant" or lose valuable members if its policies are not progressive (II.1.7, II.1.15), apparently to inculcate fear and a sense of urgency sufficient to accomplish a rapid change of

policy.

VIII.3.2 The exercise of due diligence by those considering changes in WMA or national association policy requires that they make themselves aware of the strategy and tactics used to shape debate and decision-making, especially tactics that discourage adequate reflection and foresight.

VIII.3.3 On this point, the Project agrees that the WMA and its constituent members can learn something from the CMA's approach to shaping the debate and law on euthanasia and assisted suicide. In reversing its policy against euthanasia and assisted suicide, the CMA acted precipitously and without adequate reflection or foresight, apparently to meet a deadline imposed by a pending Supreme Court decision (B2.6). This has had serious adverse consequences for objecting physicians in Canada.[1] Regardless what the WMA ultimately decides, it should not follow the CMA example in this respect.

Notes

1. Murphy S. Canadian Medical Association and euthanasia and assisted suicide in Canada: Critical review of CMA approach to changes in policy and law [Internet]. Protection of Conscience Project; 2018 Sep 26 [Cited 2018 Sep 29]. Available from: http://www.consciencelaws.org/background/procedures/assist029-01.aspx

2. WMA policy development occurs largely out of the public eye, and only WMA constituent and associate members have access to relevant documents. While this is neither unusual nor improper, it is especially advantageous to those controlling the information because they can, by limiting what they disclose, avoid awkward questions and minimize or prevent opposition to their initiatives arising within their own organizations or the public. For example, it is highly unlikely that most CMA members are aware that, on their behalf, their executive implied that the CMA might withdraw from the WMA if it continued to resist changes to its policies on euthanasia and assisted suicide (II.1.16).

3. Only three of 111 constituent WMA members expressed dissatisfaction with the assisted suicide and euthanasia policies. Dr. Blackmer argued that this was sufficient to warrant a review of the policy on euthanasia and assisted suicide because only 16 national medical associations had replied, some of the members of the Medical Ethics Committee who approved it might have been unduly influenced by the Secretariat, and decisions had sometimes been modified following discussion. Had the majority of the 16 respondents indicated dissatisfaction with the policy or had the Medical Ethics Committee been significantly divided on the issue, the argument might have had some force. As it was, to arbitrarily approve policy reviews based on such speculative claims would make a mockery of any systematic consultation process and enable manipulation of policy-making by the powerful or well-placed. The majority quite properly rejected the argument, eliciting a protest from the CMA (II.1.11, II.1.12, II.1.14).

4. During its member consultation in 2014, the CMA leadership acknowledged but discounted the fact that the great majority of Canadian physicians was opposed to changing CMA policy against assisted suicide and euthanasia and continued to work toward changing it (B2.4-5; B5.6-7). Similarly, efforts continue to change WMA policy despite strong opposition from the majority of WMA constituent members (III.1.2), and reference to the

majority view has been miminized in the revised proposal (VI.3.4.3).

5. The RDMA bioethicists writing in the *World Medical Journal* stressed that euthanasia in the Netherlands is allowed only "in the case of unbearable suffering without any prospect of improvement and when there is no reasonable alternative." de Jong A, van Dijt G. Euthanasia in the Netherlands: balancing autonomy and compassion. World Medical J [Internet]. 2017 Oct [Cited 2018 Sep 29]; 63(3)10-15 [de Jong-van Digt] Available from: https://lab.arstubiedriba.lv/WMJ/vol63/october-2017/#page=12.

6. Similarly, Dr. Blackmer describes the services as "providing assisted dying for consenting adults at the end of their lives who are suffering intolerably." Blackmer J. Letter from Dr. Jeff Blackmer, Vice President, Medical Professionalism, Canadian Medical Association, to Physicians' Alliance Against Euthanasia [Internet]. Collectif des Médecins Contre L'Euthanasie; 2018 Apr 30 [Cited 2018 Sep28]. Available from: https://collectifmedecins.org/en/dr-blackmer-blog-response/.

7. The RDMA bioethicists mentioned cases of euthanasia for patients who "cannot communicate adequately" but minimized them as rare and "highly controversial." (de Jong-van Digt at p. 13). They did not refer to euthanasia provided to Dutch couples who want to die together. See Cook M. Dutch couple choose euthanasia together [Internet]. BioEdge; 2017 Aug 19 [Cited 2018 Sep 28]. Available at: https://www.bioedge.org/bioethics/dutch-couple-choose-euthanasia-together/12396?

8. Dr. Blackmer did not raise the case of an elderly couple, who, like the Dutch, were lethally injected so they could die at the same time. Grant K. Medically assisted death allows couple married almost 73 years to die together. The Globe and Mail [Internet]. 2018 Apr 1 [Cited 2018 Sep 28]. Available at: https://www.theglobeandmail.com/canada/article-medically-assisted-death-allows-couple-married-almost-73-years-to-die/.

9. The RDMA bioethicists did not acknowledge increasing pressure in the Netherlands to broaden the criteria for euthanasia based on a widespread belief that people have a right to it (IV.3.5), a point relevant to their assertion that there is no need to be concerned about a "slippery slope" if euthanasia is legalized. They did not disclose that the RDMA demands that objecting physicians facilitate euthanasia by referring patients to non-objecting colleagues(IV.3.6-7), a position that contradicts the CMA/RDMA proposal (VII.4.3.4).

10. In his *World Medical Journal* article, Dr. Blackmer did not disclose that the CMA told the Supreme Court of Canada that it seemed wrong to deny assisted suicide and euthanasia to "grievously ill" (not terminally ill) patients simply because palliative care is unavailable, or that the CMA Board of Directors had reversed Association policy and approved euthanasia and assisted suicide before the ruling. Nor did he disclose problems caused for objecting physicians as a result of the CMA change of policy and legalization of the procedures (IV.3.18, B8.6, B10.5-9, B10.19).

11. Dr. Blackmer did not mention that some Quebec emergency physicians were, for a time, failing to treat suicide victims. See Hamilton G. Some Quebec doctors let suicide victims die though treatment was available: college. National Post [Internet]. 2016 Mar 17 [Cited 2018

Sep 29]. Available from:
https://nationalpost.com/news/canada/some-quebec-doctors-let-suicide-victims-die-though-treatment-was-available-college.

12. Dr. Blackmer did not disclose concerns that people in Quebec were choosing euthanasia because palliative care was unavailable. See Lack of palliative care pushing Quebecers toward medically assisted death, College of Physicians says. CBC News [Internet]. 2018 May 31 [Cited 2018 Sep 29]. Available from:
http://www.cbc.ca/news/canada/montreal/lack-of-palliative-care-pushing-quebecers-toward-medically-assisted-death-college-of-physicians-say-1.4685470.

13. Nor did Dr. Blackmer note that the pressure for euthanasia was alarming even euthanasia supporters. See Robert Y. Vers la mort à la carte? Collège des Médecins du Québec [Internet]. 2017 May 10 [Cited 2018 Sep 29]. Available from:
http://www.cmq.org/nouvelle/fr/vers-la-mort-a-la-carte.aspx. English translation: Towards death à la carte? Physicians' Alliance against Euthanasia [Internet]. 2017 Jun 12 [Cited 2018 Sep 29]. Available from: https://collectifmedecins.org/en/dr-roberts-regrets/.

14. In a 2014 poll of 5,000 CMA members, 27% of physicians surveyed said they were willing to participate in assisted suicide, while 20% were willing to participate in euthanasia. Moore E. Doctor is hoping feds will guide on assisted suicide legislation. Edson Leader [Internet]. 2015 Feb 12 [Cited 2015 Jul 16].

15. Kirkey S. How far should a doctor go? MDs say they 'need clarity' on Supreme Court's assisted suicide ruling. National Post [Internet]. 2015 Feb 23 [Cited 2018 Sep 29]. Available from:
http://news.nationalpost.com/news/canada/how-far-should-a-doctor-go-mds-say-they-need-clarity-on-supreme-courts-assisted-suicide-ruling

16. Regional Euthanasia Review Committees. Annual Report 2016. [Internet] 2017 Apr [Cited 2018 Sep 29] p. 11. Available from:
https://english.euthanasiecommissie.nl/binaries/euthanasiecommissie-en/documents/publications/annual-reports/2002/annual-reports/annual-reports/RTE_annual_report_2016.pdf.

17. Health Canada. 2nd Interim Report on Medical Assistance in Dying in Canada [Internet]. 2017 Oct p. 6 [Cited 2018 Sep 29] Table 2. Available from:
https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-sep-2017/medical-assistance-dying-interim-report-sep-2017-eng.pdf.

18. Wiesing U. Is there a right to determine one's own death? The ethical perspective(s). Paper presented at: WMA European Region Meeting on End of life Questions. 2017 Nov 16-17; Vatican [Internet]. [Cited 2018 Sep 28]. Available from:
https://www.wma.net/wp-content/uploads/2017/05/Wiesing-WMA-EoL-Presentation-Vatican-Nov2017.pdf.

19. For example, returns in Oregon from 1998 to 2016 recorded 12 of 19 years in which persons prescribed lethal medication were known to still be alive. The size of this group

fluctuated widely from a low of about 6% (1999) to a high of about 26% (2005). From 2010 to 2016, none were known to be alive, but the status (living or dead) of 14% to 22% was simply unknown. Murphy S. Assisted suicide reported in Oregon, U.S.A.: statistics compiled from the Oregon Public Health Division annual Death with Dignity Act reports [Internet]. Protection of Conscience Project; 2017 Aug [Cited 2018 Sep 29]. Available from: http://www.consciencelaws.org/background/procedures/assist020.aspx.

20. Murphy S. Euthanasia reported in Quebec: statistics compiled from the Rapports aux directeur général au Conseil d'administration de l'établissement et à la Commission sur les soins de fin de vie (10 December, 2015 to 10 December, 2018) [Internet]. Protection of Conscience Project; 2018 Apr 3 [Cited 2018 Sep 29]. Available from: http://www.consciencelaws.org/background/procedures/assist017.aspx.

21. Carter v. Canada (Attorney General), 2012 BCSC 886 (CanLII) [Internet] [Cited 2018 Sep 29] Available from: http://canlii.ca/t/frpws

22. Murphy S. Legalization of Assisted Suicide and Euthanasia: Foundational Issues and Implications. Brigham Young University J Pub Law [Internet] 2017 Apr 01 [Cited 2018 Sep 29]; 31(2):333-394 at 361-365. Available from: https://digitalcommons.law.byu.edu/jpl/vol31/iss2/3/

23. If death does not occur within an agreed-upon time (a maximum of two hours), Dutch physicians are to provide a lethal infusion. Royal Dutch Medical Association [Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG)]. The Role of the Physician in the Voluntary Termination of Life [Internet]. Utrecht, Netherlands:KNMG; 2011 Jun 23 [Cited 2018 Sep 29] [RDMA-Role of the Physician] p. 17-18. Available from: https://www.knmg.nl/web/file?uuid=b55c1fae-0ab6-47cb-a979-1970e6f60ae6&owner=5c945405-d6ca-4deb-aa16-7af2088aa173&contentid=262.

24. BC Pharmacy Association Webinar. Physician Assisted Dying How pharmacists & physicians can work together. Speaker: Dr. Ellen Wiebe. Thursday, March 10, 2016 6:00 PM - 7:00 PM Pacific Time.

IX. PROJECT RESPONSE

IX.1 Preliminaries

IX.1 It is one thing to limit freedom of conscience by enacting laws that prevent people from doing everything that they want to do. But to force people to do things that offend their conscientious convictions cannot be reconciled with the best traditions and aspirations of liberal democracy. It is, in principle, inconsistent with the most rudimentary principles of civic friendship, a serious assault on the essential foundation of fundamental freedom, and offensive to human dignity. It is a fundamental injustice that cannot be rectified or ameliorated by appeals to theories of justice or notions of equality.

IX.2 Thus, the Protection of Conscience Project, without denying the importance of freedom of conscience in its widest sense, restricts the scope of its activity to advocacy for freedom of conscience in its most essential and foundational sense. Simply put, those providing health care must not be forced to do what they believe to be wrong, or punished for refusing to do so.

IX.3 The Project does not take a position on the acceptability of euthanasia or assisted suicide. From the perspective of the Project, legalization of euthanasia or assisted suicide or a change of WMA policy against the procedures is of concern only to the extent that legalization or change threatens to disadvantage or punish physicians who refuse to do what they believe to be wrong.

IX.2 The issue

IX.2.1 If the CMA/RDMA proposal were accepted, would it have adverse consequences for physician freedom of conscience?

IX.3 Relevant considerations

IX.3.1 Most physicians refuse

IX.3.1.1 The majority of physicians believe participation in euthansia or assisted suicide is irreconcilable with their ethical obligations. Available evidence demonstrates that the overwhelming majority of physicians worldwide are opposed to the procedures and would refuse to participate (III.1.1), and that, even where the procedures are legal, relatively few physicians are directly involved in providing the services (VI.3.4). This is not denied by the CMA and RDMA.

IX.3.2.2 Many physicians opposed to providing euthanasia and assisted suicide are also opposed to facilitating or collaborating in the procedures by referral or other means because they believe that doing so makes them complicit in wrongdoing.

IX.3.2 Physician obligation to provide or facilitate medical treatment

IX.3.2.1 Although euthanasia and assisted suicide can be provided by non-medical personnel if authorized by law, when the law authorizes physician administered euthanasia and physician assisted suicide, the procedures are usually thought to be medical services or forms of medical treatment, notwithstanding contrary views among those opposed to them. Medical associations that approve physician participation in the procedures

can be expected to take this position (IV.3.4, VII.4.3.4, B9.3, B10.7).

IX.3.2.2 Physicians are understood to have an ethical obligation to provide or facilitate access to medical treatment or services needed by their patients. When professional or public authorities classify euthanasia and assisted suicide as medical treatments, providing or facilitating homicide and suicide becomes the norm, and refusal to do so the exception that requires justification or excuse. (VII.4.2.3).

IX.3.2.3 Where the state undertakes to finance and provide or arrange for the delivery of medical treatment, physicians may come to be seen as state employees obligated to deliver or facilitate the delivery of all legal medical treatments and services as a condition of employment.[1] This is complemented and supported by theories or models of social contract professionalism.

IX.3.2.4 Since relatively few physicians are willing to provide the services, patients must find a way to connect with willing physicians. This leads to demands that objecting physicians faciliate access by referral or other means (VII.4.3.4, B.10.19).

IX.3.3 Rights claims

IX.3.3.1 The CMA/RDMA proposal asserts, by implication, that people have a right to euthanasia and assisted suicide (VI.3.2, VII.5.2). This claim is increasingly common and consistent with the view that people have a right to health care and medical treatment. Whatever the moral or legal merits of such claims, they provide a basis for demands that physicians provide or facilitate euthanasia.

IX.3.3.2 A more refined claim of a right to equitable access to health care is made for the same purpose. When joined to human rights laws prohibiting discrimination on the basis of disability, the claim of a right to equitable access can ground a complaint against a physician who provides euthanasia for the terminally ill, but not for the clinically depressed. Hence, physicians who agree to provide euthanasia or assisted suicide for one legally eligible patient may find that they cannot legally refuse to provide the services for any legally eligible patient, regardless of the condition or circumstances.[2]

IX.3.3.3 In either case, to seek to enforce these claims with respect to euthanasia and assisted suicide would invoke the power of the state to compel unwilling individuals to become parties to homicide and suicide, and to punish or disadvantage them if they refuse.

IX.3.4 Likelihood of conflict

IX.3.4.1 The foregoing considerations indicate that legalization of euthanasia and assisted suicide has the potential to cause serious difficulties for the overwhelming majority of physicians who are opposed to the procedures.

IX.3.4.2 Proportionate to death from all causes, relatively few patients die from euthanasia and assisted suicide (VII.5.8). However, everyone dies. Hence, where the procedures are legal, every physician in general practice and many in other specialities may be confronted with a request for euthanasia or assisted suicide, especially in specialties like oncology and palliative care (VII.3.6.3). Everyone entering the medical profession will be faced with this issue.

IX.3.4.3 Euthanasia and assisted suicide rates provide some indication of the likelihood that

objecting physicians will encounter ethical conflicts with patients or colleagues where the procedures are legal. However, the rate of requests for euthanasia and assisted suicide is a more reliable indicator, since it is the need to respond to a request for the procedures that may cause difficulties for objecting physicians. Request rates are typically higher than euthanasia/assisted suicide death rates.

IX.3.4,4 Generally speaking, the broader the grounds for euthanasia and assisted suicide, the greater the likelihood that conflicts of conscience will arise. For example: physicians willing to provide the services in the last days of a terminal illness may not be willing to provide them for chronic depression.

IX.3.4.5 Generally speaking, the wider the range of people legally entitled to authorize euthanasia, the greater the likelihood of conflicts of conscience. For example: physicians willing to provide euthanasia at the request of competent patients may not be willing to provide euthanasia at the request of a family member for someone with dementia who is not otherwise ill.

IX.4 Response to the issue

IX.4.1 It is reasonable to believe that the CMA/RDMA proposal would, if accepted, encourage the legalization of physician administered euthanasia and physician assisted suicide around the world (VII.5.7).

IX.4.2 The proposal posits a right to euthanasia and assisted suicide that is unrestricted with respect to eligibility criteria and other conditions under which they might be provided. For example, it does not limit provision of the procedures to terminal illness, does not preclude the procedures as a response to mental illness, disability, or chronic medical conditions, and does not require access to palliative care as a prerequisite. It does not limit provision of the services to adults: adolescents, children and infants are not excluded. It does not exclude euthanasia of incompetent patients authorized by advanced directives (VII.2.4).

IX.4.3 To the extent that legalization does occur in accordance with the proposal, particuarly in view of its unrestricted scope, the overwhelming majority the world's physicians represented by WMA members would be exposed to demands that could generate serious conflicts of conscience and ultimately place those unwilling to provide or cooperate in providing the services in serious professional jeopardy (IX.3.1.1, IX.3.4.4, X.3.4.5).

IX.4.4 The protection of conscience provisions in the proposal do not afford sufficient protection for objecting physicians, especially in light of the increased probability of conflict due to the virtually unrestricted scope of the proposal. The provisions are not well-grounded and actually rejected by one of the co-authors of the proposal (VII.4).

IX.4.5 The experience of objecting physicians in Canada demonstrates that the WMA should not follow the example of the CMA by precipitously changing its policy without sufficient reflection and forethought.[3]

IX.4.6 Given the particular gravity of the consequences of invoking state power against objecting physicians with respect to participation in homicide and suicide, the WMA should not change its policy on euthanasia and physician assisted suicide without first

establishing a sound and robust policy to protect physician freedom of conscience.

IX.4.7 However, a sound policy concerning physician freedom of conscience cannot be developed within the narrow perspective afforded by controversies about particular procedures. The Project recommends, instead, a broad and principled approach be taken to develop a single protection of conscience policy.

Notes

1. Dr. Preston Zuliani (President of the College of Physicians and Surgeons of Ontario, Canada's largest state medical regulator). "In our society, we all pay for this medical system to receive services. And if a citizen or taxpayer goes to access those services and they are blocked from receiving legitimate services by a physician, we don't feel that's acceptable." Laidlaw S. Does faith have a place in medicine? Toronto Star [Internet]. 2008 Sep 18 [Cited 2018 Sep 29]. Available from: http://www.thestar.com/living/article/500852. The College demands that objecting physicians provide "effective referrals" for all services, including euthanasia and assisted suicide, notwithstanding their moral or religious beliefs (VII.4.3.3).

2. "[I]f a doctor willingly prescribes pain-relieving drugs to alleviate suffering - for arthritis, back pain, cancer, stomach ulcer, et cetera - but selectively refuses to prescribe secobarbital or pentobarbital to a patient who lawfully chooses to die, that differential denial of service (i.e., prescribing vs. not prescribing) needs a satisfactoryjustification, or it is discriminatory and illegal." Attaran A. The Limits of Conscientious and Religious Objection to Physician-Assisted Dying after the Supreme Court's Decision in Carter v Canada. Health L Can 2016; 36(3) 86-98 at 87.

3. Murphy S. Canadian Medical Association and euthanasia and assisted suicide in Canada: Critical review of CMA approach to changes in policy and law [Internet]. Protection of Conscience Project; 2018 Sep 26 [Cited 2018 Sep29]. Available from: http://www.consciencelaws.org/background/procedures/assist029-01.aspx

X. PROJECT RECOMMENDATION

X.1 Conscience in the medical profession

X.1.1 Speaking in Jerusalem in 2016, WMA Secretary General, Dr. Otmar Kloiber, drew attention to the expectation that conscience will guide physicians in the practice of medicine, drawing from that a lesson about the importance of freedom of conscience:

> The *Declaration of Geneva* and the *International Code of Medical Ethics* demand the physician to exercise his or her profession with conscience. That, of course, is meaningless if a conscientious objection is impossible. No physician must be forced to carry out activities that are either deemed to be unethical altogether, like participation in capital or corporal punishment, the force feeding of prisoners or to perform services he morally cannot subscribe to.
>
> In essence, physicians do not surrender their human rights when becoming a physician. Not be coerced to provide certain treatments is a matter of dignity and integrity for the physician as well.[1]

X.1.2 Consistent with Dr. Kloiber's remarks, Professor David Oderberg of Reading University expands upon the role of conscience in medicine in *A Declaration in Support of Conscientious Objection in Health Care*:

> In health care, conscience plays an essential role in the professional judgment – often subtle and delicate – that practitioners must exercise in their daily work. If health care workers are not to be reduced to mere functionaries (of the state, of the patient, of the legal system), they must be free to exercise their professional judgment and to allow their consciences to inform that judgment. This freedom of professional judgment informed by conscience must translate into the freedom not to be involved in certain activities or practices to which there is a conscientious objection.[2]

X.2 A broad and principled approach

X.2.1 WMA policy documents occasionally refer briefly to judgements of conscience, but it does not appear that the Association has ever attempted to explain why conscience is central to medical practice, or to connect this idea clearly to the exercise of freedom of conscience. Further, all of the brief references to the subject have been made within the context of controversies associated with specific practices or issues.[3,4,5,6]

X.2.2 A significant shortcoming of procedure-specific policy-making and legislation is that it is inflexible. A policy or law that prevents coercion with respect to abortion does not apply to artificial reproduction, eugenic practices or human experimentation. Responding to ethical controversies spawned by the rapid advance of medical technology is especially challenging. It is not practical for the WMA to spend one to three years developing a protection of conscience policy applicable to a single procedure, and repeat the process every time a new controversy arises.

X.2.3 Moreover, when policies are developed in the midst of controversies about specific

procedures or problems, the policy response may be shaped by features unique to the circumstances and prove problematic when considered in other contexts. A special problem arises in the case of morally contested procedures, when what ought to be judicious reflection on freedom of conscience becomes entangled in partisan debates about the acceptability of the procedures themselves. Opposing sides in such debates may well come to see such policies merely as strategic weapons to be turned to ideological advantage.

X.2.4 Conscience policies developed in relation to specific procedures tend to foster and entrench a morally partisan viewpoint, whether the viewpoint is that of a dominant majority or a powerful minority. This leads to discrimination, either by allowing conscientious objection to some procedures, but not others, or by imposing arbitrary and discriminatory limits on the exercise of freedom of conscience: by, for example, allowing physicians to refuse to refer for euthanasia, but forcing them to refer for artificial reproduction.

X.2.5 For all of these reasons, it is preferable to take a broad and principled approach that keeps the focus on the nature and importance of freedom of conscience, avoiding entanglement in controversies about the acceptability of morally contested procedures.

X.3 Avoiding authoritarian "neutrality"

X.3.1 It is equally important to reject attempts to impose authoritarian solutions masked by a pretence of neutrality. For example, a theory of social contract professionalism that has attained dogmatic status may be applied by those in power to "resolve" moral issues by subordinating them to purportedly neutral "professional" obligations. This approach is exemplified by Udo Schuklenk and Julian Savulecu, who assert that "professionalism" precludes conscientious objection.[7,8]

X.3.2 To claim, for example, that physicians act ethically or with integrity only if they conform to professional expectations could be taken to mean that "professional expectations" override the moral agency and moral integrity of physicians. This is not a neutral claim. Further, physicians may disagree profoundly about whether participation in a given morally contested procedure exemplifies adherence to or a violation of professional commitments: euthanasia is only the most recent and obvious example. Hence, an attempt to regulate the exercise of freedom of conscience by demanding conformity to a theory of professionalism that fails to respect the moral agency of physicians will generate unjust discrimination and exacerbate rather than resolve conflict within the profession.

X.4 A stand-alone general protection of conscience policy

X.4.1 Assuming one avoids entanglement in disputes about the acceptability of procedures/interventions, as well as authoritarian "neutrality," a serviceable policy for protection of conscience must be based on the understanding that recognition that respect and protection of freedom of conscience serves the fundamental good and dignity of the physician as a human person, not merely professional autonomy or independence. It must include a number of basic features:

a) protection of the moral agency and integrity of physicians by ensuring that they are not compelled to do what they believe to be wrong, including referral and

other forms of close cooperation;

b) non-discrimination concerning physician judgements of conscience, both as to the acceptability of a procedure/intervention and decisions about participation or non-participation;

c) an expectation that physicians will provide patients with timely notice of deeply held beliefs that may influence their recommendation or provision of procedures/interventions the patient may request;

d) an expectation that physicians will provide information necessary to enable a patient to make informed decisions and exercise moral agency;

e) an expectation that physicians will provide information to allow patient access to other physicians, health care providers or the local, regional or provincial health care system;

f) insistence that objecting physicians cannot be expected and must not be made to assume responsibility for ensuring access to procedures to which they object; the state, other entities or non-objecting colleagues must assume that responsibility.

Notes

1. Kloiber O. Patients' Rights - A World View. The Patients' Rights Act 20 years on – Achievements and Challenges. Presentation at Peres Center for Peace, Jaffa, Israel. 2016 Jan 18 [Internet]. Protection of Conscience Project [Cited 2018 Sep 30]. Available from: http://consciencelaws.org/ethics/ethics030.aspx.

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3. World Medical Association. Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects [Internet]. 2008 Oct [Cited 2018 Sep 30] para. 3. Available from: https://www.wma.net/wp-content/uploads/2016/11/DoH-Oct2008.pdf.

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5. World Medical Association. Declaration of Lisbon on the Rights of the Patient [Internet]. 2015 Apr [Cited 2018 Sep30] Preamble. Available from: https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/

6. World Medical Association. Declaration of Oslo on Therapeutic Abortion [Internet]. 2006 Oct [Cited 2018 Sep 30] para. 3. Available from: https://www.wma.net/policies-post/wma-declaration-on-therapeutic-abortion/

7. Schuklenk, U. Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. J Med Ethics 2017;43:234-240.

8. Savulescu J, Schuklenk U. Doctors have no right to refuse medical assistance in dying, abortion or contraception. Bioethics Bioethics [Internet] 2017 [Cited 2018 Sep 29] ;31(3):162-170. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/bioe.12288.

APPENDIX "A"

WMA GENERAL ASSEMBLY AND POLICY DEVELOPMENT

Introduction

Constituent and associate WMA members should become familiar with the procedures involved in policy development and approval. The following convenient summary is taken from the briefing session of the General Assembly in Taipei, Taiwan on 22 October, 2016. Headings and subheadings have been added. Some paragraphs have been moved to group subject matter consistently.

A1. General Assembly

A1.1 The WMA Bylaws establish the General Assembly as the most powerful body within the WMA. Its most important role is to adopt official and permanent WMA policy. The delegates should represent the views of their NMAs on these having reviewed materials before the meeting in order to form a consensus. The General Assembly also elects presidents, decides when and where future meetings should be held, reviews applications for membership, considers financial statements and instructs the Council on actions to be taken in pursuit of the objectives of the WMA.

General Assembly documents

A1.2 The most important documents guiding the work of the General Assembly are the General Assembly Agenda and the Report of the Council. Delegates should review the Council Report prior to the General Assembly in order to be able to participate in the decision-making process. Most documents have been in development for over a year and NMAs are given the opportunity to comment. If delegates have concerns about a document, they should seek out Council Members before the vote or ask the Secretariat.

General Assembly rules of procedure

A1.3 The General Assembly rules of proceedings are intended to ensure that all the work is accomplished while at the same time enabling all voices to be heard. If delegates become confused about what is going on they should ask the Chair to slow proceedings down. Open discussion is allowed on all topics on the agenda; however the Chair may sometimes have to limit time for individual comments in order to ensure that all agenda items are covered.

Voting in the General Assembly

A1.4 The voting process is outlined in the document "Overview of Parliamentary Procedures." Voting in WMA meetings is based on standard parliamentary procedure. Any delegate can make a motion, which must be seconded by another delegate (if a motion comes from another WMA body, e.g. the Council, it doesn’t need a second). After it has been seconded, the Chair will invite discussion of the motion. Following discussion, delegates will be invited to vote by raising voting cards showing the

number of votes of their delegation. This depends on the number of the NMA's declared members: 1 vote for every 10,000 declared members and part of it. After votes have been counted, it is declared whether the motion has been passed or defeated.

Dr. Rudolf Henke (German Medical Association) pointed out that a rule that "any delegate can make a motion" implied that individuals could forward a motion contrary to the views of the rest of their delegation. Dr Kloiber explained that a delegation is seen as one body with the underlying assumption of harmony within a delegation. He strongly recommended that delegates should ensure that they reach consensus within their delegation prior to the meeting.

Dr Ekwaro Oboku (Uganda Medical Association) asked for clarification on the number of votes for NMAs with less than 10,000 declared members. Dr Otmar Kloiber explained that NMAs with 1- 10,000 members would have one vote, 10,001-20,000 declared members two votes, and so on.Secret ballots

A1.5 Dr Alvin Chan (Hong Kong Medical Association) asked whether there were any occasions when delegates could ask for a secret ballot apart from the presidential election. The Chair explained that a motion for a secret ballot could be forwarded at any point. This would not require a second but it would require a majority vote.

Delegate registration

A1.6 Dr Miguel Jorge (Brazilian Medical Association) pointed out that when registering for WMA meetings it is possible for people to register as a "delegate" without the knowledge of the NMA. Dr Otmar Kloiber emphasised that ticking delegate on the registration page would not mean the person would be considered an official member of the NMA delegation.

A2. Policy Development

A2.1 Input from NMAs in the development of policy is at the core of the work of the WMA. NMAs have the opportunity to provide input on policy documents throughout the year. If they do not respond to requests for comments on policy documents then they will not be successful in efforts to influence WMA policy. The Secretary General reiterated the importance of NMA input and explained that the Secretariat is there to assist NMAs in how to provide this.

A2.2 The Chair went on to explain the policy development process. This was summarised in an abridged workflow diagram:

1. Submission of document to the Secretariat in one of three official WMA languages;

2. Secretariat translates document and assigns it to proper committee for initial consideration at next meeting;

3. Committee recommends document for circulation to the NMAs for comment;

4. Secretariat compiles and reviews comments and sends revised document to the committee for consideration;

5. Committee may recirculate the revised version to NMAs for further comments;

6. Once the considered document ready, the committee submits document to the Council with the recommendation that it be approved and forwarded to the General Assembly for adoption.

A2.3 This entire process may take 1-3 years to accomplish, depending on the number of times a document is recirculated or whether it is an emergency issue. NMAs must therefore realise when they submit a document that alterations will be made and the end product may not resemble the initial document. Once they submit a document it becomes the property of the WMA. In certain rare cases the General Assembly will be asked only to accept or reject a document that has been developed in cooperation with another organisation.

A2.4 The participation of constituent members in the policy process is requested and appropriate, for example when draft policies are sent out with calls for comments. However if NMAs feel overwhelmed by the volume of documents they are asked to comment on they may be selective and focus upon the issues of particular interest to them.

A2.5 Ms Anne Trimmer (Australian Medical Association) asked about the procedure for the calls for comments. Dr Otmar Kloiber explained that open documents are posted on the website and a call for comments is sent out by email followed by a reminder.

A2.6 Dr Otmar Kloiber introduced Prof. Vivienne Nathanson, Facilitator, and Ms Marie Colegrave-Juge, Legal Advisor. He explained that Ms Marie Colegrave-Juge advises the WMA on legal issues which arise in the work of the WMA, but also on parliamentary procedures during the meetings. She also ensures that policy documents are brought into the correct format before meetings. Prof. Vivienne Nathanson is seconded to the WMA on a part-time basis to assist with process, policy, ethics and public health questions that arise concerning matters of policy, for example when members wish to bring an issue to the WMA.

Submitting ideas for policy development

A2.7 Dr Otmar Kloiber invited NMAs with ideas for policy documents to contact the Secretariat well in advance of Council and General Assembly meetings for advice on how to submit these. He pointed out, however, that they may not be able to assist with last minute requests for advice after the deadline for the submission of new policies as they will be busy preparing for the meetings.

A2.8 The Chair called upon members to come to the meetings prepared and to take influence within their medical societies and their countries on behalf of their patients and colleagues. She encouraged delegates to attend Council Meetings and seek contact with Council Members to discuss issues of concern. She closed by thanking delegates for their attendance and told them not to hesitate to ask if they don't understand anything in the future.

Accessing on-line WMA working documents, procedural guides, etc.

A2.9 Dr Wonchat Subhachaturas (Medical Association of Thailand) asked how to get a user name and password for the website. Dr Kloiber explained that NMAs should contact the Secretariat to ask for passwords for staff members in order to be able to access working documents, registrations for meetings, procedural guides and standing documents, which contain procedural details.

Joining committees

A2.10 Dr Margaret Mungherera (Uganda Medical Association) commented that communication with the NMAs is still a challenge, for example when officials change and the Secretariat is not informed of the new contact details. She asked how NMAs can join committees and working groups. Dr Otmar Kloiber asked NMAs to always inform the Secretariat of changes to contact details. Dr Ardis Hoven explained that Council Members are appointed to the three committees and the committee chairs are elected from the Council Members. Workgroups examining at defined issues generally have max. 5 members, which are assigned based on their declared willingness to participate. Workgroup members do not have to be Council Members.

A2.11 Dr Lincoln Lopes Ferreira (Brazilian Medical Association) asked if the presentation today could be incorporated into a written report for the NMAs. Dr Kloiber explained that this is already online in the form of a Delegates' Guide. There are also Council Members' Guides online.

APPENDIX "B"

CMA APPROVAL OF EUTHANASIA AND ASSISTED SUICIDE

B1. Canadian Medical Association (CMA) General Council (August, 2013)

B1.1 In June, 2012, in the case of *Carter v. Canada (Attorney General)*, a judge of the Supreme Court of British Columbia struck down the absolute criminal prohibition of physician assisted suicide and physician administered euthanasia, suspending the ruling for one year to give governments the opportunity to implement the decision.[1]

B1.2 When the CMA Annual General Council convened in August, 2013, an appeal of the Carter decision was in progress, and a euthanasia bill had been introduced in the Quebec legislature. Delegates were presented with a motion from the Quebec Medical Association that the CMA should ask "all relevant levels of government to conduct a large-scale public consultation to consider the recognition of medical aid in dying as appropriate end-of-life care."[2]

B1.3 A contentious debate followed, centred on the wording of the motion and the definition of terms, and the motion was defeated. Instead, delegates voted "to refer the issue to the CMA Board for future deliberation." The outgoing chair of the medical ethics committee said that the vote reflected "deep divisions within the medical community."[2]

B1.4 Another motion called for the CMA to replace the term "physician-assisted suicide" with "physician-assisted death" in all its official documents. According to a *Globe and Mail* report, this motion also generated a "passionate debate."

> "Suicide is an unhappy word," said John O'Brien-Bell of Surrey, B.C., a past CMA president. "Assisting suicide is also illegal." Lawrence Erlick of Scarborough, Ont., tried to find a compromise, suggesting the unwieldy term "patient-requested medically assisted death." Robin Saunders, chair of the CMA ethics committee, would have none of it. "Let's call a spade a spade: It's euthanasia," he said.

Delegates voted to have the CMA Board review the issue and make a decision.[3]

B1.5 However, delegates did pass the following motion:

> 36. The Canadian Medical Association supports the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying. (DM 5-22).[4]

B2. CMA Board decides to shape the debate and the law

The decision

B2.1 In October, 2013, the BC Court of Appeal reversed the *Carter* trial court ruling.[5] The Court of Appeal quoted the CMA policy against physician participation in euthanasia

and assisted suicide, setting it beside the policies of other associations, as the trial judge did, to make the point that the evidence at trial "did not demonstrate a clear consensus of public or learned opinion on the wisdom of permitting physician-assisted suicide."[6] It was generally understood that the case would be appealed to the Supreme Court of Canada.

B2.2 The CMA Board of Directors held a retreat the same month, apparently for the purpose of deciding upon a course of action concerning euthanasia and physician assisted suicide. In describing the "dilemma" faced by the Board, Dr. Blackmer noted that polls had demonstrated that the large majority of physicians were opposed to euthanasia and assisted suicide, but the public was increasingly in favour of the procedures. Consistent with the position of the majority of physicians, CMA policy was against both. According to CMA Vice-President Dr. Jeff Blackmer, the choice faced by the Board was to leave the policies unchanged, or "play a more active role in representing its membership." The Board opted to become involved in what Dr. Blackmer called the "national conversation." It meant to shape the debate and law concerning euthanasia and assisted suicide, and authorized "a substantial budget and significant internal resources" for that purpose.[7] CMA President Chris Simpson later explained, " "We realized that this was something that society needs us to lead on."[8]

Shaping the debate and the law: in brief

B2.3 The great majority of CMA members opposed legalization of euthanasia and assisted suicide, but, in representing CMA members in the "conversation," the Board appears to have decided to include both majority and minority perspectives. This was challenging but worthwhile, and need not have had any adverse effects on physician freedom of conscience.

B.2.4 However, by the summer of 2014, it appears that the Board's plan to shape the debate and the law had evolved into a plan to overturn CMA policy against the procedures, notwithstanding the opposition of the majority of physicians, apparently because it had concluded that euthanasia and/or assisted suicide should be legalized in at least some cases. According to Dr. Chris Simpson, then CMA President, the Board decided that there was no consensus on the procedures, and "There can't be a one-size-fits-all. We have to have the ability to fit everybody's legitimate concerns and aspirations here."[9]

B2.5 Belief that the *Carter* case would result in legalization of the procedures also seems to have contributed to the Board's plan to change CMA policy.[10,11] The Directors wanted to ensure not only that the CMA would be involved in writing and implementing a new law,[12,13,14,15] but would be in the vanguard of what would be a momentous change.[16,17,18,19] That meant being on the right side of history if, as widely expected, the Supreme Court ruled that the law should be changed.[20,21] However, that also meant achieving a major policy change at the General Council in August, as the next opportunity to do so would not come for another year.

B2.6 Beginning in June, 2014, with a General Council two months away and a Supreme Court hearing expected in the fall, the Board put into action what was probably a still evolving plan, without reflecting adequately upon the effects of their actions on medical practice and the fundamental freedoms of physicians. As a result, they were

surprised by elements of the Supreme Court ruling and ill-prepared to respond, especially to challenges to physician freedom of conscience.

B3. CMA Board revises euthanasia and assisted suicide policy (December, 2013)

B3.1 In December, 2013, the CMA Board approved changes to Association policy on euthanasia and assisted suicide.[22] The update, published in 2014, introduced new terminology and reiterated the Association's opposition to the procedures. Three statements in the policy are of particular interest:

> A change in the legal status of these practices in Canada would represent a major shift in social policy and behaviour. *For the medical profession to support such a change and subsequently participate in these practices, a fundamental reconsideration of traditional medical ethics would be required.* (p. 2, emphasis added)
>
> Physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition of euthanasia and assisted suicide. Because of the controversial nature of these practices, their undeniable importance to physicians and their unpredictable effects on the practice of medicine, these issues must be approached cautiously and deliberately by the profession and society. (p. 2)
>
> The CMA recognizes that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. The CMA wishes to contribute the perspective of the medical profession to the examination of the legal, social and ethical issues. (p. 3)

B3.2 There was no reference to the resolution passed by the Annual General Council in 2013 asserting "the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying" (B1.4), but this would have been premature. Assisted suicide or euthanasia were still illegal, and the Association still stated that physicians should not participate in either.

CMA studies euthanasia & assisted suicide (January-June, 2014)

B3.3 During 2014, pursuing the direction given by the Board the previous October, CMA officials quietly studied the provision of physician assisted suicide and euthanasia in Oregon, Washington, Montana, Vermont and New Mexico, Netherlands, Belgium and Switzerland.[11] It also held five town hall meetings across Canada in the first half of the year, ending on 27 May in Mississauga. With respect to euthanasia and assisted suicide, the report about the meetings noted that "the public often had diametrically opposed views,"[23] was divided on whether or not the procedures should be legalized,[24] and stated that the potential impact of legalization on the medical profession "should be carefully considered and studied further."[25]

B3.4 Six meetings were also held with physicians across the country, and a website was maintained for physician-only comment from February to the end of May. The report of the consultation stated that the meetings and on-line responses were characterized

by "diametrically opposed views" on euthanasia and assisted suicide.[26] The majority of CMA members participating opposed physician involvement in the procedures,[27] (71.5% of an on-line poll[28]), while "[a] significant minority" (25.8% of poll respondents[28]) believed that the policy "should at least be reviewed if not revised to support some form of physician-assisted dying."[27].

B3.5 A majority of about 66% in the recent Irish abortion referendum has been described as "overwhelming,"[29] a "landslide"[30] and "decisive."[31] By this standard, a larger-than-overwhelming majority of Canadian physicians opposed a change in CMA policy. No one has suggested that the referendum result left the Irish government doubtful about its mandate. However, the CMA consultation report - finalized at about the time the Board seems to have launched its plan to change CMA policy (B2.6, B5.1)- stated that the Association "was not given a clear cut mandate on future activity dealing with the sensitive area of euthanasia and physician-assisted dying."[27]

CMA announces plan to intervene in Carter v. Canada (April, 2014)

B3.6 The month before the town hall meetings ended, CMA President Dr. Louis Hugo Francescutti and Dr. Jeff Blackmer announced that the Association would intervene in the Supreme Court of Canada in the Carter case.

> . . . the CMA will be seeking intervener status before the Court, not to offer a polarizing "pro" or "con" view on an already divisive issue - our policy is clear and speaks for itself - but to share a narrative of insights on the physician's perspective. The goal would be to provide the Court with a deeper understanding and appreciation of the findings from the CMA's dialogue on end-of-life care, the spectrum of options and the current CMA policy perspective. We would also highlight the challenges posed to physicians' understanding of their traditional roles if the Court were to change the law.[32]

B3.7 Dr. Blackmer and Francescutti also claimed that the 2013 Annual General Council rejected the motion calling for national consultation "to regard medical aid in dying as appropriate care" because "medical aid in dying" had never, until that point, been properly defined." This substantially understated the significant differences that were evident to those observing the proceedings (B1.3-4). They did, however, make the following observations:

> One person's right is another person's obligation, and sometimes great burden. And in this case, a patient's right to assisted dying becomes the physician's obligation to take that patient's life.
>
> We have heard from many of our members that this prospect makes them not only uncomfortable but downright terrified. . .
>
> . . .only a tiny minority of patients at the end of their lives request access to medical aid in dying. Until we can provide access to palliative care to all Canadians who need it, this is where the focus of our attention should remain . . . [32]

B3.8 Given the concern expressed by Dr. Blackmer and Dr. Francescutti in April, 2014 about imposing an obligation to kill upon physicians, and the ramifications of doing so, one would expect this to have been a constant concern of the CMA Board of

Directors with respect to the legalization of euthanasia and assisted suicide. However, it does not seem to have been considered again. The failure to attend to this issue left most physicians unaware of its significance, and of the significance of the policy direction taken by the CMA Board of Directors from June, 2014.

B4. CMA applies for intervener status in Carter v. Canada (June, 2014)

B4.1 In June, 2014, the CMA applied for leave to intervene at the Supreme Court of Canada in *Carter v. Canada*. The application was supported by an affidavit by Dr. Chris Simpson, president-elect.[12] Quoting then CMA policy, he emphasized deep divisions of opinion among physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary (para. 23).

B4.2 With reference to physicians, Dr. Simpson observed that a 2011 survey indicated that only 16% of Canadian physicians would provide euthanasia or assisted suicide, while 44% would refuse (para. 33). He noted that it was clear that the public was divided on the issue (para. 38, 39d).

B4.3 While drawing attention to the strong opposition of Quebec palliative care physicians to the province's proposed euthanasia law, as well as doubts expressed by some family physicians, Dr. Simpson nonetheless noted that physicians had "worked through and continue to assess the appropriate ethical perspectives" of euthanasia, and that both the Quebec Medical Association and Collège des médecins du Québec supported the legislation (para. 44).

B4.4 In describing then current CMA policy, Dr. Simpson drew the court's attention to worries about a "slippery slope." However, he made special note that a Royal Society panel of experts had concluded that there was "no basis to these arguments." (para. 29)

B4.5 The affidavit acknowledged but downplayed then CMA policy against physician participation in euthanasia and assisted suicide, stating that it was "not a certainty nor is it perpetually frozen in time" (para. 28):

> . . .while the policy states that the CMA is opposed to physician-assisted death "Canadian physicians should not participate in euthanasia or assisted suicide"), it frames it as a societal issue and envisages the possibility of change, as informed by a dialogue between physicians, patients and the legislatures. . .(para. 25)

B4.6 Consistent with statements made two months earlier by Dr. Blackmer and Dr. Francescutti (B3.6-7), Dr. Simpson stated that a CMA intervention would not offer "a black and white perspective" (para. 57), which "would be a disservice to the issues and the Court," since, he wrote, "Such a perspective does not exist," adding, "The CMA's current policy is not static and can change (para. 58, emphasis added).

B4.7 The affidavit also envisaged a key role for physicians should the law be changed:

> If the law changes, physicians will be key players in any assisted death regime. They will play two critical roles. First, they will have to determine whether an individual patient's wish to be assisted in dying

> meets the threshold. Second, they will have to prescribe the agents leading to death, and to provide the patient with bedside care through the process leading to death. Plainly, assisted death, if sanctioned by law, has no prospect of implementation unless physicians in sufficient numbers across the country are persuaded that the sanctioned regime is ethical, practical, and in accordance with existing medical standards. . . (para. 56)

B4.8 Nothing in the affidavit suggested that the CMA would oppose legalization of physician assisted suicide and euthanasia, and it did not state that the CMA would support it. However, it clearly implied that, should the court legalize the procedures, the Association would likely change its policy, and that physicians would be "key players" whose cooperation would be needed to make assisted suicide and euthanasia available.

B5. CMA Board resolution on euthanasia and assisted suicide (June-July, 2014)

B5.1 During 2014 there was continual discussion of physician assisted suicide and euthanasia by the CMA Board of Directors. CMA Board member Dr. Ewan Affleck proposed that the Board sponsor a resolution at the August Annual General Council. What he later told the Northern News Service suggests that this probably occurred in June.

> "CMA applied for intervener status with the Supreme Court," said Affleck.
>
> "That was some of the urgency in developing our position, we knew the Supreme Court was moving forward and we wished to have a clear position."[33]

B5.2 At that point, the CMA's position was clear; the Association opposed physician participation in euthanasia and assisted suicide. If Dr. Affleck and others on the Board included in his "we" wanted a "clear position," they must have wanted something different. Dr. Affleck, who described himself as "passionate about the issue of end-of-life choices" because of personal experiences, explained what happened.

> "We had been discussing this issue at length at the level of the board for a good long while because it is an important issue," said Affleck.
>
> "We had a lot of debates and then I sat down and wrote a proposal for a motion and then took it back to the board as a board member and it was quite uniformly well accepted."[33]

B5.3 The resolution proposed by Dr. Affleck stated:

> The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide.[34]

B5.4 The Board thus agreed that the CMA should support physicians who participate in

assisted suicide and euthanasia as well as those who refuse to do so, but this could hardly be considered a "clear position" when read in conjunction with existing CMA policy. The Board's support for the resolution conflicted with CMA policy against physician participation.

B5.5 However, the resolution had to be accompanied by a supporting rationale, which, according to CMA rules, is the means by which the General Council gives policy guidance and direction to the Board.[35] Thus, as the sponsor of the resolution, the Board wrote - or at least approved in advance - the kind of guidance it wanted to use to resolve the apparent conflict.

B5.6 The rationale for the motion noted the "polarizing nature" of the subject reflected in divisions among the public and CMA members. It argued that unanimity among Association members seemed unlikely, and that those supporting and those opposing assisted suicide and euthanasia could marshal "just moral and ethical arguments" to support their respective positions. While the wording of the motion seemed to suggest the adoption of a laissez-faire position concerning participation by individual physicians, the rationale went much further, asserting that the current prohibition "may adversely impact patients with terminal conditions and unremitting suffering from obtaining compassionate care."

> Implicit in CMA's mission statement, helping physicians care for patients is the centrality of the patient in the mandate of Canadian physicians.
>
> CMA's current policy on euthanasia and assisted suicide suggests that Canadian physicians should not participate in assisted death. This poses a dilemma for CMA, as it could be suggested that a prohibition on physician-assisted death bars physicians from providing a service desired by some patients to alleviate pain and suffering.[34]

B5.7 The CMA *Code of Ethics*, it was argued, "implies the paramount importance of honouring the will of the patient in determining the course of therapy they receive, including end-of-life therapy."

> Given that evidence supports that there are competent Canadians with terminal illness who seek the services of physicians to assist them with dying, how then can Canadian physicians justify withholding a service against the will of a patient?[34]

B5.8 Rhetorical questions are meant to elicit expected answers. The answer obviously expected by the Board of Directors in this case was that the CMA could not justify refusing assisted suicide and euthanasia to competent patients who are terminally ill and want to kill themselves or have a physician kill them.

B5.9 This strongly suggests that, at least by June, 2014, the Directors had come to believe that CMA should formally approve physician participation in assisted suicide and euthanasia, in order, as Dr. Simpson said, accommodate "everybody's legitimate concerns and aspirations."(B2.4) However, they did not put this to the General Council. Instead, the resolution they sponsored was ostensibly limited to the exercise of freedom of conscience, supported by an appeal to adopt a policy of neutrality:

> Rather than choosing to prohibit or approve physician-assisted death, CMA will best serve Canadians seeking quality health care by highlighting that physicians may follow their conscience when deciding whether to participate within the bounds of existing law.[34] (Emphasis added)

B5.10 Consistent with the conclusion noted in B5.8, the appeal to neutrality included the decidedly non-neutral view that physician assisted suicide and euthanasia could be considered "quality health care" in at least some circumstances.

B6. CMA General Council (August, 2014)

Briefing materials

B6.1 Briefing materials were prepared for the CMA board of directors and delegates to the Annual General Council. The materials included relevant resolutions passed at the 2013 Annual General Council, an outline of the town hall meetings held in 2014 and a backgrounder for the strategy session on Care at the End of Life (Appendix 2).[36] The 2013 resolution that physicians had a right to conscientious objection was listed with eight other resolutions passed at the same time (p. A2-1). It was not included in the summary of CMA policy that followed.

B6.2 Key elements of the then current CMA policy on euthanasia and assisted suicide were partially reproduced, the redaction of one of which is noteworthy:

> For the medical profession to [*support such a change and subsequently*] . . . participate in these practices, a fundamental reconsideration of traditional medical ethics would be required." (p. A2-2) [*Replaced by elipsis*]

If even supporting legalization of euthanasia and assisted suicide would require "a fundamental reconsideration of traditional medical ethics," one would expect that a briefing note to delegates would have directed their attention to that point rather than away from it, especially since the Board planned to ask them to support a change in policy conducive to legalization.

B6.3 The backgrounder reported that the CMA had applied for leave to intervene in the *Carter* case. It posed five strategic questions to focus the discussion. Three referred to euthanasia and assisted suicide; the last presumed a "need for euthanasia and assisted suicide."

> 3) Should the CMA revise its current policy on euthanasia and assisted suicide?
>
> 4) If the law is changed in Canada to make euthanasia or assisted suicide legal how should the medical profession respond?
>
> 5) If access to palliative care services was universal, would it eliminate the *need* for euthanasia and assisted suicide? (p. A2-4) [Emphasis added]

B6.4 Included in the backgrounder was "Schedule 'A'", which outlined patient eligibility, process, and physician obligations respecting euthanasia/assisted suicide in jurisdictions where the preocedures are legal. It stated that objecting physicians in

Washington, Vermont, Oregon, Belgium, and Luxembourg "have a duty to transfer patient care to another physician who can fulfil the request." (p. A2-7) This was erroneous and misleading: erroneous, because the law in Vermont said nothing of the sort;[37]37 misleading, because it could have been taken to mean that the objecting physician has a duty to initiate the transfer to a willing colleague. This was not required in any of the jurisdictions listed. All that is required is that objecting physicians transfer the patient's medical records as requested by the patient.[38,39,40,41]

Adoption of resolution on freedom of conscience (19 August, 2014)

B6.5 The resolution proposed by Dr. Affleck was seconded by outgoing CMA President Dr. Francescutti:

> The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide. (DM 5-6)[34]

B6.6 It was argued on the floor that "current policy on euthanasia and physician-assisted suicide does not sufficiently reflect the broad spectrum of opinions on the matter held by Canadian physicians," since it prohibited physician participation in euthanasia and assisted suicide. In contrast, the most recent survey of Canadian physicians found almost 45% of physicians supported legalizing assisted suicide, about 36% favoured legalization of euthanasia, and almost 27% were willing to be involved with providing assisted suicide if the acts were legalized.[42]

B6.7 Of course, the survey results also revealed that 55% of physicians surveyed were against legalizing assisted suicide, 64% against legalizing euthanasia, and 73% were unwilling to be involved with assisted suicide, but it appears that those citing the statistics preferred to accentuate the positive rather than the negative. It also appears that the numbers of those willing or unwilling to provide euthanasia, if available, were not reported. Again, evaluating the returns using the standard applied to the Irish abortion referendum, an overwhelming majority of physicians remained opposed to euthanasia and assisted suicide.

B6.8 Nonetheless, this approach offered some strategic advantage in view of the possibility that the Supreme Court might strike down the law, especially if the Association maintained its policy against physician participation in the procedures. In that case, the resolution would have left willing physicians free to apply the law without putting them in conflict with CMA policy. It offered the Association as a whole and individual members a way to agree to disagree, at least until the policy could be revisited if the law changed.

B6.9 On the face of it, the 2014 resolution did no more than affirm the 2013 resolution supporting physicians who refuse to participate in euthanasia, while adding the promise of support for physicians wanting to do so. In the event that the procedures were legalized, the resolution appeared to commit the CMA to impartially defend both groups - nothing more. Dr. Blackmer later explained the resolution as "the other side" of conscientious objection: "almost conscientious permission."[43] Even delegates opposed to euthanasia and assisted suicide would probably have been swayed by such considerations. On the other hand, voting against the resolution would have been a

vote against physician freedom of conscience that would arguably have nullified the 2013 resolution in support of a right to conscientious objection. In view of all of this, it is not surprising that the outcome of the vote was 91% in favour of the resolution.

B6.10 Professor Margaret Somerville, initially satisfied with the resolution, later changed her mind:

> The CMA's motion, as worded and subsequently interpreted, placed its voting members in an untenable situation. Their only options were to vote either for protection of conscience and for euthanasia or against both. The possibility of voting for freedom of conscience and against euthanasia, as I believe most would, was eliminated.[44]

B6.11 Unnoticed at the time was the fact that the CMA's promise to support physicians providing legal euthanasia and assisted suicide was unlimited. It was not conditional upon patients having to meet certain criteria to qualify, such as decision-making capacity or having a terminal illness.

B6.12 A CMA report of the meeting noted that a "straw vote" showed 70% of delegates believed that the CMA should revise its policy on euthanasia and assisted suicide, and "78% felt universal access to palliative care services would not eliminate the need for euthanasia and physician-assisted death."[42] These votes were obviously in response to "strategic questions" 3 and 5 posed to the delegates in their briefing material (B6.3)

B6.13 It is difficult to verify the validity of the "straw votes" as a reflection of the views of the entire CMA membership because of the contrary views expressed during the earlier extensive physician consultations (B3.4) and the bias evident in the information supplied to delegates (B6.2-3). Especially important, one cannot determine whether the desire for policy change expressed in response to Strategic Question 3 indicated approval of euthanasia and assisted suicide or a preference for a policy of neutrality - as urged by those supporting the Board resolution.

B7. CMA officials comment (August-September, 2014)

B7.1 Two days after the vote, the CMA Board of Directors confirmed the resolution on freedom of conscience in relation to assisted suicide and euthanasia.[45] The confirmation of the resolution left the prohibition against physician participation untouched. Some commentators - Professor Somerville among them - initially believed that the resolution was an affirmation of physician freedom of conscience rather than an expression of support for physician participation in assisted suicide and euthanasia. In fact, that is exactly what Dr. Jeff Blackmer told *The Catholic Register*.

> ". . .It (the new policy) doesn't say we favour a change in the law," said Dr. Jeff Blackmer, the CMA's executive director of ethics.
>
> The CMA stance opposing euthanasia remains in place.
>
> "Our position is still that Canadian physicians should not participate in euthanasia or assisted suicide," Blackmer said.[46]

B7.2 Dr. Blackmer maintained the distinction in another interview:

> "One of the options would have been to say our policy is unchanged.

> We could say ethics trumps the law."
>
> He noted that in Belgium, where euthanasia was legalized in 2002, the Belgian Medical Association continues to discourage physician participation in the practice.[43]

B7.3 CMA President Dr. Chris Simpson also took this approach during an interview in the first week of September.

> Simpson said he is in full agreement with Affleck - that the CMA not taking a stance one way or the other on doctor-assisted deaths by passing the motion, but only allowing Canadian physicians to follow their conscience.
>
> "What we are doing is protecting doctors and allowing them to follow their conscience on this issue," he said.
>
> Simpson said if a doctor does not believe in helping a patient end their life, they shouldn't have to and shouldn't be forced by law to do so.[47]

B7.4 With respect to euthanasia and assisted suicide, he noted that some commentator had described the resolution as "a softening of the CMA's stance on doctor-assisted death."

> "I prefer to think of it as a tightening of definitions when it comes to doctors and their role around end of life care. This is a very complex, controversial issue for doctors and the public at large."
>
> "The CMA had to be careful in its use of terminology in finalizing Affleck's motion."[47]

B7.5 This response is noteworthy for three reasons. First: that Dr. Simpson preferred to describe what happened as "a tightening of definitions" did not amount to a denial that softening had occurred or was occurring. Second: the term "medical aid in dying" - the only specialized term used in the text of Dr. Affleck's motion - had been defined in CMA policy six months before he brought the motion to the Board. His motion involved no "tightening of definitions." Third: what Dr. Simpson described as being "careful in its use of terminology in finalizing Affleck's motion" must have been a reference to the care taken in drafting the supporting rationale, since the text of the motion introduced no new terminology and changed no definitions.

B7.6 Comments by Dr. Simpson in an earlier interview provide more insight into his thinking. He expressed sympathy for physicians concerned by the prospect that euthanasia and assisted suicide might be legalized.

> Most doctors aren't opposed to the notion of patients being able to choose how and when they die, "but they're uncomfortable with the role they're being asked to play," Simpson said.
>
> "That discomfort comes a lot from this uncertainty: Am I going to be compelled to do it if I don't want to do it? Am I going to be asked to make decisions that I'm really uncomfortable with?"[48]

B7.7 However, referring to some kinds of cancer and diseases that cause "uncontrollable pain" and suffering that cannot be alleviated by even the best palliative care, he said,

"[W]e would all agree that if we were in that situation we would be looking for potentially other solutions"[48] - an obvious if euphemistic reference to death by lethal injection or assisted suicide.

B7.8 Dr. Simpson's claim that "we would all agree" to such solutions contradicted the CMA's repeated acknowledgement that there was no agreement about the acceptability of euthanasia and assisted suicide. However, it was consistent with the views he expressed in the application to intervene in Carter, as well as the arguments in favour of euthanasia and assisted suicide offered by the CMA Board in supporting Dr. Affleck's motion.

B7.9 More significant was his response to the suggestion that someone other than physicians should provide euthanasia and assisted suicide. He said, "I don't think we want to be reneging on our responsibilities to serve our patients."[48] This could be understood to support the view that, in some circumstances, physicians have a legal or professional obligation to kill a patient or to help a patient kill himself.

B7.10 As outgoing CMA President, Board member and seconder of Dr. Affleck's motion, Dr. Louis Francescutti was well placed to anticipate what the CMA Board would do. The conclusion that CMA Directors supported physician participation in euthanasia and assisted suicide (B5.8) is supported by a comment he made just after Dr. Affleck's motion was accepted by the General Council. He noted that the CMA's official policy had not changed, but "it's only a matter of time."[49]

B7.11 In November, 2014, looking back on the adoption of the resolution, Sandra Martin headlined it as "an overwhelming change." Dr. Simpson, interviewed for the column, called it "a sea change"[8] - not just a "tightening of definitions."[47]

B8. CMA intervention in *Carter v. Canada*

B8.1 The CMA factum for its intervention in Carter was filed a week after the end of the Annual General Council.[50] Counsel for the Association Harry Underwood made an oral submission during the Supreme Court of Canada hearing in mid-October, 2014, making clear that the Association was not arguing for or against the legalization of assisted suicide or euthanasia.[51]

B8.2 He explained that physicians had been historically barred from providing euthanasia and assisted suicide because of ethical considerations, notably a physician's obligation "to secure patient well-being."

> But the concept of patient well-being is capable of an interpretation which encompasses the patient's right to choose death, where the alternative is certain suffering, a choice which is also supported by the concept of patient autonomy. Thus, going back to first principles, the two approaches are each possible.[52]

B8.3 He went on to say that the profession was divided between these approaches, "each defensible on the basis of established medical ethical considerations and compassion." In light of this, he said, referring to the resolution passed at the General Council in August, the Association had decided that physicians "who can square their participation with their own consciences" could provide euthanasia and assisted suicide, "without overriding the consciences" of objecting physicians. He told the

Court that CMA policy would be changed to reflect this.[53]

B8.4 This reinforced statements in the CMA factum:

> The CMA's policies are not meant to mandate a standard of care for members or to override an individual physician's conscience. (para. 9)
>
> 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. (para. 16)

B8.5 "As long as such practices remain illegal," the factum stated, "the CMA believes that physicians should not participate in medical aid in dying," but, should the law change, "the CMA would support its members who elect to follow their conscience."(para. 3)

B8.6 This promise was was unconditional. Consistent with the resolution sponsored by the Board in August, the factum and oral submission conveyed the message that the Association would support physicians who decided to participate in legal euthanasia or assisted suicide, no matter how broadly the Court or legislatures might cast the rules governing the procedures. The CMA offered no suggestions concerning criteria for eligibility should the law be changed, but did tell the Court that it seemed wrong to deny assisted suicide and euthanasia to "grievously ill" (not terminally ill) patients simply because palliative care is unavailable (para. 20).

B8.7 In the last half of his presentation, Mr. Underwood addressed practical concerns raised by the legalization of physician assisted suicide and euthanasia. Notably absent from his list of concerns was the fact that, as late as August, the great majority of physicians were opposed to the procedures. However, he had earlier insisted that the law should protect both objecting and non-objecting physicians,[54] a point also made in the factum.

> [N]o physician should be compelled to participate in or provide medical aid in dying to a patient, either at all, because the physician conscientiously objects . . . or in individual cases, in which the physician makes a clinical assessment that the patient's decision is contrary to the patient's best interests. Notably, no jurisdiction that has legalized medical aid in dying compels physician participation. (para. 27)

B8.8 The distinction made in the factum (but not in the oral submission) between participation and provision is important. In this context, "participation" is a broader term that would seem to include referral. The CMA was well aware of longstanding and increasingly strident demands that physicians be compelled to refer for morally contested services like abortion.[55] The Association was also well aware that Jocelyn Downie, one of the leading advocates for compulsory referral for abortion, had joined other experts in recommending mandatory referral for euthanasia and assisted suicide (III.4.10); the CMA President had cited their report[56] in his affidavit (B4.4). Downie was, in fact, live-tweeting from the Supreme Court during the hearing.[57]

B8.9 However, rather than directing the court's attention to this problem, the CMA factum suggested vaguely that the Court could "indicate that a practicable legislative regime for medical aid in dying must legally protect those physicians who choose to provide

this new intervention to their patients, as well as those who do not." (para. 28) Worse, it advised the Court that, if a physician declines to participate, "every jurisdiction that has legalized medical aid in dying has adopted a process for eligible patients to be transferred to a participating physician."(para. 27) Here the factum cited the erroneous and misleading "Schedule A" prepared for the August AGM, which could be understood to require objecting physicians to collaborate in delivering the services(B6.4).

B8.10 Having watched the hearing, Udo Schuklenk, one of Downie's fellow experts, criticized the joint intervention by the Protection of Conscience Project, Faith and Freedom Alliance and Catholic Civil Rights League because it argued against forcing objecting physicians to refer for euthanasia and assisted suicide. He did not mention the CMA submission.[57]

B9. CMA Board approves euthanasia and assisted suicide (December, 2014)

Policy against euthanasia and assisted suicide reversed

B9.1 In December, 2014, while the country awaited the decision of the Supreme Court in Carter, the CMA Board of Directors approved a change in Association policy on euthanasia and assisted suicide, renaming it "Euthanasia and Assisted Death."[58] When the revised policy was published, the CMA issued a statement that it "and other changes to the CMA's approach to end-of-life care issues . . . codify resolutions adopted by delegates at the association's annual meeting in August."[59]

B9.2 This was misleading. The revised policy did codify the resolution that urged the Association to support for physicians who "follow their conscience." Recall, however, that the resolution was not presented as an approval of euthanasia and assisted suicide, but as a position of neutrality concerning physician participation in the practices, a distinction emphasized by both the CMA Director of Ethics and the CMA President shortly after the General Council (B7).

B9.3 Instead, the revised policy formally approved physician assisted suicide and euthanasia, subject to legal constraints, classifying both practices as "end of life care."

> There are rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying. In such a case, and within legal constraints, medical aid in dying may be appropriate. The CMA supports patients' access to the full spectrum of end of life care that is legal in Canada.[58]

B9.4 Once more, this affirmation was unconditional. The CMA Board of Directors promised to ensure patient access to "the full spectrum" of end-of-life care, including euthanasia and assisted suicide, no matter what the criteria might be. The policy did not exclude minors, the incompetent or the mentally ill, nor did it limit euthanasia and assisted suicide to the terminally ill or those with uncontrollable pain. It referred only to "patients" and "the suffering of persons with incurable diseases." Thus, the Directors committed the Association to support euthanasia and assisted suicide not only for competent adults, but for any patient group and for any reason approved by the courts or legislatures.

B9.5 As noted above (B3.1), the previous policy included a grave warning: For the medical profession to support such a change and subsequently participate in these practices, a fundamental reconsideration of traditional medical ethics would be required. Not having attempted such an exercise, the Board simply deleted the statement. It also deleted a number of cautionary statements and references to concerns found in the earlier version.

B9.6 Delegates had neither been presented with nor had they approved a resolution to this effect at the Annual General Council. However, by approving the resolution supporting the right of physicians to act according to their conscience, the delegates implicitly approved the accompanying rationale that, having been carefully drafted by the Directors, could be understood to authorize the changes. In bringing about the change of policy in this manner, the CMA Board of Directors may have been following long-established practices acceptable to the members of the Association. They might, in addition, cite the "straw votes" at the General Council and the absence of general protest as evidence of support for their reversal of CMA policy.

B10. Effects of the policy change

A blank cheque for the Supreme Court

B10.1 The CMA Board of Directors decided to lead society and shape the debate and law on assisted suicide and euthanasia (B2). They convinced delegates at the General Council to approve an ostensibly neutral policy that favoured provision of the procedures, which was widely seen as an overwhelming change (B7.11).

B10.2 In its application to intervene in Carter, the Board assured the Supreme Court of Canada that CMA policy against euthanasia and assisted suicide was "not a certainty" nor "perpetually frozen in time," that it was "not static and can change," (B4.5-6) and reaffirmed this in its intervention (B8.3, B8.5). It suggested no limits to circumstances under which euthanasia and assisted suicide might be provided, but did tell the Court that it seemed wrong to refuse to provide the services simply because palliative care was unavailable (B8.6). Finally, it implied that the Court could count on the cooperation of the Association, no matter what their ruling might be (B4.7, B8.5, B8.6).

B10.3 Finally, the Board reversed CMA policy against physician participation, deleting statements of concern that might have impeded legalization, and unconditionally approved euthanasia and assisted suicide as legitimate forms of medical treatment that should be provided "without undue delay"to persons suffering from incurable diseases - should the law change. It published the new policy while the Court was considering its ruling in Carter, probably with a reasonable expectation that the Court would consider it in its decision - which it did.

B10.4 By doing all of this, the CMA Board of Directors effectively wrote a blank cheque for the judges of the Supreme Court of Canada to legalize euthanasia and physician assisted suicide on any terms acceptable to the judges, assured that the Association would accept and cooperate with legalization on whatever terms the Court set.

A professional obligation to kill

B10.5 By formally approving physician assisted suicide and euthanasia rather than adopting a neutral position, and by committing the CMA to support patients's access to physician assisted suicide and euthanasia under conditions set by law, the Board implicitly agreed that, in some circumstances, physicians have a professional obligation to kill patients or to help them kill themselves (B7.9).

B10.6 Further, by classifying euthanasia and assisted suicide as "end of life care," the Board made participation in euthanasia and assisted suicide normative for the medical profession. This effectively mandated a standard of care for its members, something the Association had told the Supreme Court the CMA did not mean to do (B8.4).

B10.7 The new policy also imposed a single ethical standard upon the entire profession, something the CMA had told the Supreme Court would be inappropriate (B8.4). Once legalized, euthanasia and assisted suicided became therapeutic medical services.[60,61] Refusing the services in the circumstances set out by law became an exception to professional obligations requiring justification or excuse. This is why, since Carter, the debate in Canada has been largely about whether or under what circumstances physicians and institutions should be allowed to refuse to provide or faciliate homicide and suicide.

A limit on refusing to kill

B10.8 It also explains an important caveat the Directors added to the 2014 policy's reference to freedom of conscience:

> A physician should not be compelled to participate in medical aid in dying should it be become legalized. However, there should be no undue delay in the provision of end of life care, including medical aid in dying.[58]

B10.9 Notice that, apart from mere legality, the policy placed no limits on criteria for euthanasia and assisted suicide, and no limits on what non-objecting physicians might agree to do, but implied that freedom of conscience for objecting physicians could be limited in order to ensure timely patient access to the services.

Other foreseeable unforeseen consequences

B10.10 All of the preceding effects of changing CMA policy against euthanasia and assisted suicide might have been foreseen by the CMA Board had the Directors not been so intent upon changing it within the time frame imposed by the *Carter* case. Their lack of foresight began to become evident on the eve of Supreme Court decision in *Carter*.

B10.11 Just before the ruling, CMA President Dr. Chris Simpson said there was "a lot of moral angst" among physicians[14] about what conditions or kinds of illness would justify the procedures[13,17] what kind of suffering - physical, psychological or both - should make someone eligible,[17] and how terminal illness should be defined.[13] Among his other questions: should assisted suicide and euthanasia be offered only to competent adults, or also to the mentally ill, or clinically depressed17 or those with dementia?[13] Should substitute decision makers be able to ask for euthanasia or assisted suicide on behalf of someone unable to do so?[13,14,17]

B10.12 Just after the ruling, Dr. Simpson said that he had not anticipated that the judges

would permit euthanasia and assisted suicide for any "grievous and irremediable medical condition" rather than terminal illness.[60] Dr. Blackmer acknowledged that physicians who were willing to provide euthanasia in cases of terminal illness might be less willing to do so for suffering caused by other medical conditions.[62]

B10.13 A few days later, Dr. Blackmer expressed concern about the eligibility criteria set by the Court. Blindess is "irremediable," he noted, and said that the Carter decision would probably allow euthanasia and assisted suicide for chronic depression and spinal cord injuries.

> My feeling is that there would be much more support for a tighter framework in terms of requiring that the patient be terminal. This is not to minimize in any way the suffering of people who do not have a terminal illness, it is just that for a lot of doctors, this opens too many doors and generates too many questions. . . My conversations with doctors to date indicate more of a comfort level with tight parameters.[63]

However, he believed that the CMA "might have very little ability" to influence how the Carter criteria would be developed[63] - something the CMA Board might usefully have considered when planning their intervention and before embarking upon their plan to change CMA policy.

B10.14 Dr. Blackmer also complained that the term "grievous" is entirely subjective and "is not a technical medical term."[63] Expanding upon this a few months later, he referred to "some angst and discomfort" among physicians about the breadth of the Carter criteria.

> "I've now given dozens or hundreds of presentations on this and every time I speak about it and I ask doctors, 'Look, have any of you ever told a patient that you're really sorry but their condition is grievous?' Of course, no one ever has," Blackmer said. "No doctor in Canadian history, I don't think, has ever told a patient that they're suffering from a 'grievous" condition. So none of us know what that means."[64]

B10.15 All of these complaints are astonishing. Neither the CMA's factum nor its oral submission at the Supreme Court of Canada suggested that assisted suicide or euthanasia should be limited to patients with terminal illnesses, nor, in its intervention, did the CMA suggest any criteria whatever as relevant for the purpose of determining eligibility for the procedures. The revised policy, Euthanasia and Physician Assisted Death, did not exclude minors, the incompetent or the mentally ill as candidates for assisted suicide or euthanasia, nor did it limit its application to the terminally ill or those with uncontrollable pain. It referred directly only to "patients" and "the suffering of persons with incurable diseases."

B10.16 The question put to the courts by the plaintiffs from the very beginning in 2011 was never about terminal illness, but about "grievous and irremediable illness."[65] The term was defined in the trial court ruling, where it was used extensively,[66] and it appeared again in the first sentence of the appellants' factum filed in the Supreme Court of Canada.[67] Finally, the CMA factum, "reviewed and approved by several senior CMA elected officials,"[44] stated that it seemed wrong to deny assisted suicide and euthanasia to "*grievously ill*" patients just because palliative care is unavailable (emphasis

added)[68]68 - yet Dr. Blackmer later claimed that "none of us know what that means."(B10.14)

B10.17 In sum, all of the concerns voiced by Dr. Simpson and Dr. Blackmer after the *Carter* ruling existed when the CMA intervened in the case, but the CMA Board did not raise them. Instead, it worked steadily to remove or minimize obstacles that might have impeded legalization of physician assisted suicide and euthanasia. The legal criteria set for euthanasia and physician assisted suicide by the Supreme Court of Canada were actually more restrictive than anything the CMA had proposed in its intervention or included in its new policy.

B10.18 Arguably, the CMA Board contributed substantially to the legalization of physician suicide and euthanasia on the broad terms set by the Court, and so were themselves, in large measure, responsible for the "angst and discomfort" and profound unease of Canadian physicians following the ruling.

Physician freedom of conscience

B10.19 The CMA Board, having concentrated on shaping the debate and changing CMA policy, was quite unprepared mount a cogent, articulate and persuasive defence of physician freedom of conscience, particularly the burning issue of referral (B8.8). For example, in March, 2015 the Board insisted that "no physician or other health care provider should be forced to take part in any aspect of the assisted dying process against their wishes,"[69] including referral.[70] Two months later, the Board pulled back, deleting reference to other health care providers and affirming only that no one should be compelled to provide euthanasia and assisted suicide.[71] By August, the CMA President was saying that physicians unwilling to perform the procedures "should refer patients to someone who would be willing and able to help make it happen."[72] It is remarkable that, in the midst of the confusion reflected by these shifting statements, the CMA offered to instruct the WMA about "these complex issues" (II.1.4).

B11. Postscript

B11.1 The CMA later produced a strong defence of physician freedom of conscience in relation to referral for euthanasia and assisted suicide.[73] Current CMA policy on euthanasia and assisted suicide has been improved in this respect, more carefully articulating the issues of access to services and protection of freedom of conscience (or moral integrity). In particular, it states that objecting physicians "are not required to provide it, or to otherwise participate in it, or to refer the patient to a physician or a medical administrator who will provide assistance in dying to the patient." It also appears to put the onus on the state "to implement an easily accessible mechanism to which patients can have direct access" to obtain the services so that physicians can adhere to their moral commitments.[61]

B11.2 These changes deserve recognition and thanks, but they were late in coming. The submission on referral came only in January, 2016, almost a year after the *Carter* ruling, and more than four years after mandatory referral for euthanasia and assisted suicide had been recommended by a panel of experts (B4.4, B8.8). The articulation of physician freedom of conscience found in current policy on the procedures dates from May,2017 - more than three years after *Carter*.

B11.3 Better late than never, to be sure, but, by then, objecting physicians were on the defensive in an environment made more treacherous and, at times, more hostile by legalization of physician assisted suicide and euthanasia.

Notes

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10. Dr. Chris Simpson (CMA President): "I was not surprised, we were not surprised. Perhaps the unanimous decision was a little bit of a surprise. But, at the CMA, we've been, we've been preparing for this eventuality for the last year and a half or two years." Geddes Full Transcript, lines 4-7.

11. Dr. Blackmer: "I think we're looking at the possibility that the court will refer this back to the lawmakers . . . They could suggest some framework from the bench that we might want to be in a position to comment on fairly quickly. . . We're preparing for all eventualities. . ." Kirkey S. Canadian doctors preparing for 'all eventualities' in case top court strikes down ban on assisted suicide. National Post [Internet]. 2014 Dec 21 [Cited 2018 Sep 30]. Available from: http://news.nationalpost.com/2014/12/21/canadian-doctors-preparing-for-all-eventualities-in-case-top-court-strikes-down-ban-on-assisted-suicide/

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13. "Should the justices rule the law on assisted death and euthanasia is unconstitutional and needs amendment, 'we feel pretty strongly that we want to be at the table' to help draft a new law and guidelines for physicians and patients, CMA president Dr. Chris Simpson said Thursday." Ubelacker S. Doctors ready for Supreme Court decision on assisted suicide. CTV News [Internet]. 2015 Feb 5 [Cited 2018 Sep 30]. Available from: http://www.ctvnews.ca/health/doctors-ready-for-supreme-court-decision-on-assisted-suicide-1.2223268.

14. Dr. Chris Simpson (CMA President): "We'll be very interested in having a lot of input into the operational details." Grant K. Canadian doctors drafting new rules in case doors open to assisted suicide. The Globe and Mail [Internet]. 2015 Feb 5 [Cited 2018 Sep 30]. Available from: http://www.theglobeandmail.com/news/national/canadian-doctors-drafting-new-rules-in-case-doors-open-to-assisted-suicide/article22798448/.

15. "President Dr. Chris Simpson said the CMA believes it must play a key role in helping to draft the legislation that is needed to make physician-assisted dying available." Branswell H. Many Cdn MD's unsure about assisted death, assessing SCOC ruling. Times Colonist [Internet]. 2015 Feb 6 [Cited 2018 Sep 30]. Available from: https://www.timescolonist.com/canadian-mds-many-hesitant-about-assisted-death-assessing-supreme-court-ruling-1.1755088

16. Dr. Chris Simpson (CMA President): "Now that the decision has come down, we want to really take a leadership role in helping to craft the legislation and the rules and regulation around it." Hume J. Supreme Court strikes down ban on assisted suicide. Toronto Sun [Internet]. 2015 Feb 6 [Cited 2018 Sep 30]. Available from: http://www.torontosun.com/2015/02/06/supreme-court-strikes-down-ban-on-assisted-suicide.

17. Dr. Chris Simpson (CMA President): "[W]e're going to need to hit the ground running if we want to lead and do this well." Kirkey S. Helping suffering patients die may be doctor's most humane option, Canadian Medical Association says. National Post [Internet]. 2015 Feb 4 [Cited 2018 Sep 30]. Available from: http://news.nationalpost.com/news/canada/helping-suffering-patients-die-may-be-doctors-most-humane-option-canadian-medical-association-says.

18. Dr. Chris Simpson (CMA President): "[T]hat's exactly what we'll be seeking: is some mechanism for, for us to have a prominent role in the, in the crafting of the new rules and regulations and, and legislation." Geddes Full Transcript, lines 150-152.

19. "The CMA is well positioned to continue to play a leadership role in the debate around end-of-life care in Canada," said Simpson. Rich P. CMA positioned to take lead role in crafting new regulations [Internet]. Canadian Medical Association; 2018 Feb 6 [Cited 2018 Sep 30]. Available from: https://www.cma.ca/En/Pages/end-of-life-cma-positioned-to-take-lead-role-in-crafting-new-regulations.aspx.

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21. Dr. Chris Simpson (CMA President): "It's a really historic moment and I'm very mindful of, of the role that physicians have to play and . . . I'm really, really proud of how the CMA has handled this over the last two or three years." Geddes Full Transcript, lines 160-162.

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53. CMA Oral Submission, 228:32/491:20.

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APPENDIX "C"

2016 and 2018 CMA/RDMA PROPOSALS COMPARED

Project Reference		
MEC 203/Euthanasia-Physician Assisted Dying/Apr2016	↕	**MEC 210/Euthanasia and PAD/Oct2018**
Preamble	**A**	**Preamble**
~~1. The issue of euthanasia and physician assisted suicide is controversial. Nevertheless, given the developments worldwide it is important that the WMA engages in an open and respectful discussion in this matter.~~	**B**	
2. Several jurisdictions ~~in Europe, North America and South America~~ have legalized certain forms of assisted dying under specific conditions. In these cases, such legalization has been a result of extensive legislative processes, court decisions and debate in society. In all of these locales, some physicians have agreed to provide euthanasia or assistance in dying out of compassion for their patients, in order to alleviate intractable and hopeless pain and suffering.	**C**	**1.** Several jurisdictions have legalized certain forms of euthanasia and assisted death under specific conditions **and through a democratic process**. In these cases, such legalization has been a result of extensive legislative processes, court decisions and debate in society. In all of these locales, some physicians have agreed to voluntarily provide euthanasia or assistance in dying to help meet the immediate needs of their patients, in order to alleviate intractable and hopeless pain and suffering.
3. For the purposes of this policy document, the following definitions are used:	**D**	**2.** For the purposes of this policy document, the following definitions are used:
Euthanasia means: the act of deliberately ending the life of a patient at his or her own request	**E**	**3. Euthanasia means**: the **voluntary** act of deliberately ending the life of a person at his or her own request.
Physician assisted death (PAD) means: deliberately enabling a patient to end his life by prescribing or providing medical substances to cause death.	**F**	**4. Physician assisted death means: where a physician** deliberately enables a patient to end his or her life by prescribing or providing medical substances **whose sole intent** is to cause death.

Project Reference		
MEC 203/Euthanasia-Physician Assisted Dying/Apr2016	↕	**MEC 210/Euthanasia and PAD/Oct2018**
4. The powers of modern medicine are growing. Whereas a cancer diagnosis once almost certainly meant a death sentence, nowadays it is possible to live on for years, ~~and sometimes even be cured~~. However, these improvements in treating illness and prolonging life also require other considerations. Some treatments are extremely invasive, while others have severe side effects and can have damaging consequences. ~~When are medical interventions no longer useful, and when are other types of care more appropriate?~~	**G**	5. The powers of modern medicine are growing. Whereas, **for example**, a cancer diagnosis once almost certainly meant a death sentence, nowadays it is possible to live on for years. However, these improvements in treating illness and prolonging life also require other considerations. Some treatments are extremely invasive, while others have severe side effects that can have damaging consequences **and will not always cure the patient.**
5. Palliative care is part of good and appropriate medical care. The physician should adopt an attitude towards suffering that is compassionate and humane, and act with empathy, respect and tact. ~~Abandonment of the patient when he or she needs palliative care is unacceptable.~~	**H**	**6.** Palliative care **when available** is part of good and appropriate medical care. The physician should adopt an attitude towards **pain and** suffering that is compassionate and humane, and act always with empathy, respect and tact.
6. Appropriate end-of-life care should routinely respect and promote patient autonomy and shared decision-making, and be respectful of the values of the patient and his or her family. ~~Physicians must carefully consider the views and needs of the patient and his or her family, and not merely on the medical condition or disease.~~ Physicians must also focus on quality of care, and on the choices that can be made together with their patients as they near their end of lives. Patients must be free to decide for themselves what treatments they want and the manner and circumstances of their death and may not be forced to die in ways they would not wish.	**I**	**7.** Appropriate end-of-life care should routinely respect and promote patient autonomy and shared decision-making, and be respectful of the values of the patient and his or her family. Physicians must also focus on quality of care, and on the choices that can be made together with their patients as they near the end of their lives. Patients must be free to decide for themselves what treatments they want and the manner and circumstances of their death and may not be forced to die in ways they would not wish.

Project Reference		
MEC 203/Euthanasia-Physician Assisted Dying/Apr2016	↕	**MEC 210/Euthanasia and PAD/Oct2018**
7. The medical profession has a centuries-long tradition of healing with the goal of preventing death when possible, alleviating suffering whenever feasible and providing care and comfort always. Euthanasia and physician assisted dying challenge these concepts, because physicians are taught that all life has value, and it is not their traditional role to prescribe, administer or provide medical substances with no therapeutic intent other than to cause death.	**J**	**8.** The medical profession has a centuries-long tradition of healing with the goal of preventing death when possible, alleviating suffering whenever feasible and providing care and comfort always. Euthanasia and physician assisted death challenge these concepts, because physicians are taught to respect human life, and it is not their traditional role to prescribe, administer or provide medical substances with no therapeutic intent other than to cause death.
~~For the majority of physicians, this is an irresolvable ethical conflict.~~	**K**	**Therefore, euthanasia and physician assisted death for many physicians present a conflict between respecting human life and alleviating suffering.**
	L	**Diverse responses to resolve this dilemma reflect the diverse cultural, legal, traditional, and regional standards of medical care throughout the world.**
RECOMMENDATIONS	**M**	**RECOMMENDATIONS OR PROPOSAL**
	N	**9. There are several jurisdictions in the world that through extensive democratic legislative processes, court decisions and public debate have legalized certain forms of euthanasia and assisted death under specific conditions.**
8. The WMA does not support euthanasia or physician assisted suicide, but WMA does not condemn physicians who follow their own conscience in deciding whether or not to participate in these activities, within the bounds of the legislation, in those jurisdictions where euthanasia and/or physician assisted dying are legalized.	**O**	The WMA does not support **or sanction** euthanasia or physician assisted death, but also does not condemn **or label as unethical** those physicians who follow their own conscience in deciding whether or not to participate in these activities, within the bounds of applicable legislation, in those jurisdictions where euthanasia and/or physician assisted death are legalized **and follow a person's voluntary and well-considered request.**

Project Reference		
MEC 203/Euthanasia-Physician Assisted Dying/Apr2016	↕	**MEC 210/Euthanasia and PAD/Oct2018**
	P	**Attitudes toward euthanasia and physician assisted death are evolving and are a matter of individual conviction and conscience that should be respected.**
9. No physician should be forced to participate in euthanasia or assisted suicide against their personal moral beliefs. Equally, no ~~conscientiously objecting~~ physician should be forced to refer a patient ~~directly~~ to another physician.	**Q**	**10.** No physician should be forced to participate in euthanasia or assisted death against their personal moral beliefs. Equally, no physician should be forced to refer a patient to another physician **in order to provide assistance in dying.**
Jurisdictions that legalize euthanasia or physician assisted suicide must provide mechanisms that will ensure access for those patients who meet the appropriate requirements. Physicians, individually or collectively, must not be made responsible for ensuring access.	**R**	**11.** Jurisdictions that legalize euthanasia or physician assisted death must provide mechanisms that will ensure access for those persons who meet the appropriate requirements. Physicians, individually or collectively, must not be made responsible for ensuring access.
	S	**Where the law allows euthanasia and physician assisted death to be performed, the procedure should be performed by a competent physician or other health care provider.**
10. The WMA also calls on all states to work to ensure access to high quality palliative care services for those in need. Euthanasia and physician assisted suicide should never be used as a substitute for palliative care ~~but should be seen as a last resort for those whose intractable and hopeless suffering cannot be alleviated through any other ordinary means.~~	**T**	**12.** The WMA also calls on all members to work to ensure access to high quality palliative care services for those in need. Euthanasia and physician assisted death should not be a substitute for palliative care.
	U	**13. Patients must be supported appropriately and provided with necessary medical and psychological care along with appropriate counselling at the end of their life, irrespective of the legal possibilities of euthanasia and physician assisted death.**