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Revision Date: 2021 Apr 28



Submission to the College of Physicians and Surgeons of Ontario

Re: *Medical Assistance in Dying* (December, 2018 update)

Abstract

The focus of this submission is confined to the exercise of freedom of conscience by practitioners who refuse to do what they believe to be unethical or immoral in relation to euthanasia and assisted suicide (“medical assistance in dying”: EAS, MAiD).

Unanticipated changes in a patient’s condition may trigger an urgent request for immediate provision of EAS that has already been approved. This can be problematic if the responsible EAS practitioner is unavailable to respond. EAS practitioners should be required to be available to respond to urgent requests once EAS has been approved.

Falsification of EAS death certificates is contrary to accepted international standards and can be considered deceptive, unethical or professionally ill-advised. EAS practitioners unwilling to falsify death certificates should be accommodated by the College and Office of the Chief Coroner.

Current policy does not give sufficient attention to criminal responsibility. Practitioners incur grave criminal liability if they facilitate EAS for patients they believe are ineligible. Persons in authority incur criminal liability if they attempt to compel them to facilitate EAS for such patients. Practitioner-patient discussion must be informed by the fact that counselling suicide remains a criminal offence. The policy fails to recommend reflection and caution in presenting euthanasia and assisted suicide as treatment options.

Confirmation that objecting practitioners are not required to personally kill their patients is welcome, but this should not be seen as a concession. The Project also welcomes the statement that objecting practitioners are not obliged to assess EAS eligibility. However, the claim that they have a fiduciary duty to collaborate in killing their patients should be given no weight because it is not supported by the judicial decisions the College cites to that effect.

Practitioners may have clinical reasons for refusing an EAS request; the policy statement to the contrary should be deleted. Overbroad expressions open to abuse for ideological reasons should be replaced (e.g., replace “impede access” with “interfere with access”).

With respect to “effective referral,” the policy erroneously implies that refusal to make an effective referral for EAS amounts to patient abandonment. It demonstrates either confusion or hypocrisy and moral partisanship in relation

to the moral/ethical significance of referral.

College policy that practitioners unwilling to collaborate in killing their patients should take up hair restoration or leave medical practice may adversely affect access to health care and patient safety. To require unwilling citizens to collaborate in killing other people and punish or disadvantage them if they refuse is a dangerous and especially repugnant idea. It stands in violent contradiction to the solicitude for human life, dignity and freedom that ought to characterize a democratic society. This issue was not argued or even considered by the trial court or Ontario Court of Appeal in rulings on CPSO policy.

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Introduction

The Project does not take a position on the acceptability of euthanasia and practitioner-assisted suicide (EAS). The Project's interest is confined to the exercise of freedom of conscience by practitioners who refuse to do what they believe to be unethical or immoral. Thus, much of the policy *Medical Assistance in Dying (MAiD)*¹ and *Advice to the Profession: Medical Assistance in Dying (Advice: MAiD)*² is outside the scope of this submission.

This submission assumes that the College will revise its policy to reflect amendments to the *Criminal Code* enacted by Bill C-7. In particular, it assumes that the College will develop guidelines specific to providing euthanasia and assisted suicide as treatment for mental illness. Comments on this topic are limited to aspects of the present policy likely to be problematic for practitioners unwilling to provide the services for that purpose.

I. Avoiding conflicts in urgent situations

Discussion

- I.1 In commenting upon the draft policy *Medical Assistance in Dying* in 2016, the Project warned that the failure to cause death in assisted suicide may incapacitate a patient, making it impossible for the patient to consent to euthanasia to remedy the failure.³
- I.2 The Project's 2016 recommendations to address this were partially incorporated into the College's current policy [*MAiD*, para. 9]. The issue was addressed by Bill C-7's amendment to the *Criminal Code*, substantially enacting the Project's 2016 recommendations on this point.⁴
- I.3 A second potential problem identified by the Project in 2016 remains unaddressed in the policy, which states that the College "does not consider a request for medical assistance in dying to be an emergency." [*MAiD*, note 13].
- I.4 Under the terms of the law and the policy, an EAS practitioner may agree to provide euthanasia or assisted suicide for an eligible patient at a future date and time. This may be done to accommodate the desire of geographically distant family members to be present at the patient's death, or because the practitioner visits the community only periodically.
- I.5 As explained in the 2016 submission,⁵ between the time that agreement is made and the appointed time, a sudden deterioration of the patient's condition may cause the patient to ask for immediate relief by euthanasia or assisted suicide. This situation is more likely to arise if the originally appointed time for euthanasia/assisted suicide is some days later than the agreement to provide the procedure.

Issues

- I.6 There will be no problem if an EAS practitioner is immediately available to fulfil the request. However, a conflict may arise if the responsible EAS practitioner is absent or unavailable. Other available practitioners willing to alleviate the patient's distress by palliative interventions may be unwilling to kill the patient or assist with suicide. This can cause stress and anxiety for all concerned and generate pressure on objecting practitioners.

Recommendations

- I.7 For a number of reasons it is best to avoid addressing this issue within the context of the concept of "emergency" (as that term has generally been understood in medical ethics and law). It is sufficient to consider it within the context of an urgent request.
- I.8 *MAiD* note 13 should be deleted. Policy provisions to the following effect should be adopted [Appendix "A", A.1]:
 - i) In all cases, a practitioner who has agreed to provide euthanasia or assisted suicide (the most responsible EAS practitioner) should personally administer the lethal drug

or be personally present when it is ingested, and remain with the patient until death ensues.

- ii) The most responsible EAS practitioner must be continuously available to promptly provide the service in response to an urgent request from the time the agreement is made to the time that the procedure is performed, unless the patient withdraws the request for the service.
- iii. The most responsible EAS practitioner must also arrange for a second EAS practitioner to promptly provide the service in response to an urgent request if the most responsible EAS practitioner cannot be continuously available or is unable to act promptly in response to an urgent request.
- iv. The second EAS practitioner must be continuously available to act promptly upon an urgent request in the place of the most responsible EAS practitioner.

II. Falsifying death certificates

Policy specifics

II.1 *MAiD* policy requires EAS practitioners to complete death certificates if the Office of the Chief Coroner decides that no investigation is required [*MAiD*, para. 21]. It also states:

Para. 22. When completing the death certificate, physicians:

- a) **must** list the illness, disease or disability leading to the request for MAID as the cause of death; and
- b) **must not** make any reference to MAID or the drugs administered on the death certificate. (emphasis in original)

II.2 Other parts of the policy affirm these requirements.

Discussion

II.3 This practice is contrary to international standards for identifying causes of death⁶ that are acknowledged by the Ontario government.⁷ The contradiction becomes apparent if one compares euthanasia by lethal injection by practitioners legally authorized to provide it (physicians and nurse practitioners) and euthanasia by unauthorized practitioners (registered nurses) in identical circumstances following exactly the same procedural guidelines. According to Ontario government direction and CPSO policy [*MAiD*, para 22], the death of a blind patient from a lethal injection

- a) would be certified as a natural death caused by blindness if the injection were given by a nurse practitioner legally providing euthanasia;⁸
- b) would be certified as homicide caused by injection of a toxic substance if the injection were given by a registered nurse.⁹

II.4 The falsification of death certificates as directed by the Ontario government and CPSO reflects the definition of forgery, though the *Criminal Code* makes clear that falsification of documents “at the request” of the government or College is *not* forgery. However, within the present context, it is relevant that the *Code* uses the word “request” — not “direction.” Thus, the exemption in criminal law does not imply that governments have the authority to require unwilling practitioners to falsify death certificates [Crim. Code §366].

II.5 Professor Carolyn McLeod of the University of Western Ontario was one of the architects of the College policy of effective referral.¹⁰ Falsification of death certificates was cited by Professor McLeod in 2006 as an example of the corruption of professional norms.¹¹

II.6 The Ontario government and College apparently believe that legal euthanasia and assisted suicide are beneficial forms of medical treatment. However, beneficial medical treatments do not require a bureaucracy of medical deception. Deception increases the likelihood of conflict and controversy. Indeed, some EAS supporters may worry that mandating deceptive

practices is counterproductive. Issues

- II.7 Some EAS practitioners may be uncomfortable lying or dissembling to families about how their loved ones died, which would seem to be unavoidably associated with falsifying causes of death. Some may be concerned that falsifying records and lying to families is likely to undermine the trust essential to the practice of medicine. Others may have principled objections to falsifying documents, lying, dissembling and other forms of deception under any circumstances. Finally, some may consider falsification ill-advised because it is likely to compromise important epidemiological data. For example, blindness is not considered a terminal illness, so certifying blindness as a cause of death would introduce anomalies into important vital statistics records.

Recommendations

- II.8 Even if government policy is that death certificates should be falsified, practitioners should not be compelled to participate in or support what they consider to be deceptive, unethical or professionally ill-advised practices. Objecting practitioners should be accommodated.
- II.9 If the Ontario government will not change its policy on falsification of death certificates, accommodation of objecting EAS practitioners can be managed through the existing reporting system. This requires EAS practitioners to report every euthanasia/assisted suicide case to the Office of the Chief Coroner (OCC).
- II.10 *Medical Assistance in Dying* paragraph 22 should be revised to the following effect [Appendix “A”, A.2]:

MAiD Para. 22: When completing the death certificate, the government has requested that physicians:

- a) ~~must~~ list the illness, disease or disability leading to the request for MAID as the cause of death; and
- b) **must not** make any reference to MAID or the drugs administered.
on the death certificate.

Practitioners who object to this for reasons of conscience or professional judgement should note their refusal/objection in the reports they are required to submit to the OCC about each MAID death. The OCC can then arrange for a willing coroner to complete the death certificate as requested by the government.

III. Criminal law limits on College policy

Discussion

- III.1 Neither the Supreme Court of Canada nor parliament entirely struck down murder and assisted suicide laws, nor did they change the law on parties to offences, counselling offences and conspiracy, which are relevant to requirements for “effective referral” and other elements of *MAiD* policy.
- III.2 The law on murder, manslaughter, criminal negligence and assisted suicide applies to practitioners in relation to a patient described in §241.2(1) and (2) of the *Criminal Code* who makes a request for assisted suicide or euthanasia in one respect only: eligibility. Practitioners are exempt from prosecution for these offences if they believe the patient is eligible under the terms of the law [§227, 241.3 *Crim. Code*].
- III.3 When practitioners provide euthanasia or assisted suicide they are invariably of the opinion that the patient *is* eligible for the service, so this provision is irrelevant to their practice unless it can be proved beyond reasonable doubt that they did *not* believe the patient was eligible. It is difficult to imagine how this might ever be proved, short of an admission by an accused.
- III.4 Practitioners who believe that a patient is eligible who knowingly fail or refuse to adhere to procedural safeguards cannot be charged for murder or manslaughter. At most, they can be charged for an offence punishable on indictment or summary conviction for which the maximum penalty is imprisonment for five years [§241.3 *Crim Code*]: the same penalty provided for assault [§266 *Crim. Code*].
- III.5 Practitioners who are of the opinion that a patient is *not* eligible for euthanasia or assisted suicide under §241.2(1) or (2) could be charged for murder, manslaughter, or assisting suicide were they to lethally inject the patient or assist with suicide, or if they made an effective referral for that purpose. They would likewise be guilty of counselling suicide or counselling murder, manslaughter etc. were they to suggest assisted suicide or euthanasia as treatment options.
- III.6 Prominent mental health practitioners do not believe that mental illness can be considered an irremediable condition,¹² so this issue likely to become especially important in two years, when euthanasia and assisted suicide become available for treating mental illness. Nonetheless, even outside the context of an eligibility assessment, similar concerns may arise with respect to other eligibility criteria, such as voluntariness or capacity. For example, they may reflect a practitioner’s prior knowledge of a patient. Concerns may also surface as a caring practitioner thoroughly and sensitively explores the reasons underlying a patient’s request.
- III.7 One can be guilty of counselling an offence even if the offence is not committed [§464 *Crim. Code*] and a party to a conspiracy whether or not an offence is committed [§465 *Crim. Code*]. Further, one can be a party to an offence by aiding or abetting [§21(b) or (c) *Crim. Code*] even if the principal party (the practitioner who actually provides euthanasia or assisted

suicide) is not criminally liable, not charged or is acquitted.¹³ However, it is not clear if a homicide or assisted suicide must be shown to have occurred in relation to potential criminal responsibility for aiding or abetting.

- III.8 In any case, the fact that practitioners having a different view of eligibility may later provide euthanasia or assisted suicide and may not be criminally responsible, charged or convicted does not appear to be relevant to decision-making by practitioners obliged to comply with the criminal law in relation to a patient they consider ineligible for these services.
- III.9 The present policy is consistent with these conclusions when it states that practitioners “**must** be satisfied” that patients meet eligibility criteria [*MAiD*, para. 2, emphasis in original] and “**must** use their professional judgement” in making this determination [*MAiD*, para. 3, emphasis in original].
- III.10 In view of the foregoing, the Project’s position is that the College has no basis to proceed against practitioners who, having the opinion that a patient is not eligible for euthanasia or assisted suicide, refuse to do anything that would entail criminal responsibility for homicide/assisted suicide, including “effective referral.”
- III.11 Moreover, if practitioners are of the opinion that a patient is *not* eligible for euthanasia or assisted suicide under §241.2(1) or (2), it would seem that the College would commit the offence of counselling [§464 Crim. Code] if it were to advise them or attempt to persuade or coerce them to participate by effective referral or by presenting the services as treatment options.
- III.12 Finally: practitioners are clearly able to provide information about legal assisted suicide in response to a patient's request or enquiries [Crim. Code §241(5.1)]. However, counselling (recommending) suicide remains a criminal offence [Crim. Code §241(1)a], so practitioners are liable to be charged if they suggest assisted suicide to a patient who has not asked about it or about euthanasia.

Issues

- III.13 The present policy is deficient in several respects.
- a) The issue of criminal responsibility is not given sufficient attention. Specifically, the policy does not make clear
- i) that practitioners who suggest assisted suicide to patients who have not asked about it or euthanasia are liable to be charged for counselling suicide;
 - ii) that practitioners incur grave criminal liability if they do anything in furtherance of providing euthanasia or assisted suicide for patients they believe to be ineligible;
 - iii) that persons in authority incur criminal liability if they attempt to persuade or compel a practitioner to act in furtherance of providing euthanasia or assisted suicide, notwithstanding the practitioner’s opinion that a patient is ineligible. This is particularly important for preceptors, clinical supervisors and hospital authorities;

iv) that persons in authority incur criminal liability for counselling an offence if they attempt to persuade or compel a practitioner to suggest assisted suicide to a patient who has not asked about it or euthanasia.

b) The policy states that effective referral is required whenever euthanasia/assisted suicide is refused, making no exception if the practitioner believes the patient is ineligible [*MAiD*, para. 20]. As discussed above, referring an ineligible patient for euthanasia/assisted suicide would *prima facie* be a criminal offence.

Recommendations

III.13 The policy *Medical Assistance in Dying* and the related document, *Advice to the Profession: Medical Assistance in Dying* should

- (a) explicitly caution practitioners that they are liable to be charged for counselling suicide if they suggest assisted suicide to patients who have not asked about it or euthanasia;
- (b) explicitly caution practitioners that any support, encouragement, or facilitation of euthanasia/assisted suicide of a patient whom they believe to be ineligible makes them criminally liable as parties to murder, manslaughter and assisted suicide;
- (c) explicitly caution persons in authority that they would be criminally liable as parties to murder, manslaughter and assisted suicide and criminal counselling if they were to attempt to persuade or compel a practitioner to provide or facilitate euthanasia or assisted suicide, notwithstanding the practitioner's opinion that a patient is ineligible;
- (d) explicitly caution persons in authority that they would be criminally liable for counselling an offence if they were to attempt to persuade or compel a practitioner to suggest assisted suicide to a patient who has not asked about it or euthanasia [Appendix "A", A.3, A.4, A.5].

IV. Freedom of conscience: general review

Introduction

- IV.1 The decision of the Ontario Court of Appeal in the challenge to the College demand for effective referral by objecting physicians¹⁴ was not the last word on the subject, notwithstanding the College's frequent citation of the ruling in defence of the policy requiring effective referral by objecting practitioners.
- IV.2 In the first place, the case was argued and decided in relation to freedom of religion, not freedom of conscience. We await a challenge based squarely on freedom of conscience and arguments not yet judicially considered.
- IV.3 Second, the substantive issue underlying disputes about freedom of conscience in relation to euthanasia and assisted suicide is especially grave: the morality of killing people.¹⁵
- IV.4 Finally, apprehension and even revulsion expressed in some quarters by the offer of lethal injection as treatment for disability and mental illness^{16,17} suggests that opposition to coerced collaboration in homicide and suicide is unlikely to abate, and may increase.

MAiD policy on freedom of conscience^{18,19}

- IV.5 The Project welcomes the College's clarification that it does not require objecting practitioners to personally kill their patients. To be clear, the Project's position is that in a democratic society this ought to be the norm. It would be remarkable to consider this either a "concession" or an element in the "accommodation" of freedom of conscience.
- IV.6 The Project also welcomes the College's statement that objecting practitioners are not obliged to assess patients' eligibility for euthanasia and assisted suicide (*Advice: MAiD*).

Re: fiduciary obligations

- IV.7 The College claims that practitioners who refuse to kill patients or help them commit suicide have a fiduciary obligation to arrange for them to be killed or helped to commit suicide when that is in a patient's best interests. In support of this claim the policy cites the Ontario Court of Appeal decision noted above, but this attributes weight to the decision that it does not have.
- IV.8 In the first place, the trial court did not even mention fiduciary duty, finding, instead, that the requirement for physicians to place patients' interests before their own (by making an "effective referral") arose as a consequence of practising medicine "in a single payor, publicly funded healthcare system which is structured on the basis of patient-centered care."²⁰
- IV.9 The Court of Appeal, apart from noting the reference to fiduciary duty in CPSO policy,²¹ made only a single passing reference to the fiduciary nature of the physician-patient relationship.²² It cited only two cases on that point, *McInerney v. MacDonald*²³ and *Norberg v. Wynrib*,²⁴ without further elaboration. Neither case was remotely concerned with the

exercise of freedom of conscience by physicians, let alone state coercion of physicians to become parties to homicide and suicide. Moreover, the Court overlooked passages and citations in both cases that do not support and arguably contradict the CPSO's position.

- IV.10 The preceding paragraphs have given more attention to the law on fiduciary duty than is apparent in the cursory references by the Ontario Court of Appeal. The Court did not even attempt a serious examination of the College's claim that physicians have a fiduciary duty to collaborate in killing their patients, so the College's citation of the ruling on this point should be given no weight.

Patient welfare

- IV.11 One of the reasons given for insisting upon effective referral is that some patients who want a service may be so isolated and burdened by illness, physical or mental disability or language barriers that they are unable to connect with service providers themselves even if they are provided with contact information and an explanation of how to use it. In its focus on patient autonomy, rights and choice rather than patient welfare, MAiD fails to identify common ground that affords an opportunity to accommodate both patients and objecting physicians.
- IV.12 Patients who are so debilitated or circumstantially handicapped that they are unable to contact health care personnel or obtain medical treatment are clearly at risk and in need of assistance in all circumstances, not just in relation to accessing a morally contested service. Physicians encountering such patients should recognize this problem and respond to it in all situations out of concern for their welfare and safety. This can be done by finding a responsible and reliable person who can help patients to overcome circumstantial handicaps, enabling them to obtain necessary assistance and navigate the health care system. The helper could be a family member, friend, social worker, outreach worker, etc. In the Project's experience, objecting physicians would likely do this in any case. See further discussion on this point below (Part V.9 - V.12).

Conscientious objection [MAiD para. 11(a) to (d)]

Treat patients respectfully; do not impede access [para. 11(a)]

- IV.13 The policy requires that practitioners who refuse to provide euthanasia or assisted suicide must treat patients respectfully. The experience of the Project is that patients are normally treated respectfully by objecting physicians, though refusal itself is sometimes misunderstood or deliberately misconstrued as a disrespectful act.
- IV.14 To "impede access" is unacceptable if that means some positive act of interference, such as discouraging other health care providers from seeing the patient, or some wrongful act, like misleading a patient or refusing to release medical records belonging to a patient. On the other hand, practitioners who simply refuse to help patients find someone willing to kill them or help them commit suicide are no more impeding patients than colleagues who refuse to help patients find someone willing to provide virginity certificates or sell organs.

Notification of objections [para. 11(b)]

- IV.15 The expectation that physicians will personally advise patients of their objections is entirely in keeping with the intentions of objecting physicians made known to the Project.
- IV.16 That objections are in all cases "due to personal and not clinical reasons" is incorrect. Objecting physicians may have both clinical and ethical/moral objections to providing euthanasia and assisted suicide. Where both reasons exist, it is appropriate to inform the patient of both. Indeed: to withhold clinical reasons would seem to violate the requirements of informed medical decision-making.

Do not express personal moral judgements [para. 11(c)]

- IV.17 Refusal to kill patients, help them commit suicide and refusal to collaborate in homicide or suicide for reasons of conscience obviously manifests a moral or ethical judgement. Moreover, practitioners are expected to advise patients of their objections. Objecting practitioners must not be accused of wrongfully expressing personal moral judgements simply because they refuse to kill or collaborate in killing their patients and explain their refusal to their patients.
- IV.18 Some patient beliefs or habits (which can be understood as aspects of a lifestyle) may have adverse effects upon their health (anti-vaccination beliefs, diet, exercise, alcohol consumption and drug use, etc.). The current text of MAiD could be understood to prevent physicians from legitimately engaging patients on such issues for fear of being accused of criticizing patient beliefs or lifestyles.

Providing information [para. 11(d)]

- IV.19 In the Project's experience, objecting physicians are willing to provide information necessary to enable informed medical decision making, so the expectation that they will provide information on all treatment options, including euthanasia and assisted suicide, should not be problematic. However, this is subject to two qualifications.
- IV.20 First: counselling (recommending) suicide remains a criminal offence [Crim. Code §241(1)a]. Although practitioners are clearly able to provide information about legal assisted suicide in response to a patient's request or enquiries [Crim. Code §241(5.1)], they cannot be expected to "offer the option" of assisted suicide outside the context of a patient-led discussion. To direct or advise practitioners to make an unsolicited offer of assisted suicide would be a *prima facie* criminal offence [Crim. Code §464(a)]. This is complicated because "medical assistance in dying" includes both euthanasia and assisted suicide. Thus, making an unsolicited global offer of MAiD would amount to counselling suicide, but a specific and exclusive offer of euthanasia would not.
- IV.21 Second: information necessary to enable informed medical decision-making must be provided. However, what information should be provided and the point at which it ought to be provided must be guided by and responsive to the circumstances and expressed interests of each patient. This should be left to the good judgement individual practitioners based on of knowledge of and interaction with their patients. It may well be harmful or even abusive to

offer euthanasia as treatment option (e.g., a patient just blinded or paralysed by an industrial accident; a mentally ill patient). At other times it may be at least insensitive: for example, upon a diagnosis of dementia, congestive heart failure, chronic obstructive pulmonary disease, or stage four kidney disease.

Issues

- IV.22 The term "impeding access" is overbroad and thus open to ideological abuse at the expense of objecting practitioners.
- IV.23 The assertion that conscientious objection cannot be based on clinical reasons is erroneous.
- IV.24 The caution against expressing personal moral judgement is overbroad and thus open to ideological abuse at the expense of objecting practitioners.
- IV.24 The caution against criticizing patient beliefs or lifestyles may make physicians reluctant to engage patients about beliefs or habits that may adversely affect their health.
- IV.25 The policy provides no guidance in relation to counselling suicide, which remains a criminal offence.
- IV.26 The policy fails to recognize that appropriate reflection and caution is required in presenting euthanasia and assisted suicide as treatment options.

Recommendations

- IV.27 The College should have a single general policy that addresses the exercise of freedom of conscience by physicians that can be applied to all procedures or services. The Project addresses this in its submission on *Professional Obligations and Human Rights*.
- IV.28 However, if the College maintains the current policy structure, MAiD should be amended to recognize a general responsibility to connect patients with responsible and reliable persons who can help them overcome problems of isolation and neglect and obtain necessary services. In addition, *MAiD* paragraph 11 should be amended to reflect the recommendations in Appendix "A" (A.4).

V. Freedom of conscience: effective referral

Policy specifics

- V.1 The policy states that physicians who refuse to provide euthanasia/assisted suicide "must not abandon the patient" and must make an "effective referral." Further information about effective referral is provided in *Advice: MAiD*. To make an effective referral is to "take positive action to ensure the patient is connected in a timely manner to a non-objecting, available and accessible physician. . . health care professional or agency that provides [euthanasia/assisted suicide] or connects the patient directly with a health care professional who does."
- V.2 *Advice: MAiD* explains that an effective referral need not involve a referral "in the formal clinical sense," and that objecting practitioners may delegate a reliable person to make the effective referral.
- V.3 The policy specifies that the referral must be "timely," so that patients will not experience "adverse clinical outcomes"[*MAiD*, para 11(e)] such as deterioration in their clinical condition or prolonging "untreated pain or suffering." [*Advice: MAiD*].
- V.4 *Advice: MAiD* emphasizes that objecting practitioners must "ensure" that the patient is connected directly to an EAS practitioner or an EAS delivery agency.

Discussion

- V.5 The policy links the principle of non-abandonment to the demand for effective referral, which invites the unwarranted inference that refusing to provide an effective referral amounts to patient abandonment. There is no necessary connection between the two. A practitioner does not abandon a patient by offering treatments a patient refuses to accept, nor does a practitioner abandon a patient by refusing to make an effective referral for treatments a patient wants but which the practitioner considers to be ineffective or harmful. It would be more to the point to remind objecting practitioners of a continuing obligation to provide services unrelated to services they refuse to provide.
- V.6 Practitioners who object to euthanasia/assisted suicide for reasons of conscience will not personally provide the services. Some may be willing to make effective referrals because they believe that effective referral absolves them of moral responsibility for a patient's death at the hands of another person. However, others refuse to make effective referrals because they believe that referral makes them complicit in killing their patients.
- V.7 The Canadian Medical Association (CMA) has drawn the College's attention to these distinctions and the need to respect them in policy-making:

For the majority of physicians who will choose not to provide assistance in dying, referral is entirely morally acceptable; it is not a violation of their conscience. For others, referral is categorically morally unacceptable; it implies forced participation procedurally that may be connected to, or make

them complicit in, what they deem to be a morally abhorrent act. In other words, referral respects the conscience of some, but not others. . .

It is the CMA's strongly held position that there is no legitimate justification to respect one notion of conscience (i.e. the right not to participate in assisted dying), while wholly discounting another because one may not agree with it. As such, in seeking an approach that achieves an appropriate balance, the CMA sought to articulate a duty that achieves an ethical balance between conscientious objection and patient access in a way that respects differences of conscience. It is the CMA's position that the only way to authentically respect conscience is to respect differences of conscience.²⁵

- V.8 Objecting practitioners are typically willing to work cooperatively with patients and others in relation to patient access to euthanasia and assisted suicide as long as cooperation does not involve an act that establishes a causal connection to or *de facto* support for killing patients. This enables an approach that accommodates both patients and practitioners. Again, the CMA:

The argument that only mandatory referral puts patients' interests first or respects patient autonomy – and that not making a referral does not – is fundamentally erroneous. There are many ways to conceptualize a physician's positive obligations to her patient that do not require the imposition of a duty to refer and thus uphold conscience rights. . .

. . . articulating a physician's positive obligations of what she ought to do if she declines to provide or participate in an act on grounds of deeply held beliefs does not *de facto* translate to making a referral. It is the CMA's position that there is no logical or ethical basis for this argument.²⁶

- V.9 In the Project's experience, objecting practitioners will provide patients with information that enables them to make informed decisions and that facilitates patient contact with other health care service providers or agencies. By this means these practitioners avoid any positive action causally connected to killing their patients, while patients remain free to pursue euthanasia/assisted suicide.
- V.10 Similarly, objecting practitioners are likely to refuse to do something that they believe implies their support for or establishes a causal connection to killing their patients. Thus, they would provide contact information for health care providers or services generally, but may refuse to direct patients specifically to an EAS practitioner or EAS delivery service.
- V.11 So, for example, these practitioners may provide contact information for Telehealth Ontario, but not the MAiD Care Coordination Service (CCS). Both services can connect patients to EAS practitioners, but the CCS is dedicated to providing euthanasia and assisted suicide, while Telehealth facilitates access to all services. There is no significant practical difference for the patient, but there is a significant ethical difference for the practitioners.

- V.12 This applies also when objecting practitioners connect patients to responsible and reliable persons who can address problems of isolation and neglect and help them obtain necessary services (see IV.11-12) It is possible the helpers (like Telehealth) might help a patient obtain euthanasia or assisted suicide. However, in the Project's experience, objecting physicians would not consider this a reason to refuse to make a connection for patients needing this kind of support.
- V.13 To sum up, practitioners who refuse to provide effective referrals are willing to cooperate with measures taken to accommodate practitioner freedom of conscience and patient access to euthanasia, but not to collaborate in killing their patients. The difference between cooperation and collaboration is illustrated by one of the four examples of “effective referral” the College offers in *Advice:MAiD*:
- a) The objector/delegate contacts an EAS practitioner and arranges for the patient to be seen.
 - b) The objector/delegate contacts an EAS delivery agency like the Ontario Care Coordination Service.
 - c) A practice group in a hospital, clinic or family practice identifies patients seeking EAS and connects them with a non-objecting practitioner.
 - d) A practice group identifies an EAS practitioner/facilitator with whom an objecting practitioner connects the patient.
- V.14 Example (c) may involve cooperation, but it does not entail collaboration. Someone in the group *other than* the objecting practitioner takes “positive action” to connect the patient with a non-objecting practitioner. Example (c) illustrates acceptable accommodation of freedom of conscience precisely because (contrary to the College’s assertion) it does *not* fit the College’s definition of effective referral.
- V.15 Effective referral as defined by the College demands that the practitioner — not the patient or another team member — personally take positive action to *ensure* the patient connects with an EAS practitioner or EAS delivery service. A referral that is not *effective* in facilitating access to euthanasia/assisted suicide is not an “*effective* referral.”
- V.16 Objecting physicians who refuse to provide effective referrals reasonably hold that doing something *effective* to facilitate the killing of their patients is collaboration that makes them morally culpable for grave wrongdoing. The validity of this position can be verified by considering effective referral for euthanasia/assisted suicide had the Supreme Court not ordered legalization of the procedures in *Carter v. Canada*.²⁷
- V.17 But for the *Carter* decision, practitioners providing an effective referral for euthanasia/assisted suicide could be charged for murder or assisted suicide if patients were killed, or conspiracy to commit murder or assisted suicide if they were not. Similarly, many objecting physicians hold that by effective referral for euthanasia/assisted suicide they are morally implicated in grave wrongdoing: homicide/suicide. With respect to conclusions of criminal and moral culpability for referring patients to others for lethal injection, the reasoning is identical.

- V.18 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 criminal responsibility or parties to offences. The reasoning that supports the law against aiding or abetting murder is exactly the same reasoning applied by practitioners who refuse to provide effective referral for euthanasia. It is, moreover, reasoning that the College understands, accepts and applies in prohibiting female genital mutilation by physicians – *and referral* for the procedure. College policy states:
- The *Criminal Code* prohibits the performance of *or referral* for FGC/M (see Sections 268(3), 21-22 and 273.3(1)) (emphasis added)²⁸
- The *Criminal Code* does *not* mention referral, but the College correctly states that the *Code* prohibits referral, because the College recognizes that to refer for FGC/M is to aid or abet FGC/M, and aiding or abetting FGC/M is a crime.
- V.19 This demonstrates that the College’s assertion that effective referral for euthanasia/assisted suicide does not “signal” endorsement or support for the procedures [*Advice:MAiD*] is either disingenuous or the product of badly muddled wishful thinking. An objecting practitioner’s conclusion that referral for euthanasia involves moral culpability because it aids or abets homicide is supported by exactly the same reasoning the College applies when it asserts that referral for FGC/M involves criminal responsibility because it aids or abets FGC/M. It is thus reasonable for practitioners to hold that aiding or abetting euthanasia/assisted suicide by effective referral makes them morally responsible collaborators in killing their patients, or in arranging for them to be killed, even if, ultimately, they are not.
- V.20 While *Carter* means that euthanasia and assisted suicide in circumstances defined by law are no longer criminal offences, the ruling does not affect the legitimacy and reasonable plausibility of a moral/ethical/religious belief that it is gravely wrong to deliberately kill people or help them to commit suicide, even if the law approves. Having this belief is not currently a reason to exclude someone from health care professions.
- V.21 Further, based on the preceding discussion, practitioners having this belief may reasonably conclude that they *must* refuse to make an effective referral for euthanasia/assisted suicide because collaboration in killing their patients would be gravely immoral or contrary to good medical practice.
- V.22 The College position is that the freedom to hold this belief is broader than the freedom to act upon it: that practitioners who refuse to collaborate in killing their patients should be excluded from medical practice, or at least removed from any form of medical practice in which they may receive an EAS request (moving, for example, to hair restoration).²⁹ This has serious practical implications for access to health care. For example, it would now require these practitioners to leave general practice and terminate all clinical Covid 19 pandemic activities. In two years, only practitioners willing to provide or collaborate in euthanasia and assisted suicide as treatment for mental illness will be able to continue in psychiatric practice.
- V.23 Driving physicians unwilling to collaborate in killing patients from medical practice also has implications for the safety of patients. Joseph Arvay, chief counsel for the *Carter* appellants,

lauded physician's unwillingness to harm their patients as an outstanding virtue that made them ideal euthanasia practitioners. "[I]t is an irrefutable truth," he told the Supreme Court of Canada, "that all doctors believe it is their professional and ethical duty to do no harm."

Which means, in almost every case, that they will want to help their patients live, not die. It is for the very reason that we advocate only physician assisted dying and not any kind of assisted dying because we know physicians will be reluctant gatekeepers, and only agree to it as a last resort.³⁰

Excluding physicians unwilling to collaborate in killing their patients from medical practice would thus seem to weaken what one of Canada's most prominent EAS advocates described as the most fundamental safeguard for patients.

Issues

- V.24 The wording of the policy invites the erroneous inference that refusal to make an effective referral for euthanasia/assisted suicide amounts to patient abandonment.
- V.25 *Medical Assistance in Dying* demonstrates either confusion or hypocrisy and moral partisanship and in relation to the moral/ethical significance of referral. It favours practitioners willing to kill or collaborate in killing patients and disadvantages and threatens practitioners who refuse to do so.
- V.26 The College's demand that objecting practitioners unwilling to collaborate in killing their patients should leave the profession or confine their practice to specialties like hair restoration may adversely affect access to health care and patient safety.
- V.27 Finally, that the state can require unwilling citizens to collaborate in killing other people and punish or disadvantage them if they refuse is a dangerous and especially repugnant idea. It stands in violent contradiction to the solicitude for human life, dignity and freedom that ought to characterize a democratic society. This issue was not argued or even considered by the trial court or Ontario Court of Appeal in rulings on CPSO policy.^{31, 32}

Recommendations

- V.28 The College should have a single general policy that addresses the exercise of freedom of conscience by physicians that can be applied to all procedures or services. The Project addresses this in its submission on *Professional Obligations and Human Rights*. However, if the College maintains the current policy structure, *MAiD* paragraph 11 should be amended to reflect the recommendations in Appendix "A" (A.3) and (A.4), and *Advice:MAiD* should be amended to reflect the recommendations in Appendix "A" (A.5).

Appendix “A”

Recommended Revisions

The College should have a single general policy that addresses the exercise of freedom of conscience by physicians that can be applied to all procedures or services. The Project addresses this in its submission on *Professional Obligations and Human Rights*. However, if the College maintains the current policy structure, *Medical Assistance in Dying and Advice to the Profession: Medical Assistance in Dying* should be amended to the following effect.

A.1 *MAiD* note 13

(Ref Part I: Avoiding conflicts in urgent situations)

Delete *MAiD* note 13 and adopt new provisions to the following effect:

- i) In all cases, a practitioner who has agreed to provide euthanasia or assisted suicide (the most responsible EAS practitioner) should personally administer the lethal drug or be personally present when it is ingested, and remain with the patient until death ensues.
- ii) The most responsible EAS practitioner must be continuously available to promptly provide the service in response to an urgent request from the time the agreement is made to the time that the procedure is performed, unless the patient withdraws the request for the service.
- iii) The most responsible EAS practitioner must also arrange for a second EAS practitioner to promptly provide the service in response to an urgent request if the most responsible EAS practitioner cannot be continuously available or is unable to act promptly in response to an urgent request.
- iv) The second EAS practitioner must be continuously available to act promptly upon an urgent request in the place of the most responsible EAS practitioner.

A.2 *MAiD* Paragraph 22

(Ref Part II: Falsification of death certificates)

Current *MAiD* Paragraph 22

When completing the death certificate, physicians:

Recommended *MAiD* Paragraph 22

When completing the death certificate, the government has requested that physicians:

Current MAiD Paragraph 22

- a) **must** list the illness, disease or disability leading to the request for MAID as the cause of death; and

- b) **must not** make any reference to MAID or the drugs administered on the death certificate.

Recommended MAiD Paragraph 22

- a) list the illness, disease or disability leading to the request for MAID as the cause of death; and

- b) **not** make any reference to MAID or the drugs administered on the death certificate.

Practitioners who object to this for reasons of conscience or professional judgement should note their refusal/objection in the reports they are required to submit to the OCC about each MAID death. The OCC can then arrange for a willing coroner to complete the death certificate as requested by the government.

A.3 MAiD Paragraph 11

(Ref Part III, IV: Criminal law | Freedom of conscience: general review)

Current MAiD Paragraph 11

Consistent with the expectations set out in the College’s Professional Obligations and Human Rights Policy, physicians who decline to provide MAID due to a conscientious objection

- a) **must** do so in a manner that respects patient dignity and **must not** impede access to MAID;

- b) **must** communicate their objection to the patient directly and with sensitivity, informing the patient that the objection is due to personal and not clinical reasons;

- c) **must not** express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient,

Recommended MAiD Paragraph 11

Physicians who decline to provide MAID on the basis of their conscientious convictions or professional judgement

- a) **must** do so in a manner that respects patient dignity and **must not** interfere with access to MAID;

- b) **must** communicate their reasons to the patient directly and with sensitivity;

- c) **must not** criticize or denigrate the beliefs, lifestyle, identity or characteristics of the patient. This should not be understood to preclude respectful discussion of beliefs or habits that may adversely affect a patient's health.

Current *MAiD* Paragraph 11

d) **must** provide the patient with information about all options for care that may be available or appropriate to meet their clinical needs, concerns, and/or wishes and must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs,

Recommended *MAiD* Paragraph 11

d) must provide the patient with information about all options for care that may be available or appropriate to meet their clinical needs, concerns, and/or wishes and must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs, subject to the following considerations:

i) Assisted suicide is one method of medical assistance in dying, but counselling suicide remains a criminal offence. Absent an inquiry or expression of interest from a patient, practitioners should not suggest assisted suicide or medical assistance in dying as treatment options. This does not preclude suggesting euthanasia alone.

ii) What information is clinically relevant to informed decision making and the point at which it ought to be provided must be guided by and responsive to the facts in each case and expressed interests of each patient.

iii) Suggesting euthanasia or assisted suicide in certain situations may be insensitive, offensive, harmful or even abusive. Careful reflection, prudent judgement and a focus on the best interests of individual patients are required.

A.4 *MAiD* Paragraph 11

(Ref Part III, V: Criminal law | Freedom of conscience: effective referral)

Current *MAiD* Paragraph 11

[...physicians who decline to provide MAiD . . .]

Recommended *MAiD* Paragraph 11

[Physicians who decline to provide MAiD . . .]

Current *MAiD* Paragraph 11

- (e) **must not** abandon the patient and **must** provide the patient with an effective referral
- i) physicians **must** make the effective referral in a timely manner and **must not** expose patients to adverse clinical outcomes due to a delay in making the effective referral.

Recommended *MAiD* Paragraph 11

- e) must respond to patient requests or enquiries expeditiously so as to enable interventions that are most likely to cure or mitigate the patient's medical condition, prevent it from deteriorating further, avoid interventions involving greater burdens or risks to the patient, and avoid delay in processing the patient's request for *MAiD*;
- f) if the patient appears to be unable to contact other service providers without assistance, must ensure that the patient is connected with a family member or other reliable and responsible person who can assist;
- g) must continue to provide care and treatment for the patient unrelated to *MAiD*, unless the physician and patient agree to other arrangements;
- h) unless they believe the patient is **not eligible** for *MAiD*, advise affected patients that they may seek *MAiD* from other practitioners;
- i) when appropriate, communicate to a person in authority a patient's request for a complete transfer of care so that the person in authority can facilitate the transfer. Physicians who believe the patient is **not eligible** for *MAiD* must communicate their opinion in writing to the person in authority.
- j) upon the request of a person in authority or the patient, transfer the patient's records to someone identified by the person in authority or patient. Physicians who believe the patient is **not eligible** for *MAiD* must communicate their opinion in writing to the person receiving the records.
- k) if consistent with their conscientious convictions and professional judgement,

Current MAiD Paragraph 11

Recommended MAiD Paragraph 11

- i) arrange for the patient to be seen by a practitioner willing to provide medical assistance in dying; or
- ii) arrange for a transfer of care to another practitioner willing to provide medical assistance in dying; or
- iii) enable patient contact with the MAiD Care Coordination Service or Ontario Telehealth; or
- iv) enable patient contact with health care personnel or services in the community or in institutional settings who will ensure that the patient has access to all available treatment options, including medical assistance in dying and palliative care.

l) if unable to comply with 11(e to k), promptly arrange for the patient to be seen by an available health care practitioner accessible to the patient who is able to do so.

A.5 Advice: MAiD

(Ref Part III, V: Criminal law | Freedom of conscience: effective referral)

Current Advice: MAiD

Recommended Advice: MAiD

Effective Referrals: What Physicians Need to Know

What Physicians Need to Know

The College recognizes that physicians have the right to limit health services they provide for reasons of conscience or religion and so may choose not to be involved in assessing or providing MAiD.

Physicians must not make referrals or do anything else that would support or facilitate medical assistance in dying in the case of a patient whom they consider to be **ineligible**.

In all other cases, the College recognizes that physicians have the right to limit health services they provide for reasons of conscience or religion and so may choose not to be involved in assessing or providing MAiD

Current Advice: MAiD

In recognizing this right, the College does not require physicians to assess a patient’s eligibility for MAID or provide MAID in any circumstances.

When physicians limit the health services they provide for reasons of conscience or religion, the College requires that they provide patients with an effective referral.

[Strike out all from “What is an effective referral? to “Other Frequently Asked Questions”]

Recommended Advice: MAiD

In recognizing this right, the College does not require physicians to assess a patient’s eligibility for MAID or provide MAID in any circumstances.

When physicians decline to provide MAID for reasons of conscience or religion, the College requires that they comply with College policy, “Medical Assistance in Dying.”

[Replace with]

The objective is to ensure access to care and respect for patient autonomy without violating the professional or moral integrity of physicians.

Patients who are so debilitated or circumstantially handicapped that they are unable to contact health care personnel or obtain medical treatment are clearly at risk and in need of assistance in all circumstances, not just in relation to accessing MAiD. Physicians encountering such patients should recognize this problem and respond to it in all situations out of concern for their welfare and safety. This can be done by finding a responsible and reliable person who can help patients to overcome circumstantial handicaps, enabling them to obtain necessary assistance and navigate the health care system. The helper could be a family member, friend, social worker, outreach worker, etc.

Physicians who choose to facilitate medical assistance in dying may do so by any reasonable means consistent with professional obligations, including formal clinical referral or informal methods of communication. They may delegate this responsibility to someone whom they know to be capable and reliable.

Current Advice: MAiD

Recommended Advice: MAiD

Physicians who decline to facilitate medical assistance in dying **for eligible** patients for reasons of conscience or professional judgement

— must not interfere with patient access to MAiD. They must respect patient dignity, be respectful and sensitive in communicating with patients and provide them with information necessary to enable informed medical decision-making. [MAiD, para. 11(a) to (d)]

— must act expeditiously and avoid delays [MAiD, para. 11(e)]

— must continue to provide care and treatment for the patient unrelated to MAiD, unless the physician and patient agree to other arrangements. [MAiD, para. 11(f)]

— **unless they believe the patient is not eligible** for MAiD, advise affected patients that they may seek MAiD from other practitioners; [MAiD, para. 11(g)]

— cooperate with transfers of care requested by or on behalf of a patient. Physicians who believe the patient is **not eligible** for MAiD must communicate their opinion in writing. [MAiD, para. 11(h-i)]

In addition, they must act on one of the following options: [MAiD, para. 11(j)]

i) arrange for the patient to be seen by a practitioner willing to provide medical assistance in dying; or

ii) arrange for a transfer of care to another practitioner willing to provide medical assistance in dying; or

iii) enable patient contact with the MAiD Care Coordination Service or Ontario Telehealth; or

Current Advice: MAiD

Recommended Advice: MAiD

iv) enable patient contact with health care personnel or services in the community or in institutional settings who will ensure that the patient has access to all available treatment options, including medical assistance in dying and palliative care.

Physicians unable to comply options (i) to (iv) must promptly arrange for the patient to be seen by an available health care practitioner accessible to the patient who able to do so.

Notes

1. “Medical Assistance in Dying” (December, 2018), College of Physicians and Surgeons of Ontario (website), online:
<<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying>> [CPSO MAiD Policy].
2. "Advice to the Profession: Medical Assistance in Dying" (1 October, 2020), College of Physicians and Surgeons of Ontario (website), online:
<<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying/Advice-to-the-Profession-Medical-Assistance-in-Dying>> [CPSO Advice: MAiD].
3. “Protection of Conscience Project Submission to the College of Physicians and Surgeons of Ontario Re: Interim Guidance on Physician Assisted Death” (10 January, 2016), *Protection of Conscience Project* (website), online:
<<https://www.consciencelaws.org/publications/submissions/submissions-022-001-cpso.aspx#II.1>> [2016 Submission] at II.3.2– II.3.4.
4. Canada, Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Session, 43rd Parliament, 2020-2021, cl 7 [new §241.2(3.5)] (assented to 17 March, 2021), online: <<https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent>>.
5. 2016 Submission, *supra* note 3 at II.2.
6. World Health Organization, *International Statistical Classification of Diseases and Related Health Problems, 10th revision*, vol 2, 2nd ed (Geneva, Switzerland: World Health Organization, 2004) para 4.1.2. online:
<https://www.who.int/classifications/icd/ICD-10_2nd_ed_volume2.pdf#page=29>.
7. Ministry of Government and Consumer Services, Office of the Registrar General, *Handbook of Medical Certification of Death and Stillbirth: Prepared for Physicians and Coroners* (Thunder Bay, Ontario: Service Ontario, 2019 Dec) [2019 Handbook] at p 8, International Classification of Diseases (ICD) and p 40, Definitions of Manner of Death (per ICD 10 Vol. 1 Tabular List), Box 20 (Accident, suicide, homicide, or undetermined (specify)). online:
<https://www.publications.gov.on.ca/store/20170501121/Free_Download_Files/300146.pdf#page=9>,
<https://www.publications.gov.on.ca/store/20170501121/Free_Download_Files/300146.pdf#page=41>.
8. 2019 Handbook, *supra* note 7 at p 23. online:
<https://www.publications.gov.on.ca/store/20170501121/Free_Download_Files/300146.pdf#page=24>.
9. 2019 Handbook, *supra* note 7 at p 38–40. online:
<https://www.publications.gov.on.ca/store/20170501121/Free_Download_Files/300146.pdf#page>

e=39>.

10. “Protection of Conscience Project Submission to the College of Physicians and Surgeons of Saskatchewan Re: Conscientious Refusal, Appendix ‘B’- Development of the CPSS Draft Policy Conscientious Refusal” (5 March, 2015) *Protection of Conscience Project* (website), online: <<https://www.consciencelaws.org/publications/submissions/submissions-014-003-cpss.aspx>>.

11. Carolyn McLeod, “Demanding Referral in the Wake of Conscientious Objection to Abortion” in JC Cohen and JE Keelan eds *Comparative Program on Health Law and Society, Lupina Foundation Working Papers Series 2004–2005*. (Toronto: University of Toronto, Munk Centre for International Studies, 2006) online: Munk School of Global Affairs, University of Toronto <https://munkschool.utoronto.ca/wp-content/uploads/2013/05/January_2006_CPHS_working_paper1.pdf#page=144> at 136–137.

12. K. Sonu Gaind. “MAID for mental illness is grave discrimination.” *Toronto Star* (1 March, 2021). online: <<https://www.thestar.com/opinion/contributors/2021/03/01/maid-for-mental-illness-is-grave-discrimination.html>> [Gaind].

13. *R v Johnson*, 2017 NSCA 64 at para 78 (CanLII). online: <<https://canlii.ca/t/hrj8h>>.

14. *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 (CanLII), online: <<https://canlii.ca/t/j08wq>> [CMDS v CPSO 2019].

15. Sean Murphy, “To kill — or not to kill? That is the question. An answer for a Dying With Dignity clinical advisor”(27 January, 2020), *Protection of Conscience Project* (website), online: <<https://www.consciencelaws.org/law/commentary/legal105.aspx>>.

16. *Gaind*, *supra* note 12.

17. United Nations Human Rights Office of the High Commissioner, News Release, “Disability is not a reason to sanction medically assisted dying – UN experts” (25 January, 2021), online: <<https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687&LangID=E>>.

18. *CPSO MAiD Policy*, *supra* note 1 at p 3, “Conscientious Objection”.

19. *CPSO Advice: MAiD*, *supra* note 2 at p 1–2, “Effective Referral”.

20. *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 (CanLII), online: <<https://canlii.ca/t/hq4hn>> [CMDS v CPSO 2018] at para 197.

21. *CMDS v CPSO 2019*, *supra* note 14 at para 21.

22. *CMDS v CPSO 2019*, *supra* note 14 at para 187.

23. *McInerney v. MacDonald*, [1992] 2 S.C.R. 138, at p. 149, online: <<https://scc-csc.lexum.com/scc-csc/scc-csc/en/884/1/document.do>>.
24. *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, at pp. 270-72, 274, online: <<https://scc-csc.lexum.com/scc-csc/scc-csc/en/893/1/document.do>>.
25. Canadian Medical Association, “Submission to the College of Physicians and Surgeons of Ontario Consultation on CPSO Interim Guidance on Physician-Assisted Death” (13 January, 2016), *Protection of Conscience Project* (website), online: <<https://www.consciencelaws.org/background/policy/associations-013.aspx>>.
26. *Ibid.*
27. *Carter v. Canada (Attorney General)*, 2015 SCC 5, online: <<https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>>.
28. College of Physicians and Surgeons of Ontario, “Female Genital Cutting (Mutilation)” (September, 2011), *College of Physicians and Surgeons of Ontario* (website), at endnote 2, online: <<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Female-Genital-Cutting-Mutilation>>.
29. *CMDS v CPSO 2019*, *supra* note 14 at para 71.
30. Supreme Court of Canada, “35591, Lee Carter, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave) Webcast of the Hearing on 2014-10-15” (15 October, 2015), online: Supreme Court of Canada, <<https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2014/2014-10-15--35591&date=2014-10-15&fp=n&audio=n>> at 00:20:02 - 00:20:40.
31. *CMDS v CPSO 2018*, *supra* note 20.
32. *CMDS v CPSO 2019*, *supra* note 14.