Canadian Medical Association and euthanasia and assisted suicide in Canada
Critical review of CMA approach to changes in policy and law

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ABSTRACT

In December, 2013, the Canadian Medical Association (CMA) Board of Directors decided to shape the debate and law concerning euthanasia and assisted suicide and revisit CMA policy opposing physician participation in the procedures. By the summer of 2014 it was clear that the overwhelming majority of physicians supported the existing policy. However, it appears that the Board decided the policy should be changed before the Supreme Court of Canada decided the case of Carter v. Canada.

The Board sponsored an ostensibly neutral resolution affirming support for the right of physicians to follow their conscience in deciding whether or not to provide euthanasia/assisted suicide if the law changed. The resolution was overwhelmingly approved. Unnoticed at the time was that the resolution was not conditional upon eligibility criteria, such as decision-making capacity or terminal illness.

The CMA intervention at the Supreme Court of Canada in the Carter case emphasized that existing CMA policy against euthanasia and assisted suicide would be changed to reflect the resolution. It conveyed the message that the Association would support physicians who decided to participate in euthanasia or assisted suicide no matter how broadly the Court or legislatures might cast the rules governing the procedures.

The Board reversed CMA policy about two months before the Court ruled. It formally approved physician assisted suicide and euthanasia, subject only to legal constraints. The policy did not exclude minors, the incompetent or the mentally ill, nor did it limit euthanasia and assisted suicide to the terminally ill or those with uncontrollable pain. It classified both as "end of life care," promising support for patient access to the procedures should they be legalized. Support for physicians refusing to participate in euthanasia or assisted suicide was qualified by the statement that there should be no "undue delay" in providing them. Implicit in all of this was a new ethical paradigm: that in some circumstances, physicians have a professional obligation to kill patients or to help them kill themselves.

The new policy effectively wrote a blank cheque for the Supreme Court of Canada to legalize euthanasia and physician assisted suicide on any terms acceptable to the judges. After the Court struck down the law CMA officials
expressed concern about the criteria set by the Court. It was implied that the Supreme Court was to blame for anxiety and profound discomfort among Canadian physicians because it had imposed upon them an obligation to kill, contrary to centuries of medical ethics and practice.

However, the concerns voiced by CMA officials after the *Carter* ruling existed when the CMA intervened in the case, and the CMA did not raise them then. In fact, the Supreme Court gave legal effect to a policy the CMA had already adopted, and the criteria the Court set for the procedures were actually more restrictive than anything the CMA had proposed. The Court cannot be blamed because CMA leaders were ill-prepared to deal with the consequences of a ruling entirely consistent with their own policy.

The consequences fell most heavily upon physicians who refused, for reasons of conscience, to provide euthanasia and assisted suicide or to collaborate in providing the services by referral or other means. Since *Carter*, the debate in Canada has been largely about whether or under what circumstances physicians and institutions should be allowed to refuse to provide or facilitate the services. While it is generally agreed that physicians should not be compelled to personally provide them, there are strident demands that physicians unwilling to kill their patients or help them commit suicide should be forced to refer patients to someone who will.

This review demonstrates that the CMA Board of Directors focus in 2014 was on the role physicians would play in providing euthanasia and assisted suicide should the law change. The Board knew that the overwhelming majority of Canadian physicians would not participate in euthanasia or assisted suicide. The fundamental conflict presented by imposing an obligation to kill upon unwilling physicians was foreseeable and had been foreseen by CMA officials. Attacks upon physician freedom of conscience, particularly with respect to referral, were predictable.

However, the Board failed to consider physician freedom of conscience in relation to assisted suicide and euthanasia except the extent that it could be used to further its policy goals. As a result, after the *Carter* ruling, CMA officials were quite unprepared to mount a cogent, articulate and persuasive defence of physician freedom of conscience, especially in relation to referral. They discovered that state authorities and the public were often unreceptive and even hostile to physicians unwilling to arrange for patients to be killed by someone else. Negotiating at a significant disadvantage of their own making, they were desperate to find a policy "acceptable to the regulators" and to objecting physicians whose fundamental freedoms they had rashly jeopardized.

The CMA has since produced a strong defence of physician freedom of conscience in relation to referral for euthanasia and assisted suicide, and sound protection of conscience provisions have been incorporated into a revised CMA policy on the procedures. However, by the time these statements appeared, objecting physicians were on the defensive in a treacherous and even hostile environment, compelled to launch an expensive constitutional challenge to defend fundamental freedoms of conscience and religion. The outcome of that case will determine if they will be able to continue to practise medicine if they refuse to collaborate in killing their patients.

The World Medical Association (WMA) and national medical associations are free to decide to change their policies on physician participation in euthanasia or assisted suicide. This review demonstrates that they should not follow the example of the Canadian Medical Association if they wish to safeguard the fundamental freedoms of physicians and health care workers.
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INTRODUCTION

The Canadian Medical Association (CMA) and Royal Dutch Medical Association (RDMA) are attempting to convince the World Medical Association (WMA) to drop its opposition to euthanasia and assisted suicide. It appears that the CMA is recommending its own management of the controversial subject as a progressive model that should be followed by the WMA and other national associations.

Since legalization of physician assisted suicide and euthanasia has potentially serious implications for freedom of conscience among health care workers, decisions by the WMA and its constituent members should be informed by a critical review of the CMA's approach to changes in policy and law. This review considers the CMA's approach to euthanasia and assisted suicide only in relation to its impact on physician freedom of conscience.

Part I focuses on the period from August, 2013 to December, 2014. During this time, the CMA Board of Directors actively engaged in a process leading to reversal of CMA policy against physician participation in euthanasia and assisted suicide and affirmation of the procedures as legitimate forms of end-of-life medical care. The transition from opposition to affirmation was facilitated by the acceptance of an ostensibly neutral resolution on physician participation in euthanasia and assisted suicide. Part I briefly considers the CMA's intervention in the landmark case of Carter v. Canada, and concludes with a consideration of the broad effects of the policy change and intervention in relation to the outcome of the case and the consequences for objecting physicians.

Part II begins on the eve of the Supreme Court of Canada decision in Carter in February, 2015 and concludes in the fall of 2015 with the approval of the CMA's draft framework for providing euthanasia and assisted suicide. It describes the response of the CMA Board to attacks on physician freedom of conscience in the maelstrom unleashed by the Carter decision, particularly in relation to the critical and controversial issue of referral. It also documents attempts by CMA officials to shape a policy on physician freedom of conscience that would accommodate the expectations of medical regulators. Part II concludes with a postscript on current CMA policy and the position of objecting physicians.
PART I
PRELIMINARIES TO CARTER

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

Reaffirmation of support for conscientious objection to euthanasia/assisted suicide

In June, 2012, in the case of Carter v. Canada (Attorney General), a judge of the Supreme Court of British Columbia struck down the absolute criminal prohibition of physician assisted suicide and physician administered euthanasia, suspending the ruling for one year to give governments the opportunity to implement the decision.³

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

A contentious debate followed, centred on the wording of the motion and the definition of terms, and the motion was defeated. Instead, delegates voted "to refer the issue to the CMA Board for future deliberation." The outgoing chair of the medical ethics committee said that the vote reflected "deep divisions within the medical community."⁴

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

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

Delegates voted to have the CMA Board review the issue and make a decision.⁵

However, delegates did pass the following motion:

36. The Canadian Medical Association supports the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying. (DM 5-22).⁶

CMA Board decides to shape the debate and the law (October, 2013)

The decision

In October, 2013, the BC Court of Appeal reversed the Carter trial court ruling.⁷ The Court of Appeal quoted the CMA policy against physician participation in euthanasia and assisted suicide, setting it beside the policies of other associations, as the trial judge did, to make the point that the
evidence at trial "did not demonstrate a clear consensus of public or learned opinion on the wisdom of permitting physician-assisted suicide." It was generally understood that the case would be appealed to the Supreme Court of Canada.

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

**Shaping the debate and the law: in brief**

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

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

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

Beginning in June, 2014, with a General Council two months away and a Supreme Court hearing expected in the fall, the Board put into action what was probably a still evolving plan, without reflecting adequately upon the effects of their actions on medical practice and the fundamental freedoms of physicians. As a result, they were surprised by elements of the Supreme Court ruling and ill-prepared to respond, especially to challenges to physician freedom of conscience.
CMA Board revises euthanasia and assisted suicide policy (December, 2013)

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

A change in the legal status of these practices in Canada would represent a major shift in social policy and behaviour. For the medical profession to support such a change and subsequently participate in these practices, a fundamental reconsideration of traditional medical ethics would be required. (p. 2, emphasis added)

Physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition of euthanasia and assisted suicide. Because of the controversial nature of these practices, their undeniable importance to physicians and their unpredictable effects on the practice of medicine, these issues must be approached cautiously and deliberately by the profession and society. (p. 2)

The CMA recognizes that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. The CMA wishes to contribute the perspective of the medical profession to the examination of the legal, social and ethical issues. (p. 3)

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

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

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

Six meetings were also held with physicians across the country, and a website was maintained for physician-only comment from February to the end of May. The report of the consultation stated that the meetings and on-line responses were characterized by "diametrically opposed views" on euthanasia and assisted suicide. The majority of CMA members participating opposed physician involvement in the procedures (71.5% of an on-line poll), while "[a] significant minority" (25.8% of poll respondents) believed that the policy "should at least be reviewed if not revised to support some form of physician-assisted dying."

A majority of about 66% in the recent Irish abortion referendum has been described as
"overwhelming,"30 a "landslide"31 and "decisive."32 By this standard, a larger-than-overwhelming majority of Canadian physicians opposed a change in CMA policy. No one has suggested that the referendum result left the Irish government doubtful about its mandate. However, the CMA consultation report - finalized at about the time the Board seems to have launched its plan to change CMA policy - stated that the Association "was not given a clear cut mandate on future activity dealing with the sensitive area of euthanasia and physician-assisted dying."28

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

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

. . . the CMA will be seeking intervener status before the Court, not to offer a polarizing "pro" or "con" view on an already divisive issue - our policy is clear and speaks for itself - but to share a narrative of insights on the physician's perspective. The goal would be to provide the Court with a deeper understanding and appreciation of the findings from the CMA's dialogue on end-of-life care, the spectrum of options and the current CMA policy perspective. We would also highlight the challenges posed to physicians' understanding of their traditional roles if the Court were to change the law.33

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

One person's right is another person's obligation, and sometimes great burden. And in this case, a patient's right to assisted dying becomes the physician's obligation to take that patient's life.

We have heard from many of our members that this prospect makes them not only uncomfortable but downright terrified. . .

. . .only a tiny minority of patients at the end of their lives request access to medical aid in dying. Until we can provide access to palliative care to all Canadians who need it, this is where the focus of our attention should remain . . . 33

Given the concern expressed by Dr. Blackmer and Dr. Francescutti in April, 2014 about imposing an obligation to kill upon physicians, and the ramifications of doing so, one would expect this to have been a constant concern of the CMA Board with respect to the legalization of euthanasia and assisted suicide. However, it does not seem to have been considered again. The failure to attend to this issue left most physicians unaware of its significance, and of the significance of the policy direction taken by the CMA Board from June, 2014.
CMA applies for intervener status in *Carter v. Canada* (June, 2014)

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

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

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

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

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

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

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

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

> If the law changes, physicians will be key players in any assisted death regime. They will play two critical roles. First, they will have to determine whether an individual patient's wish to be assisted in dying meets the threshold. Second, they will have to prescribe the agents leading to death, and to provide the patient with bedside care through the process leading to death. Plainly, assisted death, if sanctioned by law, has no prospect of implementation unless physicians in sufficient numbers across the country are persuaded that the sanctioned regime is ethical, practical, and in accordance with existing medical standards. . . (para. 56)

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

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

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

"CMA applied for intervener status with the Supreme Court," said Affleck.

"That was some of the urgency in developing our position, we knew the Supreme Court was moving forward and we wished to have a clear position."n34

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

"We had been discussing this issue at length at the level of the board for a good long while because it is an important issue," said Affleck.

"We had a lot of debates and then I sat down and wrote a proposal for a motion and then took it back to the board as a board member and it was quite uniformly well accepted."n34

The resolution proposed by Dr. Affleck stated:

The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide.35

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

However, the resolution had to be accompanied by a supporting rationale, which, according to CMA rules, is the means by which the General Council gives policy guidance and direction to the Board.36

Thus, as the sponsor of the resolution, the Board wrote - or at least approved in advance - the kind of guidance it wanted to use to resolve the apparent conflict.

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

Implicit in CMA's mission statement, helping physicians care for patients is the centrality of the patient in the mandate of Canadian physicians.

CMA's current policy on euthanasia and assisted suicide suggests that Canadian physicians should not participate in assisted death. This poses a dilemma for CMA, as it could be suggested that a prohibition on physician-assisted death bars physicians from providing a service desired by some patients to alleviate pain and suffering.35

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

Given that evidence supports that there are competent Canadians with terminal illness who seek the services of physicians to assist them with dying, how then can Canadian physicians justify withholding a service against the will of a patient?35

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

This strongly suggests that, at least by June, 2014, the Board had come to believe that CMA should formally approve physician participation in assisted suicide and euthanasia, in order, as Dr. Simpson said, accommodate "everybody's legitimate concerns and aspirations."10 However, they did not put this to the General Council. Instead, the resolution they sponsored was ostensibly limited to the exercise of freedom of conscience, supported by an appeal to adopt a policy of neutrality:

Rather than choosing to prohibit or approve physician-assisted death, CMA will best serve Canadians seeking quality health care by highlighting that physicians may follow their conscience when deciding whether to participate within the bounds of existing law.35 (Emphasis added)

Consistent with the conclusion about the Board's opinion, the appeal to neutrality included the decidedly non-neutral view that physician assisted suicide and euthanasia could be considered "quality health care" in at least some circumstances.

CMA General Council (August, 2014)

Briefing materials

Briefing materials were prepared for the CMA Board and delegates to the Annual General Council. The materials included relevant resolutions passed at the 2013 Annual General Council, an outline of the town hall meetings held in 2014 and a backgrounder for the strategy session on Care at the End of Life (Appendix 2).37 The 2013 resolution that physicians had a right to conscientious objection
was listed with eight other resolutions passed at the same time (p. A2-1). It was not included in the summary of CMA policy that followed.

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

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

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

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

3) Should the CMA revise its current policy on euthanasia and assisted suicide?

4) If the law is changed in Canada to make euthanasia or assisted suicide legal how should the medical profession respond?

5) If access to palliative care services was universal, would it eliminate the need for euthanasia and assisted suicide? (p. A2-4) [Emphasis added]

Included in the backgrounder was "Schedule 'A'", which outlined patient eligibility, process, and physician obligations respecting euthanasia/assisted suicide in jurisdictions where the procedures are legal. It stated that objecting physicians in Washington, Vermont, Oregon, Belgium, and Luxembourg "have a duty to transfer patient care to another physician who can fulfil the request." (p. A2-7) This was erroneous and misleading: erroneous, because the law in Vermont said nothing of the sort; misleading, because it could be taken to mean that the objecting physician has a duty to initiate the transfer to a willing colleague. This was not required in any of the jurisdictions listed. All that was required is that objecting physicians transfer the patient's medical records as requested by the patient.39,40,41,42

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

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

> The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide. (DM 5-6)35

It was argued on the floor that "current policy on euthanasia and physician-assisted suicide does not sufficiently reflect the broad spectrum of opinions on the matter held by Canadian physicians," since it prohibited physician participation in euthanasia and assisted suicide. In contrast, the most recent
survey of Canadian physicians found almost 45% of physicians supported legalizing assisted suicide, about 36% favoured legalization of euthanasia, and almost 27% were willing to be involved with providing assisted suicide if the acts were legalized. Of course, the survey results also revealed that 55% of physicians surveyed were against legalizing assisted suicide, 64% against legalizing euthanasia, and 73% were unwilling to be involved with assisted suicide, but it appears that those citing the statistics preferred to accentuate the positive rather than the negative. It also appears that the numbers of those willing or unwilling to provide euthanasia, if available, were not reported. Again, evaluating the returns using the standard applied to the Irish abortion referendum, an overwhelming majority of physicians remained opposed to euthanasia and assisted suicide.

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

On the face of it, the 2014 resolution did no more than affirm the 2013 resolution supporting physicians who refuse to participate in euthanasia, while adding the promise of support for physicians wanting to do so. In the event that the procedures were legalized, the resolution appeared to commit the CMA to impartially defend both groups - nothing more. Dr. Blackmer later explained the resolution as "the other side" of conscientious objection: "almost conscientious permission." Even delegates opposed to euthanasia and assisted suicide would probably have been swayed by such considerations. On the other hand, voting against the resolution would have been a vote against physician freedom of conscience that would arguably have nullified the 2013 resolution in support of a right to conscientious objection. In view of all of this, it is not surprising that the outcome of the vote was 91% in favour of the resolution.

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

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

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

A CMA report of the meeting noted that a "straw vote" showed 70% of delegates believed that the CMA should revise its policy on euthanasia and assisted suicide, and "78% felt universal access to palliative care services would not eliminate the need for euthanasia and physician-assisted death." These votes were obviously in response to "strategic questions" 3 and 5 posed to the delegates in their briefing material.
It is difficult to verify the validity of the "straw votes" as a reflection of the views of the entire CMA membership because of the contrary views expressed during the earlier extensive physician consultations and the bias evident in the information supplied to delegates. Especially important, one cannot determine whether the desire for policy change expressed in response to Strategic Question 3 indicated approval of euthanasia and assisted suicide or a preference for a policy of neutrality - as urged by those supporting the Board resolution.

**CMA officials comment (August-September, 2014)**

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

"...It (the new policy) doesn't say we favour a change in the law," said Dr. Jeff Blackmer, the CMA's executive director of ethics.

The CMA stance opposing euthanasia remains in place.

"Our position is still that Canadian physicians should not participate in euthanasia or assisted suicide," Blackmer said.

Dr. Blackmer maintained the distinction in another interview:

"One of the options would have been to say our policy is unchanged. We could say ethics trumps the law."

He noted that in Belgium, where euthanasia was legalized in 2002, the Belgian Medical Association continues to discourage physician participation in the practice.

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

Simpson said he is in full agreement with Affleck - that the CMA not taking a stance one way or the other on doctor-assisted deaths by passing the motion, but only allowing Canadian physicians to follow their conscience.

"What we are doing is protecting doctors and allowing them to follow their conscience on this issue," he said.

Simpson said if a doctor does not believe in helping a patient end their life, they shouldn't have to and shouldn't be forced by law to do so.

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

"I prefer to think of it as a tightening of definitions when it comes to doctors and their role around end of life care. This is a very complex, controversial issue for doctors..."
and the public at large."

"The CMA had to be careful in its use of terminology in finalizing Affleck's motion." 48

This response is noteworthy for three reasons. First: that Dr. Simpson preferred to describe what happened as "a tightening of definitions" did not amount to a denial that softening had occurred or was occurring. Indeed, in November, 2014, looking back on the adoption of the resolution, he called it "a sea change" - not just a "tightening of definitions." 48 Second: the term "medical aid in dying" - the only specialized term used in the text of Dr. Affleck's motion - had been defined in CMA policy six months before he brought the motion to the Board. His motion involved no "tightening of definitions." Third: what Dr. Simpson described as being "careful in its use of terminology in finalizing Affleck's motion" must have been a reference to the care taken in drafting the supporting rationale, since the text of the motion introduced no new terminology and changed no definitions.

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

Most doctors aren't opposed to the notion of patients being able to choose how and when they die, "but they're uncomfortable with the role they're being asked to play," Simpson said.

"That discomfort comes a lot from this uncertainty: Am I going to be compelled to do it if I don't want to do it? Am I going to be asked to make decisions that I'm really uncomfortable with?" 49

However, referring to some kinds of cancer and diseases that cause "uncontrollable pain" and suffering that cannot be alleviated by even the best palliative care, he said, "[W]e would all agree that if we were in that situation we would be looking for potentially other solutions" - an obvious if euphemistic reference to death by lethal injection or assisted suicide.

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

More significant was his response to the suggestion that someone other than physicians should provide euthanasia and assisted suicide. He said, "I don't think we want to be reneging on our responsibilities to serve our patients." 49 This could be understood to support the view that, in some circumstances, physicians have a legal or professional obligation to kill a patient or to help a patient kill himself.

As outgoing CMA President, Board member and seconder of Dr. Affleck's motion, Dr. Louis Francescutti was well placed to anticipate what the CMA Board would do. The conclusion that CMA Board supported physician participation in euthanasia and assisted suicide is supported by a comment he made just after Dr. Affleck's motion was accepted by the General Council. He noted that
the CMA's official policy had not changed, but "it's only a matter of time."50

CMA intervention in Carter v. Canada (August-October, 2014)

The CMA factum for its intervention in \textit{Carter} was filed a week after the end of the Annual General Council.51 Counsel for the Association Harry Underwood made an oral submission during the Supreme Court of Canada hearing in mid-October, 2014, making clear that the Association was not arguing for or against the legalization of assisted suicide or euthanasia.52

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

But the concept of patient well-being is capable of an interpretation which encompasses the patient's right to choose death, where the alternative is certain suffering, a choice which is also supported by the concept of patient autonomy. Thus, going back to first principles, the two approaches are each possible.53

He went on to say that the profession was divided between these approaches, "each defensible on the basis of established medical ethical considerations and compassion." In light of this, he said, referring to the resolution passed at the General Council in August, the Association had decided that physicians "who can square their participation with their own consciences" could provide euthanasia and assisted suicide, "without overriding the consciences" of objecting physicians. He told the Court that CMA policy would be changed to reflect this.54

This reinforced statements in the CMA factum:

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

It is acknowledged that just moral and ethical arguments form the basis of arguments that both support and deny assisted death. The CMA accepts that, in the face of such diverse opinion, based on individuals' consciences, it would not be appropriate for it to seek to impose or advocate for a single standard for the medical profession. (para. 16)

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

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

In the last half of his presentation, Mr. Underwood addressed practical concerns raised by the
legalization of physician assisted suicide and euthanasia. Notably absent from his list of concerns was the fact that, as late as August, the great majority of physicians were opposed to the procedures. However, he had earlier insisted that the law should protect both objecting and non-objecting physicians, a point also made in the factum (para. 28).

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

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

However, rather than directing the court's attention to this problem, the CMA factum suggested vaguely that the Court could "indicate that a practicable legislative regime for medical aid in dying must legally protect those physicians who choose to provide this new intervention to their patients, as well as those who do not." (para. 28) Worse, it advised the Court that, if a physician declines to participate, "every jurisdiction that has legalized medical aid in dying has adopted a process for eligible patients to be transferred to a participating physician."(para. 27) Here the factum cited the erroneous and misleading "Schedule A" prepared for the August AGM, which could be understood to require objecting physicians to collaborate in delivering the services.

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

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

Policy against euthanasia and assisted suicide reversed

In December, 2014, while the country awaited the decision of the Supreme Court in Carter, the CMA Board approved a change in Association policy on euthanasia and assisted suicide, renaming it "Euthanasia and Assisted Death." When the revised policy was published, the CMA issued a statement that it "and other changes to the CMA's approach to end-of-life care issues . . . codify resolutions adopted by delegates at the association's annual meeting in August." This was misleading. The revised policy did codify the resolution that urged the Association to support for physicians who "follow their conscience." Recall, however, that the resolution was not presented as an approval of euthanasia and assisted suicide, but as a position of neutrality concerning
physician participation in the practices, a distinction emphasized by both the CMA Director of Ethics and the CMA President shortly after the General Council.

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

There are rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying. In such a case, and within legal constraints, medical aid in dying may be appropriate. The CMA supports patients' access to the full spectrum of end of life care that is legal in Canada.59

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

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

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

**Effects of the policy change**

**A blank cheque for the Supreme Court**

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

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

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

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

A professional obligation to kill

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

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

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

A limit on refusing to kill

It also explains an important caveat the Board added to the 2014 policy's reference to freedom of conscience:

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

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

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

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

Just after the ruling, Dr. Simpson said that he had not anticipated that the judges would permit euthanasia and assisted suicide for any "grievous and irremediable medical condition" rather than terminal illness. Dr. Blackmer acknowledged that physicians who were willing to provide euthanasia in cases of terminal illness might be less willing to do so for suffering caused by other medical conditions.

A few days later, Dr. Blackmer expressed concern about the eligibility criteria set by the Court. Blindess is "irremediable," he noted, and said that the Carter decision would probably allow euthanasia and assisted suicide for chronic depression and spinal cord injuries.

My feeling is that there would be much more support for a tighter framework in terms of requiring that the patient be terminal. This is not to minimize in any way the suffering of people who do not have a terminal illness, it is just that for a lot of doctors, this opens too many doors and generates too many questions. . . My conversations with doctors to date indicate more of a comfort level with tight parameters.

However, he believed that the CMA "might have very little ability" to influence how the Carter criteria would be developed - something the CMA Board might usefully have considered when planning its intervention and before embarking upon its plan to change CMA policy.

Dr. Blackmer also complained that the term "grievous" is entirely subjective and "is not a technical medical term." Expanding upon this a few months later, he referred to "some angst and discomfort" among physicians about the breadth of the Carter criteria.

"I've now given dozens or hundreds of presentations on this and every time I speak about it and I ask doctors, 'Look, have any of you ever told a patient that you're really sorry but their condition is grievous?' Of course, no one ever has," Blackmer said. "No doctor in Canadian history, I don't think, has ever told a patient that they're suffering from a 'grievous' condition. So none of us know what that means."

All of these complaints are astonishing. Neither the CMA's factum nor its oral submission at the Supreme Court of Canada suggested that assisted suicide or euthanasia should be limited to patients...
with terminal illnesses, nor, in its intervention, did the CMA suggest any criteria whatever as relevant for the purpose of determining eligibility for the procedures. The revised policy, Euthanasia and Physician Assisted Death, did not exclude minors, the incompetent or the mentally ill as candidates for assisted suicide or euthanasia, nor did it limit its application to the terminally ill or those with uncontrollable pain. It referred directly only to "patients" and "the suffering of persons with incurable diseases."

The question put to the courts by the plaintiffs from the very beginning in 2011 was never about terminal illness, but about "grievous and irremediable illness." The term was defined in the trial court ruling, where it was used extensively, and it appeared again in the first sentence of the appellants' factum filed in the Supreme Court of Canada. Finally, the CMA factum, "reviewed and approved by several senior CMA elected officials," stated that it seemed wrong to deny assisted suicide and euthanasia to "grievously ill" patients just because palliative care is unavailable (emphasis added) - yet Dr. Blackmer later claimed that "none of us know what that means."

In sum, all of the concerns voiced by Dr. Simpson and Dr. Blackmer after the Carter ruling existed when the CMA intervened in the case, but the CMA Board did not raise them. Instead, it worked steadily to remove or minimize obstacles that might have impeded legalization of physician assisted suicide and euthanasia. The legal criteria set for euthanasia and physician assisted suicide by the Supreme Court of Canada were actually more restrictive than anything the CMA had proposed in its intervention or included in its new policy.

Arguably, the CMA Board contributed substantially to the legalization of physician suicide and euthanasia on the broad terms set by the Court, and so were themselves, in large measure, responsible for the "angst and discomfort" and profound unease of Canadian physicians following the ruling.

Notes

1. Murphy S. World Medical Association urged to change policy against euthanasia, assisted suicide: Canadian & Royal Dutch Medical Association want censure dropped. Protection of Conscience Project, 13 February, 2018 (http://www.consciencelaws.org/ethics/ethics033-01.aspx)


9. Martin S. The story behind the CMA's overwhelming change on assisted death. The Globe and Mail, 6 November, 2014


11. Dr. Chris Simpson (CMA President): "I was not surprised, we were not surprised. Perhaps the unanimous decision was a little bit of a surprise. But, at the CMA, we've been, we've been preparing for this eventuality for the last year and a half or two years." Geddes Full Transcript, lines 4-7.

12. Dr. Blackmer: "I think we're looking at the possibility that the court will refer this back to the lawmakers . . . They could suggest some framework from the bench that we might want to be in a position to comment on fairly quickly. . . We're preparing for all eventualities. . ." Kirkey S. Canadian doctors preparing for 'all eventualities' in case top court strikes down ban on assisted suicide. National Post, 21 December, 2014

13. In the Supreme Court of Canada (On Appeal from the Court of Appeal of British Columbia) Affidavit of Dr. Chris Simpson, Motion for Leave to Intervene by the Canadian Medical Association (5 June, 2014) [Simpson Affidavit] para. 56
14. "Should the justices rule the law on assisted death and euthanasia is unconstitutional and needs amendment, 'we feel pretty strongly that we want to be at the table' to help draft a new law and guidelines for physicians and patients, CMA president Dr. Chris Simpson said Thursday." Ubelacker S. Doctors ready for Supreme Court decision on assisted suicide. CTV News, 5 February, 2015 (http://www.ctvnews.ca/health/doctors-ready-for-supreme-court-decision-on-assisted-suicide-1.2223268) Accessed 2018 Sep 10.


16. "President Dr. Chris Simpson said the CMA believes it must play a key role in helping to draft the legislation that is needed to make physician-assisted dying available." Branswell H. Canadian MDs, many hesitant about assisted death, assessing Supreme Court ruling. Times Colonist, 6 February, 2018 (https://www.timescolonist.com/canadian-mds-many-hesitant-about-assisted-death-assessing-supreme-court-ruling-1.1755088) Accessed 2018 Sep 10.

17. Dr. Chris Simpson (CMA President): "Now that the decision has come down, we want to really take a leadership role in helping to craft the legislation and the rules and regulation around it." Hume J. Supreme Court strikes down ban on assisted suicide. Toronto Sun, 6 February, 2015 (http://www.torontosun.com/2015/02/06/supreme-court-strikes-down-ban-on-assisted-suicide) Accessed 2018 Sep 10.


19. Dr. Chris Simpson (CMA President): "[T]hat's exactly what we'll be seeking: is some mechanism for, for us to have a prominent role in the, in the crafting of the new rules and regulations and, and legislation." Geddes Full Transcript, lines 150-152.


22. Dr. Chris Simpson (CMA President): "It's a really historic moment and I'm very mindful of, of the role that physicians have to play and . . . I'm really, really proud of how the CMA has handled this over the last two or three years." Geddes Full Transcript, lines 160-162.


26. CMA Public Consultation, p. 17.


28. CMA Member Consultation, p. 2.

29. CMA Member Consultation, p. 11.


40. Luxembourg: "A physician who refuses to comply with a request for euthanasia or assisted suicide is required, at the request of the patient or support person, to communicate the patient's medical record to the doctor appointed by him or by the support person." Legislation Regulating Palliative Care, Euthanasia and Assisted Suicide, Art. 15. Protection of Conscience Project (http://www.consciencelaws.org/law/laws/luxembourg.aspx).

41. Washington: "If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider." Washington Death With Dignity Act, RCW 70.245.190(1)d. Protection of Conscience Project
42. Oregon: "If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider." Death With Dignity Act, ORS 127.885 s.4.01(4). Protection of Conscience Project (http://www.consciencelaws.org/law/laws/usa-oregon.aspx).


55. "Consistent with the matter as being a matter of conscience, the law should offer protection to those physicians who choose to participate in physician assisted death if it is legalized, and those who do not." CMA Oral Submission, 229:29/491:20 (http://www.consciencelaws.org/law/commentary/legal073-009.aspx#229:29/491:20).


69. CMA Factum, para. 20.
PART II
CMA ON FREEDOM OF CONSCIENCE AFTER CARTER

On Carter's eve

On the eve of the Carter ruling, Dr. Simpson said that CMA members would not likely support any measure that would compel an unwilling physician to kill a patient or even to refer a patient to a colleague willing to do so. He was optimistic that "the right of physicians not to be involved" could be preserved by ensuring that "enough people and enough places" would provide euthanasia and assisted suicide for patients.¹

However, the long-standing controversy about physician freedom of conscience was still bubbling, and other comments made just before the ruling indicated that it would quickly come to a full boil if the Court struck down the law.

Dr. Catherine Ferrier of McGill University Health Centre in Montreal said that she would neither provide euthanasia nor refer a patient to someone who would because she would be "sending somebody to their death." In response, Dr. James Downar, a palliative and critical care physician and euthanasia activist, said:

I think we need to recognize that conscientious objection in this context can serve as a barrier and we need a very robust system to make sure that the physician's right to conscientious objection does not impinge on the patients' right to receive what would be a legal treatment.²

Carter, the CMA, and the obligation to kill

Dr. Downar's reference to a patient's "right" implied an obligation to kill. Recall that CMA officials had explicitly recognized that legalization of physician-administered euthanasia and assisted suicide would impose such an obligation on physicians.³ Over a year after the Supreme Court delivered its ruling in Carter, Dr. Blackmer once more acknowledged this.

If you ask the public, what you're really asking them is, 'Do you want to have a right to access these interventions if you come to the end of your life and you're suffering?' That's a very different question than if you ask a medical professional, 'Do you want to kill your patients? Or do you want to assist in the death of your patients?' One is a right, the other is an obligation. Those are intricately related. If someone in society has a right to something, it means someone else has an obligation to provide that.⁴

He went on to assert that the Supreme Court of Canada imposed an obligation to kill upon Canadian physicians, implying that the Supreme Court was to blame for the problems and conflicts this created for the medical profession.

So basically the Supreme Court that has told Canadian physicians, after centuries of this being illegal and completely in opposition to all teachings in medical ethics, 'We are now going to make this legally available, and you as a profession have an obligation to step forward and provide it.'⁴
Aside from contradicting what the CMA told the Supreme Court in its intervention,\(^5\) this is manifestly unfair and inaccurate.

The fundamental conflict presented by imposing an obligation to kill upon unwilling physicians was foreseeable and had been foreseen by CMA officials,\(^3\) and the consequent attacks upon physician freedom of conscience, particularly with respect to referral, were predictable. They knew that the overwhelming majority of Canadian physicians would refuse to make killing patients part of their medical practice.\(^4\) Nonetheless, on behalf of the medical profession, the CMA Board accepted an obligation to kill when it reversed CMA policy against euthanasia and assisted suicide two months before the Carter ruling (See Part I: CMA Board approves euthanasia and assisted suicide).

The Supreme Court gave legal effect to a policy the CMA had already approved, but it was a legal effect more restricted than what the revised CMA policy would have allowed. The Supreme Court cannot be faulted because CMA leaders were ill-prepared to deal with the consequences of a ruling entirely consistent with their own policy, and realized, too late, that events set in chain by the *Carter* decision were beyond their control.

After the ruling, CMA officials found themselves caught between anxious physicians who wanted nothing to do with killing their patients and activists accusing objectors of patient abandonment. And it seems they discovered, to their dismay, that state authorities were not nearly as receptive to CMA lobbying as they had anticipated. Dr. Blackmer later disclosed that his attempt to explain the burden imposed on physicians who provide euthanasia was dismissed by "some very senior federal politicians" in "not very nice language."

> I even had one tell me, 'I think doctors love to play God, and you're all gonna be just fine with this because it's just an extension of your desire to play God.'

> . . . I told this federal politician I was very offended by that, and that to suggest that - even behind closed doors - was incredibly insulting to a profession that's now being asked to do this. This was a politician who in public was saying how much we trust the medical profession.\(^4\)

Months before this disclosure, a source reporting first hand observations advised the Project Administrator that the CMA and its officials were being "beat up" institutionally and personally when they attempted to defend physician freedom of conscience, especially in relation to referral, and were encountering marked hostility to objecting physicians among government representatives and the public.\(^6\)

This demonstrates that CMA officials were actually struggling, against the odds, to support objecting physicians, and this was admirable. However, it was also predictable; that was why the Protection of Conscience Project, Catholic Civil Rights League and Faith and Freedom Alliance intervened in *Carter* at the Supreme Court of Canada in defence of physician freedom of conscience, emphasizing the issue of referral.

Long before the *Carter* decision there had been increasingly strident demands for mandatory referral for morally contested services, including referral for euthanasia and assisted suicide. CMA officials were fully aware of the controversy about referral. For forty-five years the CMA had consistently maintained the position that objecting physicians were not obliged to collaborate in what they
believed to be wrongdoing by finding someone else to do it. Arguments for compulsory referral made during years of skirmishing about abortion were simply retooled and applied to euthanasia.7

However, while CMA officials had repeatedly affirmed the Association's commitment to protect physician freedom of conscience, they had never developed a principled foundation for that commitment, and the Board did not do so before reversing CMA policy on euthanasia and assisted suicide. Its focus was on the role the CMA and physicians would play in implementing new euthanasia and assisted suicide laws, not on freedom of conscience, except to the extent that it could be used to further its goal of changing the CMA's policy.

As a result, when the Carter decision was released, the CMA was ready to spring into the saddle to help plan the provision of the services,8,9 but was quite unprepared to mount a cogent, articulate and persuasive defence of physician freedom of conscience, especially in relation to referral. This became evident in the weeks and months following the Carter decision.

Carter - Day 1

CMA officials on conscience

Once the ruling was announced,10 CMA President Dr. Chris Simpson immediately pointed out that "there was nothing in the language in the ruling today that suggested that individual physicians would be compelled" to provide euthanasia or assisted suicide. He was pleased that the Supreme Court quoted the new CMA policy that "supports physicians being able to follow their conscience in choosing whether to participate in medical aid in dying."9

- We can't just simply say we're going to compel physicians to do things that they personally, morally and ethically can't do.11
- I think it's fair to say no patient would want a physician to be individually coerced into doing something that they felt was against their personal moral, morals or ethics or religious beliefs. That's not going to serve anybody well.12
- Doctors are far more deeply divided on assisted suicide than the general public, Simpson said, "and we'll be looking really carefully for language that protects individual doctors' right to conscientiously object, and not participate. My early feeling is that there is a lot of reassuring language on that."11

Dr. Simpson referred to the Supreme Court comment that the rights of patients and physicians would have to be reconciled.

- The core of that reconciliation will be that we respect individual doctors' rights to conscientiously object.
- That's in patients' best interests. Ultimately, no patient is going to want their physician pulled in against their will to help them with such a profound issue.13

He emphasized the need to find the correct balance between "the need now to provide this service in an equitable way to the small number of patients who need it and are eligible for it" while protecting individual physicians who wanted no part of it.11
What we want to do is really make sure patients who are eligible under the new rules have access to this therapeutic service, but at the same time we need to be very careful that physicians have the right to conscientious objection for moral or ethical reasons or religious reasons.\textsuperscript{14}

An important element in Dr. Simpson's approach to the problem was his conviction that only a very small number of patients would actually ask for euthanasia or assisted suicide, and that there were more than enough doctors in Canada willing to do as they wished.

Simpson said the number of patients who would likely be eligible for, or even request assisted death, would be so small, based on experience in other jurisdictions, that there would be sufficient numbers of doctors to provide equitable access for all, "without compelling a large number of doctors to personally participate."\textsuperscript{11}

While acknowledging that some physicians would refuse to be involved, Dr. Simpson cautioned that "society now has a different view" and the Supreme Court had ruled that "patients have a right to equitable access" to physician-assisted suicide and euthanasia "and it's up to us to figure out how to achieve that."\textsuperscript{11}

We need to have a system that balances the right of physicians not to participate, and perhaps not even to refer, but that has to be done in a way that doesn't impair access for patients who would qualify for this. [Emphasis added].\textsuperscript{11}

Two things warrant attention here. First: the Court actually said nothing about "equitable access." Dr. Simpson may, at this point, have actually been articulating the position of the CMA Board.

The second was, arguably, more important: his qualifier, "...and perhaps not even to refer" - as if this might be an excessive concession, or was at least negotiable - that Dr. Ferrier might, perhaps, not have to "send somebody to their death," as she put it.\textsuperscript{2}

On the other hand, in other interviews immediately after the ruling, Dr. Simpson admitted that there was "no consensus" in the medical profession that physicians should provide euthanasia and assisted suicide,\textsuperscript{13} correctly identified and indicated that he understood the issue of referral:

"The ruling appears to be quite clear that physicians should not be compelled to participate and for many the act of participation is the act of referral somewhere else," Simpson said.

"So we really need to develop capacity in the country to provide the service without compelling every single physician, and even most physicians, to participate."\textsuperscript{15}

**Euthanasia/assisted suicide activists push back on conscience**

Dr. Simpson's comments were promptly challenged by Professor Jocelyn Downie of Dalhousie University, who was a member of the winning legal team in Carter. Professor Downie had long argued that objecting physicians should be forced to facilitate procedures they believe to be wrong - even if the procedure in question is killing people. "I would say that they have a duty to refer," she said, "But that will get spelled out in the legislation."\textsuperscript{16}

Dr. James Downar and Dr. Brett Belchetz, both members of a group that intervened in Carter in
support of euthanasia and assisted suicide, were pleased with the Supreme Court ruling. The day after the judgement Dr. Downar acknowledged "the right to conscientious objection is a really critical one" and "clearly an important moral question."

"We have to recognize that, similar to abortion and other things in medical practice, there are physicians who will object to this," Downar said. "We want to make sure that nobody feels they're forced to participate."17

However, Dr. Downar soon made clear that physicians unwilling to kill patients or help them commit suicide should be forced to direct them to someone who would.

Downar said it is critical that legislators involve stakeholders in crafting a process to ensure all Canadians have access to physicians who will assist them in dying if they meet prescribed conditions. Any process must also require doctors who have a conscientious objection to refer patients to a colleague who will medically assist them with dying.13

Dr. Belchetz referred to a draft policy of the College of Physicians and Surgeons of Ontario (CPSO), Professional Obligations and Human Rights, suggesting it as a model that could be used to accommodate physicians who did not want to be involved with killing patients or helping them to commit suicide. The draft policy permitted physicians to refuse to provide abortion, contraception or other services for reasons of conscience on the condition that they provide an "effective referral" - that is, promptly help the patient obtain the procedure elsewhere.17 This was unacceptable to many objecting physicians, and a constitutional challenge to the policy was launched after it was enacted.18

**CMA officials on referral**

**Vice-President hedges**

Dr. Jeff Blackmer identified referral as the central problem facing the CMA following the Carter ruling.

For those who do not want to participate, the basic principle is this: If you do not want to, you do not have to do it and no one is going to force you to do it. I have not heard anyone say anything to the contrary. The real crux of the issue is what I call the referral question. If I refuse to participate, do I then have a moral, legal, or regulatory obligation to refer to someone who will provide that service?19

He referred to controversial draft policies proposed by the Colleges of Physicians and Surgeons of Ontario and Saskatchewan that had not been finalized. They had generated overwhelming opposition in public consultations precisely because of their demand that objecting physicians should be forced to refer for morally contested procedures.20 He noted that they did not mention specific procedures. "Understandably," he said, "a number of our members are very concerned."

"Now the flip side of that is the issue of access. To what extent can physicians exercise their moral views if this has a detrimental impact on patient care?

CMA policy is essentially silent on mandatory referral. As a result of [the CMA] being silent, the policy has been interpreted as saying [referral] should not be
mandated, which is probably accurate. We need to have a more open discussion on this as part of discussions on the legislated framework.19

The assertion that CMA policy was "essentially silent on mandatory referral" and that it was only "probably accurate" to say the CMA opposed it was noteworthy. For forty five years, the CMA had held that physicians should not be obliged to make referrals for procedures to which they object for reasons of conscience.

A 1977 revision of the Code of Ethics that was taken to imply the contrary generated major controversy and was reversed the following year. CMA Director of Ethics Dr. John R. Williams, Dr. Blackmer's predecessor, at least twice explicitly repudiated the idea that objecting physicians could be forced to do what they believed to be wrong - including referral. In 2007, Dr. Blackmer himself rejected claims that CMA policy obliged objecting physicians to refer for abortions. The following year, the Chair of the CMA Ethics Committee reaffirmed the Association's support for physicians who refused to refer for abortion for reasons of conscience.7 Since Dr. Blackmer was well aware of this history, his statement that "a more open discussion on this" was needed was remarkable, as if the previous discussions had never occurred, or decisions made at Annual General Councils had not been sufficiently "open."

It is true that, in 2007, Dr. Blackmer wrote an article in the World Medical Journal in which, citing four sources, he asserted that "the majority of the current literature, if not current policy and legislation, appears to support the obligation to refer." He also wrote that objecting physicians must not "actively or passively" obstruct patients from obtaining services from another clinician (emphasis added), without defining "passive obstruction."21 However, Dr. Blackmer's comments about referral in the article cannot be understood to have displaced the well-established contrary position of the CMA, which, at the time of the Carter ruling, had not changed.

CMA President faces question, avoids answer

Dr. Blackmer initially took comfort in the results of the CMA's 2014 poll of 5,000 CMA members. 27% of physicians surveyed said they were willing to participate in assisted suicide, while 20% were willing to participate in euthanasia. Assuming that the results can be applied to the whole Association, that indicated about 21,600 physicians available for assisted suicide and 16,000 for euthanasia.22

"That's thousands and thousands of physicians across the country," he said elsewhere. "For most Canadians, access might not be a problem."17

However, Carter also established broad eligibility criteria - quite possibly broader than what the willing physicians surveyed in 2014 had in mind. Thus, the actual number of physicians willing to participate may have fallen once the ruling was issued and they realized what would be expected of them.

There are indications that a shift of this kind began to occur after the ruling. Dr. Simpson was asked about physicians being expected to provide euthanasia for a patient physically incapable of self-administering a lethal drug. He avoided giving a direct answer to the question.

Simpson calls this one of the "important nitty-gritty details" yet to be worked out. It's
a question that needs to be explored by doctors groups, legislators and legal experts as a framework for how medical aid in dying will actually be delivered.23

In fact, this was not simply a "nitty-gritty detail." This was exactly the proposition put to the trial court by the plaintiffs and pursued in their appeals: that physicians should be able to lethally inject patients who were incapable of committing suicide even with assistance.24 The Supreme Court of Canada agreed, and that is what Carter approved. The only "nitty-gritty detail" that remained to be worked out in this respect was whether or not the attending physician would have to personally kill the patient in such circumstances, or if the actual killing could be done by someone else. Since at least a very large number of physicians were opposed to killing patients, this was probably not the kind of discussion that Dr. Simpson cared to have in the media.

"A lot of doctors regard the prescribing of a lethal substance as the moral equivalent to actually administering a lethal substance," he said. And while hooking up an IV and giving a fatal dose could be done by any trained physician, "many doctors are saying there should be another class of clinicians who does only this."

"I'm not sure that really absolves anybody because the hard work is in the decision-making. The hard work is not in hooking up the IV."23

CMA officials "really grappling" with physician resistance to referral

By the last week of February, feedback from concerned physicians was beginning to trouble Dr. Blackmer. In the first place, it seems that legalization of euthanasia in addition to assisted suicide was proving to be of greater concern to more physicians than the CMA had anticipated. Saying that the CMA was uncertain if the Carter ruling permitted both assisted suicide and euthanasia, he noted "pushing the syringe themselves" made physicians much more uneasy than assisted suicide. "Many thousands of physicians" considered euthanasia and assisted suicide quite different.

A strong, philosophical argument could be made "that you're probably splitting hairs from a moral standpoint - that the act of writing the prescription is probably morally equivalent" to actively administering a lethal injection with the intention of ending a patient's life, Dr. Blackmer said.

"But regardless of that, there's clearly a certain percentage of doctors who feel that that's not the case - that they would be comfortable with writing that prescription where they would not be comfortable with injecting the medication directly," he said.22

It is puzzling that, two weeks after the ruling, CMA officials were still not sure if Carter approved both euthanasia and assisted suicide. From the very beginning, almost four years earlier, it was abundantly clear that the case was about the legalization of both physician assisted suicide and physician administered euthanasia.24 Both were authorized by the trial court judge25 and both were unambiguously approved by the Supreme Court of Canada (para. 40, 127).10

Quite apart from concerns about assisted suicide vs. euthanasia, Dr. Blackmer was getting emails daily from physicians, most - "five or six in the last hour alone," he told a reporter - who were not
only unwilling to kill patients or help patients kill themselves, but who were also unwilling to refer patients for euthanasia or assisted suicide.

The CMA does not have a policy on the issue. Its policy on abortion, however, is silent on mandatory referral. "That has been interpreted as meaning that the CMA does not support mandatory referral, and I think that is probably a reasonably accurate interpretation," Dr. Blackmer said.

But, "We are currently really grappling with this," he said.22

As noted previously, the CMA had consistently and publicly opposed mandatory referral for abortion for decades, so the claim that its actual position was unclear is unsupportable. The fact that, in 2015, were CMA officials "really grappling" with the issue in such critical circumstances was a consequence of their failure to grapple with it before they decided to shape the debate and the law on euthanasia and assisted suicide (See Part I: CMA Board decides to shape the debate and the law).

CMA officials take stand against mandatory referral

When, in March, the CMA Board endorsed seven foundational principles concerning assisted suicide and euthanasia, two were particularly relevant to physician freedom of conscience. "Equity" addressed the issue of access to the procedures, equating them with "any other medically approved intervention." The second seemed to reflect feedback from increasingly concerned physicians.

**Equity** - all Canadians who meet the criteria should have access to assisted dying, as for any other medically approved intervention.

**Respect for conscientious objection by physicians and other care providers;** no physician or other health care provider should be forced to take part in any aspect of the assisted dying process against their wishes.26

CMA President Dr. Chris Simpson took a particularly strong position when interviewed by the media about the development.

No physician in the country should be forced to play a role in any aspect of assisted dying against their moral or religious beliefs - including referring patients to another doctor willing to help them die, the Canadian Medical Association says.

Legalized physician-assisted death will usher in such a fundamental change in practice "we simply cannot accept a system that compels physicians to go against their conscience as individuals on something so profound as this," CMA president Chris Simpson said in an exclusive interview.

Dr. Simpson said that many doctors who conscientiously object to assisted dying feel the very act of referral "is contrary to their personal ethics or moral or religious beliefs."

He said resources could be provided to allow patients to "self-refer" for assisted death - for example, a website listing the names of doctors willing to provide it.

"Then the patient themselves can take that initiative rather than have the physician
who they are normally attached to, who conscientiously objects, make the call," Dr. Simpson said.

Hospital administrators, an ombudsman or local health authorities could also be legislated to act on the behalf of patients, he said.

"I can't emphasize enough that in us taking this position about conscientious objection we feel equally strong that we need to have other mechanisms to make sure that patients who need the service get it," Dr. Simpson said.27

Again citing the 2014 survey indicating that about 25% of physicians were willing to participate in physician-assisted suicide (not euthanasia) Dr. Simpson said, "I don't think there's going to be a shortage of physicians who are going to be willing to help patients," although he conceded that access to euthanasia and assisted suicide in rural or remote regions might be difficult and would have to be worked out.27

EAS activists push back on mandatory referral

The strong statement prompted immediate responses from euthanasia activists. One, Professor Udo Schuklenk, was one of the authors of the Royal Society of Canada report cited as a reliable authority by Dr. Smith in the CMA's application to intervene in Carter.28 Professor Schuklenk wondered why physicians should be allowed to "opt out" at all.27

Wanda Morris, CEO of Dying with Dignity Canada, did not go that far. She said that objecting physicians should not be forced to directly provide euthanasia or assist with suicide.

"But imagine a scenario where you have a patient who is on their death bed, they're very weak, and the attending doctor says, 'I want nothing to do with this, I won't even refer.' Are they effectively denying that patient his or her rights?"27

Morris argued that physicians should only be allowed to refuse to refer patients for assisted suicide and euthanasia if physician referral is made unnecessary by a "legislative or regulatory framework" that can assure access to the services.29

Euthanasia activists Dr. James Downar and Dr. Derryk Smith complained that the CMA President was unfairly prioritizing the rights of physicians over the rights of patients.

"Terminally or grievously ill patients are rarely able to advocate for themselves," said Dr. James Downar, a palliative care physician in Toronto. "If a physician refuses to provide a treatment and refuses to involve anyone else, then it is hard to imagine how that patient's request will be respected."

"It is understandable that, for religious or ethical reasons, some doctors won't want to provide assistance in dying," Smith said. "However, it is the beliefs and healthcare needs of the patient that are critical in these situations. Patients seeking assisted dying should not be denied access to medical care just because of the beliefs of their doctor."29

Their reaction had an immediate effect. Another CMA statement appeared a week later under the headline, "We need clear guidelines on referral in physician assisted dying: Simpson." It included
statements by Dr. Simpson supportive of physician freedom of conscience, but added:

Mandatory referral in physician-assisted dying is one of the major issues that need to be resolved in the wake of the unanimous court ruling. While the CMA does not have specific policy in this controversial area, it will be consulting with its members in the coming months and hopes to have guidance following its General Council meeting in August.\textsuperscript{30}

While it was technically correct to say that the CMA did not have a stand-alone policy on referral, the statement creates the false impression that the referral controversy was something new to the Association and that it had not previously taken a position on the issue.

**CMA Board pulls back on support for objecting physicians**

In May, the Board approved the draft framework, Principles-Based Approach to Assisted Dying in Canada,\textsuperscript{31} adding two foundational principles to the seven published in March. It also backed away from the strong commitment to physician freedom of conscience\textsuperscript{26,27} that had provoked sharp criticism by EAS activists.\textsuperscript{27,29}

\textbf{March, 2015}

Respect for conscientious objection by physicians and other care providers; no physician or other health care provider should be forced to take part in any aspect of the assisted dying process against their wishes.\textsuperscript{26}

\textbf{May, 2015}

Respect for physician values: Physicians can follow their conscience when deciding whether or not to provide medical aid in dying without discrimination. This must not result in undue delay for the patient to access these services. No one should be compelled to provide assistance in dying.\textsuperscript{31}

The March statement affirmed support not only for physicians, but other health care workers, and referred to "conscientious objection," which is a particular expression of freedom of conscience. Only physicians were mentioned in the revised statement, and respect for constitutionally guaranteed freedom of conscience was downgraded to respect for physician "values."

The March statement referred to "tak[ing] part in any aspect of the assisted dying process." This statement was broad enough to encompass referral. The revised text offered support only for those who refuse to provide euthanasia and assisted suicide, thus implicitly withdrawing support for physicians who refuse to facilitate the procedures by referral or other means.

The phrase "without discrimination" was ambiguous. It was not clear if it meant that physicians who follow their consciences should not be discriminated against, or if it meant that, in deciding whether or not to provide euthanasia or assisted suicide, physicians must not engage in illicit discrimination.

Finally, the condition that there must be no "undue delay" in accessing EAS services provided grounds for suppressing physician freedom of conscience if facilities, institutions or the government failed to provide resources needed to ensure access without involving objecting physicians.
"Help eligible patients end lives or refer them to someone who will, CMA to urge Mds"
National Post, August, 2015

By the opening of the General Council in August, the CMA Board seemed poised to reverse the Association's longstanding opposition to mandatory referral, just as it had reversed the policy against physician participation in euthanasia and assisted suicide. Contradicting the position he had taken only four months earlier, CMA President Dr. Chris Simpson was reported as saying that physicians unwilling to provide assisted suicide or euthanasia "should refer patients to someone willing and able to make it happen."

We don't support anything that's going to impede patients from access a legal service. . . Maybe the third party is a hospital CEO. . . So, if the attending physician says, 'the patient has requested assisted dying, I'm not comfortable having anything to do with this' … somebody would then sort of take charge of finding a physician, or finding the service to be done, so that the care is handed over formally to someone else who can facilitate it.32

Principles-Based Approach to Assisted Dying in Canada was the draft framework used to organize consultation and deliberation among CMA members and was the focus of critical decision-making at the CMA's Annual General Council in August, 2015. Prior to the Council the CMA distributed the document widely, including not just the medical community but "patient groups, public groups, and groups such as the . . . Christian Medical and Dental Society, the anti-euthanasia coalition and Dying with Dignity."33

Consistent with CMA policy and Dr. Simpson's statements as the Council opened, the draft framework presumed an obligation to kill patients or help them commit suicide in the circumstances defined by the Supreme Court. Moreover, it asserted that physicians were obliged to "ensure equitable access" to euthanasia and assisted suicide,34 a claim unacceptable to many objecting physicians.

The key provision in the framework offered protection of conscience for physicians who refused to personally kill patients or help them commit suicide, but not for physicians who refused to refer them to colleagues who would do so.

5.2 Conscientious objection by a physician
Physicians are not obligated to fulfill requests for medical aid in dying. There should be no discrimination against a physician for their refusal to participate in medical aid in dying. In order to reconcile physicians' conscientious objection with patient access to care, a system should be developed whereby referral occurs by the physician to a third party that will provide assistance and information to the patient.31 (Emphasis added)

"Refusal to participate" in 5.2 actually meant only refusing to personally provide a lethal injection or write a lethal prescription. Most readers were probably not aware of this because it was not explained in the document, and it may not have been known even to all of the small number of participants in
the on-line dialogue where it was disclosed. This restricted definition of "participation" was not only contrary to common usage; it was inconsistent with distinction between providing and participating found in the CMA's submission to the Supreme Court of Canada and in the Carter ruling.

All 80,000 CMA members were invited to discuss the draft framework and related topics in an on-line member dialogue (forum, chat room) about EAS policy, but only 595 registered. In fact, by 19 July, 2015, only 144 CMA members had participated, less than 0.0025% of the membership. Of these, 94 contributed to only one of seven topic strands.

A report of the on-line dialogue stated that physician freedom of conscience was "by far the most hotly debated issue." Many objecting physicians found referral for euthanasia and assisted suicide unacceptable because they believed that it made them complicit in the acts, even if the referral was made "to a neutral individual or organization." Most rejected the proposal in 5.2 to refer patients "to a third party that will provide assistance and information.

The report noted that other dialogue participants disagreed, summarizing their concerns in a quote from one of them:

"I have also heard from many patients and families who have indicated that this might be an unacceptable burden under what will likely be extremely difficult circumstances," said one physician.

This "one physician" was actually the moderator, Dr. Jeff Blackmer, whose other on-line statements were explicitly identified in the report.

The dialogue is of doubtful value as an indicator of general opinion among CMA members because there were so few participants and all were self-selected. However, Dr. Blackmer's contributions can be taken to reflect the perspective of the CMA leadership. This can be summed up as:

- The discussion is over.
- Physicians are obliged to support euthanasia and assisted suicide.
- Self referral/direct patient access is unacceptable.

The discussion is over

CMA policy had long stated that "a fundamental reconsideration of traditional medical ethics would be required" before physician participation in euthanasia and assisted suicide could be approved, and it told the Supreme Court that ethical positions for and against physician participation in the procedures were both defensible. Despite this, the CMA Board took sides, as it were: it committed the Canadian medical profession to providing euthanasia and assisted suicide if the procedures were legalized. It did not have to do this; as Dr. Blackmer explained, the CMA could have said, "ethics trumps the law."

But he took the opposite position in moderating the on-line dialogue. He told participants, "the debate on whether physicians as a profession will be participating is now basically a moot one." "It is a done deal," he said. "But we still have an opportunity to help shape what it will look like in
This approach shut down continuing debate about what the CMA had previously described as an unresolved ethical dispute, and it precluded reconsideration of the Board's commitment to physician participation. All that remained to be settled were practical points associated with implementing the Carter regime, like identifying patients eligible for euthanasia or assisted suicide and delivering the services. Dr. Blackmer acknowledged that not everyone would "feel comfortable" about doing this, but, "[w]e need to work out, as a profession, a system whereby those who do qualify will have access in a timely manner as for any other type of intervention."

**Physicians are obliged to support euthanasia and assisted suicide**

From the perspective of objecting physicians, the problem with this expectation was the implied collective professional obligation to facilitate access to euthanasia and assisted suicide. Those opposed to killing patients were not simply "uncomfortable" about working out how that could be done efficiently, but rejected such collaboration as morally repugnant. One of the participants argued that the fact that the Supreme Court struck down the law did not imply that physicians had a collective or individual obligation to ensure access to EAS services.

Dr. Blackmer admitted that "this might be factually correct."

But given the current situation, where these acts will soon be legal, and where we know that approximately 20% of our colleagues will elect to participate, it is very difficult for the medical profession to ignore reality.

Having the opinion that this is unethical or ought not to be part of medical practice is, of course, quite reasonable, and many will agree with this position.

However, if the profession were to refuse to participate in working out a system that meets the needs of physicians, we would most certainly be doing so to our own detriment, and to that of our many colleagues who will participate and need our assistance and support, regardless of what our own personal views might be.

His concern was that if "the profession as a collective" declined to participate in implementing the law, then "others" (i.e. non-physicians) would be making the rules for the "25% or so" of physicians providing EAS services. However, "25% or so" amounted to about 20,000 physicians, surely a number sufficient to provide the medical perspective thought necessary to inform the regulatory process.

While it was obvious that the profession could not "ignore reality," the reality indicated by his statistics included the fact that 75% to 80% of physicians would refuse to provide euthanasia or assisted suicide.

Which reality should have been the focus of CMA policy making?

In fact, CMA officials were attempting to accommodate both groups.

"Whether you agree with euthanasia or not, whether you decide to participate or not," wrote Dr. Blackmer, "we will be at the table protect your rights and interests."
Granted this was the intention, having formally endorsed the position of EAS providers, the CMA was compromised in its support of EAS objectors. Objecting physicians quite reasonably held that their rights and interests were ignored, not protected, by an expectation that they would assist and support the provision of euthanasia and assisted suicide. This seems to have been lost on CMA officials.

Dr. Blackmer attempted to overcome their resistance with an appeal to the authority of the overwhelming vote in favour of the resolution at the 2014 Annual General Council.\(^\text{50}\)

I would like to note that it is our members, who voted on this issue, who chose to support all Canadian physicians, yourself included, whether they decide to participate in assisted dying or not. We know that 25% of physicians are likely to participate in assisted dying. It is our obligation as a collective to support them, no matter what our own individual and personal views on this difficult and complex issue.\(^\text{51}\)

This misrepresented the resolution. Dr. Blackmer said at the time that it did not imply support for euthanasia or assisted suicide.\(^\text{52}\) It affirmed only the right of physicians to choose whether or not to provide euthanasia or assisted suicide if the law changed: nothing more. It did not impose a collective obligation to support or facilitate the provision of the services should the law change.\(^\text{53}\)

The actual source of a purported collective obligation was not the 2014 resolution, nor even the Carter decision, but the Board's commitment on behalf of the entire profession to "support access to the full spectrum of end of life care" - including euthanasia and assisted suicide. The Board came to the 2015 Annual General Council intent upon keeping that commitment, convinced that, in Section 5.2 of the draft framework, it was offering those who disagreed the best deal they were going to get.

**Self referral/direct patient access is unacceptable**

Dr. Blackmer introduced Section 5.2 to the on-line dialogue in his first comment in the thread "Conscientious objection and equitable access." He argued that it was necessary "to find a balance between the right to conscientious objection and the right of patients to access an intervention that has now been deemed to be legal."\(^\text{43}\)

In fact, the CMA had already faced and resolved this problem. In revising its Code of Ethics in 1970 after abortion law reform, it decided that physicians unwilling to provide a service for reasons of conscience were expected to give timely notice to patients, so that patients can find another physician willing to provide it. The policy was explicitly affirmed by the CMA General Council in 1971.\(^\text{54}\)

Except for a short period in 1977/78, the CMA had maintained this position for 45 years.\(^\text{7}\) Within the context of accommodating conscientious objection by physicians, this approach came to be known as "self-referral" or "direct access," with the understanding that the state or other agencies could help connect patients with willing physicians. The CMA Board and president had strongly advocated self referral in March27 but had promptly retreated when challenged by EAS activists.

Dr. Blackmer, well aware of all of this, merely said that self-referral "may be one possibility," adding, "I have also heard from many patients and families who have indicated that this might be an unacceptable burden under what will likely be extremely difficult circumstances." He then proposed "referral to an independent third party" as something to be considered, soliciting feedback.\(^\text{43}\)
The description of the proposal was vague and could obviously entail unacceptable complicity and was opposed by a number of participants, so Dr. Blackmer provided more information.

Let me clarify that this is not referral to a physician who will be providing the intervention. It is intended to serve as a "middle ground." Most patients who receive this referral will not access assisted dying, but rather will learn about the variety of options available to them, including palliative and spiritual care. It does not facilitate access to assisted dying. It facilitates access to information.\(^{55}\)

He emphasized that the proposal did not entail "effective referral," a term defined by the College of Physicians and Surgeons of Ontario:

An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency.\(^{57}\)

Rather than "effective referral", he said, "We are examining the option of referral to an independent third party, which would not necessarily result in assisted dying - and would not be likely to do so in the majority of cases."\(^{56}\)

The distinction between providing information to enable informed medical decision-making and facilitating a morally contested procedure by effective referral was valid and important. However, most objecting physicians are willing to personally advise patients "about the variety of options available to them, including palliative and spiritual care." There would actually be no need for most to refer patients for that purpose, so dialogue participants may have considered the Board's "preferred solution" to be irrelevant in most cases.\(^{56}\)

More important, the acceptability of the "third party" solution depended upon what the third party would actually do. Providing assistance and information was not problematic, but active third party facilitation would be. As Dr. Simpson's comments at the opening of the Council indicated, that possibility was not ruled out, and a third party system had yet to be designed. It is not surprising that objecting physicians were reluctant or unwilling to accept an arrangement before such important details had been worked out.

In any case, when they persisted in expressing preference for self-referral or direct access, Dr. Blackmer became more emphatic in rejecting the idea. He explained that the CMA had tried "to work with the regulators to find language that might meet the needs of both objectors and their patients," and did not understand Section 5.2 to mandate referral. If physicians refused to accept the third party proposal, he warned, "there is a very real possibility that mandatory direct referral to a non-objecting physician will be imposed."

"This is the outcome we are trying to avoid," he said, "a 'win-lose scenario' where we have no control over the final outcome."\(^{58}\)

In fact, having declared euthanasia and assisted suicide to be legitimate forms of end-of-life care, having affirmed that it would ensure patient access to the procedures, and having qualified its support for physician freedom of conscience by insisting that there should be no "undue delay" in providing them, the CMA lost "control of the final outcome" once the Supreme Court ruled in Carter. Regulators could quite plausibly claim that demanding "effective referral" was simply a
logical application of commitment made by the CMA when it reversed its policy against euthanasia and assisted suicide.

CMA officials, negotiating at a significant disadvantage of their own making, were desperate to find a policy "acceptable to the regulators" and to objecting physicians whose fundamental freedoms they had rashly jeopardized. Thus, Dr. Blackmer repeatedly hammered home the message that if physicians continued to support only self-referral, mandatory effective referral would be imposed. 46,56,58

"The key," he said, "is in finding a solution that will ensure both and protect the physicians' right to conscientious objection while not impeding access." 46

The problem, however, was that the largest medical regulator in the country had already imposed a policy of effective referral for every other morally contested service so that physicians would not "impede access to care" by conscientious objection, 57 and would later extend the policy to include euthanasia and assisted suicide 59 because, consistent with CMA policy, it saw "no qualitative difference" between therapeutic homicide and suicide and "other health care services" 60 (in the framework's reference to "equity," "any other approved medical intervention").

**CMA delegates reject effective referral**

Writing three years later in response to criticism of CMA lobbying to change World Medical Association policy against euthanasia and assisted suicide, Dr. Blackmer remarked that objecting physicians had "made tearful pleas at several CMA General Council meetings, asking their non-objecting colleagues to support them and to defend their rights." 61

He did not acknowledge that this was necessary because the Board had reversed CMA policy against euthanasia and assisted suicide, affirmed both as medical care, and insisted that all physicians are obliged to ensure equitable and timely access to them "as for any other type of intervention." 44 This effectively shifted the onus to physicians to show why they should not be parties to killing eligible patients. This was why objecting physicians, in particular, needed the support of their colleagues, and why they were forced to resort to begging, tearful pleading and expensive constitutional court challenges in support of their fundamental freedoms.

Fortunately, physicians surveyed about the issue in 2015 seem to have been supportive. Statistics presented at the Council disclosed that only 17% supported the Board's "preferred solution" and over 50% held that objecting physicians either had no obligation to do anything further (31%) or provide only support and information — not referral (20%).

Source: Murphy S. A "uniquely Canadian approach" to freedom of conscience: Provincial-Territorial Experts recommend coercion to ensure delivery of euthanasia and assisted suicide. Appendix "D" - Canadian Medical Association on euthanasia and assisted suicide

Overall, only 19% believed objecting physicians should be forced to refer (a proportion remarkably close to the proportion of physicians said to be willing to provide EAS services), while almost 68% clearly believed that objecting physicians should not be required to refer patients for anything other
than information.

At the General Council, delegates were presented with a refinement of the wording in Section 5.2 developed by physician groups representing those opposed to euthanasia and assisted suicide.\textsuperscript{62} It specified that objecting physicians should "physicians are expected to provide the patient with complete information on all options available to them, including assisted dying, and advise the patient on how they can access any separate central information, counseling, and referral service," making it clearer that referral to an EAS delivery service was not expected.\textsuperscript{63} Delegates approved this option by a margin of about 75\%\textsuperscript{64} — by Irish abortion referendum standards, a landslide.

This was a development of the basic framework provided by the Code of Ethics and the CMA's longstanding position of physician freedom of conscience in relation to morally contested procedures. It was, however, a largely pragmatic response guided by a general notion of "striking a balance" between patient and physician autonomy or rights. It was specific to euthanasia and assisted suicide, and it was unsupported by principled ethical or philosophical rationale. It is unlikely that more than this could have been achieved in the circumstances, and objecting physicians were fortunate to have achieved this much.

The CMA Board later approved Principles-based Recommendations for a Canadian Approach to Assisted Dying as amended at the Annual General Council.\textsuperscript{65} The framework was not a policy document in the ordinary sense, but was meant to provide interim guidance in discussions with federal and provincial authorities, which had yet to respond to the Carter ruling.

**Postscript**

The CMA later produced a strong defence of physician freedom of conscience in relation to referral for euthanasia and assisted suicide.\textsuperscript{66} Current CMA policy on euthanasia and assisted suicide has been improved in this respect, more carefully articulating the issues of access to services and protection of freedom of conscience (or moral integrity). In particular, it states that objecting physicians "are not required to provide it, or to otherwise participate in it, or to refer the patient to a physician or a medical administrator who will provide assistance in dying to the patient." It also appears to put the onus on the state "to implement an easily accessible mechanism to which patients can have direct access" to obtain the services so that physicians can adhere to their moral commitments.\textsuperscript{67}

These changes deserve recognition and thanks, but they were late in coming. The submission on referral came only in January, 2016, almost a year after the Carter ruling. The articulation of physician freedom of conscience found in current policy on the procedures dates from May, 2017 - more than three years after Carter.

Moreover, mandatory referral for euthanasia and assisted suicide was recommended by a Royal Society panel of experts in 2011.\textsuperscript{68} The CMA cited this report in its 2014 application to intervene in Carter - but only because the experts dismissed the risk of a "slippery slope" should euthanasia and assisted suicide be legalized.\textsuperscript{69} It took the CMA over four years to respond to the experts' tendentious claim that referral is an acceptable form of accommodation, and almost seven years to reject their demand that physicians should be forced to refer for euthanasia and assisted suicide. There was arguably no need for the CMA to respond to the experts in 2011; it was then opposed to
physician participation altogether, so the issue of referral was moot. That was certainly not the case in 2014, when the Board was planning its intervention in Carter.

Finally, by the time the CMA did respond, objecting physicians were on the defensive in a treacherous and even hostile environment. A policy demanding effective referral for all morally contested services is the subject of a constitutional challenge in Ontario. The trial court ruled against the physician plaintiffs, who have appealed the decision. The case will likely go to the Supreme Court of Canada, and the outcome will determine whether or not physicians unwilling to be parties to killing their patients will be able to continue to practise medicine in Canada.
CONCLUSION

The Canadian Medical Association and Royal Dutch Medical Association are attempting to convince World Medical Association to drop its opposition to euthanasia and assisted suicide. This review was prompted by the CMA's further suggestion that the WMA and other national associations should follow the CMA's example in revising euthanasia and assisted suicide policy.

While changes to euthanasia and assisted suicide policies can be considered from a number of perspectives and entail serious engagement with grave moral/ethical issues, the focus of the Protection of Conscience Project is limited to ensuring that the freedom of conscience of physicians and other health care workers is not violated by compelling them to do what they believe to be wrong.

Hence, this review does not address the acceptability of euthanasia or assisted suicide, nor the arguments for or against legalization or changes in medical association policy. It considers the CMA's efforts to shape the debate and the law on euthanasia and assisted suicide only in relation to its impact on physician freedom of conscience.

This review demonstrates that, if the World Medical Association (WMA) or some of its constituent national medical associations wish to change their policies on physician participation in euthanasia or assisted suicide, they should not follow the example of the Canadian Medical Association if they wish to prevent physicians and other health care workers from being compelled to do what they believe to be wrong.

Before advocating changes of policy or law that could involve such a risk, a medical association must establish a robust, comprehensive and rationally defensible protection of conscience policy that takes fully into account the issue of complicity arising from various forms of cooperation. It should also ensure that its policy cannot be ignored or overridden by the state or by powerful or influential private interests, if, need be, by insisting that it be supported by appropriate legislation.

Notes


4. Proudfoot S. A CMA doctor on the burdens and ethics of assisted death. MacLeans, 8 June, 2016
5. Compare "completely in opposition to all teachings in medical ethics" with text accompanying notes 52 and 53 in Part I.


14. Doctor-assisted suicide a therapeutic service, says Canadian Medical Association: Many technical questions remain following Supreme Court decision to allow medical aid in dying. CBC News, 6 February, 2015

15. Hume J. Supreme Court strikes down ban on assisted suicide. Toronto Sun, 6 February, 2015

16. Branswell H. Canadian MDs, many hesitant about assisted death, assessing Supreme Court ruling. Times Colonist, 6 February, 2018

17. Ballingall A. Assisted death: How to weigh doctors' rights with right to die? Canada's medical circles abuzz with debate over how to balance newly recognized right to assisted death with doctors' right not to provide it. The Star, 7 February, 2015


(http://consciencelaws.org/blog/?p=5649).


22. Kirkey S. How far should a doctor go? MDs say they 'need clarity' on Supreme Court's assisted suicide ruling. National Post, 23 February, 2015


25. Carter v. Canada (Attorney General) 2012 BCSC 886 (http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886cor1.htm) Accessed 2015-07-05. In the summary of the ruling, the judge states that Taylor "will be permitted to seek, and her physician will be permitted to proceed with, physician assisted death." (para. 19). However, the judge later specifies she is striking down the "impugned provisions" to the extent that they prohibit physician-assisted suicide or consensual physician-assisted death." (para. 1393(b), emphasis added.) "Consensual physician-assisted death" is distinguished from physician-assisted suicide in the plaintiffs' Amended Notice of Claim (para. 7, 8) and defined as the act of a medical practitioner that causes the death of a patient. This is acknowledged by the judge in the ruling (para. 23). The judge herself does not define the term, but "consensual physician-assisted death" is encompassed by her definition of euthanasia (para. 38). Consistent with this, the constitutional exemption granted to plaintiff Gloria Taylor states that "the mechanism for the physician-assisted death shall be one that involves her own unassisted act and not that of any other person," unless she is "physically incapable." (para. 1414(f)) This would authorize a lethal injection by a physician, which, but for the ruling, would be homicide, not assisted suicide.


29. DWD responds to CMA statement on assisted dying. Dying with Dignity, 6 March, 2015 (https://www.dyingwithdignity.ca/2015/03/06/dwd-responds-to-cma-statement-on-assisted-dying


33. Canadian Medical Association Annual General Council 2015, Education session 2: Setting the context for a principles-based approach to assisted dying in Canada. Ed2-webast - 14:00-14:30.


35. Project Administrator's Redacted Record of 2015 CMA On-line Consultation [CMA On-line Consultation]: Principles based approach to assisted dying, Blackmer Comment No. 14 (ca. 2015-07-05). Note: The date of comments in the on-line dialogue was given only as "X days ago" or "one month ago," and the time was not indicated. The dates given here are based on the information provided in the dialogue. For reference purposes, numbers have been assigned to Dr. Blackmer's comments, beginning with "1" in each topic thread.

36. "[N]o physician should be compelled to participate in or provide" (Emphasis added). In the SCC on appeal from the BCCA, Factum of the Intervener, The Canadian Medical Association (27 August, 2014) para. 27 (http://www.consciencelaws.org/archive/documents/carter/2014-08-27-cma-factum.pdf).

37. "[N]othing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. . . a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief." (Emphasis added) Carter-SCC, para. 132.

Dying-e.pdf) Accessed 2018 Sep 10 ["Summary Report"].


42. Summary Report, p. 10.

43. CMA On-line Consultation: Conscientious objection and equitable access. Blackmer Comment No. 1 (ca. 2015-06-19).


46. CMA On-line Consultation: Principles based approach to assisted dying, Blackmer Comment No. 9 (ca. 2015-07-01).

47. CMA On-line Consultation: Principles based approach to assisted dying, Blackmer Comment No. 13 (ca. 2015-07-01).

48. CMA On-line Consultation: Conscientious objection and equitable access, Blackmer Comment No. 1 (ca. 2015-06-19).

49. CMA On-line Consultation: Conscientious objection and equitable access, Blackmer Comment No. 2 (ca. 2015-06-19).

50. See Part I: CMA General Council (August, 2014), Adoption of resolution on freedom of conscience.

51. CMA On-line Consultation: Principles based approach to assisted dying, Blackmer Comment No. 10 (ca. 2015-07-01).


55. CMA On-line Consultation: Conscientious objection and equitable access, Blackmer Comment No. 6 (ca. 2015-07-07).

56. CMA On-line Consultation: Review and comment on the draft framework, Blackmer Comment No. 4 (ca. 2015-07-07).


58. CMA On-line Consultation: Principles based approach to assisted dying, Blackmer Comment No. 14 (ca. 2015-07-05).


62. Christian Medical Dental Society, the Federation of Catholic Physicians Societies and Canadian Physicians for Life.


69. Simpson Affidavit, para. 29.
