Project Backgrounder

Re: Joint intervention in *Carter v. Canada*

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Introduction:

In June, 2012, a British Columbia Supreme Court Justice struck down Canada's absolute ban on assisted suicide as well as the rule that one cannot legally consent to be murdered. The decision pertained only to cases of physician-assisted suicide or homicide.[1] The ruling was overturned in the Court of Appeal of British Columbia in a 2/1 decision.[2] The plaintiffs appealed to the Supreme Court of Canada.

In a 1993 decision in *Rodriguez v. British Columbia (Attorney General)*[3] the Supreme Court of Canada upheld the constitutional validity of the law against assisted suicide. Since the circumstances in the Carter case are very similar, the current appeal involves important questions about the legal rule of stare decisis: the practice of lower courts being bound by higher courts' rulings. Two further developments since the trial and appellate court decisions add to the significance of the case.

First, the province of Quebec has passed a provincial statute that purports to legalize euthanasia by physicians, claiming, in that respect, that provincial jurisdiction over health care trumps federal jurisdiction in criminal law. The same claim was originally made by the plaintiffs.[4] They did not pursue it at trial or in the Court of Appeal, but have resurrected it in this appeal.[5] Second, the Canadian Medical Association has withdrawn its official opposition to physician assisted suicide and euthanasia.[6]

The Catholic Civil Rights League, Faith and Freedom Alliance and the Protection of Conscience Project were jointly granted intervener status in *Carter* by the Supreme Court of Canada. The joint factum voiced concern that legalization of physician assisted suicide and euthanasia would likely adversely affect physicians and health care workers who object to the procedures for reasons of conscience. The factum was supplemented by a ten minute oral presentation.

In the event that the Supreme Court of Canada strikes down the criminal law as it relates to euthanasia or assisted suicide, the interveners urged the Court to "make clear to the legislature that any legislation in this area must protect the freedom of conscience of healthcare providers," ensuring that "healthcare providers are not directly or indirectly coerced into becoming parties to killing patients or assisting patients kill themselves."

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I. Overview

1. A legal right to euthanasia by physicians or physician assisted suicide implies that physicians sometimes have an obligation to kill patients or help them kill themselves,[7] and that others may be obliged to facilitate this.

2. An obligation to at least facilitate euthanasia and assisted suicide is implied in the appellants' notice of claim, in their factum, in testimony at trial, in a report accepted as evidence at trial, and in the rights claims advanced.

3. For moral or religious reasons, an undetermined number of healthcare providers will refuse to participate in killing patients. Their beliefs reflect current Canadian law. A ruling in favour of the appellants would have a detrimental effect upon the fundamental freedoms of these healthcare providers if not accompanied by robust protection freedom of conscience and religion.

4. Only a minority of physicians actually kill patients or assist in suicide even where the procedures are legal. Most of the conflicts resulting from legalization of assisted suicide or euthanasia will probably be precipitated by refusal to participate indirectly in killing, or by discrimination against objecting health care providers. At least initially, most efforts to suppress freedom of conscience will be directed to forcing physicians to facilitate killing by referral or other means.

5. In discerning reasonable limits to freedom of conscience and religion, the distinction between belief and conduct, while valid, is insufficient. A further distinction must be made between perfective and preservative freedom of conscience.

6. The state may sometimes limit perfective freedom of conscience by preventing people from doing what they believe to be good. However, to suppress preservative freedom of conscience by forcing people to do what they believe to be wrong is fundamentally unjust, offensive and dangerous. If the limitation of preservative freedom of conscience can be justified, it will only be as a last resort and in the most exceptional circumstances. An exceptionally cautious approach is proportionate to the potentially dangerous consequences of imposing a duty to do what is believed to be wrong.

7. Moreover, the law should not suppress a plausible moral worldview in favour of one that is less plausible. If both of the conflicting worldviews are equally plausible, or if the issue is in doubt, both must be accommodated.

8. If one insists that ordering principles that inform public policy should be empirically verifiable whenever possible and capable of logical and coherent development, it would seem that correct legal and moral reasoning ought to acknowledge the essential primacy of dependency as an ordering principle, not autonomy. Alternatively, if autonomy-centred and dependency-centred worldviews are considered equally plausible, both should be accommodated. In either case, there is no justification for using the coercive power of law to suppress or disadvantage moral worldviews like those exemplified in Christian, Islamic and Jewish medical ethics or in other cultural or religious traditions.

II. The obligation to kill

9. The assertion of a legal right to euthanasia or assisted suicide is explicit in Quebec's *Act Respecting End of Life Care* (ARELC)[8] and in the claims advanced by the appellants.[9] This implies that, in some circumstances, physicians should have a legal and/or professional obligation to kill a patient or to help a patient kill himself. Statements by the past and current presidents of the Canadian Medical Association concerning the Association's change of policy on euthanasia and assisted suicide can be understood to support that view.[10]

10. An implied obligation to assist in killing extends to those whose participation is reasonably necessary if physicians are to fulfil their own obligation to kill, even if they do not participate directly in the lethal act: pharmacists, for example.[11]

11. An obligation to kill must be distinguished from the authority to use potentially deadly force by the police or military, or the justification for the use of potentially deadly force in self-defence. In the latter cases, the law recognizes that death resulting from the use of deadly force may sometimes be so highly probable as to be predictable. Nonetheless, neither the authority to use deadly force nor legal justifications for it involve an obligation to kill. Someone who shoots a deadly aggressor in self-defence may not administer a coup-de-grâce if the first shot is merely disabling. There is no obligation to kill even in military combat; deliberately killing disabled enemies is a crime.[12]

12. Since an obligation to kill is not imposed even upon people whose professional obligations may entail responsibility for killing, to impose upon physicians an obligation to kill would be unique and extraordinary, though not unprecedented. An obligation to kill was formerly imposed on public executioners. The essence of that obligation was captured by Blackstone's explanation that "if, upon judgment to be hanged by the neck till he is dead, the criminal be not thoroughly killed, but revives, the sheriff must hang him again."[13]

13. That is what an obligation to kill would require of a physician. If a lethal injection failed to cause death, a physician would have to inject him again, or take additional steps to ensure the patient is "thoroughly killed." This is implied in the Quebec euthanasia law, which requires a physician who has administered a lethal substance to a patient to remain with the patient "until death ensues."[14] It is also implied in the reasoning of the American Medical Association, which forbids physicians to participate in executions even by pronouncing death.[15]

14. It would thus seem to be difficult to legalize physician-assisted suicide without also legalizing euthanasia. In the case of a failed assisted suicide that incapacitates a patient, it could be argued that the physician who contracted to help the patient kill himself is obliged to fulfil the contract by providing euthanasia. The argument would have greater force if the patient had sought assisted suicide to avoid the kind of incapacitation caused by the failed suicide attempt.

III. Focus of the intervention

15. For reasons of conscience or religion, an undetermined number of Canadian healthcare will refuse to directly or indirectly participate in the killing of patients or suicide. Their views are consistent with the current Canadian legal framework, and with an undetermined proportion of the population they serve.

16. A ruling in favour of the appellants would have a detrimental effect upon the fundamental freedoms of these health care providers, unless the Court directs that robust protection be provided for them. Such direction should clarify principles needed to correct a dangerous error that has become increasingly widespread: that the state or a profession may impose upon people a duty to do what they believe to be wrong - even if that means killing people.

IV. A misplaced objection

17. The trial judge stated that there was no need to consider the situation of objecting health care providers, since the plaintiffs did not assert that physicians should be compelled to provide euthanasia or assist in suicide.[16] The appellants opposed this intervention for the same reason.[17]

18. However, this is a misplaced objection. In fact, only a minority of physicians - sometimes a very small minority - actually kill patients or assist in suicide even where the procedures are legal.[18] Moreover, most euthanasia/assisted suicide supporters do not insist that objecting physicians personally kill patients or assist in suicide.[19] Instead, they demand that objectors become parties to euthanasia or assisted suicide by referral or other means.[20]

19. Identical demands have been made for years concerning other morally contested procedures, like abortion.[21] Thus, most of the conflicts adverse effects experienced by objectors resulting from a ruling in favour of the appellants will probably be precipitated by refusal to participate indirectly in killing,[22] or when they are denied employment hospital privileges or excluded from palliative care units,[23] just as qualified maternity nurses are now denied employment in at least one major Canadian maternity hospital if they are unwilling to assist with abortion.[24]

V. The issue in the trial and appeal record and penumbra

20. An obligation to at least facilitate euthanasia and assisted suicide was implicit in the appellants' factum.[25] It was implicit in the appellants' notice of claim[26] and in the testimony of a plaintiff witness, Professor Margaret Battin, who implied that a physician's refusal to provide assisted suicide or euthanasia would amount to unethical abandonment of patients.[27] It appears as an explicit assertion in a report[28] introduced as evidence by the appellants.[29] Professor Jocelyn Downie, one of the authors of the report, instructed the appellant's expert witnesses.[30]

21. Professor Downie and colleagues have drafted a *Model Conscientious Objection Policy* for Canadian physicians. Should euthanasia or assisted suicide be permitted, their policy would require physicians unwilling to kill patients themselves to "make a referral to another health care provider who is willing and able to accept the patient and provide the service."[31] Moreover, should the delay involved jeopardize the patient's "well-being," the model insists that physicians personally provide "legally permissible and publicly funded" services (i.e., kill the patient or assist in suicide), "even in circumstances where the provision of health services conflicts with physicians' deeply held and considered moral or religious beliefs."[32]

22. Finally, the issue is embedded in the rights language that permeates the lower court rulings and arguments advanced by the parties. This language encourages claims that, in the name of human rights, physicians have a duty to do what they believe to be wrong, an extreme position exemplified

by a statement of the Ontario Human Rights Commission (OHRC):

> It is the Commission's position that doctors, as providers of services that are not religious in nature, must essentially "check their personal views at the door" in providing medical care.[33]

VI. An inadequate distinction: believing vs. acting

23. The OHRC (and others) justify this assertion by quoting a statement of the Supreme Court of Canada: "the freedom to hold beliefs is broader than the freedom to act on them."[34]

24. The statement is certainly correct, but it not responsive to all of the questions that arise about freedom of conscience and religion in a pluralistic democracy. With respect, the Court cannot have intended the remark to become a mantric solution for every problem arising from the exercise of freedom of conscience or religion. More refined distinctions are required.

VII. Refining the analysis

25. One of them is the distinction between perfective and preservative freedom of conscience, reflecting the two ways in which freedom of conscience is exercised: by pursuing apparent goods and avoiding apparent evils.[35]

26. It is generally agreed that the state may limit the exercise of perfective freedom of conscience by preventing people from doing what they believe to be good, if it is objectively harmful, or if the limitation serves the common good. There is disagreement about the application of these principles, but no polity could survive without restrictions of some sort on human acts, so some limitation of perfective freedom of conscience is not unexpected.

27. Though the state may limit perfective freedom of conscience, it does not follow that it is equally free to suppress preservative freedom of conscience by forcing people to do what they believe to be wrong.

28. As a general rule, it is fundamentally unjust and offensive to force people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instills attitudes more suited to totalitarian regimes than to the demands of responsible freedom.

29. Preservative freedom of conscience is not unlimited. In fact, it is, to begin with, a much more limited form of freedom of conscience that is far less demanding of society. But it is more essential to individual integrity and society, so that even the strict approach taken to limiting other fundamental rights and freedoms is insufficiently refined to be applied to it. Like the use of potentially deadly force, if the limitation of preservative freedom of conscience can be justified, it will only be as a last resort and only in the most exceptional circumstances.

VIII. A demonstrable need for caution

30. This exceptionally cautious approach is proportionate to the potentially serious consequences

of imposing a duty to do what is believed to be wrong. For example, some who support the "war on terror" posit a "duty to do what is wrong," including a duty to kill non-combatants and to torture terrorist suspects.[36] Within the context of this appeal, the ultimate consequences of suppressing preservative freedom of conscience are crystalizing in Quebec, where a purported right to euthanasia has been enacted in the *Act Respecting End of Life Care* (ARELC), which the appellants recommend as an example of an appropriate exercise of provincial jurisdiction.[37]

31. Quebec is the only province in which the medical regulator has made the mistake of including duty to do what one believes to be wrong in a code of ethics. Supporters of ARELC, citing the Collège des médecins du Québec *Code of Ethics*, insist that physicians unwilling to kill patients must help find a colleague who will.[38]

32. If ARELC is found to be constitutional, some physicians will begin to kill patients, while physicians opposed to killing patients will refuse to kill patients or encourage or facilitate the killing of patients by counselling, referral or other means. Objectors would, despite the law, continue to view euthanasia as planned and deliberate murder.

33. At this point, the unique character of the 'duty to do what is wrong' movement comes into focus. It is not sufficient to simply encourage and allow willing physicians to kill patients. Physicians are to be compelled to become parties to the killing of patients, even if they believe it to be wrong - even if they believe it to be murder - and will be punished if they refuse.

34. This is quite extraordinary, even if there are precedents for it.[39] To hold that the state can rightfully compel citizens become parties to what they sees murder, and justly penalize him if they refuses surely goes beyond anything that could possibly have been intended by the Supreme Court in *Trinity Western University v. College of Teachers*.

35. This demonstrates the need to distinguish between perfective and preservative freedom of conscience, to insist that the burden lies upon the state to prove that reasonable accommodation of preservative freedom of conscience is impossible, and to set the standard of proof that must be met by the state at an exceptionally high level, the rules for the use of deadly force providing the most suitable paradigm.

IX. Autonomy and the illusion of neutrality

36. The appellants state that "autonomy, compassion and non-abandonment play a central role in medical ethics and that physicians are ethically required, within the law, to act in their patients' best interests."[40]

37. This is the justification offered by those who would impose upon objecting physicians a duty to do what they believe to be wrong, including a duty to participate in killing patients. It is obvious that the justification is based on contested presumptions that killing is medical treatment, and that being killed may be in the patient's "best interests."

38. Less obvious is the illusion of moral neutrality created by the appeal to autonomy. Given the absence of agreed-upon religious, moral or ethical standards in a pluralist democracy, the Royal Society panel of experts recommends that euthanasia and assisted suicide should be legalized "on the basis of the value ascribed by Canadian political and constitutional culture to the value of

autonomy."[41]

39. They argue that, in defined circumstances, physicians should be allowed to kill patients, but deny physicians the freedom to refuse to facilitate killing. Their reasoning is that allowing physicians to kill advances patient autonomy, while refusing to participate in killing denies or at least illegitimately impedes the autonomy of others by introducing (an inadmissible) moral judgement.

40. In reality, moral judgement precedes any decision about whether or not to kill a patient. The experts' moral judgment is that it is morally permissible for physicians to participate in killing patients in defined circumstances, and morally impermissible for them to refuse to do so. It is absurd to suggest that refusing to facilitate the killing of a patient involves moral judgement, but deliberately killing a patient does not.

41. By adopting the "value" of autonomy as their paramount ordering principle, the experts do not avoid moral judgement. They simply make autonomy their principal moral standard. Thus, the autonomous choice of an informed patient makes euthanasia and assisted suicide morally permissible, even for frivolous reasons.[42]

X. Autonomy as an article of faith

42. The justification offered for this belief is that autonomy (as understood by the expert panel) is the de facto centre of a social consensus around which Canadians can "work out difficult questions of political morality in a fair and equitable manner."[43] This notion may be reflected even in opposition to euthanasia and assisted suicide when it is argued that legalization of the procedures undermines the authentic autonomy of vulnerable people, so that "'Choice' is an illusion."[44]

43. It is not unreasonable to recognize autonomy as a widely-accepted "value" that may serve to build consensus in some circumstances. However, to insist that it must be accepted as the sole or principal presumptive ordering principle in moral reasoning is a dogmatic and authoritarian claim, particularly when the choice of autonomy as an ordering principle is disputed.

XI. Autonomy and freedom of conscience and religion

44. Notwithstanding the Royal Society experts' belief that euthanasia and assisted suicide can be justified by respect for autonomy, an undetermined number of health care providers will refuse to do anything that contributes to killing patients because they act upon different beliefs. Should they be forced to conform to the belief in autonomy favoured by the experts and made to do what they believe to be wrong? The need to protect preservative freedom of conscience (para. 25-35) suggests that the answer is "no." Three further reasons support this answer.

45. The first is prudence. If it is not absolutely certain that the moral beliefs of euthanasia and assisted suicide advocates are correct, it is possible that the refusing health care providers are correct, so it would be unjust to penalize them. At present, no consensus on this is possible even on the balance of probabilities.[45] Further, accommodation of objecting physicians and preventing discrimination against them would provide an additional safeguard against abuse, while maintaining moral diversity in medical practice will ensure continuing debate within the medical profession that should clarify moral issues and help to avoid error.[46]

46. The second is respect for human dignity, emphasized by Madam Justice Bertha Wilson in *R v. Morgentaler*: "that the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life."[47] The "one conception of the good life" includes a conception based on a preference for the presumptive centrality of autonomy as an ordering principle in ethics and law.

XII. Criterion of comparative plausibility

47. When a dispute arises because the state or other authorities tries to compel health care providers to do what they believe to be wrong, such as facilitating the killing of patients, the first point to note is that the dispute involves conflicting moral claims, not a "neutral" claim by the state or other party and a "moral" claim by a health care provider. (para. 36-41).

48. In such cases, following Madam Justice Wilson's advice, the coercive power of law should not be used to suppress a plausible moral worldview in favour of one that is less plausible. If both conflicting worldviews are equally plausible, or if the issue is in doubt, both must be accommodates. Superadded to this is the special and onerous obligation to accommodate the exercise of preservative freedom of conscience (para. 29, 35).

XIII. A plausible alternative to autonomy

49. All empirical evidence demonstrates that what is more essentially characteristic of human beings and human society is dependency and interdependency rather than autonomy and self-determination. Moreover, working from principles of dependency and interdependency, one can logically and coherently develop concepts of compassion, non-abandonment and fiduciary duty, as well as the possibility of degrees of autonomy, which, paradoxically, can develop only with the assistance of others. In contrast, it is impossible, or at least very difficult, to logically develop or explain any of these concepts working from the principle of autonomy.

50. If one insists that ordering principles that inform public policy should be empirically verifiable whenever possible and capable of logical and coherent development, it would seem that correct legal and moral reasoning ought to acknowledge the essential primacy of dependency as an ordering principle, not autonomy. In that case, there is no justification for using the coercive power of law to suppress moral worldviews informed by principles of dependency and interdependency in favour of an establishment worldview based on autonomy. It is relevant here to note that the primacy of human dependency and interdependency is one of the fundamental principles informing Christian, Islamic and Jewish medical ethics,[48]48 to say nothing of other religious and cultural traditions.

51. Adopting a more conservative approach, if one holds that moral worldviews based on autonomy and those based on dependency are at least equally plausible, respect for human dignity requires that both be accommodated.

XIII. Conclusion

52. To the extent that the Court might find the impugned legislation to be of no force and effect, it should direct legislators and health care regulators to provide robust protection for the freedoms and equality of those who decline to support or participate in physician-assisted suicide or euthanasia

for reasons of conscience or religion. That protection must ensure that healthcare providers are not directly or indirectly coerced into becoming parties to killing patients or assisting patients kill themselves.

53. The direction should include guidance to refine the analysis used in the limitation or balancing of fundamental freedoms, including the need to stringently safeguard preservative freedom of conscience and apply the criterion of comparative plausibility.

Notes:

1. *Carter v. Canada (Attorney General)* 2012 BCSC 886. Supreme Court of British Columbia, 15 June, 2012. Vancouver, British Columbia. (http://consciencelaws.org/archive/documents/carter/2012-06-15-Carter-v-canada.pdf) Hereinafter "*Carter v. Canada*." The judgement refers to the "impugned provisions" of the Criminal Code, including the law against counselling or assisting suicide (Criminal Code, Section 241) and the law that consent is not a defence to a charge of murder (Criminal Code, Section 14). *Carter v. Canada*, para. 101.

2. *Carter v. Canada* (Attorney General), 2013 BCCA 435 (http://www.courts.gov.bc.ca/jdb-txt/CA/13/04/2013BCCA0435.htm) Accessed 2014-10-06)

3. *Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (1993), 107 D.L.R. (4th) 342, 85 C.C.C. (3d) 15 (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1054/index.do) Accessed 2012-06-27.

4. In the Supreme Court of British Columbia between Lee Carter, Hollis Johnson, Dr. William Schoichet, the British Columbia Civil Liberties Association and Gloria Taylor, Plaintiffs, and Attorney General of Canada, Defendant. *Amended Notice of Civil Claim* (15 August, 2011) Part 3, para. 2-3 (Hereinafter "*Amended Notice of Civil Claim*") (http://consciencelaws.org/archive/documents/carter/2011-08-15-noticeofclaim02.pdf)

5. In the Supreme Court of Canada (on appeal from the Court of Appeal of British Columbia) between Lee Carter, Hollis Johnson, Dr. William Schoichet, the British Columbia Civil Liberties Association and Gloria Taylor, Appellants (Respondents/Cross-Appellants) and Attorney General of Canada, Respondent (Appellant/Cross-Respondent) and Attorney General of British Columbia, Respondent (Appellant) and Attorney General of Ontario, Attorney General of British Columbia and Attorney General of Quebec, Interveners. (Hereinafter "In the SCC on appeal from the BCCA") *Factum of the Appellants*, para. 40-53. (http://bccla.org/wp-content/uploads/2012/12/2014-05-13-Appellants-Factum.pdf) Accessed 2014-08-18.

6. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association*, para. 1-3, 5, 16-17. (http://www.consciencelaws.org./archive/documents/carter/2014-08-27-cma-factum.pdf)

7. "The term killing does not necessarily entail a wrongful act or a crime, and the rule 'Do not kill' is not an absolute rule. Standard justifications of killing, such as killing in self-defense, killing to rescue a person endangered by another persons' wrongful acts, and killing by misadventure (accidental, non-negligent killing while engaged in a lawful act) prevent us from prejudging an action as wrong merely because it is killing." Beauchamp TL, Childress JF, *Principles of Biomedical Ethics* (7th ed.) New York: Oxford University Press, 2013, p. 176

8. Section 4 of the *Act Respecting End of Life Care* states that eligible patients have a right to "end-of life-care," which includes euthanasia and palliative care. (https://www.canlii.org/en/qc/laws/stat/rsq-c-s-32.0001/latest/rsq-c-s-32.0001.html) Accessed 2014-10-14.

9. In the BCSC, *Amended Notice of Civil Claim*, Part 1, para. 64(c), Part 3, para. 5-7, 9-11; In the SCC on appeal from the BCCA, Factum of the Appelllants, para. 4, 123, 162-164, 182(e). (http://www.consciencelaws.org/archive/documents/carter/2011-08-15-noticeofclaim02.pdf)

10. Outgoing President of the CMA, Dr. Louis Hugo Francescutti, commenting on the vote at the CMA general meeting, Dr. Francesutti said, "We delivered a very clear, concise message to Canadians that physicians will always be there, in this most difficult time, which is end of life." Kirkey S. "Canadian doctors want freedom to choose whether to help terminal patients die." *canada.com*, 19 August, 2014. (http://o.canada.com/news/national/canadian-doctors-want-freedom-to-choose-whether-to-help-terminal-patients-die) Accessed 2014-10-06. The new CMA President, Dr. Chris Simpson, in responding to a suggestion that someone other than physicians should provide euthanasia and assisted suicide, said, "I don't think we want to be reneging on our responsibilities to serve our patients, either." Kirkey S. "Doctor-assisted death appropriate only after all other choices exhausted, CMA president says." *canada.com*, 26 August, 2014 (http://o.canada.com/news/national/doctor-assisted-death-appropriate-only-after-all-other-choices-exhausted-cma-president-says) Accessed 2014-10-06.

11. In the BCSC, *Amended Notice of Civil Claim,* Part 1, para. 7-10. (http://www.consciencelaws.org/archive/documents/carter/2011-08-15-noticeofclaim02.pdf)

12. Moore, O. "Former Canadian army officer accused of murder speaks out." *Globe and Mail*, 4 September, 2012. (http://www.theglobeandmail.com/news/national/former-canadian-army-officer-accused-of-murder-speaks-out/article4518314/) Accessed 2014-08-14.

13. Blackstone, W. *Commentaries on the Laws of England* (12th ed.), Vol. 4. London: Strahan & Woodfall, 1795, p. 405. Citing 2 Hal. P.C. 412, 2 Hawk. P.C. 463

14. *Act Respecting End of Life Care*, section 30 (https://www.canlii.org/en/qc/laws/stat/rsq-c-s-32.0001/latest/rsq-c-s-32.0001.html) Accessed 2014-10-08.

15. "A physician charged with determining death where initial attempts at execution failed would have to signal that death was not achieved and indicate that the execution attempt must be repeated. In some cases, the physician might have to specifically indicate which drug, what amount of electricity, or what amount or type of gas must be added or repeated in order to complete the execution." American Medical Association, CEJA Report A – I-92, *Physician Participation in Capital Punishment*, p. 4. (https://download.ama-assn.org/resources/doc/code-medical-ethics/x-pub/206b.pdf) Accessed 2014-10-09.

16. *Carter v. Canada*, para. 211. (http://consciencelaws.org/archive/documents/carter/2012-06-15-Carter-v-canada.pdf)

17. In the SCC on appeal from the BCCA, *Appellants' Response to Motions to Intervene*, 20 June, 2014, para. 5(c) (http://www.consciencelaws.org/archive/documents/carter/2014-06-20-response-to-interventions.pdf)

18. Murphy S. "Redefining the Practice of Medicine: Euthanasia in Quebec, Appendix 'C'." *Protection of Conscience Project* (July, 2014) (http://www.consciencelaws.org/law/commentary/legal068-012.aspx)

19. Speaking for the Quebec Association for the Right to Die with Dignity Association, Hélène Bolduc told a Quebec legislative committee that the Association respected "the freedom of the professional" and never had any intention of forcing physicians to provide euthanasia, as "there is not a doctor who would do it well if, in addition, it was not his inclination to do so, and it is not to anyone's advantage to give this impression." Consultations & hearings on Quebec Bill 52, Wednesday, 25 September 2013 - Vol. 43 no. 38: *Quebec Association for the Right to Die with Dignity* (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#107 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#107)

20. Belgian Association of General Practitioners, Academic Centre for General Practice at the Catholic University of Leuven, Department of General Practice at the University of Ghent, *Policy Statement on End of Life Decisions and Euthanasia (Standpunt over medische beslissingen rond het levenseinde en euthanasie)* 4 December, 2003, Proposition 6 (http://www.consciencelaws.org/background/procedures/assist008-002.aspx); Royal Dutch Medical Society (KNMG) Position Paper, *The Role of the Physician in the Voluntary Termination of Life* (23 June, 2011), p. 40 (http://knmg.artsennet.nl/web/file?uuid=9075af1d-e5de-47a1-a139-e07ef4a7c4f4&owner=a8a9ce0e-f42b-47a5-960e-be08025b7b04&contentid=100970)

21. For example, Rodgers S. Downie J. "Abortion: ensuring access." *CMAJ* July 4, 2006 vol. 175 no. 1 (http://www.cmaj.ca/content/175/1/9.full) Accessed 2014-02-14.

22. Murphy S. "Redefining the Practice of Medicine: Euthanasia in Quebec, Part 6- Participation in Killing." *Protection of Conscience Project* (July, 2014)

(http://www.consciencelaws.org/law/commentary/legal068-006.aspx)

23. Murphy S. "Redefining the Practice of Medicine: Euthanasia in Quebec, Part 5- An Obligation to Kill (Discrimination for refusing to kill)" Protection of Conscience Project (July, 2014) (http://www.consciencelaws.org/law/commentary/legal068-005.aspx#Discrimination_for_refusing_to_kill

24. Confidential Protection of Conscience Project correspondence. The victim decided against legal recourse because he/she was concerned that it would prevent him/her from getting another job. He/she is now employed elsewhere, but remains concerned that his/her employment or professional opportunities may be adversely affected if particulars are made public.

25. In the SCC on appeal from the BCCA, Factum of the Appellants (13 May, 2014) para. 4, 123, 162-164 (http://bccla.org/wp-content/uploads/2012/12/2014-05-13-Appellants-Factum.pdf) Accessed 2014-10-14.) Accessed 2014-08-18)

26. In the BCSC, Amended Notice of Civil Claim, Part 1, para. 55, 64(c); Part 3, para. 9-11, 18. (http://www.consciencelaws.org/archive/documents/carter/2011-08-15-noticeofclaim02.pdf)

27. *Carter v. Canada*, para. 239-240. (http://consciencelaws.org/archive/documents/carter/2012-06-15-Carter-v-canada.pdf) Others have made the same claim: see Angell M., Lowenstein E. "Letter re: Redefining Physicians' Role in Assisted Dying." N Engl J Med 2013; 368:485-486 January 31, 2013 DOI: 10.1056/NEJMc1209798 (Accessed 2014-08-16)

28. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making (November, 2011) p. 62, 69, 101 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

29. *Carter v. Canada*, para. 120-130 (http://consciencelaws.org/archive/documents/carter/2012-06-15-Carter-v-canada.pdf)

30. *Carter v. Canada*, para. 124 (http://consciencelaws.org/archive/documents/carter/2012-06-15-Carter-v-canada.pdf)

31. Downie J, McLeod C, Shaw J. "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons." *Health Law Review*, 21:3, 2013, para. 5.3

32. Downie J, McLeod C, Shaw J. "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons." *Health Law Review*, 21:3, 2013, para. 5.4

33. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code."* 15 August, 2008. (http://www.ohrc.on.ca/en/resources/submissions/physur) Accessed 2014-03-08.

34. *Trinity Western University v. College of Teachers,* [2001] 1 S.C.R. 772, 2001 SCC 31 (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1867/index.do) Accessed 2014-07-29. Quoted in *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code."* 15 August, 2008. (http://www.ohrc.on.ca/en/resources/submissions/physur) Accessed 2014-03-08.

35. This section draws from an extended discussion of the subject in Murphy S, Geunis S.J. "Freedom of Conscience in Health Care: Distinctions and Limits." *J Bioeth Inq*. 2013 Oct; 10(3): 347-54 (http://rd.springer.com/article/10.1007/s11673-013-9451-x#)

36. 36. Gardner J. "Complicity and Causality," 1 Crim. Law & Phil. 127, 129 (2007). Cited in Haque, A.A. "Torture, Terror, and the Inversion of Moral Principle." New Criminal Law Review, Vol. 10, No. 4, pp. 613-657, 2007; *Workshop: Criminal Law, Terrorism, and the State of Emergency*, May 2007. (http://ssrn.com/abstract=958059) Accessed 2014-02-19.

37. In the SCC on appeal from the BCCA, *Factum of the Appellants*, para. 156, note 312. (http://bccla.org/wp-content/uploads/2012/12/2014-05-13-Appellants-Factum.pdf) Accessed 2014-10-14.

38. Murphy S. "Redefining the Practice of Medicine- Euthanasia in Quebec, Part 9: Codes of Ethics and Killing." *Protection of Conscience Project* (July, 2014) (http://consciencelaws.org/law/commentary/legal068-009.aspx)

39. Himmelstein DU, Woolhandler S. "The Silence of the Doctors: Fifty Years After Nuremberg." J *Gen Intern Med*. Jun 1998; 13(6): 422–423. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1496966/) Accessed 2014-08-16.

40. In the SCC on appeal from the BCCA, *Factum of the Appellants*, para. 9. (http://bccla.org/wp-content/uploads/2012/12/2014-05-13-Appellants-Factum.pdf) Accessed 2014-10-14.

41. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 40
(http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

42. The assertion occurs within the context of a discussion of assisted suicide, but the justification they offer would hold for euthanasia as well. Schuklenk U, van Delden J.J.M,

Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 51 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

43.Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 42 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

44. "Choice is an Illusion: A human rights organization opposing assisted suicide and euthanasia, sometimes termed 'death with dignity' or 'aid in dying.'" (Accessed 2014-08-18)

45. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise*. Cambridge, Mass.: The MIT Press, 2008, p. 84-85, 135. (Hereinafter "*Conflicts*")

46. *Conflicts*, p. 85.

47. *R. v. Morgentaler* (1988) 1 S.C.R. 30, p. 166 (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do) Accessed 2014-08-19.

48. Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*. Washington: U.S. Conference of Catholic Bishops, 2007, para. 192-196; Sachedina A. *Islamic Biomedical Ethics: Principles and Application*. Oxford: University Press, 2009, p. 12-13; Steinberg A. "Jewish Medical Ethics." The Schlesinger Institute for Jewish Medical Ethics, p. 38-39.