Protection of Conscience Project
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Submission to the Special Joint Committee on Physician Assisted Dying

Parliament of Canada (31 January, 2016)

I. Introduction

I.1 The Protection of Conscience Project does not take a position on the acceptability of euthanasia or physician assisted suicide or the merits of legalization of the procedures. The Project's concern is to ensure that health care workers who object to providing or participating in homicide and suicide for reasons of conscience or religion are not compelled to do so or punished or disadvantaged for refusal.

II. Provincial-Territorial recommendations

II.1 The Provincial-Territorial Expert Advisory Group on Physician Assisted Dying made 43 recommendations concerning the implementation of the Supreme Court of Canada ruling in *Carter v. Canada (Attorney General).*[1] The following are of particular concern:

- that objecting facilities should be forced to arrange for homicide or assisted suicide elsewhere by initiating patient/resident transfers;
- that objecting physicians or health care workers should be forced to actively enable homicide or suicide by
    - providing referrals, or
    - arranging direct transfers, or
    - enlisting or arranging the enlistment of patients in a euthanasia/assisted suicide delivery system analogous to an organ transplant system.

II.2 These recommendations are inconsistent with genuine accommodation of freedom of conscience and religion, inasmuch as many conscientious objectors reasonably consider them to involve unacceptable complicity in homicide and suicide. The reasonableness of their position can be verified by considering it within the context of law and public policy.

III. Complicity in public policy and law

III.1 With respect to the legal context, but for the *Carter* decision, it appears that physicians who acted in accordance with any of these recommendations would be exposed to prosecution as a party to the offence of first degree murder or assisted suicide, or conspiracy to commit first degree murder or assisted suicide. In addition, they would

be civilly liable for damages arising from the homicides or suicides to which they were parties.

III.2 The public policy context is provided by the case of Maher Arar. In 2002, Arar, a Canadian citizen, was detained in New York, interrogated and "rendered" to Syria by U.S. authorities. In Syria he was imprisoned for almost a year, "interrogated, tortured and held in degrading and inhumane conditions."[2] A subsequent "comprehensive and thorough" investigation "did not turn up any evidence that he had committed any criminal offence" and disclosed "no evidence" that he was a threat to Canadian security."[3] A commission of inquiry was appointed to investigate "the actions of Canadian officials" in the case.[4]

III.3 What concerned the Canadian public and the government was whether or not Canada was complicit in the torture of Maher Arar. That concern surfaces repeatedly in the report of the commission of inquiry: in briefing notes to the Commissioner of the RCMP,[5] in the testimony of the Canadian Ambassador to Syria,[6] in references to the possibility of RCMP complicity in his deportation,[7] about the perception of complicity if CSIS agents met Mr. Arar in Syria,[8] in the suggestion that evidence of complicity could show "a pattern of misconduct,"[9] and in the conclusions and recommendations of the report itself.[10]

III.4 The issue of complicity arose again in 2007 when a report in Toronto's *Globe and Mail* alleged that prisoners taken in Afghanistan by Canadian troops and turned over to Afghan authorities were being mistreated and tortured.[11] "Canada is hardly in a position to claim it did not know what was going on," said the *Globe*. "At best, it tried not to know; at worst, it knew and said nothing."[12] On this view, one can be complicit in wrongdoing not only by acting, but by failing to act, and even by silence.

III.5 The Arar Inquiry and the concerns raised by the *Globe and Mail* story about Afghan detainees make sense only on the premise that one can be morally responsible for acts actually committed by another person: precisely the position taken by physicians who would refuse to comply with demands that they help find a colleague who will kill patients or help a patients kill themselves.

III.6 The *Carter* decision changed the law on murder and assisted suicide by making exemptions in defined circumstances, but it did not change the reasoning that underpins the law on parties to offences - the same reasoning that triggered the commission of inquiry investigating the treatment of Maher Arar, the same reasoning that sparked the *Globe and Mail* editorial about the treatment of Afghan detainees, and the same reasoning used by physicians and health care providers who would refuse to facilitate euthanasia or assisted suicide by referral.

III.7 The reasoning that underpins the law on parties to criminal offences, civil liability and public policy on complicity in torture cannot be dismissed as ethically or legally irrelevant to the exercise and protection of fundamental freedoms of conscience and religion.

IV. Coerced complicity in homicide and suicide

IV.1 The position of the Provincial-Territorial Expert Advisory Group and some influential or powerful individuals or groups is that a learned or privileged class, a profession or state

institutions can legitimately compel people to be parties to homicide or suicide - and punish them if they refuse.

IV.2 Nothing of the kind is stated or implied in *Carter*. This is not a reasonable limitation of fundamental freedoms, but a reprehensible attack on them and a serious violation of human dignity. From an ethical perspective, it is incoherent, because it posits the existence of a moral or ethical duty to do what one believes to be wrong. From a legal and civil liberties perspective, it is profoundly dangerous. If the state can demand that citizens must be parties to killing other people, and threaten to punish them or discriminate against them if they refuse, what can it not demand? Yet the Group appears to experience resistance to coerced participation in homicide and suicide as a "uniquely Canadian" mountain to be climbed.[13]

IV.3 If so, it is a legitimate response to a uniquely Canadian demand. Other countries have demonstrated that it is possible to provide euthanasia and physician assisted suicide without suppressing fundamental freedoms. None of them require "effective referral," physician-initiated "direct transfer" or otherwise conscript objecting physicians into euthanasia/assisted suicide service (Appendix "A"). It appears that they recognize a point made by Dr. Monica Branigan when she appeared before the Committee: that one "cannot build a sustainable system on moral distress."[14]

V. Federal and provincial jurisdiction

V.1 Provincial governments have primary jurisdiction over human rights law, subject to the *Canadian Charter of Rights and Freedoms*. By virtue of the subject matter in this particular case (homicide and suicide), the federal government has jurisdiction in criminal law.

V.2 Criminal law is not used to enforce or defend fundamental rights and freedoms *per se*. For that, Canada relies upon human rights statutes. But Canada does use the criminal law to prevent and to punish particularly egregious violations of fundamental freedoms that also present a serious threat to society: unlawful electronic surveillance, unlawful confinement and torture, for example.

V.3 Coercion, intimidation or other forms of pressure intended to force citizens to become parties to homicide or suicide is both an egregious violation of fundamental freedoms and a serious threat to society that justifies the use of criminal law.

V.4 For this reason, whatever might be decided about laws regulating euthanasia and assisted suicide, the Project proposes that the federal government make it a matter of law and national public policy that no one can be compelled to become a party to homicide or suicide, or punished or disadvantaged for refusing to do so, even if the homicide or suicide is not a criminal offence. Appendix "B" offers an amendment to the *Criminal Code* designed to achieve that end.

Notes:

1. Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report* (30 November, 2015) (http://www.consciencelaws.org/archive/documents/2015-12-14-prov-panel.pdf) For commentary on the Report, see Murphy S. "A uniquely Canadian approach" to freedom of conscience: Experts recommend coercion to ensure delivery of euthanasia and assisted suicide." Protection of Conscience Project, 22 January, 2016.

(http://www.consciencelaws.org/law/commentary/legal073-012.aspx)

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

3. *Arar Inquiry: Analysis and Recommendations,* p. 35-36 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

4. *Deputy Prime Minister Issues Terms of Reference for the Public Inquiry into the Maher Arar Affair.* (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Terms_of_Reference.pdf) Accessed 2008-09-08

5. Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar, *Report of the Events Relating to Maher Arar: Factual Background*, (hereinafter "*Arar Inquiry"*) Vol. 1, p. 64. (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

6. *Arar Inquiry:* Vol. I, p. 271. Accessed 2008-09-08.

7. *Arar Inquiry:* Vol. I, p. 299.

8. *Arar Inquiry:* Vol. I, p. 309-310.

9. *Arar Inquiry:* Vol. II, p. 770 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_II_English.pdf) Accessed 2016-01-27

10. *Arar Inquiry: Analysis and Recommendations,* p. 29, 35, 199, 271, 345-346.

11. Smith, Graeme, "From Canadian custody into cruel hands." *Globe and Mail*, 23 April, 2007 (http://www.theglobeandmail.com/news/world/from-canadian-custody-into-cruel-hands/articlA585956/?page=all) Accessed 2016-01-27

12. Editorial, "The truth Canada did not wish to see." *Globe and Mail*, 2 April, 2007. (http://www.theglobeandmail.com/opinion/the-truth-canada-did-not-wish-to-see/article1074431/) Accessed 2016-01-27.

13. Meeting No. 5, PDAM Special Joint Committee on Physician Assisted Dying, 26 January, 2016. *Maureen Taylor, speaking for the Provincial-Territorial Expert Advisory Group on Physician Assisted Dying* - 19:07:53 to 19:08:11. (http://parlvu.parl.gc.ca/XRender/en/PowerBrowser/PowerBrowserV2/20160126/-1/24370?useragent=Mozilla/5.0 (Windows NT 6.1; WOW64; Trident/7.0; SLCC2; .NET CLR 2.0.50727; .NET CLR 3.5.30729; .NET CLR 3.0.30729; Media Center PC 6.0; .NET4.0C; .NET4.0E; InfoPath.3; GWX:DOWNLOADED; rv:11.0) like Gecko) Accessed 2016-01-28

14. Meeting No. 6, PDAM Special Joint Committee on Physician Asssisted Dying, 27 January, 2016. *Dr. Monica Branigan, speaking for the Canadian Society of Palliative Care Physicians* - 17:29:02 to 17:29:30

Appendix "A"
International comparisons

A1. Netherlands

A1.1 Consensual homicide and assisted suicide continue to be prohibited by the *Penal Code* in the Netherlands. The Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* does not actually authorize either physician-assisted suicide or euthanasia, but provides a defence to criminal charges for physicians who adhere to its requirements.[1] In this respect, it is analogous to the provisions of the Canadian *Criminal Code* on therapeutic abortion from 1969 to 1988, and to the exemptions offered in the *Carter* decision.

A1.2 One of the requirements of the Dutch law is that the physician must believe that the patient's request is "well-considered." Another is that the physician must believe that the patient's suffering is "lasting and unbearable." A physician who did not actually believe one or both of these things and who killed a patient or helped a patient commit suicide or aided or abetted either act would have no defence to a charge of murder or assisted suicide.

A1.3 Physicians who object to euthanasia and assisted suicide for reasons of conscience usually do not believe that a request for either can be "well-considered." Moreover, they may not believe that a patient's suffering is "lasting and unbearable," particularly if the suffering can be relieved. On both points, the available defence requires actual belief; doubt is insufficient to provide a defence to a criminal charge.

A1.4 Since the legal prohibition of homicide and assisted suicide is not displaced in such circumstances, there can be no obligation on the part of objecting physicians to provide or refer for euthanasia or physician-assisted suicide. They have no obligation to commit or cooperate in the commission of a criminal offence. The Royal Dutch Medical Association makes this clear:

> Physicians are never lawfully required to fulfil a request for euthanasia. If, for whatever reason, they object to euthanasia they are not required to cooperate.[2]

A1.5 There is no duty to participate in or refer for euthanasia or assisted suicide in the Netherlands.

A2. Luxembourg

A2.1 A physician who refuses to perform euthanasia or assisted suicide must notify a patient of his refusal and the reasons for it.

> The doctor who refuses to respond to a request for euthanasia or assisted suicide shall be obliged, on the request of the patient or of the person of trust, to send the patient's medical file to the doctor appointed by the latter or by the person of trust.[3]

A2.2 This is a patient-initiated transfer of medical records.

A3. Belgium

A3.1 A physician who refuses to perform euthanasia or assisted suicide must notify a patient of his refusal and the reasons for it, and, at the request of the patient, transfer the medical file to another physician.[4]

A3.2 The obligation to notify the patient and transfer records upon request are identical to those found in the law in Luxembourg. What is described here is a patient-initiated transfer of medical records.

A3.3 Moreover, consensual homicide continues to be prohibited in Belgium. Like the law in the Netherlands, the *Belgian Act on Euthanasia of May 28, 2002*, does not actually authorize euthanasia, but provides a defence to criminal charges for physicians who adhere to its requirements.[5] In this respect, it is analogous to the provisions of the Canadian *Criminal Code* on therapeutic abortion from 1969 to 1988 and to exemptions offered in the *Carter* decision.

A3.4 One of the requirements of the Belgian law is that the physician must ensure that the patient's request is "well-considered." Another is that the physician must ensure that the patient is in "a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated." A physician who did not actually ensure all of these things and who killed a patient or aided or abetted homicide would have no defence to a charge of murder.

A3.5 Physicians who object to euthanasia for reasons of conscience usually do not think that they can ensure that a request for it is "well-considered." Moreover, they are unlikely to think that a patient's condition can be described as "medically futile," and may well believe that suffering can be alleviated. On both points, the available defence requires a firm conclusion; doubt is insufficient to provide a defence to a criminal charge.

A3.6 Since the is a legal prohibition of homicide is not displaced in such circumstances, there can be no obligation on the part of objecting physicians to provide or refer for euthanasia. They have no obligation to commit or cooperate in the commission of a criminal offence.

A4. Oregon

A4.1 A physician who is unable or unwilling to provide assisted suicide must, at the request of the patient, transfer the medical file to another physician. This is a patient-initiated transfer of medical records like that required in Luxembourg and Belgium.

A4.2 The Oregon *Death with Dignity Act* allows health care facilities to prohibit "participation" in assisted suicide on their premises. In that particular situation - when a physician wants to refer a patient for assisted suicide - the law provides that "participation" does not include referral. Thus, the health care facility may prohibit the provision of a lethal drug on its premises, but may not prohibit a referral by a willing physician to an external source.[6]

A4.3 The special definition of "participation" to exclude referral in this particular situation confirms that the term would normally be understood to include referral; a special definition would otherwise be unnecessary.

A5. Washington (state)

A5.1 A physician who is unable or unwilling to provide assisted suicide must, at the request of the patient, transfer the medical file to another physician. This is a patient-initiated transfer of medical records like that required in Luxembourg, Belgium and Oregon.

A5.2 The Washington *Death with Dignity Act* allows health care facilities to prohibit "participation" in assisted suicide on their premises. In that particular situation - when a physician wants to refer a patient for assisted suicide - "participation" does not include referral. Thus, the health care facility may prohibit the provision of a lethal drug on its premises, but may not prohibit a referral by a willing physician to an external source.[7] The provision is identical to that in Oregon's *Death with Dignity Act*.

A5.3 The special definition of "participation" to exclude referral in this particular situation confirms that the term would normally be understood to include referral; the special definition would otherwise be unnecessary.

A6. Vermont

A6.1 Vermont's *Patient Choice and Control at the End of Life Act* is not silent on the subject of referral. It imposes a duty of referral only on physicians who wish to provide assisted suicide [§ 5283.a(7)].[8] The statute does not impose a duty of referral on physicians who refuse to participate in assisted suicide.

A6.2 Instead, the statute states that "a physician, pharmacist, *nurses or other person* shall *not* be under *any* duty, *by law*, or contract, to *participate* in the provision of a lethal dose of medication to a patient." [§ 5285(a). Emphasis added] Note particularly that the statute nullifies any duty that might be said to exist at common law or through the operation of another statute.

A6.3 Since, in Vermont, only physicians can prescribe a lethal does of medication and only physicians or pharmacists can dispense it, the extension of protection to nurses or other persons indicates that the term "participate" is used in the statute in its normal sense, to encompass other acts that may contribute to the provision of lethal medication, such as referral.

A7. California

A7.1 California's assisted suicide law provides that health care providers may refuse to "participate" in any way in the provision of assisted suicide. They may refuse "to inform a patient regarding his or her rights" to assisted suicide, and they may refuse to refer to a physician who provides assisted suicide.[9]

> If a health care provider is unable or unwilling to carry out a qualified individual's request under this part and the qualified individual transfers care to a new health care provider, the individual may request a copy of his or her medical records pursuant to law.[10]

A7.2 Facilities may prohibit employees, contractors or others working within the scope of their employment on their premises from participating in assisted suicide,[11] as long as it first provides notice of its policies.[12] Having given notice, they may take action for policy violations.[13] However, they may not prohibit employers, contractors, etc. from participating in assisted suicide elsewhere.[14]

A7.3 Facilities may not prohibit employees, contractors or others on their premises from performing a diagnosis or assessment (even if it could be used for the purpose of facilitating assisted suicide), informing a patient of the diagnosis, prognosis, etc. advising a patient about the availability of assisted suicide elsewhere, or, upon the patient's request, providing a referral to another health care provider for assisted suicide.[15]15 The provision is analogous to laws in Oregon (A4.2) and Washington (A5.2).

A7.4 In the particular situation described in A7.3, when a physician wants to refer a patient for assisted suicide, "participation" does not include referral. The special definition of "participation" to exclude referral in this particular situation confirms that the term would normally be understood to include referral; the special definition would otherwise be unnecessary.

Notes:

1. *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (http://www.eutanasia.ws/documentos/Leyes/Internacional/Holanda Ley 2002.pdf) Accessed 2015-07-24.

2. Royal Dutch Medical Association, *Euthanasia in the Netherlands* (http://knmg.artsennet.nl/Dossiers-9/Dossiers-thematrefwoord/Levenseinde/Euthanasia-in-the-Netherlands-1.htm) Accessed 2015-07-24.

3. *Euthanasia and Assisted Suicide: Law of 16 March, 2009 - 25 Questions, 25 Answers. Appendix 1: Law of 16 March, 2009 on euthanasia and assisted suicide*, Chapter VIII, Article 15. Grand Duchy of Luxembourg, Ministry of Health, Ministry of Social Security (June, 2010) (http://www.sante.public.lu/publications/sante-fil-vie/fin-vie/euthanasie-assistance-suicide-25-questions-reponses/euthanasie-assistance-suicide-25-questions-reponses-en.pdf) Accessed 2015-07-24.

4. Kidd D. (Trans.) "Belgian Act on Euthanasia of May 28, 2002" Section 14. *Ethical Perspectives* 9 2002 (2-3) p. 182. (Hereinafter "BAE")(http://www.ethical-perspectives.be/viewpic.php?TABLE=EP&ID=59) Accessed 2016-01-14.

5. *BAE*, Section 3.

6. Oregon, *Death with Dignity Act*, Section 5(3)d(B)iii (http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx) Accessed 2015-07-26.

7. Washington, *Death with Dignity Act*, 70.245.190(2)d(ii)C (http://app.leg.wa.gov/rcw/default.aspx?cite=70.245.190) Accessed 2015-07-26.

8. Vermont, Act 39- *Patient Choice and Control at the End of Life Act* (http://legislature.vermont.gov/statutes/fullchapter/18/113) Accessed 2015-04-25.

9. *An act to add and repeal Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code, relating to end of life* (Hereinafter "California HSC") 443.14 (e)2 (http://www.consciencelaws.org./law/laws/usa-california-002.aspx)

10. *California HSC* 443.14 (e)3

11. *California HSC* 443.15 (a)

12. *California HSC* 443.15 (b)

13. *California HSC* 443.15 (c)

14. *California HSC* 443.15 (d)

15. *California HSC* 443.15 (f)3

Appendix "B"

An Act to Safeguard Against Homicide and Suicide
Section 241.1 Criminal Code

Compulsion to participate in homicide or suicide
241.1(1) Every one commits an offence who, by an exercise of authority or intimidation, compels another person to be a party to homicide or suicide.

Punishing refusals to participate in homicide or suicide
241.1(2) Every one commits an offence who

a) refuses to employ a person or to admit a person to a trade union, professional association, school or educational programme because that person refuses or fails to agree to be a party to homicide or suicide; or

b) refuses to employ a person or to admit a person to a trade union, professional association, school or educational programme because that person refuses or fails to answer questions about or to discuss being a party to homicide or suicide.

Intimidation to participate in homicide or suicide
241.1(3) Every one commits an offence who, for the purpose of causing another person to be a party to homicide or suicide

(a) suggests that being a party to homicide or suicide is a condition of employment, contract, membership or full participation in a trade union or professional association, or of admission to a school or educational programme; or

(b) makes threats or suggestions that refusal to be a party to homicide or suicide will adversely affect

(i) contracts, employment, advancement, benefits, pay, or
(ii) membership, fellowship or full participation in a trade union or professional association.

Definitions
241.1(4) (a) For the purpose of this section, "person" includes an unincorporated organization, collective or business.

(b) For the purpose of subsection (1), "homicide" and "suicide" include attempted homicide and suicide.

Punishment
241.1(5) (a) Every one who commits an offence under subsection (1) is guilty of an indictable offence and liable to imprisonment for life.

(b) Every one who commits an offence under subsection (2) is guilty of an indictable offence and liable to imprisonment for ten years.

(c) Every one who commits an offence under subsection (3) is guilty of an indictable offence and liable to imprisonment for five years.

About the Protection of Conscience Project

The Project is a non-denominational, non-profit initiative, supported by an Advisory Board drawn from different disciplines and religious traditions, a Human Rights Specialist and an Administrator, all of whom serve without remuneration. It was conceived as an initiative rather than an organization, association or society; it has no 'members' or structures of an incorporated entity. The Project does not take a position on the morality of contentious procedures. Instead, it critiques policies of coercion and encourages accommodation of objecting health care workers.

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. Thus, the Project restricts the scope of its activity to advocacy for freedom of conscience in this 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.

In 2014, the Project joined the Catholic Civil Rights League and Faith and Freedom Alliance in an intervention at the Supreme Court of Canada in *Carter v. Canada*. The intervention asked the Court to provide legislatures with adequate direction to preserve freedom of conscience among health care workers should the Court strike down the law against euthanasia and assisted suicide.