"A uniquely Canadian approach" to freedom of conscience

Experts recommend coercion to ensure delivery of euthanasia and assisted suicide

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Abstract

The Experts' recommendations are intended to extend and maximize the impact of the *Carter* ruling. They will effectively require all institutions, facilities, associations, organizations and individuals providing either health care or residential living for elderly, handicapped or disabled persons to become enablers of euthanasia and assisted suicide. This will entail suppression or significant restriction of fundamental freedoms.

The broader the criteria for the provision of morally contested procedures, and the more people and groups captured in the Experts' enablers' net, the greater the likelihood of conflicts of conscience. Relevant here are recommendations to make euthanasia/assisted suicide available to mentally ill and incompetent persons, and to children and adolescents, even without the knowledge of their parents.

The Experts' distinction between "faith-based" and "non-faith-based" facilities is meaningless. They impose identical obligations on both. All will be forced to allow homicide and suicide on their premises, or compelled to arrange for euthanasia or assisted suicide elsewhere.

Likewise, they recommend that objecting physicians be forced to actively enable homicide or suicide by providing referrals, arranging direct transfers or enlisting or arranging the enlistment of patients in a euthanasia/assisted suicide delivery system.

The Supreme Court did not rule that people ought to be compelled to become parties to homicide and suicide, but that is what the Experts recommend. This is not a reasonable limitation of fundamental freedoms, but a reprehensible attack on them and a serious violation of human dignity.

Other countries make euthanasia and assisted suicide available without attacking fundamental freedoms. In this respect, the Experts' claim to have produced "a uniquely Canadian approach to this important issue" is regrettably accurate. They fail to provide any evidence that the suppression of freedom of fundamental freedoms they propose can be demonstrably justified in a free and democratic society.

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I. Background

I.1 Formation and work of the Advisory Group

I.1.1 The Provincial-Territorial Expert Advisory Group on Physician Assisted Dying was formed in August, 2015, under the auspices of the government of the province of Ontario, in response to the ruling of the Supreme Court of Canada in *Carter v. Canada* (Appendix "A").

I.1.2 The venture involved the three Canadian territories (Yukon, Northwest Territory and Nunavut) and eight other provinces (excluding Quebec).[1] The Group functioned with the support of a secretariat provided by the Ontario Ministry of Health and Long Term Care.[2] The announcement of the formation of the Advisory Group did not explain how the nine Experts were selected, or by whom.[3]

I.1.3 From August until November, 2015, the Experts received 58 written submissions, held teleconferences with 24 groups or individuals[4] and conducted other research. The Experts' Final Report offers non-binding advice to the provincial and federal governments about how to implement the ruling of the Supreme Court of Canada in *Carter v. Canada*. It includes 43 specific recommendations. This commentary reviews 19 of them.

II. Overview of the Final Report

II.1 Moral/ethical unanimity

II.1.1 The Experts were unable to agree on whether or not a person NOT diagnosed with a grievous and irremediable medical condition should be able to complete an advanced directive authorizing euthanasia or assisted suicide.[5] Nor could they agree about whether state control of freedom of conscience and religion should be exercised by legislation or by medical regulators.[6]

II.1.2 With the exception of these two points, all 43 recommendations and everything else proposed in the Report enjoy the unqualified support of all nine Experts, made obvious by the frequent use of the words "we" and "our." The unanimity is remarkable, particularly since the Experts propose criteria for euthanasia and assisted suicide broader than those laid down by the Supreme Court, as well as recommending policies and legislation to extend and maximize the impact of the *Carter* ruling.

II.1.3 A single statement explains how the Experts arrived at their unanimous conclusions. We are told that their deliberations "involved re-considering and sometimes putting aside deeply-held personal views to find common ground in the interest of Canadian patients and the public."[7]

II.1.4 This means that, among the nine Experts, it is "common ground" that killing patients "should be treated as one appropriate medical practice within a continuum of services available at the end-of-life."[8] It means that all nine Experts believe that it is morally/ethically acceptable for health care professionals to kill people in defined circumstances to relieve pain or suffering. If that were not the case, at least one dissenting

opinion ought to have been included in the Report, at least with respect to the broadening of eligibility criteria and the coercion of objecting physicians and institutions. There are none.

II.1.5 To say that one *agrees* that it is morally/ethically acceptable to kill people to put an end to their suffering means that is what one actually *believes*. It would be absurd to suggest otherwise. Someone who *agrees* with capital punishment in certain circumstances clearly *believes* that it is morally acceptable in those circumstances. The Experts' unanimous view that euthanasia and assisted suicide are morally/ethically acceptable therapies gives direction to the Report and has a notable impact on their recommendations.

II.1.6 It also affects the tone of the Report. Apparently on the strength of their unanimous opinion, the Experts adopt a condescending attitude toward the presumed minority who object to euthanasia and physician assisted suicide. Thus, they acknowledge sympathetically that killing patients and helping them commit suicide "remains ethically challenging for *some*." (Emphasis added.)[9]

II.1.7 Nonetheless, the Experts want governments and regulators to use the force of law and policy to compel the 'ethically challenged' to accept their unanimous judgment that killing people in order to end suffering, albeit in defined circumstances, is not only legally, morally and ethically acceptable, but legally, morally and ethically obligatory. In support of this, they offer a "Statement of Principles and Values."

II.2 "Statement of Principles and Values"

II.2.1 Under this head, the Experts list a number of "individual and institutional rights and duties" and "pan-Canadian principles" upon which they relied to produce their recommendations. Among them they include the statement, "When rights conflict, they must be reconciled,"[10] a point repeated elsewhere in the Report.[11]

II.2.2 What the Experts do not acknowledge is that there is fundamental disagreement about the meaning and scope of virtually all of the rights, duties and principles they identify.

II.2.3 For example: a "right to patient autonomy" is commonly acknowledged, and there is broad agreement about what that means in many circumstances. A particular understanding of patient autonomy underlies decision of the Supreme Court in *Carter*, and it is natural for the Experts to apply it in recommendations intended to implement the decision.

II.2.4 However, the Euthanasia Prevention Coalition also appealed to patient autonomy in its leading arguments *against* euthanasia when it intervened in the *Carter* case. Legalizing assisted suicide and euthanasia, it said, would diminish "real autonomy" and would be "fundamentally inconsistent with the principles of autonomy and choice."[12,13]

II.2.5 Further: even those who agree that patient autonomy justifies euthanasia and assisted suicide may not agree that it justifies the Experts' view that assisted suicide should be available to the mentally ill, or that unwilling physicians should be forced to participate in killing their patients.

II.2.6 The same kind of difficulty attends the other rights and duties they list. Most Canadians agree that "the rights of freedom of conscience and religion" are important, but the meaning and scope of these rights and freedoms are sharply disputed. Everyone agrees that patients must not be "abandoned," but many do not agree that offering palliative care while refusing to provide lethal injection constitutes abandonment. Protection from illicit discrimination is generally accepted as sound public policy, but a number of Canadian law societies manifest their opposition to discrimination by apparently discriminating against Trinity Western University.[14]

II.2.7 Now, any 'reconciliation of rights' is impossible absent agreement about the nature and scope of the rights in question. For example, the Experts assert a right to assisted suicide and euthanasia under the rubrics of a right to "equitable access to health services." However, this is based on their presumption that homicide and suicide are therapies, a presumption generally rejected by objecting health care professionals. To demand that objectors accept the Experts' presumption does not reconcile freedom of conscience, but steamrollers it, and that is true even if *Carter* is cited as authority for the presumption.

II.2.8 Hence, while the Experts' "Statement of Principles and Values" is useful as a framework for purported justification of what they propose - including the suppression of fundamental freedoms - it is useless as a starting point for a genuine 'reconciliation of rights.'

II.3 Recommendations broadening *Carter* criteria for assisted suicide, euthanasia

II.3.1 The Experts recommend that criteria for therapeutic homicide and suicide be extended by legislation beyond those set by the Supreme Court of Canada in *Carter*. This is possible because the Court set only the base line for legislation. Parliament cannot restrict the *Carter* criteria, but it can broaden them.

II.3.2 The broadening of some aspects of *Carter* does not directly impact the exercise of freedom of conscience and religion by individuals, groups and institutions. For example: public funding for euthanasia and assisted suicide is not required by *Carter*, but it is recommended by the Experts. Such recommendations, and others pertaining to oversight, reporting, research, etc. are not considered here.

II.3.3 However, the broader the criteria for the provision of morally contested procedures, the greater the likelihood of disagreement and of conflicts of conscience among those expected to provide them. Further: some recommendations that do not modify the *Carter* criteria have practical consequences that may result in conflicts of conscience among health care workers. These recommendations are discussed in detail in Appendix "B."

II.4 Recommendations impacting freedom of conscience and religion

II.4.1 Patient autonomy is one of the principal justifications offered for legalizing therapeutic homicide and suicide.[15] On the other hand, those supporting euthanasia and assisted suicide frequently emphasize that most people who obtain the services are anything but vulnerable. In his oral submission, lawyer Joseph Arvay told the Supreme Court how one

of his clients had climbed Mount Kilimanjaro and gone to Russia to protest the U.S. boycott of the Olympics, and described another as "a Renaissance man." These were people, he said, who had a "zest for life."

> These aren't vulnerable people. These are the people we're representing. People who have a determined wish to die. People who are vulnerable never get through the hoops. Because the hoops are really quite onerous. A person who's really depressed will never get through the hoops. That's what the evidence was in the case.[16]

II.4.2 Later in his submission, he attacked assumptions and theories that disabled persons "are too vulnerable or too fragile or too brainwashed by ablest society to resist the suggestion of doctors or family members that they are better off dead." This is, he said, "not only patronizing, it's infantilizing."[17]

II.4.3 In contrast, the Experts adopt an "infantilizing" view of patients. They argue that patients must be completely relieved of the "burden" of finding someone willing to kill them or help them commit suicide, and that this "burden" must be assumed by "those with the greatest power and voice," including "*health care providers*, professions, regulators and institutions." (Emphasis added.)[18]

II.4.4 Mr. Arvay assured the Supreme Court of Canada that vulnerable people would be protected by 'onerous hoops' if the Court struck down the law, but the Experts seem to believe that patients are so weak and vulnerable that others have to take over to ensure that they can get through them. Ultimately, the Experts say, "It is imperative that the burden of transfer to another physician, institution or third party not fall on the patient," and they demand that the burden should fall on objecting physicians and institutions in some circumstances.[19]

II.4.5 Within this context, the Experts introduce the term: "critical enabler." A "critical enabler" is any law, regulation, policy or institution critical to enabling access to euthanasia and assisted suicide, including hospitals, hospices, long term care facilities, other institutional providers and regional health authorities.[20] "Critical enabler" clearly communicates moral complicity in homicide and suicide, so it is a useful term.

II.4.6 Although the Experts do not expressly apply the term to individuals, it is clear that the Experts want to force individual and institutional health care providers to become "critical enablers" in some circumstances - even if the individuals or institutions hold that killing patients and helping them commit suicide is gravely wrong. Their recommendations concerning institutional and individual conscientious objection are discussed in detail in Appendix "C."

III. The Experts' "uniquely Canadian approach"

III.1 Broadened criteria and increasing likelihood of conflict

III.1.1 Appendix B1: "Irremediable medical condition". The Experts want euthanasia and assisted suicide made available upon a diagnosis of any very serious illness, disease or

disability for which treatment is unsuccessful or refused, including mental illness.

III.1.2 It appears that a large majority of physicians will not be willing to provide therapeutic homicide or suicide for those who are not terminally ill, let alone for those who are mentally ill. Of this group, a significant number may refuse to facilitate euthanasia or assisted suicide for the mentally ill or those not terminally ill through "effective referral" or similar means. Presumably, similar trends would be observed among other health care professionals.

III.1.3 Appendix B2, B3: Euthanasia approved for future suffering. The Experts recommend that people who are not suffering should be able to authorize euthanasia and assisted suicide by an advance directive as long as they have been diagnosed with a very serious illness, disease or disability for which treatment is unsuccessful or refused, including mental illness. Their goal is to ensure that such patients - especially those diagnosed with dementia - can be lethally injected after they become incompetent.

III.1.4 Assuming that an advance directive made when a patient is competent is binding, the Expert recommendation implies that an advance directive authorizing euthanasia that is signed by a competent patient becomes an irrevocable death warrant when the patient becomes incompetent.

III.1.5 CMA surveys indicate that the number of physicians willing to provide euthanasia or assisted suicide ranges from 6% to 29%, depending upon the condition of the patient, and excluding reference to safeguards. However, it appears that such surveys have always proposed or have always been assumed to refer to a scenario involving a patient who is actually suffering, not someone who anticipates suffering some time in the future. It seems doubtful that they are a reliable indicator of support for what the Experts propose.

III.1.6 A further complication is that the health care professional who receives and approves such an advance directive may not be the person required to lethally inject the patient some time later. Particularly in the case of dementia, health care professionals may unwilling to kill a patient on the basis of an advance directive, especially a patient who does not appear to be suffering and apparently wants to live. This has already been illustrated in the case of Margaret Bentley.[21]

III.1.7 Appendix B4: No waiting/reflection period. The Experts want euthanasia and assisted suicide made available as soon as the patient has been found eligible and competent. They reject the imposition of a waiting/reflection period, which, they say, would "impose an arbitrary barrier to access."

III.1.8 The Experts' enthusiasm for therapeutic homicide and suicide eclipses the more cautious approach of the Canadian Medical Association and seems to surpass that of the plaintiffs/appellants in *Carter*. The regime proposed by the Experts reflects, instead, the policies of Amsterdam's Levenseinde Kliniek (End of Life Clinic), which pulls out all stops to deliver "emergency euthanasia" in response to the upsurge of requests during the Christmas season.

III.1.9 However, Levenseinde Kliniek has been twice reprimanded by the euthanasia oversight

committee for failing to exercise proper care, and a number of pharmacists have refused to provide euthanasia drugs for clinic physicians, usually in cases of dementia, psychiatric illness, or patients simply wished to die. This suggests that conflicts of conscience among health care professionals are likely to be more prevalent in the absence of a waiting/reflection period.

III.1.10 **Appendix B5: Adolescents and children.** The Experts reject what they call "arbitrary age limits." They argue that euthanasia and assisted suicide should be provided to children and adolescents who are judged competent to decide whether or not their lives are worth living. In this they go further than the Supreme Court of Canada, but also further than the successful appellants in *Carter*.

III.1.11 This recommendation must be read within the context of the other recommendations to appreciate its full significance. The Experts want euthanasia and assisted suicide made available to children and adolescents who are mentally ill, by means of advance directives based on anticipated suffering, and that there be no waiting/reflection periods. According to the Experts, parents must not be allowed to interfere, and may not even be made aware that their children have asked to be killed or helped to commit suicide.

III.1.12 Conflicts of conscience among health care professionals are likely to be more prevalent in the face of demands that they participate in providing euthanasia and assisted suicide for children and adolescents, particularly in the more controversial circumstances noted in III.1.11.

III.1.13 **Appendix B6: Euthanasia/assisted suicide by non-physicians.** The Experts recommend that nurse practitioners be able to process euthanasia and assisted suicide requests, including the provision of second opinions. The Experts also recommend that other health care professionals, acting under the direction of physicians, should be able to give lethal injections or provide lethal prescriptions. Even personal support workers should, they say, be able to give patients the lethal medication used for assisted suicide.

III.1.14 Allowing non-physicians to provide assisted suicide and euthanasia would increase the likelihood of disagreement and conflicts of conscience among other health care professionals and others who would not otherwise be involved with killing patients or helping them commit suicide. On the other hand, it might relieve some of the pressure on objecting physicians to become directly or indirectly involved in the services.

III.1.15 **Appendix B7: Doctor shopping.** The Experts recommend that competent patients who have been found ineligible for euthanasia and assisted suicide should be allowed to look for physicians (or nurse practitioners) willing to declare them eligible.

III.1.16 The paradigm example of this practice is the Levenseinde Kliniek (End of Life Clinic) in Amsterdam, which deals only with patients whose applications for euthanasia have been rejected by their own physicians. As noted above (III.1.9), the clinic has been criticized for some of its practices. CMA surveys of physicians suggest that the majority of Canadian physicians would be unwilling to participate in euthanasia or assisted suicide if approved for the reasons accepted by the Clinic.

III.1.17 Conflicts of conscience among health care professionals asked or ordered to participate in killing patients are more likely if they suspect that doctor shopping has compromised the process leading to an authorization or order to do so.

III.1.18 Appendix B8: Physicians need not be present at suicides. The Experts recommend that physicians, nurse practitioners or others who prescribe lethal medication should not be required to be present when the patient ingests it, despite the fact that complications and adverse effects are more likely in suicides.

III.1.19 Among other issues, conflicts of conscience may arise among health care professionals

- who consider it unethical or at least imprudent to absent themselves when the drug is taken, particularly in the case of patients who are mentally ill; or
- who are called upon to lethally inject a patient who has not been killed by the prescribed medication, particularly if they have had no previous involvement in the case.

III.1.20 Appendix B9: Euthanasia/assisted suicide wherever people live and die. The Experts want euthanasia and assisted suicide provided in extended care facilities, assisted living facilities, group homes, correctional institutions - wherever people live and die (III.2.1).

III.1.21 It will be difficult for health care professionals, care aides, personal support workers etc. who do not want to be involved with euthanasia and assisted suicide to find work anywhere in Canada where they can be sure that they will not be required to be involved with killing patients or residents or helping them commit suicide.

III.1.22 Appendix B10: Families, caregivers may not be advised. The Experts note that families and caregivers may be advised of plans for euthanasia or assisted suicide only if the patient agrees. This would seem to require at least some dissembling or duplicity on the part of health care professionals and others involved to keep families in the dark.

III.1.23 Conflicts of conscience are likely to be more prevalent among health care professionals who are uncomfortable lying or dissembling to families, and those who object to euthanasia who are not directly involved will almost certainly consider participation in deception to involve unacceptable complicity in killing, even if it occurs after the fact.

III.2 Institutions, associations, organizations

III.2.1 Appendix C1.1: The meaning of "institution". The Experts want all health care institutions to become "critical enablers" of euthanasia and assisted suicide,[22] but they do not stop with health care institutions. The Experts want euthanasia and assisted suicide to be provided wherever people live,[23] and "wherever people are living and dying."[24]

III.2.2 The Experts' recommendations are aimed at every institution, facility, association, organization or private individual providing either health care or residential living for elderly, handicapped or disabled persons in Canada. This includes nursing homes, retirement homes, assisted living and extended care facilities, and group homes for mentally handicapped or disabled persons such as those run by L'Arche. Many of these

individuals and groups may hitherto have had no expectation that they would be actively involved in enabling euthanasia and assisted suicide.

III.2.3 **Appendix C1.2: All "institutions" must allow/arrange euthanasia/assisted suicide.** While they Experts purport to distinguish between "faith-based" and "non-faith-based" facilities, the distinction is meaningless. They impose identical obligations on both. Among them, all facilities must allow euthanasia and assisted suicide on their premises if they cannot arrange for it to be done elsewhere through a safe and timely transfer of the patient/resident.

III.2.4 In sum, the Experts recommend that all health care and residential facilities become critical enablers of euthanasia and assisted suicide, and that no exceptions be made for private or faith-based institutions.

III.2.5 To ensure conformity, the Experts recommend that legislators prohibit anyone in Canada from establishing or operating private facilities that absolutely prohibit euthanasia or assisted suicide, or that refuse to arrange for the procedures elsewhere.

III.2.6 **Appendix C1.3: All "institutions" must disclose policies**. The Experts want all of these facilities forced to formulate a policy that sets out how they will assist residents, patients or clients to access euthanasia and assisted suicide, and notify applicants of that policy.

III.2.7 As the Experts' other recommendations make clear, the requirement for notification is not intended to allow objecting institutions to continue to operate without involvement in euthanasia and assisted suicide. Its practical and immediate effect will be to force them to develop policies to ensure access to both.

III.2.8 **Appendix C1.4: "Institutions" may not manifest or enforce commitments.** The Experts recommend a regulatory regime apparently designed to prevent facilities from manifesting and making effective a commitment to palliative care, religious or moral beliefs, or a philosophy of life or medicine that excludes killing patients/residents or helping them to commit suicide.

III.2.9 Thus, the Experts would prohibit objecting facilities from disciplining or dismissing employees or physicians who, while working in the facility, actively subvert its fundamental commitments by promoting or arranging for euthanasia or assisted suicide during interactions with patients/residents.

III.3 **Objecting physicians: information, disclosure, non-discrimination**

III.3.1 The Experts offer four recommendations intended to control the behaviour of physicians who, for reasons of conscience, refuse to kill patients or help them commit suicide. Reference to "physicians" here must be understood to apply to other health care workers who are acting in the place of physicians, since the Experts want other health care professionals to provide and participate directly in euthanasia and assisted suicide.

III.3.2 Of the four recommendations, the first three concern providing information necessary for medical decision making, disclosure of views, and a warning against illicit

discrimination. These require only clarification or comment.

III.3.3 **Appendix C2.1: Objecting physicians must provide information.** The Experts recommend that physicians should be required to offer the options of therapeutic homicide or suicide, "regardless of their personal beliefs."

III.3.4 The Project's experience is that physicians who object to providing morally contested procedures do not normally object to providing information that a patient needs in order to make informed decisions, so this is unlikely to be problematic.

III.3.5 However, it is not clear whether or not the Experts want physicians forced to gratuitously offer euthanasia and assisted suicide as treatment options in the absence of any indication of interest from a patient.

III.3.6 The gratuitous suggestion of physician assisted suicide even to patients who meet the *Carter* criteria may expose physicians to criminal prosecution, since counselling suicide remains a criminal offence.

III.3.7 In addition, physicians may believe that offering assisted suicide or euthanasia to patients just blinded or paralysed by an industrial accident may be harmful or abusive. They may also be reluctant to gratuitously offer assisted suicide and euthanasia as treatment options upon a diagnosis of other "irremediable medical conditions" like dementia, congestive heart failure, or chronic obstructive pulmonary disease.

III.3.8 **Appendix C2.2: Objecting physicians must disclose views and their implications.** The Experts recommend that physicians "appropriately inform their patients of the fact and implications of their conscientious objections," and provide ongoing treatment "in a non-discriminatory manner."

III.3.9 This requirement is unobjectionable, but it illustrates a bias arising from the Experts' unanimous view that killing patients and helping them commit suicide in defined circumstances is legally and morally/ethically normative.

III.3.10 Their unanimity on this point seems to have prevented them from seeing that the views of physicians who do *not* object to killing patients or helping them commit suicide *also* have implications for patients. Requirements for disclosure and discussion of the implications of their views should apply equally to objecting and non-objecting physicians.

III.3.11 **Appendix C2.3: Objecting physicians must not illicitly discriminate.** The Experts' warning against illicit discrimination is directed to only to objecting physicians: another example of discriminatory bias. A warning against illicit discrimination ought to be addressed to both objecting and non-objecting physicians.

III.3.12 There is actually more reason to offer a warning about illicit discrimination to physicians *willing* to provide euthanasia and assisted suicide, because they are more likely to be charged with illicit discrimination if they attempt to limit the scope of their practices: to provide euthanasia or assisted suicide only for the terminally ill, for example.

III.4 Objecting physicians must become critical enablers

III.4.1 Physicians who, for reasons of conscience or religion, refuse to kill patients or help them commit suicide are expected, nonetheless, to become critical enablers of euthanasia and assisted suicide. The Experts offer them three alternative enabling mechanisms: referral, direct transfer of care, and transfer to a system/third party.

III.4.2 The alternatives are not problematic for physicians who have no objections to euthanasia or assisted suicide, but who do not wish to write lethal prescriptions or lethally inject patients themselves. Nor would they be unacceptable to physicians whose moral reasoning leads them to conclude that the alternatives absolve them of culpable complicity in homicide or suicide.

III.4.3 However, all three alternatives are unacceptable to physicians who consider them to involve unacceptable complicity in wrongdoing.

III.4.4 Appendix C2.4.2, C2.4.3: Referral or direct transfer of care. In refusing to refer patients for euthanasia or assisted suicide, these physicians are acting no differently than fellow citizens who would refuse to provide contact information for a crack dealer or a pimp trafficking in adolescent flesh. The same reasoning underlies their refusal to arrange for a patient to be killed by initiating the direct transfer as required by the Experts.

III.4.5 Appendix C2.4.4: Referral to "system/third party". The third alternative is the most complicated: a publicly-funded system analogous to existing organ transplant systems. The Experts believe that systems designed for delivering hearts and livers to save patients lives can be replicated to deliver lethal injections and toxic prescriptions to end them.

III.4.6 Since physicians are expected to actively participate in the former, the Experts believe that they should be forced to actively participate in the latter, if such a system is developed and publicly funded. In the absence of such a system, the Experts demand that objecting physicians arrange for patients to be killed or helped to commit suicide by direct transfer.

III.4.7 In other words, the Experts demand that objecting physicians actively demonstrate the same level of professional and moral commitment to killing patients and helping them commit suicide that they demonstrate in arranging for organ transplants. This is just as unacceptable to many objecting physicians as referral and direct transfer.

III.4.8 Appendix C2.4.5: The Experts' proposal and the CMA's proposal. The Experts' description of their "system/third party" is similar to a proposal supported by the Canadian Medical Association, but there are some notable differences.

III.4.9 The CMA's proposed "separate central information, counseling, and referral service" differs from the Experts "system/third party" in three fundamental ways.

III.4.10 First: unlike the Experts' proposal, the CMA proposal is consistent with the *Carter* ruling. *Carter* and the CMA proposal both explicitly affirm physician freedom to refuse to

provide *or participate* in euthanasia or assisted suicide.

III.4.11 Second: the CMA proposal does not require objecting physicians to contact the central service or initiate a transfer of patients and records. The initiative remains with the patient. Objecting physicians respond as usual to a patient-initiated request for transfer of care.

III.4.12 Third: the CMA proposal was not presented or understood to require active participation of objecting physicians analogous to what is expected in relation to organ transplantation.

IV. Project response

IV.1 Expert recommendations broadening *Carter* criteria

IV.1.1 There is good reason to believe that the broadening of the Carter criteria in the manner suggested by the Experts (III.1) will increase the likelihood of conflicts of conscience among physicians and other health care workers, as well as the likelihood that those in positions of power and influence will attempt to suppress freedom of conscience in order to deliver euthanasia and assisted suicide. This makes robust protection of conscience policies and legislation all the more necessary.

IV.2 Expert recommendations and fundamental freedoms in general

IV.2.1 Recommendations concerning the obligations of "institutions," if implemented, will affect scores of institutions, facilities, associations, organizations and private individuals or groups providing either health care or residential living for elderly, handicapped or disabled persons in Canada, most of whom likely do not realize what the Experts have in store for them.

IV.2.2 A number of the recommendations directed at these groups will, if implemented, involve the suppression or significant restrictions of fundamental freedoms of association, belief, opinion, expression, religion or conscience. Some, such as the Experts' plan to prohibit even private non-conformist facilities, affect all of these freedoms.

IV.2.3 It is appropriate for the Project to take note of this, since these recommendations are indicative of the mindset and intentions of the Experts, and with the trajectory they will impart to public policy if they are accepted. However, most of these issues do not fall within the scope of Project advocacy.

IV.3 Expert recommendations and freedom of conscience

IV.3.1 The Project's concern is exclusively with recommendations intended to suppress freedom of conscience by forcing people to do what they believe to be wrong: in this case, forcing them to participate directly or indirectly in homicide or suicide.

IV.3.2 The following recommendations are unacceptable:

- that objecting facilities should be forced to allow people to be killed or helped to commit suicide on their premises;

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

IV.3.3 The position of the Experts expressed in these recommendations is that a learned or privileged class, a profession or state institutions can legitimately compel people to do what they believe to be wrong - even gravely wrong - even killing someone or being a party to homicide or suicide - and punish them if they refuse.

IV.3.4 Nothing of the kind is stated or implied in *Carter* (Appendix "A"). This is not a reasonable limitation of fundamental freedoms, but a reprehensible attack on them and a serious violation of human dignity. From an ethical perspective, it is incoherent, because it posits the existence of a moral or ethical duty to do what one believes to be wrong. From a legal and civil liberties perspective, it is profoundly dangerous. If the state can demand that citizens must be parties to killing other people and threaten to punish them or discriminate against them if they refuse, what can it not demand?

IV.3.5 Other countries have hitherto demonstrated that it is possible to provide euthanasia and physician assisted suicide without suppressing fundamental freedoms. None of them require "effective referral," "direct transfer" or otherwise conscript objecting physicians into euthanasia/assisted suicide service (Appendix "E"). In this respect, the Experts' claim to have produced "a uniquely Canadian approach" is regrettably accurate.[25]

IV.3.6 The Canadian Medical Association (CMA) drew attention to international practice in a recent submission to the College of Physicians and Surgeons of Ontario:

> As many have argued, it is entirely possible not to compromise or limit patient access on any level without compromising the exercise of conscience. The argument to the contrary is not empirically supported internationally, where no jurisdiction has a requirement for mandatory effective referral, and yet patient access does not seem to be a concern.[26]

IV.3.7 Within the context of the Experts' recommendations, the Project considers the following comment by the CMA particularly apt:

> It is in fact in a patient's best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement. At a time when some feel that we are seeing increasingly problematic behaviours, and what some view as a crisis in professionalism, medical regulators ought to be articulating obligations that encourage moral agency, instead of imposing a duty that is essentially punitive to those for whom it is intended and renders an impoverished understanding of conscience.[27]

IV.4 Legislative response

IV.4.1 In Canada, provincial governments have primary jurisdiction over human rights law, subject to the *Canadian Charter of Rights and Freedoms*. In view of the notable ethical aggression demonstrated by the Provincial-Territorial Expert Advisory Group and by some medical regulators (notably the College of Physicians and Surgeons of Ontario),[28] provincial legislators should establish as a matter of law and public policy that people cannot be forced by the state, employers or professional or occupational organizations to do what they believe to be wrong, or punished or disadvantaged for refusing to do so. This formal support for what the Project terms preservative freedom of conscience is foundational.[29]

IV.4.2 By virtue of the subject matter in this particular case (homicide and suicide), the federal government has jurisdiction in criminal law. Criminal law is not used to enforce or defend fundamental rights and freedoms *per se.* For that, Canada relies upon human rights statutes. But Canada does use the criminal law to prevent and to punish particularly egregious violations of fundamental freedoms that also present a serious threat to society: unlawful electronic surveillance, unlawful confinement and torture, for example.

IV.4.3 Coercion or intimidation intended to force citizens to become parties to homicide or suicide is both an egregious violation of fundamental freedoms and a serious threat to society that justifies the use of criminal law. For this reason, whatever might be decided about laws regulating euthanasia and assisted suicide, the Project proposes that the federal government make it a matter of law and national public policy that people cannot be compelled to become parties to homicide or suicide, or punished or disadvantaged for refusing to do so. Appendix "F" offers an amendment to the *Criminal Code* designed to achieve that end.

V. Conclusion

V.1 Experts less unanimous in their opinions might have produced a report less condescending toward those who continue to find killing patients "ethically challenging," more tolerant of ethical/moral diversity, and more respectful of the moral agency of physicians. As it stands, their Final Report is a playbook for ethical/moral imperialism under cover of the rule of law.

V.2. The rule of law is a fundamental principle. However, as Professor Roger Trigg observes, "When those in power over-rule conscience, even through the administration of law, that could itself undermine the basis of the rule of law, the purpose of which is to prohibit the use of arbitrary power."[30]

V.3 Legislators and medical regulators should note that the Experts' Final Report fails to provide any evidence that the suppression of freedom of fundamental freedoms they propose can be demonstrably justified in a free and democratic society.

Notes:

1. Ontario Ministry of Health and Long Term Care, Backgrounder: *Provincial-Territorial Expert Advisory Group Convened On Physician-Assisted Dying* (14 August, 2015) (https://news.ontario.ca/mohltc/en/2015/8/provincial-territorial-expert-advisory-group-convened-on-physician-assisted-dying.html) Accessed 2015-12-18.

2. Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report* (30 November, 2015) (Hereinafter "Report"), p. 1 (http://www.consciencelaws.org/archive/documents/2015-12-14-prov-panel.pdf)

3. Ontario Ministry of Health and Long Term Care, News Release: Provinces, Territories Establish Expert Advisory Group On Physician-Assisted Dying. Ontario Leading Provincial-Territorial Co-Ordination to Seek Advice from Experts. (14 August, 2015) (https://news.ontario.ca/mohltc/en/2015/08/provinces-territories-establish-expert-advisory-group-on-physician-assisted-dying.html) Accessed 2015-12-18.

4. *Report*, p. 57-58.

5. *Report*, p. 32.

6. *Report*, p. 60.

7. *Report*, p. 14.

8. *Report*, p. 19.

9. *Report*, p. 45.

10. *Report*, p. 18.

11. *Report*, p. 3, 15, 43-44.

12. *Factum of the Interveners, Euthanasia Prevention Coalition and Euthanasia Prevention Coalition - British Columbia* (28 August, 2014)(2) (9) (http://www.scc-csc.gc.ca/WebDocuments-DocumentsWeb/35591/FM210_Intervener_Euthanasia-Prevention-Coalition-and-Euthanasia-Prevention-Coalition-British-Columbia.pdf) Accessed 2015-09-10.

13. Court of Appeal, on Appeal from the order of the Honourable Madam Justice Smith of the Supreme Court of British Columbia pronounced June 15, 2012, *Factum of the Interveners - Euthanasia Prevention Coaltion and Euthanasia Prevention Coalition-British Columbia* (24 December, 2012) 3, 6, 8 (http://www.courts.gov.bc.ca/Court_of_Appeal/webcast/factums/Intervenor Euthanasia Prevention Coalition.pdf) Accessed 2015-09-10.

14. Jones A. "Ontario law society votes against accrediting graduates of B.C. university with 'abhorrent' gay sex ban." *National Post*, 24 April, 2014 (http://news.nationalpost.com/news/canada/b-c-christian-university-that-bans-gay-sex-asking-ontario-lawyers-to-accredit-new-law-school) Accessed 2016-01-01.

15. "[O]ur argument is founded on what Professor Battin sort of described as both principles of autonomy and the value of mercy. Because we are seeking . . . to constitutionalize or to strike down the law that criminalizes assistance in suicide, we don't rely on autonomy alone. We rely upon autonomy and suffering." Supreme Court of Canada, 35591, Lee Carter, et al. v. Attorney General of Canada, et al.(British Columbia) (Civil) (By Leave) Webcast of the Hearing on 2014-10-15: *Oral submission of Joseph Arvay* (hereinafter "Arvay"), 113:00 | 491:20 to 113:28 | 491:20 (http://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1938%2f201410150500wv150en%2c001&urlfr=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1940%2f201410150500wv150en%2c001&date=2014-10-15) Accessed 2015-10-28.

16. *Arvay*, 115:04 | 491:20 to 115:48 | 491:20; 118:42 | 491:20 to 119:08 | 491:20

17. *Arvay*, 126:38 | 491:20 to 127:00 | 491:20

18. *Report*, p. 43.

19. *Report*, p. 45.

20. *Report*, p. 3, 5-6, 23-27.

21. *Bentley v. Maplewood Seniors Care Society*, 2014 BCSC 165 (http://www.courts.gov.bc.ca/jdb-txt/SC/14/01/2014BCSC0165.htm) Accessed 2016-01-02.

22. *Report*, p. 43.

23. *Report*, Recommendation 27: p. 41.

24. *Report*, p. 46.

25. *Report*, Letter from the Co-chairs.

26. Canadian Medical Association, "Submission to the College of Physicians and Surgeons of Ontario: Consultation on CPSO Interim Guidance on Physician-Assisted Death"(13 January, 2016) (Hereinafter "CMA Submission") (http://www.consciencelaws.org/background/policy/associations-013.aspx)

27. *CMA Submission*

28. Protection of Conscience Project, *Submission to the College of Physicians and Surgeons of Ontario re: Interim Guidance on Physician Assisted Death* (10 January, 2016) (http://www.consciencelaws.org/publications/submissions/submissions-022-001-cpso.aspx)

29. Murphy S, Geunis S.J. *Freedom of Conscience in Health Care: Distinctions and Limits*. J Bioeth Inq. 2013 Oct; 10(3): 347-54 (http://rd.springer.com/article/10.1007/s11673-013-9451-x#)

30. Trigg RH. "Effective Referral." Paper delivered at conference, conscience and conscientious objection in health care, 23-24 November, 2015, University of Oxford. Forthcoming in the *Cambridge Quarterly of Healthcare Ethics.*

Appendix "A"
Supreme Court of Canada.
Carter v. Canada (Attorney General), 2015 SCC 5

A1. Carter criteria for euthanasia and physician assisted suicide

A1.1 In February, 2015, the Supreme Court of Canada struck down the criminal law to the extent that it prohibits physician assisted suicide and euthanasia in circumstances defined by the Court.[1]

A1.2 The ruling requires that physician assisted suicide and euthanasia be limited to competent adults who clearly consent to the procedure.[2] The use of the present tense suggests that consent cannot be established by an advance directive or provided by a substitute medical decision maker if the patient is otherwise unable to express valid consent.[3]

A1.3 According to Carter, the condition need not be terminal, but the patient must have "a grievous and irremediable medical condition (including an illness, disease or disability)."[4] The word "including" used here means that assisted suicide and euthanasia may be provided not only for "illness, disease or disability," but for other medical conditions - frailty, for example.[5]

A1.4 While the Court notes that "minor medical conditions" would not qualify[6] and that the medical condition must be "grievous," these are vague terms. Moreover, the Court does not specify whether it is the patient or the physician who determines that a condition is grievous. The medical condition must be "irremediable"; in oral argument, the appellants suggested this could be understood as "incurable."[7] However, the Court further states that individuals are entitled to refuse any treatments they find unacceptable,[8] so the ruling actually means that even treatable and curable medical conditions can be considered irremediable and incurable if the patient refuses treatment.

A1.5 Mental illness is a medical condition, and some kinds of mental illness are thought not to affect decisional capacity or competence. In passing, the Court remarks that the parameters they would propose in the reasons would not apply to "persons with psychiatric disorders."[9] However, the parameters actually laid out do not explicitly exclude mental illness, so, on this point, the ruling is ambiguous.

A1.6 Finally, the medical condition must cause "enduring suffering that is intolerable to the individual."[10] The Court does not specify that the suffering must be physical. Since it acknowledges the distinction between physical and psychological suffering[11] and pain and suffering,[12] the reference to intolerable suffering can be understood to mean both. Although the ruling does not say so, it is generally understood that suffering is subjectively assessed by the individual experiencing it.

A2. *Carter* and the criminal law

A2.1 If all of these criteria are met, a physician who kills a patient or helps him commit suicide

cannot be charged for murder or assisted suicide or any other offence. However, *Carter* did not entirely strike down murder and assisted suicide laws. They were invalidated only to the extent that they prevent homicide and assisted suicide by physicians adhering to the Court's guidelines.

A2.2 In the absence of legislation, the appropriate historical reference point for understanding the legal effect of *Carter* is the period between the 1938 case of R. v. Bourne and Canada's 1969 abortion law reform. Bourne was an English case that established a defence for physicians who provided abortions deemed necessary to preserve the life of the mother.[13]

A2.3 Though this condition was broadly construed, physicians were still liable to prosecution if the abortion were shown not to be required for that purpose. In 1967, CMA representatives told a parliamentary committee that "uncertainty about transgression of the law" was one of the reasons the Association supported reform of the abortion law.[14] Physicians wanted more than a defence to a charge. They wanted positive assurance that they would not be prosecuted.

A2.4 That assurance came when the Supreme Court of Canada struck down the abortion law entirely in the Morgentaler case. Physicians cannot be charged for providing abortions no matter what the circumstances.

A2.5 However, even with legislation - but particularly without it - it is difficult to see how physicians who are parties to homicide and suicide can entirely avoid some "uncertainty about transgression of the law." In the first place, the law against counselling suicide still stands [241(a) Criminal Code], so, while physicians may assist with suicide under the *Carter* guidelines, they can be charged if they recommend it.

A2.6 Second, as a matter of public policy, complete immunity from prosecution for murder or manslaughter can be safely guaranteed only for public executioners acting in the course of their duties. Thus, while the *Carter* ruling means that the state cannot prevent qualified patients from obtaining therapeutic homicide and suicide from physicians, it also means that physicians who fail to follow the *Carter* guidelines can be charged for first or second degree murder,[15,16] or manslaughter,[17] or administering a noxious substance.[18]

A2.7 Further, in such cases it would be a crime to conspire with the physician,[19] to do or omit to do anything for the purpose of aiding the physician,[20] to abet the physician,[21] or to counsel, procure, solicit or incite a physician to violate the *Carter* guidelines,[22] even if a patient is not ultimately killed.[23] Thus, anyone who deliberately participates in or facilitates euthanasia or assisted suicide by "effective referral" or similar means is liable to be charged unless the act is exempted by *Carter* from prosecution.

A2.8 The ruling itself is limited to the constitutional validity of the criminal law. It does not impose a legal duty on the state or upon anyone else to pay for euthanasia or assisted suicide or to provide or participate in them.

A3. *Carter* and freedom of conscience and religion

A3.1 This is essentially what the judges themselves acknowledge in *Carter*.

> In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures (para. 132). (Emphasis added)

A3.2 Note that the Court here referred to "physicians" (plural), not "a physician" (singular). This passage indicates that striking down the criminal prohibition did not, in the Court's view, create any obligation on the part of physicians (individually or collectively) to provide assisted suicide or euthanasia. The statement is limited to providing - doing the killing or providing the lethal prescription.

A3.3 However, the Court included the broader term - participation - as it continued:

> . . . we note - as did Beetz J. in addressing the topic of physician participation in abortion in R. v. Morgentaler -- that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the Charter rights of patients and physicians will need to be reconciled (para. 132). (Emphasis added)

A3.4 To suggest that this reconciliation is to be accomplished by forcing unwilling physicians to become parties to homicide and suicide is inconsistent with the comments of Justice Beetz in *Morgentaler*, cited with approval by the full bench of the Court in *Carter*:

> Nothing in the *Criminal Code* obliges the board of an eligible hospital to appoint therapeutic abortion committees. Indeed, a board is entitled to refuse . . . in a hospital that would otherwise qualify to perform abortions, and boards often do so in Canada. Given that the decision to appoint a committee is, in part, one of conscience, and, in some cases, one which affects religious beliefs, a law cannot force a board to appoint a committee any more than it could force a physician to perform an abortion.[24] (Emphasis added)

A3.5 Note that Justice Beetz, while distinguishing between appointing a committee and performing an abortion, nonetheless considered both acts to involve judgements of conscience and religious belief, and the legal suppression of one to be the equivalent of the legal suppression of the other.

A3.6 Therapeutic abortion committees did not provide abortions. In fact, members of therapeutic abortion committees were prohibited from doing so.[25] The committees facilitated abortions by authorizing them. The refusal of boards to approve the formation

of such committees was a refusal to become part of (participate in) a chain of causation culminating in abortion, even if not every case brought to a committee resulted in abortion.

A3.7 Thus, Justice Beetz' comments, affirmed by *Carter*, are authority for the proposition that the state is not only precluded from forcing individuals or institutions to provide morally contested procedures, but also precluded from forcing them to participate indirectly by referral or other forms of causal facilitation.

A3.8 At the very least, this passage indicates that the suppression or restriction of freedom of conscience or religion by compelling indirect participation in a morally contested procedure is legally equivalent to compelling direct participation, a conclusion wholly consonant with the law on criminal responsibility and civil liability. The same constitutional standard applies, whether the state means to force unwilling physicians to kill patients themselves, or to force them to arrange for patients to be killed by someone else.

A3.9 Put another way, compelling indirect participation in a morally contested act is not a constitutionally valid 'solution' for the 'problem' that arises from being unable to compel direct participation.

A3.10 The Court's statement that "the *Charter* rights of patients and physicians will need to be reconciled" is not, as some seem to think, a warrant for the suppression of freedom of conscience and religion among health care workers.

A3.11 The *Charter* right of patients clearly established by *Carter* is a legal right not to be impeded or obstructed by the state in seeking euthanasia and assisted suicide in accordance with the Court's guidelines from willing physicians, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society.

A3.12 The *Charter* right of physicians clearly established by *Carter* is their legal right not to be to impeded or obstructed by the state in providing euthanasia and assisted suicide in accordance with the Court's guidelines, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society.

A3.13 Any additional rights claims are derived by reading into the ruling what the judges either did not address, or purposefully and expressly left out.

Notes

1. *Carter v. Canada* (Attorney General), 2015 SCC 5, para. 132. (Hereinafter "Carter") (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do) Accessed 2015-06-27.

2. *Carter*, para. 4, 127, 147

3. This interpretation has been adopted by others. The College of Physicians and Surgeons of Alberta recently released a policy on euthanasia and assisted suicide that states, "PAD cannot be

provided to patients who lack the capacity to make the decision, including when consent can only be provided by an alternate decision maker, is known by patient wishes or is provided through a personal directive." (Emphasis in the original). College of Physicians and Surgeons of Alberta, Physician Assisted Death (December, 2015) (http://www.cpsa.ca/standardspractice/advice-to-the-profession/pad/) Accessed 2015-12-18

4. *Carter*, para. 4, 127, 147

5. Cimons M. "Frailty Is a Medical Condition, Not an Inevitable Result of Aging (Op-Ed)." Livescience, 29 November, 2013. (http://www.livescience.com/41602-frailty-is-medical-condition.html) Accessed 2015-06-28.

6. *Carter*, para. 111

7. "We are limiting our case to people whose condition is irremediable, or incurable if you want to use that language, because it, assisted dying should only be allowed in the most serious cases. And not just because somebody wants to. It's because their condition is not going to get any better." Supreme Court of Canada, Webcast of the Hearing on 2014-10-15, 35591, Lee *Carter*, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave). Joseph Arvay, Oral Submission, 113:35/491:20 - 114:50/491:20 (http://www.scc-csc.gc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1938/201410150500wv150en,001&urlfr=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1940/201410150500wv150en,001&date=2014-10-15) Accessed 2015-06-28

8. *Carter*, para. 127

9. *Carter*, para. 111

10. *Carter*, para. 4, 127, 147

11. *Carter*, para 40 , 64

12. *Carter*, para. 68

13. R. v Bourne (1939) 1KB 687

14. "'We don't like being lawbreakers,' Dr. Aitken told the committee in partial explanation of the C.M.A's motivation in supporting the move to expunge the Criminal Code's prohibition of abortion. Dr. Gray commented that while he knew of no doctor having been prosecuted for performing an abortion openly in a hospital, there was still the uncertainty about transgression of the law. Dr. Cannell reported there were 262 therapeutic abortions performed in Canadian hospitals between 1954 and 1965." Waring G. "Report from Ottawa." CMAJ Nov. 11, 1967, vol. 97, 1233

15. *Criminal Code* (R.S.C., 1985, c. C-46) (Hereinafter "CC"), Section 229 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-114.html); Section 231(1) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html) (Accessed 2014-07-25)

16. CC, Section 229 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-114.html); Section 231(7) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html) (Accessed 2014-07-25)

17. CC, Section 232(1) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-116.html) (Accessed 2014-07-25)

18. CC, Section 245. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-119.html) (Accessed 2014-07-25)

19. CC. Section 465. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-225.html)(Accessed 2014-07-25)

20. CC, Section 21(b). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

21. CC, Section 21(c). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html) (Accessed 2014-07-25)

22. CC, Section 22 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

23. CC, Section 464. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-224.html) (Accessed 2014-07-25)

24. R. v. Morgentaler (1988) 1 S.C.R.95-96 (Supreme Court of Canada) (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do) Accessed 2015-06-28.

25. CC, Section 287(4)a. (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-152.html?texthighlight=abortion#s-287.) Accessed 2015-06-27

Appendix "B"
Expanding *Carter* criteria, maximizing *Carter*'s impact

B1. Expanding the *Carter* criteria

B1.1 "Grievous and irremediable medical condition" includes mental illness (Recommendations 18, 20: p. 7, 15, 34, 36-37)

B1.1.1 It has been noted that the term "grievous and irremediable medical condition" is broad enough to include blindness and chronic depression.[1] The Experts affirm that it should be understood to mean "a very serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient." Cutting to the chase, this can mean any very serious illness, disease or disability for which treatment is unsuccessful or refused.

B1.1.2 Consistent with *Carter*, the Experts state that mental illness qualifies (p. 15), including mental illness for which a patient refuses treatment. This means that physicians should be able to provide therapeutic homicide or suicide precisely *because of* mental illness. However, the Experts recommend that requests from the mentally ill should receive "heightened scrutiny" to ensure that they are competent to decide whether or not they should be killed or helped to kill themselves.

B1.1.3 A survey of physicians by the CMA demonstrated that support for euthanasia or assisted suicide among physicians *willing to consider providing it* can drop by almost 50% if the patient is *not* terminally ill. Only 14% of responding physicians were willing to provide either euthanasia or assisted suicide for someone *not* terminally ill (Appendix D2.12), and only about 6% of the respondents would do so for psychological rather than physiological suffering (Appendix D2.10).

B1.1.4 These returns suggest that a large majority of physicians will not be willing to provide therapeutic homicide or suicide for those who are not terminally ill, let alone for those who are mentally ill. Of this group, a significant number may refuse to facilitate euthanasia or assisted suicide for the mentally ill or those not terminally ill through "effective referral" or similar means. Presumably, similar trends would be observed among other health care professionals.

B1.2 Suffering not a prerequisite (Recommendation 12: p. 6, 30-32, 35)

B1.2.1 The existence of "enduring" and "intolerable" suffering is one of the criteria established by *Carter*. The Experts acknowledge this requirement, and clearly wish to expedite euthanasia or assisted suicide "when suffering becomes intolerable."

B1.2.2 However, the Experts recommend, in addition, that people who ae *not* suffering should be able to authorize euthanasia and assisted suicide as long as they have been diagnosed with a "grievous and irremediable medical condition."

B1.2.3 What the Experts suggest is that, upon diagnosis, these patients should be able to have therapeutic homicide and suicide approved in advance, in anticipation of intolerable suffering.[2] Since the patient alone determines what constitutes intolerable suffering, the Experts propose that the patient should provide "a very clear statement of what the patient considers or would consider to be suffering that is intolerable." If the patient subsequently becomes incompetent, the physician would kill the patient "when certain conditions that the patient believes would constitute enduring intolerable suffering are met."

> The patient's symptoms and/or presentation at the time of the provision of the assistance will need to be assessed against the criteria for intolerable suffering set out by the patient in advance. (p. 32)

B1.2.4 Since actual experience would seem to be necessary to determine whether or not suffering is tolerable, it is by no means clear how a patient (particularly one who is not suffering) can determine this in advance. This is rather like asking a patient to predict whether or not he will regret being killed in accordance with his request.

B1.2.5 In any case, what the Experts recommend would effectively permit therapeutic homicide and suicide authorized by advance directive, on condition that the patient making the directive has been diagnosed with a "grievous and irremediable medical condition."

B1.2.6 But, assuming competence, why make such a diagnosis a condition? Why not let *anyone* make an advance directive authorizing therapeutic homicide and suicide, even if they are *not* seriously ill or disabled? The Experts could not agree upon an answer to this question.

> Some members of the Advisory Group believe that this is consistent with existing practice with respect to advance directives and so should be permitted, while others believe it is not possible to give informed consent. . . prior to a diagnosis of a grievous and irremediable medical condition. (p. 32)

B1.2.7 The Experts recommended that governments consult further for a year and then update legislation if need be.

B1.2.8 According to CMA surveys, the number of physicians willing to provide euthanasia or assisted suicide appears to range from 6% to 29%, depending upon the condition of the patient, and excluding reference to safeguards. Only about 6% of physicians would consider providing euthanasia or assisted suicide for psychological rather than physiological suffering (Appendix D2.10). However, it appears that such surveys have always proposed or have always been assumed to refer to a scenario involving a patient who is *actually* suffering, not someone who *anticipates* suffering some time in the future, so it seems doubtful that the surveys are a reliable indicator of physician support for what the Experts propose.

B1.2.9 A further complication is that the health care professional who receives and approves such an advance directive may not be the person required to lethally inject the patient

some time in the future. Particularly in the case of dementia, health care professionals may unwilling to kill a patient on the basis of an advance directive, especially a patient who does not appear to be suffering. This has already been illustrated in the case of Margaret Bentley.[3]

B1.3 Competence not a prerequisite: euthanasia for dementia (Recommendation 12: p. 29-31)

B1.3.1 According to *Carter*, only a patient who is competent can give consent for therapeutic homicide and suicide. The Experts recommend that the requirement for competence be limited to the point at which the patient consents by signing an approved declaration. As explained above, that would allow competent patients to authorize euthanasia or assisted suicide even if they subsequently became incompetent.

B1.3.2 The Experts argue that this is would be particularly advantageous for people diagnosed with dementia or other degenerative diseases, who would thus be able to authorize euthanasia in advance, at a point of their choosing, even if they are not competent when the time comes to kill them.

B1.3.3 What would happen if, after becoming incompetent, such a patient does not appear to be suffering, or wants to live?

B1.3.4 The Experts seem not to have considered this question.

B1.3.5 Certainly, the Experts state that a patient can, at any time, revoke or withdraw a request for therapeutic homicide or suicide. However, this is the only direct statement made by the Experts about revocation or withdrawal of a request in the sixty page document,[4] and the context suggests that it refers to a competent patient.

B1.3.6 Assuming that an advance directive made when a patient is competent is binding, the Expert recommendation implies that someone who signs an advance directive authorizing euthanasia when he is incompetent effectively signs his own irrevocable death warrant. It also implies that health care professionals may be expected to lethally inject dementia patients who do not appear to be suffering or who want to live (B2.9).

B1.3.7 While the CMA has not surveyed physicians about their willingness to execute advance directives by killing dementia patients who are not suffering or want to live, existing returns suggest that such an expectation would make conflicts of conscience among health care professionals more prevalent.

B1.4 Euthanasia and assisted suicide for children and adolescents (Recommendation 17: p. 29, 34)

\b1.4.1 The Supreme Court of Canada authorized euthanasia and assisted suicide for adults. The Experts reject what they call “arbitrary age limits.” They argue that euthanasia and assisted suicide should be provided to children and adolescents who are judged competent to decide whether or not their lives are worth living, given the suffering they may

experience from incurable illness or disability.

B1.4.2 A *National Post* article incorrectly reported that the recommendation was limited to "terminally ill" children; it is not. The co-chair of the Advisory Group has stated that a 12 year old child could make that decision, though not a five or seven year old. The Experts acknowledge that parents would not be able to prevent their children from being killed or helped to kill themselves.[5]

B1.4.3 It is important to consider this recommendation within the context of the others. When those recommendations are taken into account, what the Experts recommend is that

- euthanasia should be available to children and adolescents with serious and incurable medical conditions, including mental illness, as soon as they consider their suffering intolerable;
- competent children and adolescents should be able to authorize euthanasia and assisted suicide by advance directives, defining in advance what they would consider to be "intolerable suffering," so that they can be lethally injected if they are judged to be incompetent when the defined circumstances exist;
- euthanasia and assisted suicide for competent children and adolescents should not be delayed by waiting or reflection periods;
- parents would not be advised of plans to kill their children or assist with their suicide if their children did not want them to know.

B1.4.4 By making unqualified recommendations for euthanasia and assisted suicide for children and adolescents, the Experts go further than the Supreme Court of Canada, but also further than the successful appellants in *Carter*. They asked the court to strike down the law to the extent that it denied therapeutic homicide and suicide to competent *adults* They did not argue that 18 years old was a mere "arbitrary age limit." On the contrary, during his oral submission, Joseph Arvay said:

> For those born with a disability, it is not likely they will be vulnerable. They will have had years to adapt to their disability. And even if some may not, by the time they turn 18, any decision they make will be a very considered decision. It will not be an impulsive decision.[6]

B1.4.5 Conflicts of conscience among health care professionals are likely to be more prevalent in the face of demands that they participate in providing euthanasia and assisted suicide for children and adolescents, particularly in the case of the disabled or mentally ill, in the face of parental opposition, or when they are expected to conceal the cause of death from parents.

B1.5 Assessment, euthanasia and assisted suicide by non-physicians (Recommendations 7, 8, 22: p. 22, 25-26, 38)

B1.5.1 The Experts note that others, including nurses and pharmacists but also "personal support workers," may have a role to play in assisting physicians who provide euthanasia and assisted suicide. They recommend that the *Criminal Code* be revised to exempt such assistants from prosecution. Strictly speaking, this does not seem necessary, since they would not be liable to prosecution as parties to an offence for assisting with what would not be an offence to begin with.

B1.5.2 However, the Experts also recommend that the *Criminal Code* be amended to allow nurse practitioners to give lethal injections or provide lethal prescriptions, and to allow registered nurses and physician assistants acting under the direction of physicians to do so. Further, they recommend that nurse practitioners and health professionals (the latter working under the direction of physicians) be allowed do everything that is required in processing and fulfilling euthanasia/assisted suicide requests, including the second independent assessment of patient eligibility.

B1.5.3 The Experts also envisage a "personal support worker" giving a patient the lethal medication used for assisted suicide (p. 25). The term would cover a wide range of regulated and unregulated occupations, including personal care aides and group home supervisors.

B1.5.4 All of this is necessary, the Experts say, to ensure that "scope of practice legislation does not create barriers" to euthanasia and assisted suicide.

B1.5.5 Should these recommendations be adopted, it would seem that the term "physician-assisted" would no longer be appropriate.

B1.5.6 Allowing non-physicians to provide assisted suicide and euthanasia would increase the likelihood of disagreement and conflicts of conscience among other health care professionals and others who would not otherwise be directly or indirectly involved. On the other hand, it might relieve some of the pressure on objecting physicians to become directly or indirectly involved in the services.

B2. Increasing the impact of *Carter*

B2.1 The Supreme Court confined itself to setting the eligibility criteria for assisted suicide and euthanasia. It gave no direction as to safeguards or as to how or where the services were to be provided.

B2.2 A number of the Experts' recommendations thus do not go beyond what is required in *Carter*, but, nonetheless, have implications that increase its impact.

B2.3 Doctor shopping (Recommendation 25: p. 39)

B2.3.1 The Experts recommend that competent patients who have been found ineligible for euthanasia and assisted suicide should be allowed to find a physician willing to declare them eligible. Similarly, should a physician providing a second opinion conclude that a competent patient is ineligible, the Experts recommend that the primary attending physician should be able to seek a different opinion from another physician.

B2.3.2 The practice recommended by the Experts is allowed in the Netherlands. The Levenseinde Kliniek (End of Life Clinic) in Amsterdam was established in 2012 by a Dutch euthanasia advocacy group (Right-to-Die-NL).[7] It responds only to requests for euthanasia from patients whose applications for euthanasia have been rejected by their own physicians,[8] so it is the paradigm for euthanasia "doctor shopping." As noted above (B4.5), the clinic has been twice reprimanded by the euthanasia oversight committee for failing to exercise proper care, and some pharmacists have refused to provide euthanasia drugs to Clinic physicians because they did not believe that euthanasia was appropriate for a particular patient.

B2.3.3 During its first year of operations, it granted euthanasia or assisted suicide requests for 162 patients, whose suffering consisted of one or more of the following (in order of occurrence):

- physical decline or loss of strength;
- tiredness
- loss of autonomy
- loss of dignity
- psychological suffering
- loneliness
- shortness of breath
- loss of sensory functions
- loss of mental capacity

Other kinds of suffering identified by the patients but not statistically significant were pain, loss of capacity to maintain social contacts, detachment, nausea, hopelessness, bedridden and confusion. (The same suffering was identified by the 300 patients whose requests were refused).[9]

B2.3.4 The study providing this information was one of two described by two American commentators as "well done but contain[ing] gaps" and indicative of "worrisome trends." They stated that the research and other reports suggested that the 'slippery slope' argument "be taken very seriously."[10] This was disputed by the lead author of the study.[11]

B2.3.5 Leaving that point aside, CMA surveys of physicians suggest that the majority of Canadian physicians would be unwilling to participate in euthanasia or assisted suicide if approved for the reasons accepted by the Clinic. (Appendix D2.14) Conflicts of conscience among health care professionals asked or ordered to participate in euthanasia and assisted suicide are more likely if they suspect that doctor shopping has compromised the process leading to an authorization to kill a patient.

B2.4 No "waiting/reflection" period (Recommendation 26: p. 40-41)

B2.4.1 The Experts believe that "at least some time" should pass between a request for euthanasia or assisted suicide and its execution, but they rejected the idea that "a set amount of time"should be imposed because that would, in their view, "impose an arbitrary barrier to access that would negatively impact both patient decision-making and physician judgement."

B2.4.2 The Canadian Medical Association is of the view that the waiting time should be "proportionate to the patient's expected prognosis," but recommends that a minimum of 14 days should normally pass between a first and second request for euthanasia or assisted suicide, and recognizes that longer periods may be appropriate.[12]

B2.4.3 The Experts demonstrate an enthusiasm for therapeutic homicide and suicide that appears to surpass that of the lead lawyer representing the appellants in *Carter*. Speaking from his wheel chair during his oral submission to the Supreme Court of Canada, Joseph Arvay considered the need for "waiting periods," at least in some circumstances.

> And then I think about those who may be disabled in the prime of their life because of a car accident or a diving accident. And many of those may say, as soon as that happens, "I want to die," and that's an understandable reaction. But it makes sense for those people to impose a fairly long waiting period. Maybe a matter of years before we allow them to seek and obtain assistance in dying. Because our collective experience tells us that most of them, almost all of them, will, too, adapt, although some might not and we have to respect their decision.[13]

B2.4.4 The Levenseinde Kliniek (End of Life Clinic) in Amsterdam receives a notable increase in requests for "emergency euthanasia" during the holiday season, which pushes all employees to the limit to process the applications to provide the service. The Director of the Clinic states that the process can be reduced "to a very short time" so that requests can be quickly handled. He admits that this is "absolutely undesirable (absoluut onwenselijk)," but insists that "care remains paramount (blijft zorgvuldigheid voorop staan)" and that one must "help people in need (Mensen in nood moet je helpen)."[14] Clearly, a minimum waiting period would interfere with the processing of euthanasia requests during a Christmas rush.

B2.4.5 On the other hand, the Clinic has been twice reprimanded by the euthanasia oversight committee for failing to exercise proper care: once for killing an elderly woman whose medical conditions included anorexia nervosa, posttraumatic stress disorder, anxiety disorder, and depression,[15] and once for killing an elderly stroke victim who was said to be "suffering unbearably" because she did not want to live in a nursing home.[16] In April, 2014, physicians at the Clinic complained that pharmacists were refusing to provide them with euthanasia drugs, mainly because they did not believe that euthanasia was appropriate for a particular patient. Most refusals involved patients with dementia, psychiatric illness, or who simply considered their lives complete and wished to die.[17]

B2.4.6 Conflicts of conscience among health care professionals are likely to be more prevalent in the absence of a waiting/reflection period, particularly in the circumstances described by Joseph Arvay and prevailing, at times, in the Levenseinde Kliniek: especially in the case of children, adolescents and the mentally ill.

B2.5 Physicians need not be present at suicides (Recommendation 27: p. 41)

B2.5.1 The Experts recommend that physicians, nurse practitioners or others who prescribe lethal medication should not be required to be present when the patient ingests it: "The patient should have the right to choose who is present at the time of their death."

B2.5.2 The Experts acknowledge that complications and adverse effects are more likely in suicides, but state that an informed patient is entitled to take the risks. Physicians, they say, should simply "provide instructions on how to respond."

B2.5.3 What the Experts left unclear is what should be done if the patient is incapacitated but not killed by the medication.

B2.5.4 If the patient decides to take the medication without anyone else present, it appears that the Experts' position is that, having made an informed choice, the patient has made his bed and should (eventually) die in it, or suffer until he is found.

B2.5.5 If family, friends or others are present, the Experts appear to assume that they will have been instructed to call a physician, nurse practitioner, etc. to kill the patient by lethal injection. One hopes that they will not attempt to kill the patient themselves, since the *Carter* ruling provides no immunity from prosecution for them, nor have the Experts suggested it.

B2.5.6 Conflicts of conscience may arise among health care professionals who are expected to provide lethal prescriptions for assisted suicide, but who consider it unethical or at least imprudent to absent themselves when the drug is taken, particularly in the case of patients who are mentally ill. In addition, conflicts of conscience may be experienced by health care professionals who are called upon to lethally inject a patient who has not been killed by the prescribed medication, particularly if they have had no previous involvement in the case.

B2.6 Euthanasia and assisted suicide in hospitals hospices, retirement and nursing homes, etc. (Recommendation 27: p. 41)

B2.6.1 The Experts recommend that euthanasia and assisted suicide should be provided, not only in health care institutions or facilities, but "wherever patients live" if that is their wish. This may include "a retirement facility, nursing home or hospice" and "hospitals, long term care facilities and at home."[18] The Experts offer these as examples, not as an exhaustive list. The Experts offer these only as examples, not as an exhaustive list. "Wherever patients live" includes group homes, assisted living facilities and any kind of residential care facility.

B2.6.2 The Experts exempt "conscientiously objecting facilities" from this requirement, but the exemption will be available only to a small minority of facilities, and even then it is not a total exemption. (Appendix C1.)

B2.6.3 It will be difficult for health care professionals, care aides, personal support workers etc. who do not want to be involved with euthanasia and assisted suicide to find work anywhere in Canada where they can be sure that they will not be required to be involved with the procedures, or at least expected to stand by while patients or residents they know are killed or helped to commit suicide.

B2.7 Families and caregivers may not be advised (p. 29)

B2.7.1 While no formal recommendation is made with respect to the involvement of families and caregivers, the Experts note that families and caregivers may be advised "if the patient is willing and agrees." This means that patients may be killed or helped to commit suicide without the knowledge of their families, which would seem to require at least some dissembling or duplicity on the part of health care professionals involved.

B2.7.2 Conflicts of conscience are likely to be more prevalent among health care professionals who are uncomfortable lying or dissembling to families, and those who object to euthanasia who are not directly involved will almost certainly consider participation in deception to involve unacceptable complicity in killing, even if it occurs after the fact.

Notes:

1. Santi N. "From Courtroom to Bedside - A Discussion with Dr. Jeff Blackmer on the Implications of *Carter v. Canada* and Physician-Assisted Death." *UOJM* Volume 5, Issue 1, May 2015 (https://uottawa.scholarsportal.info/ojs/index.php/uojm-jmuo/article/view/1276/1270) Accessed 2015-07-04

2. Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report (30 November, 2015) (Hereinafter "*Report*"), p. 29, completion of declaration before suffering is experienced.

3. *Bentley v. Maplewood Seniors Care Society,* 2014 BCSC 165 (http://www.courts.gov.bc.ca/jdb-txt/SC/14/01/2014BCSC0165.htm) Accessed 2016-01-02

4. *Report*, p. 29. At p. 36 the Report quotes a paragraph from Federation of Medical Regulatory Authorities guidance that includes reference to the patient's right to "rescind" a request. The Report refers at p. 7, 33 and 59 to an oversight system that tracks outcomes, including "withdrawal" of requests.

5. Kirkey S. "Terminally ill children as young as 12 should have euthanasia choice, expert panel urges." *National Post*, 14 December, 2015 (http://news.nationalpost.com/news/canada/terminally-ill-children-as-young-as-12-should-have-euthanasia-choice-expert-panel-urges)

6. Supreme Court of Canada, 35591, *Lee Carter, et al. v. Attorney General of Canada, et al.* (British Columbia) (Civil) (By Leave) Webcast of the Hearing on 2014-10-15: *Oral submission of Joseph Arvay* (hereinafter "Arvay") 77:16 | 491:20 to 7:37 | 491:20 (http://www.scc-csc.gc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1938%2f201410150500wv150en%2c001&urlfr=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1940%2f201410150500wv150en%2c001&date=2014-10-15) Accessed 2015-10-28.

7. Connolly K. "Dutch mobile euthanasia units to make house calls. New scheme called 'Life End' will respond to sick people whose own doctors have refused to help them end their lives at home." The Guardian, 1 March 2012 (http://www.theguardian.com/world/2012/mar/01/dutch-mobile-euthanasia-units) Accessed 2013-11-15)

8. Levenseinde Kliniek (http://www.levenseindekliniek.nl/) Accessed 2015-12-19

9. Snijdewind MC, Willems D, Deliens L. Onwuteaka-Philipsen BD, Chambaere K. "A Study of the First Year of the End-of-Life Clinic for Physician-Assisted Dying in the Netherlands." JAMA Intern Med 2015 Oct;175(10):1633-40. doi: 10.1001/jamainternmed.2015.3978

10. Lerner BH, Caplan AL. "Euthanasia in Belgium and the Netherlands: On a Slippery Slope?" *JAMA Intern Med*. 2015 Oct;175(10):1640-1. doi: 10.1001/jamainternmed.2015.4086.

11. The JAMA Network Speciality Author Interviews, *Interview with Marianne C. Snijdewind, MA;, author of A Study of the First Year of the End-of-Life Clinic for Physician-Assisted Dying in the Netherlands, and Barron H. Lerner, MD, PhD, author of Euthanasia in Belgium and the Netherlands: On a Slippery Slope?* (http://www.stitcher.com/podcast/the-jama-network/specialty-journals-author-interviews/e/the-endoflife-clinic-for-physicianassisted-dying-in-the-netherlands-40091634) Accessed 2015-01-02.

12. Canadian Medical Association, *Principles Based Recommendations for a Canadian Approach to Assisted Dying*, p. A2-3, A2-4 (http://www.cspcp.ca/wp-content/uploads/2015/04/CMA-Framework_Assisted-dying_Approved-by-Board_OCT2015.pdf) Accessed 2015-12-18

13. *Arvay*, 77:37 | 491:20 to 78:17 | 491:20.

14. Levenseindekliniek, *Steeds meer kankerpatiënten bij Levenseindekliniek (More and more cancer patients at End of Life Clinic*) (23 July, 2015) (http://www.levenseindekliniek.nl/steeds-meer-kankerpatienten-bij-levenseindekliniek/) Accessed 2015-12-19

15. Levenseindekliniek, *Oordeel van de Regionale Toetsingscommissie Euthanasie (Judgement of the Regional Euthanasia Review Commitee*) (19 January, 2015) (http://www.levenseindekliniek.nl/wp-content/uploads/2015/01/RTE-Oordeel-2014-5.pdf) Accessed 2015-12-19

16. *DutchNews.nl* "Euthanasia clinic reprimanded for death of stroke victim."27 August, 2014. (http://www.dutchnews.nl/news/archives/2014/08/euthanasia_clinic_reprimanded.php) Accessed 2015-12-19.

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18. *Report*, p. 41.

Appendix "C"
Expert recommendations re: freedom of conscience and religion

C1. Institutions

C1.1 Meaning of "institution"

C1.1.1 The Experts want all health care institutions to become "critical enablers" of euthanasia and assisted suicide,[1] but they do not stop with health care institutions. The Experts want euthanasia and assisted suicide to be provided wherever people live,[2] and "wherever people are living and dying."[3]

C1.1.2 This means that the recommendations that refer to "institutions" apply not just to hospitals and hospices, but to correctional institutions, nursing homes, retirement homes, assisted living and extended care facilities, and group homes for mentally handicapped or disabled persons such as those run by L'Arche:[4] in short, any residential care facility.

C1.1.3 As a result, in the commentary below, while the term "institution" is retained in direct reference to the relevant recommendation, it is replaced elsewhere by "facility," and "patient" is replaced with "patient/resident."

C1.2 All "institutions" - public and private - must allow euthanasia or assisted suicide on premises, or arrange for it to be done elsewhere (Recommendation 37: p. 46-47)

Faith-based "institutions" must allow euthanasia and assisted suicide on their premises, or arrange for it to be done elsewhere (Recommendation 38: p. 47)

C1.2.1 Recommendations 37 (Non-faith based institutions) and 38 (Faith-based institutions) are confusing and misleading. The Experts purport to distinguish between the obligations of faith-based and non-faith based facilities to participate in euthanasia and assisted suicide, but, in fact, the obligations are identical. The distinction in the Report between "faith-based" and "non-faith-based" institutions is a meaningless.

C1.2.2 While it is true that more detail is provided about what is to be required of faith-based institutions, the details are primarily of interest because they illustrate that the Experts believe that religiously motivated citizens are more likely to abandon their patients or discriminate against them.[5]

C1.2.3 In brief, the Experts want to force all facilities, whether or not they are "faith-based," to allow patients/residents to be killed or helped to commit suicide on their premises, or to arrange for an "effective transfer" of the patient/resident and his records to an "institution" where that can be done.

C1.2.4 An "effective transfer" means "a safe and timely transfer to a non-objecting institution"

where the patient "can be assessed and treated by a health care provider who is willing and able to assess whether the patient meets the eligibility criteria . . .and, if so" provide euthanasia or assisted suicide.

C1.2.5 If a "safe and timely transfer" is not possible, all "institutions" must allow the patient or resident to be assessed and killed or helped to commit suicide on their premises.

C1.2.6 It is true that the Experts explicitly impose the latter requirement only on "faith-based" institutions, but it would be absurd to suppose that the Experts really want to force denominational institutions to allow euthanasia and assisted suicide in such circumstances, while exempting state institutions.

C1.2.7 It is unlikely that an objecting facility would decline to arrange a transfer for a patient/resident who merely wished to explore the possibility of euthanasia or assisted suicide in a different environment. Similarly, it is unlikely that a problem would arise if a patient/resident were to identify and request a transfer to a facility willing to provide assisted suicide or euthanasia. In neither case would the objecting facility be actively enabling euthanasia or assisted suicide.

C1.2.8 However, recall that the Experts demand that a patient/resident seeking euthanasia or assisted suicide must be completely relieved of the "burden" of finding a provider.[6] Recommendation 38 states that the objecting facility - not the individual - must "make arrangements for an effective transfer." Some facilities are likely to consider this active involvement to constitute unacceptable complicity in homicide and suicide, but the Experts want them forced to do so.

C1.2.9 Recommendations 37 and 38, understood within the context of the Report, are designed to compel all objecting facilities, from general hospitals to L'Arche group homes, to become critical enablers of euthanasia and assisted suicide, at least to the extent of helping to arrange for the procedures.

C1.3 All institutions must disclose position on and limits to providing euthanasia and assisted suicide (Recommendation 34: p. 46)

C1.3.1 Recommendation 34, if adopted, will affect every institution, facility, association, organization or private individual providing either health care or residential living for elderly, handicapped or disabled persons in Canada.

C1.3.2 First: every one will have to establish "an institutional position on physician assisted dying."

C1.3.3 Second: the default position proposed by the Experts is that all "institutions" will allow euthanasia and assisted suicide on their premises. In fact, none will be allowed to absolutely prohibit the procedures (C1.2.5).

C1.3.4 Third: facilities that don't adopt the default position and intend to limit euthanasia or assisted suicide on their premises will have obligations to ensure patients/residents can access the procedures elsewhere (C1.2.3, C1.2.4, C1.2.5).

C1.3.5 Recommendation 34 effectively requires "institutions" to disclose their "position," departures from the default position, and policies under C1.2.4.

C1.3.6 The cumulative effect of the recommendations will be to require all "institutions," from general hospitals to Ottawa L'Arche group homes, to formulate a policy on facilitating patient/resident access to euthanasia and assisted suicide, and notify residents/patients/applicants of that policy.

C1.3.7 The Experts explain that prior disclosure of institutional policies limiting euthanasia and assisted suicide will allow patients/residents to decide whether or not to enter an facility. At first glance, this seems to allow people the freedom to choose whether or not they wish to live in or be treated in facilities that allow patients/residents to be killed or commit suicide.

C1.3.8 However, if the Experts have their way, no facility in Canada - public, private or faith-based - will be allowed to completely prohibit euthanasia and assisted suicide on their premises, and all will be forced to arrange for the services to be provided elsewhere (C1.2.3).

C1.3.9 From the perspective of potential patients/residents/applicants, freedom of choice, according to the Experts, does not include the freedom to choose to live where euthanasia and assisted suicide are forbidden. Freedom to choose means, at most, the freedom to choose facilities - where they exist - that will only allow patients to be killed or commit suicide on their premises in exceptional circumstances.

C1.3.10 From a facility perspective, advance notice to potential patients/residents may help to avoid some conflicts. However, as noted above, the requirement for advance notice is not intended to allow them to operate without involvement in euthanasia and assisted suicide, but to force them to make plans to facilitate the procedures, based on the assumption that they are obliged to do so.

C1.3.11 Particularly in the case of facilities providing homes or treatment for people who are disabled, mentally handicapped or mentally ill, the requirement to advise all potential patients/residents of the facility policy on how to access euthanasia and assisted suicide may well be seen as offensive, contrary to the mandate of the facility and insensitive to or even abusive of applicants and residents.

C1.4 Institutions must not require patients or residents to give up "the right to access" assisted suicide and euthanasia (Recommendation 35: p. 46)

Institutions must not prevent physicians or employees from providing assisted suicide or euthanasia elsewhere (Recommendation 36: p. 46)

C1.4.1 Recommendations 35 and 36 must be read together, as the Experts state that both have the same purpose: "to limit the power of institutions" to restrict patient autonomy.

C1.4.2 Recommendations 35 and 36 have nothing to do with the expectation that patients will be

provided with information sufficient to make informed decisions, or that they will be advised of all "legal options," including euthanasia and assisted suicide. Those points are covered by Recommendations 31 and 32.

C1.4.3 Recommendation 35 assumes that *Carter* provides a positive right to assisted suicide and euthanasia: that it give citizens the right to demand that the state or others must kill them or help them commit suicide.

C1.4.4 In fact, the ruling provides a defence to murder and assisted suicide charges in certain circumstances - nothing more . It is, at best, a right not to be prevented from obtaining assisted suicide and euthanasia (Appendix A2.8, A3.11). Facilities cannot require individuals to give up that right.

C1.4.5 On the other hand, to manifest and make effective its opposition to killing patients or helping them to commit suicide, and/or to manifest and make effective a commitment to palliative care, religious or moral beliefs, or a philosophy of life or medicine, the management of an objecting facility could:

- refuse to allow euthanasia or assisted suicide to be provided on the premises;
- refuse to assist in finding someone willing to provide the procedures;
- refuse to arrange for euthanasia or assisted suicide elsewhere (while cooperating in transfers of care);
- prohibit emloyees or physicians in the facilty from arranging euthanasia or assisted suicide elsewhere during interactions with patients/residents (while respecting principles of informed medical decision making);
- give preference in hiring and promotion to applicants or employees supportive of facility philosophy publicize such policies and disclose them to applicants for admission, employment or privileges.

C1.4.6 Applicants for admission, employment or privileges who were unwilling to abide by such policies would be free to apply to a different facility. If they changed their minds after admission or joining facility staff, they would be free to leave. This approach does not require them to give up rights established by *Carter*.

C1.4.7 However, it appears that Recommendations 35 and 36 are intended to prohibit such policies. Taken together, they are apparently designed to prohibit objecting facilities from disciplining or dismissing employees or physicians who, while working in the facilty, actively subvert its fundamental commitments by promoting or arranging for euthanasia or assisted suicide during interactions with patients/residents. It appears that the Experts want to establish a regime that prohibits the manifestation or expression of effective opposition to euthanasia and assisted suicide.

C2. Objecting physicians/health care providers

Note: The Experts want other health care professionals to be able to provide euthanasia

and assisted suicide and to participate in delivering the services through teams, so reference to "physicians" here must be understood to apply to other health care workers who are acting in the place of physicians.

C2.1 Objecting physicians must provide information on "all options," regardless of their beliefs (Recommendation 31: p. 44)

C2.1.1 The Experts recommend that physicians should be forced to offer the options of therapeutic homicide or suicide, "regardless of their personal beliefs." Providing information responsive to a patient's questions or expressed interest would be necessary to meet the requirements of informed medical decision making.

C2.1.2 If the Experts mean only that physicians should be required to provide information necessary to allow informed decision making if a patient asks about euthanasia or assisted suicide, this is unlikely to be problematic.

- In the Project's experience, physicians who object to providing morally contested procedures do not normally object to providing information that a patient needs in order to make informed decisions.
- Moreover, the Project's experience is that objecting physicians are particularly sensitive to and anxious to respond to the difficult circumstances that may cause patients to request euthanasia or physician assisted suicide.
- The suggestions made in recent guidance from the College of Family Physicians of Canada indicate the kind of response that should be presumed and encouraged.[7]

C2.1.3 On the other hand, the Experts may believe that patient cannot provide valid informed consent to other forms of treatment if they are not apprised of the options of assisted suicide and euthanasia immediately upon diagnosis, or at least before agreeing to other forms of treatment. This would be consistent with the Experts recommendation that the options be offered to patients even if they are not suffering, so that they can complete advanced directives authorizing euthanasia and assisted suicide in anticipation of suffering (Appendix B2).

C2.1.4 It is not clear whether or not the Experts want physicians forced to gratuitously offer euthanasia and assisted suicide as treatment options in the absence of any indication of interest from a patient.

C2.1.5 In contrast, a draft policy proposed by the College of Physicians and Surgeons of Manitoba presumes that a request for euthanasia or physician assisted suicide will come from the patient. It does not impose a requirement that physicians offer patients the options of euthanasia or assisted suicide.[8] This is prudent, for three reasons.

C2.1.6 First: the *Carter* decision did not strike down the law against counselling suicide [241(a) *Criminal Code*], so the gratuitous suggestion of physician assisted suicide even to patient who meets the *Carter* criteria may expose physicians to criminal prosecution.

C2.1.7 Second: physicians may believe that it would sometimes be harmful or even abusive to gratuitously offer assisted suicide and euthanasia as treatment options: the case of a patient just blinded or paralysed by an industrial accident comes to mind.

C2.1.8 Third, and more commonly, it is likely that many physicians would find it at least insensitive to offer assisted suicide and euthanasia as treatment options upon a diagnosis of dementia, congestive heart failure, chronic obstructive pulmonary disease, stroke, or major depressive disorder, all of which would qualify as irremediable medical conditions under the terms of the *Carter* ruling.

C2.1.9 The concerns noted in C2.1.6 to C2.1.8 are likely to be common not only among objecting physicians, but among physicians willing to be involved in euthanasia and assisted suicide in at least some circumstances.

C2.2 Objecting physicians must disclose views on euthanasia and assisted suicide to patients, and the implications of their views (Recommendation 32: p. 44)

C2.2.1 The Experts recommend that physicians "appropriately inform their patients of the fact and implications of their conscientious objections," and provide ongoing treatment "in a non-discriminatory manner."

C2.2.2 Here the Experts display notable bias in favour of euthanasia and assisted suicide, ironically cloaked in a pretence of moral/ethical neutrality. Killing patients and helping them commit suicide in defined circumstances is, for the Experts, legally and morally/ethically normative - even obligatory. Hence, they do not recognize that the views of physicians who *do not object* to killing patients or helping them commit suicide *also* have implications for patients.

C2.2.3 When appropriate, both objecting and non-objecting physicians should notify patients of their views on assisted suicide and euthanasia. Any further requirement for a discussion of the implications of their views should apply equally to objecting and non-objecting physicians.

C2.3 Objecting physicians must provide ongoing treatment of patients seeking euthanasia and assisted suicide in a non-discriminatory manner (Recommendation 32: p. 44)

C2.3.1 The Experts' warning against illicit discrimination is directed to only to objecting physicians: another example of bias.

C2.3.2 If it is reasonable to suspect that *objecting* physicians might illicitly discriminate against patients who *want* euthanasia or assisted suicide, it is equally reasonable to suspect that *non-objecting* physicians might illicitly discriminate against patients who *do not* want euthanasia and assisted suicide. Thus, the warning against illicit discrimination ought to be addressed to both.

C2.3.3 Moreover, there is actually more reason to offer a warning about illicit discrimination to

physicians willing to provide euthanasia and assisted suicide, because they are more likely to be charged with illicit discrimination by human rights tribunals or regulatory authorities. University of Ottawa law professor Amir Attaran attempted to make this point, albeit in the wrong context:

> Across Canada, laws forbid service providers from discriminating against the disabled. In Ontario, the *Human Rights Code* defines a "disability" in broad terms that include serious illnesses - certainly any "grievous and irremediable" illness, to borrow the Supreme Court's phrase. Thus, when doctors offer the full standard of care to patients - but not to disabled patients, who get a lesser standard of care because it excludes assisted dying - that is discrimination.[9]

C2.3.4 For the most part, Professor Attaran's column cannot be taken seriously,[10] but the argument he attempts on this issue is not entirely without legal merit if it is recast to apply to non-objecting physicians who wish to limit the scope of their practices.

C2.3.5 Physicians who, for reasons of conscience or religion, refuse absolutely to participate directly or indirectly in assisted suicide and euthanasia are acting within the terms of the *Carter* ruling (Appendix A3).

C2.3.6 However, consistent with Professor Attaran's views, that is not necessarily true of physicians who provide euthanasia or assisted suicide in some circumstances but not in others.

C2.3.7 Physicians willing to provide euthanasia and assisted suicide for patients who are terminally ill or disabled, but not the mentally ill, might well be accused of illicitly discriminating against the mentally ill. Physicians willing to provide euthanasia and assisted suicide for patients who are terminally ill, disabled or mentally ill, but not children and adolescents, might well be accused of illicitly discriminating against children and adolescents.

C2.3.8 This is corroborated by the position of the Quebec Commission on Human Rights and Youth Rights. The Commission warned Quebec legislators that the failure to allow euthanasia for children and adolescents and the incompetent (which would include many patients with dementia and mentally illness) amounted to illicit discrimination.[11] Speaking of Bill 52, M. Jacques Fremont, head of the Commission, said that if the bill were not changed to allow euthanasia for minors and the incompetent (it was not) "I guarantee you there will be a 16 year old who will go to court" and "the prohibition for incompetent minors will be quick-fried."[12]

C2.3.9 The legal threat posed by aggressive lawyers and law professors like Professor Attaran is most credible with respect to physicians willing to directly or indirectly provide euthanasia and assisted suicide for selected sub-groups of patients (e.g., the terminally ill), but who, for reasons of conscience or for other reasons, are unwilling to do so for other sub-groups (e.g., the mentally ill). It would seem that these physicians can reduce or minimize their legal jeopardy either by participating in euthanasia and assisted suicide for *all* patients under *all* conditions allowed by law, or by absolutely refusing to participate

under any circumstances.

C2.4 Objecting physicians must act as critical enablers of therapeutic homicide and suicide (Recommendation 33: p. 44-45)

C2.4.1 Three alternatives

C2.4.1.1 Physicians who, for reasons of conscience or religion, refuse to kill patients or help them commit suicide are offered three alternatives by the Experts: referral, direct transfer of care, and transfer to a third party. The Experts do not expect objecting physicians and health care providers to assess the patient's eligibility for assisted suicide or euthanasia, but they do insist that objecting physicians and health care providers become critical enablers of euthanasia and assisted suicide.

C2.4.2 Referral

C2.4.2.1 The Experts do not define "referral." The omission is remarkable. Referral has been the centre of controversy in relation to morally contested procedures since the Project's inception in 1999. Since at least 2006, Advisory Group member Professor Jocelyn Downie has actively campaigned for compulsory "effective referral" for abortion, contraception, euthanasia and assisted suicide,[13] as that term has been defined by the College of Physicians and Surgeons of Ontario (CPSO):

> An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral.[14]

C2.4.2.2 A serious controversy over the CPSO's policy imposing a demand for effective referral for morally contested services led to an ongoing lawsuit against the College.[15] The College has since proposed that "effective referral" should be required for physicians unwilling to kill patients or help them commit suicide.[16]

C2.4.2.3 In addition to "effective referral," the term "referral" can be used in a narrow, technical sense to mean a formal arrangement for consultation with another physician. However, as it is frequently used by those demanding that physicians "refer for abortion" or "refer for euthanasia," it often means only providing contact information for a provider or directing the patient to someone who will provide the service.

C2.4.2.4 An expectation of referral under any of these forms would be not be problematic for physicians who have no objections to euthanasia or assisted suicide in principle, but who do not wish to write lethal prescriptions or lethally inject patients themselves. Nor would it be objectionable to physicians whose moral reasoning leads them to conclude that such referral absolves them of culpable complicity in homicide or suicide..

C2.4.2.5 However, all three forms of "referral" are unacceptable to physicians who consider such assistance to involve unacceptable complicity in wrongdoing. Their ethical or moral reasoning is exactly the same as that underlying refusal to provide contact information for

a crack dealer or a pimp trafficking in adolescent flesh.

C2.4.3 Direct transfer of care

C2.4.3.1 Direct transfer of care is proposed as a second alternative. The Experts explain:

> We recognize that some providers view a transfer of care as morally preferable to referral because, unlike referral, it is taken to neither explicitly nor implicitly affirm [*the moral acceptability of*] the service sought by the patient.

C2.4.3.2 The Experts propose that a direct transfer of care could be initiated after a patient has requested euthanasia or physician assisted suicide and has discussed end-of-life options with an objecting physician or health care provider.

> A health care provider could transfer the patient to another health care provider for the assessment and treatment of the patient's medical condition and, if the patient meets the eligibility criteria, provision of physician-assisted dying. The receiving health care provider must be someone who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying. (P. 45)

C2.4.3.3 The Experts' claim that this "direct transfer" cannot be understood to explicitly or implicitly affirm the moral acceptability of euthanasia or assisted suicide is disingenuous. In no sense is this different from arranging for a patient with complex medical needs to be transferred to a specialist who can provide treatment an attending physician is unable to provide. These arrangements presume and thus implicitly affirm the moral acceptability and probable efficacy of the treatment in question.

C.2.4.3.4 Bluntly, the Experts demand that objecting physicians or health care providers find a colleague willing to accept and assess their patients and kill them or help them commit suicide if they are eligible. Having found a willing colleague, they demand that objecting physicians arrange for the transfer of the patient for that purpose.

C2.4.3.5 Draft guidance from the College of Physicians and Surgeons of Ontario adds a detail not included by the Experts, but obviously required in order to effect a "direct transfer."

> The College acknowledges that the number of physicians and/or agencies to which a referral would be directed may be limited, particularly at the outset . . . and that this is relevant to any consideration of whether a physician has complied with the requirement to provide an effective referral. In light of these circumstances, the College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape.[17]

C2.4.3.6 Requiring objecting physicians to maintain up-to-date lists of health care providers willing to kill patients or help them commit suicide underscores the degree of deliberate participation expected of them.

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* Phrase added here to provide the sense that seems intended by the Experts' statement.

C2.4.4 Transfer to "a publicly-funded system" or "third party"

C2.4.4.1 In view of the foregoing, it is not surprising that the Experts concede that "direct transfer" is likely to be problematic. They offer a third option "for those who are not willing to provide a direct transfer of care on conscience or religious grounds."

C2.4.4.2 Those physicians, say the Experts, should be required to contact "a publicly-funded system designed to ensure that patients are able to access a health care provider willing to accept them as a patient for assessment" and provide euthanasia or assisted suicide if they are eligible. The objecting physicians would transfer the patient's records to the "publicly-funded system" to facilitate that process.

C2.4.4.3 The "publicly-funded system" to which the Experts refer is described in greater detail under Recommendation 4.

> We recommend the creation of a publicly-funded care coordination system to link patients with an appropriate provider of physician-assisted death. . . We recommend that this system be modelled on successful examples used in other health care services (e.g. cancer care, organ transplantation). We envision them as "patient navigators", people who have an understanding of the field, knowledge of health care providers who are willing to provide physician-assisted dying . . . While the system's initial role would be to connect patients to physicians and manage the transfer of patients, *over time they may also assist with helping patients understand the range of end-of-life options available, including palliative care*. (Emphasis added)[18]

C2.4.4.4 This "system" (or "third party") is like a bus or taxi service that objecting physicians or health care providers would be expected to call to arrange for patients to be delivered to colleagues for the purpose of having them killed or helped to commit suicide. The Experts see that as its first priority. Only later ("over time") might this "system" begin to provide more information about options, while continuing as a euthanasia/assisted suicide delivery service.

C2.4.4.5 The Experts' comparison of their "system" or "third party" to existing organ transplant arrangements is instructive. The Experts believe that killing patients and transplanting organs are both morally/ethically acceptable. Thus, policies and systems suitable for delivering hearts and livers to save patients lives can simply be adapted to deliver lethal injections and toxic prescriptions to end them.

C2.4.4.6 In British Columbia, for example, a physician who has a patient who may be a suitable candidate for organ donation calls a referral and notification number to determine if consent for donation has been given, and approaches the family after the Organ Donor Registry has been checked. The physician actively manages the case and cooperates with other health care providers until the organs have been retrieved.[19] A British Columbia physician who has a patient in need of an organ must do a preliminary assessment for contraindications and then register the patient in an on-line referral system, the first step toward matching the patient with a suitable donor and, ultimately, organ

transplantation.[20]

C2.4.4.7 Physicians managing donors and recepients are actively involved in the process leading to organ transplantation. While a transplant may not ultimately occur for reasons beyond their control, it is clear that their actions are intended to culminate in a transplant, and that they are professionally and morally engaged in the process.

C2.4.4.8 The Experts demand the same level of professional and moral commitment to killing patients and helping them commit suicide through an analogous system. This is just as unacceptable to many objecting physicians as effective referral and direct transfer.

C2.4.4.9 It does not seem that the Experts believe that these physicians are "genuinely wicked" - a position taken by Baroness Mary Warnock, another expert euthanasia activist.[21] Nonetheless, the Experts obviously believe that objecting physicians are so seriously mistaken that their views do not deserve accommodation, and that they should be forced to provide direct transfers if their "system" or "third party" is not available.

C2.4.5 The Experts' "system/third party" and the CMA's "central service"

C2.4.5.1 The Experts' description of their "system/third party" is similar to a proposal supported by the Canadian Medical Association (CMA) (Appendix D3.18), but there are some notable differences.

C2.4.5.2 Key points in the CMA proposal:

- Physicians are not obliged
  - "to provide or participate"
  - "to refer the patient to a physician or a medical administrator who will provide assisted dying"
- Objecting physicians are obligated to respond to a patient's request and must
  - provide the patient with complete information on all options available, including assisted dying; and
  - advise the patient on how they can access any separate central information, counseling, and referral service; and
  - provide relevant medical records "when authorized by the patient"; and
  - transfer the patient's chart to the new physician when authorized by the patient to do so.
- Objecting physicians must not
  - discriminate against a patient, or
  - "impede or block access" to euthanasia or assisted suicide

C2.4.5.3 The CMA central service appears to differ from the Experts "system/third party" in three ways.

C2.4.5.4 First: consistent with the terminology in *Carter* (Appendix A3.1 to A3.3), the CMA states that objecting physicians are not obliged "to provide *or participate*" in euthanasia or assisted suicide.

- At no point do the Experts make this statement. On the contrary: they believe that physicians are legally and ethically obliged to actively enable euthanasia and assisted, and their recommendations concerning their "system/third party" reflect that belief.

C2.4.5.5 Second: the CMA proposal does not require objecting physicians to contact the central service or initiate a transfer of patients and records. Their involvement is limited to providing information to the patient, and responding to requests to patient-initiated tranfer of records. The initiative remains with the patient.

- In contrast, consistent with their demand that patients be completely relieved of the "burden" of finding a willing physician, the Experts require objecting physicians to make arrangements through their "system/third party" just as physicians must make arrangements for organ transplants.

C2.4.5.6 Third: the "central information, counseling, and referral service" recommended by the CMA was acceptable to organizations representing many objecting physicians (Appendix D3.8) precisely because it was understood not to be a euthanasia/assisted suicide delivery system.

- The Experts cleary envisage their "system/third party" to function as a euthanasia/assisted suicide delivery system, analogous to an organ transplant system.

C2.4.5.7 It is not unreasonable to be concerned by these differences, and it would be imprudent to ignore them entirely. It appears that, but for the *Carter* decision, every alternative recommended by the Experts would expose a physician to prosecution as a party to the offence of first degree murder or assisted suicide, or conspiracy to commit first degree murder or assisted suicide.

C2.4.5.8 The Project's position is that the CMA position is clearly preferable because it ensures patient access without compromising physician freedom of conscience.

C2.4.5.9 Even those who see no essential difference between the CMA and the Experts' proposal have good reason to prefer the former for pragmatic reasons. Having been developed by physicians themselves, it is more likely to enjoy the support of the medical profession, and thus generate fewer problems in implementing the *Carter* decision, particularly if legislators and regulators work cooperatively with the CMA.

Notes

1. Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report (30 November, 2015) (Hereinafter "*Report*"), p. 43

2. *Report*, Recommendation 27: p. 41.

3. *Report,* p. 46

4. L'Arche: What is L'Arch? (http://www.larche.ca/en/larche/what_is_larche")Accessed 2015-12-22).

5. Thus the Experts felt it important to state, "Faith-based institutions have a duty to care for and not abandon the patients within their instititution," - a reminder not given to non-faith based institutions. *Report*, p. 47.

6. *Report*, p. 43.

7. College of Family Physicians of Canada, *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia* (September, 2015) p. 5 (http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/Guidefor Euthanasia_EN_FInal.pdf) Accessed 2015-10-30.

8. College of Physicians and Surgeons of Manitoba, *Draft Statement on Physician Assisted Dying* (15 October, 2015) (http://www.consciencelaws.org/archive/documents/cpsm/2015-10-15-cpsm-pad.pdf)

9. Attaran A. "Doctors can't refuse to help a patient die - no matter what they say." *iPolitics*, 13 November, 2015 (http://ipolitics.ca/2015/11/13/doctors-cant-refuse-to-help-a-patient-die-no-matter-what-they-say/) Accessed 2015-12-28.

10. Murphy S. "Amir Attaran and the elves: A law professor makes much ado. Responding to "Doctors can't refuse to help a patient die - no matter what they say." *Protection of Conscience Project*. (http://consciencelaws.org/law/commentary/legal073-011.aspx)

11. Consultations, Friday, 4 October 2013 - Vol. 43 no. 43: *Commission on Human Rights and Youth Rights* (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#010. (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#010)

12. Consultations, Friday, 4 October 2013 - Vol. 43 no. 43: *Commission on Human Rights and Youth Rights* (Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier), T#114. (http://www.consciencelaws.org/background/procedures/assist009-031.aspx#114)

13. See, for example, Rodgers S. Downie J. "Abortion: Ensuring Access." *CMAJ* July 4, 2006 vol. 175 no. 1 doi: 10.1503/cmaj.060548 (http://www.cmaj.ca/content/175/1/9.full) Accessed 2015-06-17; Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making (November, 2011) p. 69, 101 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23

14. College of Physicians and Surgeons of Ontario, *Professional Obligations and Human Rights* (March, 2015) (http://www.cpso.on.ca/Policies-Publications/Policy/Professional-Obligations-and-Human-Rights) Accessed 2015-12-28

15. Ontario Superior Court of Justice, Between the Christian Medical and Dental Society of Canada, the Canadian Federation of Catholic Physicians' Societies, Dr. Michelle Korvemaker, Dr. Betty-Ann Story, Dr. Isabel Nunes, Dr. Agnes Tanguay and Dr. Donaldo Gugliotta and College of Physicians and Surgeons of Ontario, *Notice of Application*, 20 March, 2015 (http://consciencelaws.org/archive/documents/cpso/2015-03-20-cmds-notice.pdf)

16. College of Physicians and Surgeons of Ontario, *CPSO Guidance on Physician Assisted Death* (Draft) Lines 156-189 (http://policyconsult.cpso.on.ca/wp-content/uploads/2015/11/CPSO-Interim-Guidance-on-Physician-Assisted-Death.pdf) Accessed 2015-12-29

17. College of Physicians and Surgeons of Ontario*, Interim Guidance on Physician Assisted Death (Draft)* Note 3, p,. 5 (http://policyconsult.cpso.on.ca/wp-content/uploads/2015/11/CPSO-Interim-Guidance-on-Physician-Assisted-Death.pdf) Accessed 2015-12-29.

18. *Report*, p. 24

19. BC Transplant, *Critical Care Resources*. (http://www.transplant.bc.ca/health-professionals/critical-care-resources) Accessed 2016-01-12.

20. BC Transplant, *Clinical Guidelines for Kidney Transplantation* (Revised January 29, 2015) p. 4 (http://www.transplant.bc.ca/sites/default/files/documents/files/Clinical Guidelines for Kidney Transplantation.pdf) Accessed 2016-01-12.

21. *News Letter*, "Doctors who refuse euthanasia 'wicked,' expert claims." 6 January, 2009. (http://www.newsletter.co.uk/news/northern-ireland-news/doctors-who-refuse-euthanasia-wicked-expert-claims-1-1880045) Accessed 2015-12-29

Appendix "D"
Canadian Medical Association on euthanasia and assisted suicide

D1. CMA policy: *Euthanasia and Assisted Death* (2014)

D1.1 The policy of the Canadian Medical Association (CMA) on euthanasia and physician assisted suicide does not exclude minors, the incompetent or the mentally ill, and the policy is not meant to apply only to the terminally ill or those with uncontrollable pain. It refers directly only to "patients" and "the suffering of persons with incurable diseases." The policy, which predates the *Carter* ruling, classifies euthanasia and assisted suicide as "end of life care." Under this rubric, the CMA supports patient access to euthanasia and assisted suicide for any patient group for any reason and under any circumstances approved by the courts or legislatures.[1]

D1.2 By formally approving physician assisted suicide and euthanasia under circumstances defined by law, the Association has taken the position that, in those circumstances, physicians have a professional obligation to kill patients or to help them kill themselves.[2] By describing this as "end of life care," the CMA has made homicide and suicide normative for the medical profession. It is the *refusal* to kill patients or assist in suicide in the circumstances set out in *Carter* that must be justified or excused as an exception to professional obligations.

D1.3 Thus, the CMA is prepared to support the exercise of freedom of conscience and religion by objecting physicians only to the extent that this does not compromise patient access to euthanasia and assisted suicide. However, it sets no limits on what non-objecting physicians might agree to do beyond what might be set by law. Notwithstanding claims that the Association supports both physicians willing to provide euthanasia and assisted suicide and those who do not, the weight and influence of the entire Association has been set against physicians who believe that it is wrong to kill patients or help them to kill themselves, or, at least, that physicians should not do so.

D1.4 The formal support of the CMA for a euthanasia/assisted suicide regime even broader than that proposed in *Carter* appears to be in tension with the opinions of many CMA members, not just objecting physicians. Unlike the Experts, Canadian physicians are anything but unanimous in their opinions about euthanasia and physician assisted suicide, and support for the *Carter* decision among them is hardly unqualified. This has been obscured by a habit of presenting the most optimistic view of physician support for the procedures.

D1.5 Both the habitually optimistic approach and the volatile nature of the opinions of physicians were evident in the analysis of CMA surveys offered to delegates at the Annual General Council (AGC) in August, 2015.

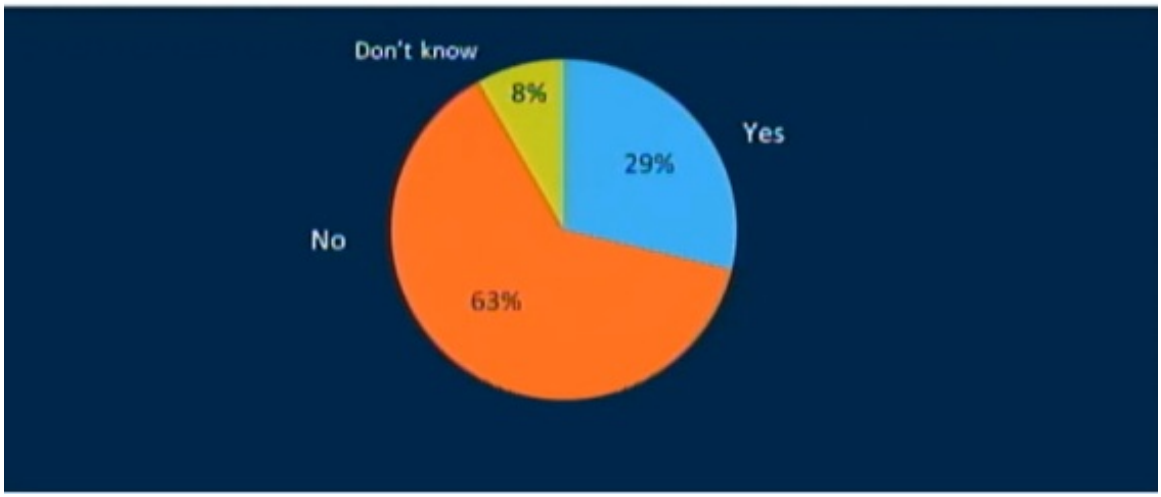
D2. CMA Annual General Council, 2015

D2.1 Surveys on support for euthanasia/assisted suicide

D2.1.1 A report prepared by CMA officials stated that "recent polls show that CMA members are evenly divided on the issue of legalizing assisted dying, and a significant minority of respondents to these polls said they will participate in offering this service to their patients."[3] The report referred to an on-line dialogue in which 595 CMA members (less than 1% of the CMA's 80,000 members) "registered to participate."[4] It did not acknowledge that only about 150 physicians contributed comments to the dialogue.

D2.1.2 The details were provided in a presentation by Dr. Blackmer at the AGC. Most of his presentation drew from two on-line surveys of about 1.75% and .465% of the CMA membership.

D2.1.3 Using slides, he produced what he called "the key on-line survey results" of a poll taken *after* the *Carter* ruling. The 2015 survey to which he referred appears to be the on-line survey consultation survey completed by 1,407 physicians.[5] The question asked was, "Following the Supreme Court of Canada decision regarding medical aid in dying, would you consider providing medical aid in dying if it was requested by a patient?"[6]



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D2.1.4 The survey question did not distinguish between assisted suicide or euthanasia, so we do not know if the respondents believed that they were answering a question about euthanasia, assisted suicide or both.

D2.1.5 From the very first, reports about the *Carter* decision in the major media constantly and almost uniformly described the decision as legalizing physician assisted *suicide*, with no

reference to euthanasia. Dr. Blackmer himself, two weeks after the ruling, claimed that he was uncertain whether the Court legalized only physician assisted suicide, or euthanasia as well.[7]

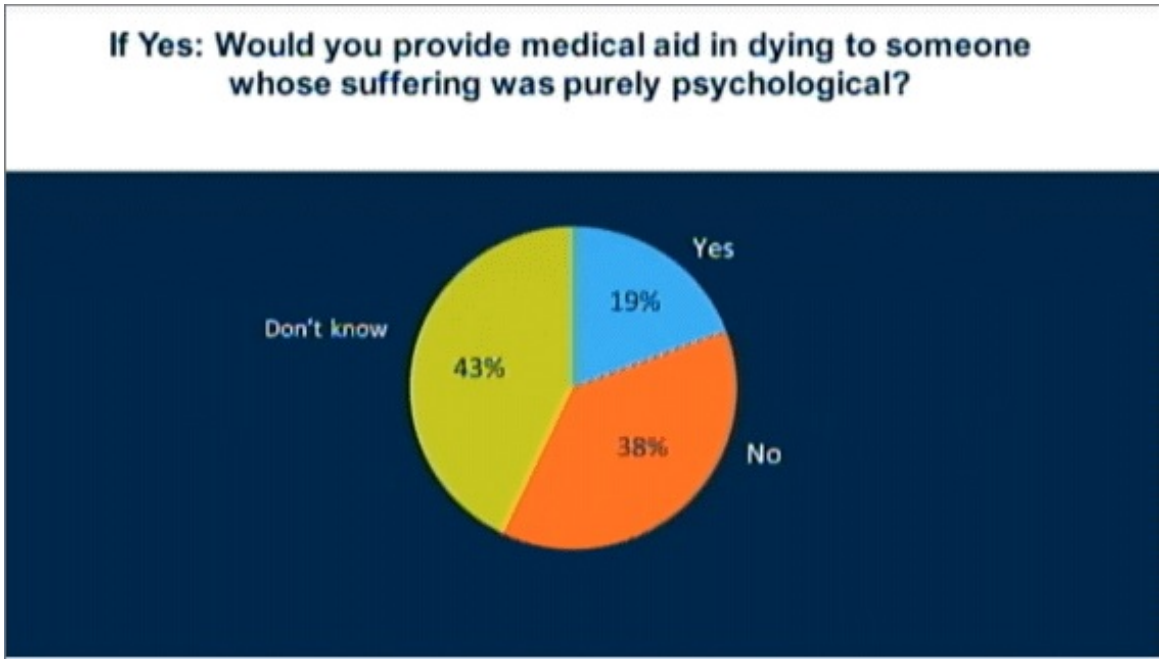
D2.1.6 Since significantly fewer physicians are willing to provide euthanasia than assisted suicide,[8] the failure to distinguish between them introduces some uncertainty into the interpretation of the results.

D2.1.7 Note that the survey asked only if physicians would "consider" providing the procedures, not if they would actually do so.

D2.1.8 29% of those surveyed stated that they would "consider" it. "That might seem to be a very small percentage," Dr. Blackmer said, "but when you think of it in terms of absolute numbers, we're talking tens of thousands of Canadian physicians that are now saying, 'I will participate.'"[9]

D2.1.9 Here we see the habitual optimism noted above (D1.4). In fact, the respondents stated that they would "consider" participating, not that they *would* participate. Further, while "tens of thousands" was arithmetically accurate (29% of 80,000 = 23,200 physicians = 2 x 10,000), the rhetorical slant was toward an optimistic evaluation of the returns.

D2.1.10 Continuing to 'unpack' the survey results, Dr. Blackmer told delegates that, of the physicians willing to consider providing either euthanasia or assisted suicide, "only 20% said yes" with respect to "someone whose suffering was purely psychological." The



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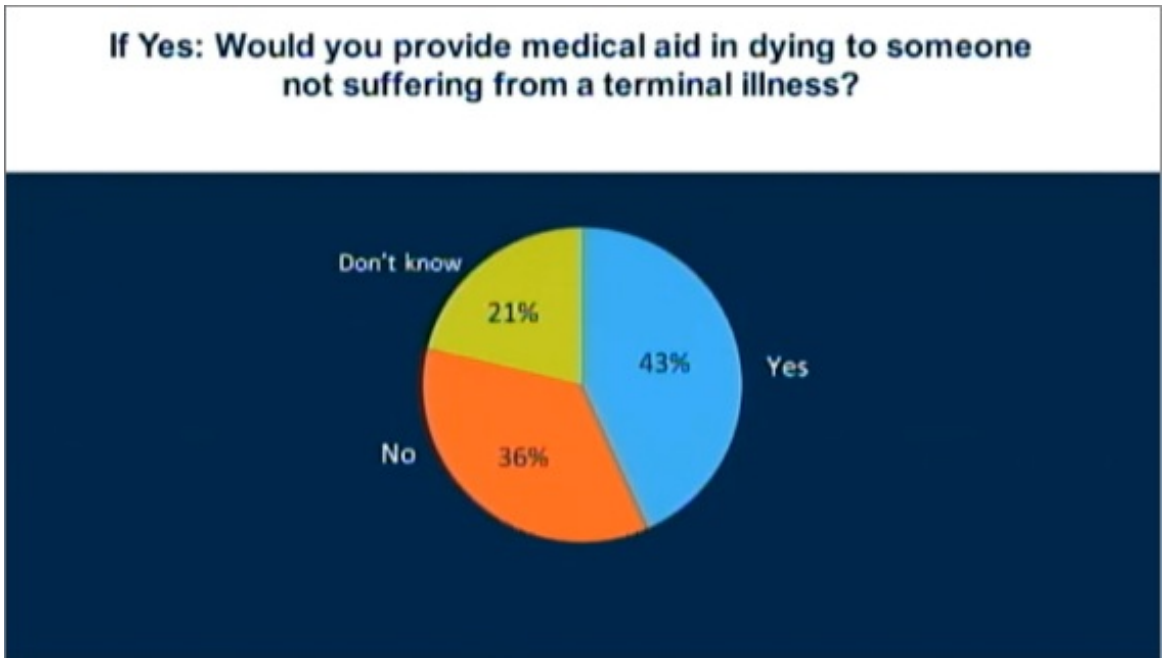
actual number noted in the chart on the slide was 19%, not 20%. He acknowledged that the response from this statistical subset represented about 6% of the total number of

respondents.[10]

D2.1.11 "And when we asked, 'Would you provide medical aid in dying to someone who is not suffering from a terminal illness,' he said, '43% said yes.'"[11]



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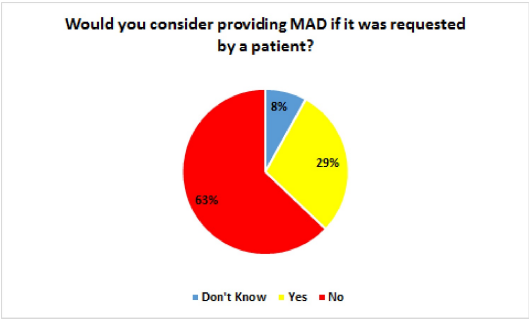
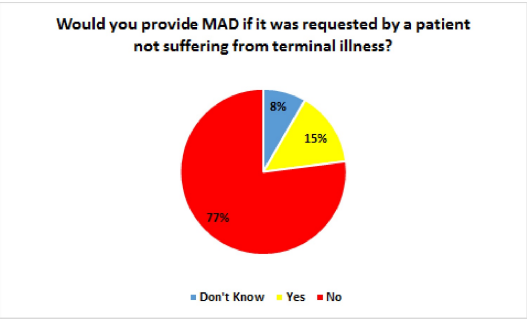
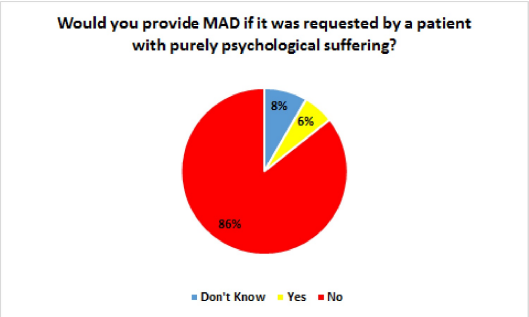
D2.1.12 Dr. Blackmer did not draw attention to the fact that this appears to represent only about 14% of the total number of respondents. His slides illustrated the responses proportionate to the subset, not to the total number of respondents, so the graphic images reflected proportionately greater support for euthanasia and assisted suicide among respondents (19% vs. 6%; 43% vs. 14%).

D2.1.13 The charts below draw on the same data used by Dr. Blackmer in the preceding charts, but graphically represent the increasingly adverse responses to the conditions specified by the survey questions.







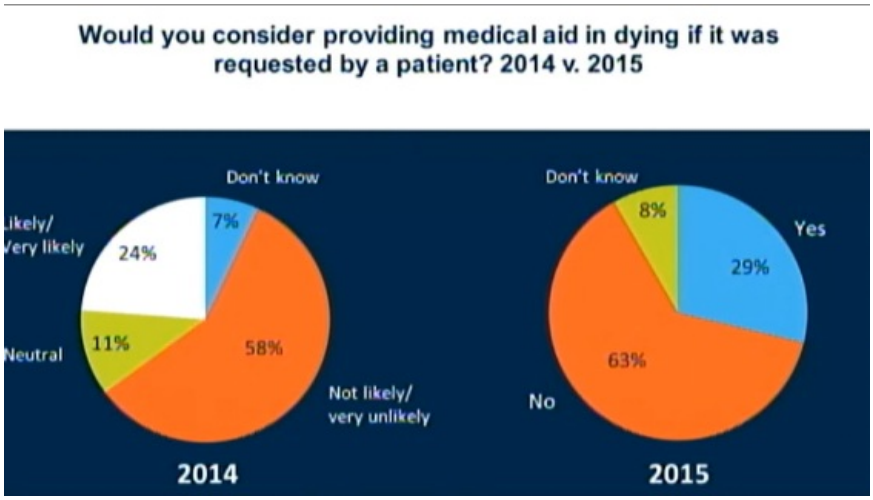
D2.1.14 An alternative and arguably more useful rendering of the 2015 survey results is possible.[12]

- The number of physicians willing to provide euthanasia or assisted suicide appears to range from 6% to 29%, depending upon the condition of the patient, and excluding consideration of safeguards.

- The number of physicians unwilling to provide euthanasia or assisted suicide ranges from 63% to 78%, again depending upon the condition of the patient, and excluding consideration of safeguards.

- Of physicians willing to consider providing euthanasia or assisted suicide, the number willing to provide the procedures for non-terminal illness drops by almost 50% , and drops by almost 80% in the case of purely psychological suffering (i.e., in the absence of pain), excluding consideration of safeguards.

D2.1.15 Dr. Blackmer presented a much more optimistic view. He showed delegates a slide with pie charts side by side for the purpose of comparing surveys done in 2014, before the *Carter* ruling, and in 2015, after it. Delegates had 24 seconds to take in the following charts and his commentary before he moved to the next slide.



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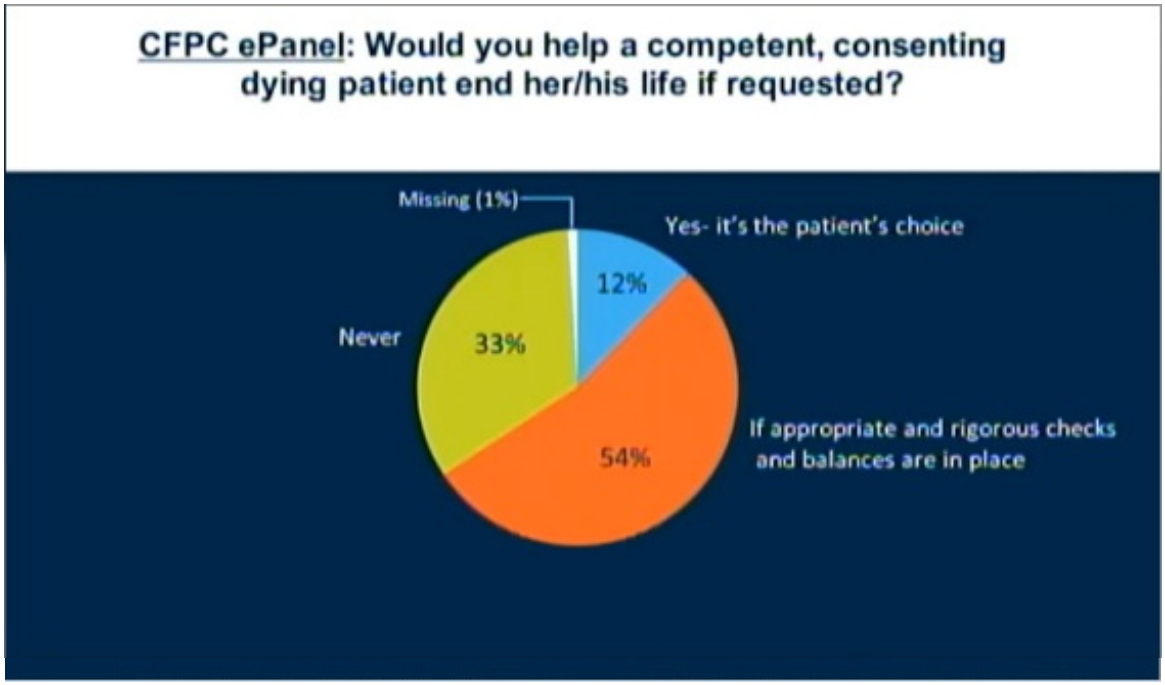
Blackmer: So this is *before* the court decision and *after* the court decision. And you can see that the number of participants who said that they were very likely or likely to participate in assisted dying has actually gone up, from 24% to 29% since the Supreme Court decision.[13]

D2.1.16 He did not point out that the number of physicians *unwilling* to consider providing the service *also* went up by 5% after the *Carter* ruling, from 58% to 63%.

D2.1.17 Again, the survey question asked physicians if they would *consider* providing the services, but Dr. Blackmer presented the responses as indicative of the number of physicians actually *willing* to do so.

D2.1.18 Apparently to reinforce the message he wanted to get across, Dr. Blackmer introduced slides to present data from a survey of family physicians concerning the *Carter* decision.[14] He cautioned delegates that "the numbers are a little smaller."[15] A "little smaller" seems to minimize the difference: 372 members compared to 1,407.



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D2.1.19 In any case, Dr. Blackmer told delegates that "59% of members actually said, 'Yes, I agree with that,' so over half of physicians agreed with the Supreme Court decision."[16]

> **Blackmer:** And when they asked, "Would you help a competent, consenting patient end his or her life," a total of 66% actually said "yes," although most of those - 54% - said, "Yes, but only if appropriate and rigorous checks and balances are in place.[17]

D2.1.20 Assuming both slides drew from 372 responses, more physicians agreed with the *Carter* decision than were willing to provide assisted suicide and euthanasia. 27% disagreed

with the decision, but 33% said they would "never" help patients end their lives.

D2.1.21 On the other hand, the willingness of others to provide euthanasia or assisted suicide was conditional. As Dr. Blackmer noted, 66% were willing to do so, but the number dropped to 12% in the absence of "appropriate rigorous checks and balances."

D2.1.22 Most important, Dr. Blackmer left out one critical word. The actual question (as stated on the slide) was, "Would you help a competent, consenting DYING patient end his or her life." (Emphasis added)

D2.1.23 The CMA's larger survey demonstrated that support for euthanasia and assisted suicide *among physicians willing to provide it* can drop by almost 50% if the patient is *not* terminally ill (D2.12-D2.13). The slide was displayed for only about 15 seconds, so it is doubtful that many delegates had a chance to reflect on the fact that the survey asked only about *dying* patients.

D2.1.24 An alternative and more cautious account of the College of Family Physicians survey results is possible.

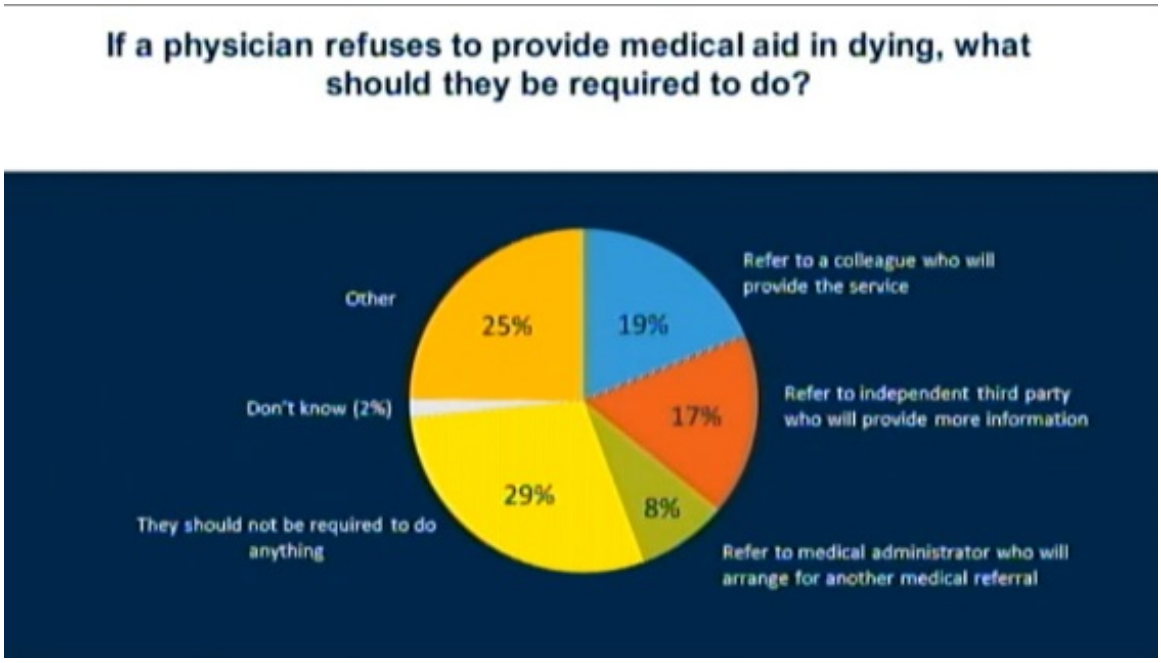
- Since the Carter decision legalized euthanasia and assisted suicide for patients who are neither dying nor terminally ill, the value of the survey in the post-*Carter* medico-legal landscape is doubtful.
- In the absence of "appropriate rigorous checks and balances," the number of family physicians willing to provide euthanasia or assisted suicide drops by over 80% to only 12% of the total number of respondents.

D2.1.25 Taking time to look at the numbers just as they were presented, they did not support the claim that physicians were "evenly divided" in their opinions about euthanasia and assisted suicide. The returns indicated that the great majority of physicians were opposed to both. Moreover, support for the procedures among favourably disposed physicians was highly volatile, depending heavily upon the diagnosis, the condition of the patient and the rigour of the regulatory regime.

D2.1.26 This was reflected in the *Globe and Mail* headline: "Less than a third of doctors willing to aid in assisted dying."[18] The *National Post* response was similar: "Majority of doctors opposed to participating in assisted death of patients."[19] The *Canadian Medical Association Journal* acknowledged that "Many doctors won't provide assisted dying."[20]

D2.2 Physician freedom of conscience

D2.2.1 Dr. Blackmer introduced what he described as "the very complex and difficult issue of conscientious objection" with the results of the on-line survey.[21] With respect to the question of what a physician who refuses to provide euthanasia or assisted suicide should be required do, "the most popular response" (29%) was, "They should not be required to do anything."



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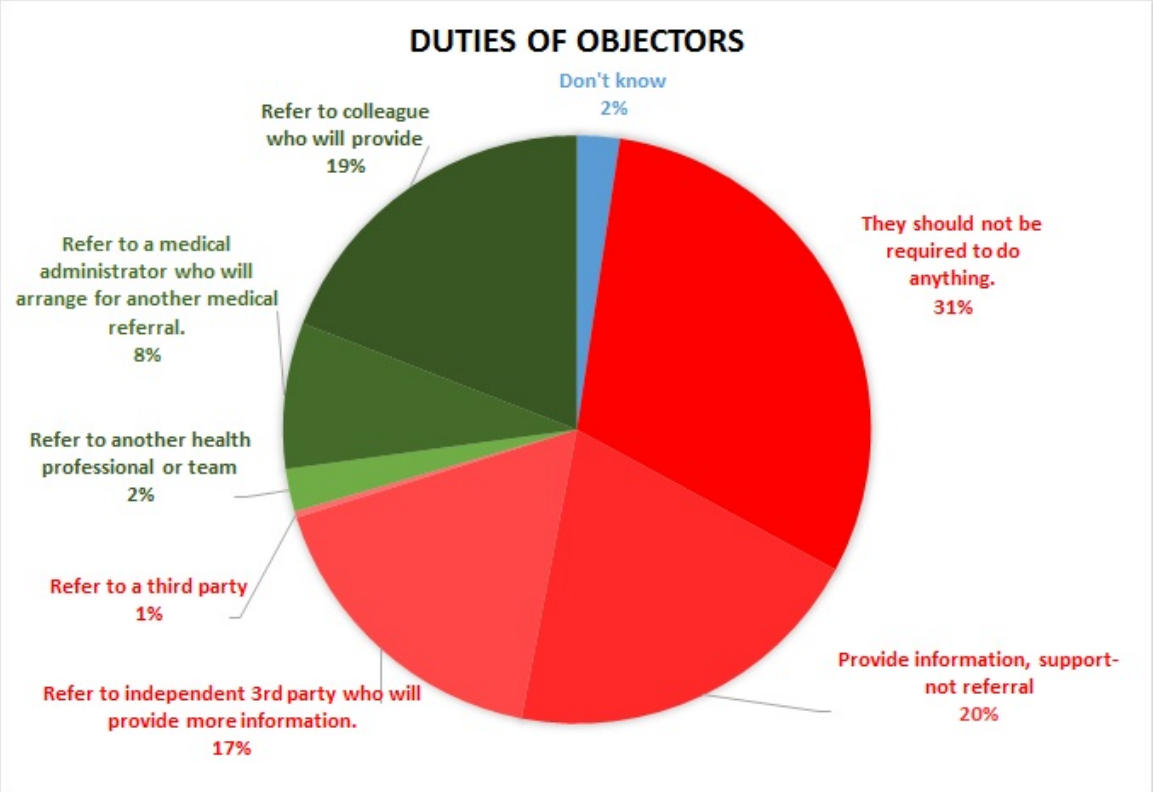
D2.2.2 25% of the responses were categorized as "other"; this was unexplained at the General Council.[22] The CMA kindly provided the Project with the summary of the returns under the category "Other," broken down as follows:

Q4_Other (Please specify). 341 relevant comments, grouped by theme:	
Provide information and support, but not referral	283 comments **83.0%**
Refer to another health professional or team of professionals	33 comments **9.7%**
Not required to do anything	20 comments **5.9%** • 2 comments from respondents who **WOULD** consider providing medical aid in dying if it was requested by a patient • 18 comments from respondents who would **NOT** consider providing medical aid in dying if it was requested by a patient
Refer to a third party	5 comments **1.5%**

D2.2.3 When joined to the information that was disclosed at the Annual General Council

(approximated in the Project chart below), it appears that the great majority of respondents (about 68%) clearly believed that objecting physicians should not be required to refer patients for anything other than information.



Protection of Conscience Project Chart

D2.2.4 "Effective referral" was favoured by 19% of respondents, 10% less than the number of physicians who identified themselves as willing to consider providing euthanasia or assisted suicide (D2.1.3).

D2.2.5 Returning to the subject later in his presentation, Dr. Blackmer noted that "the vast majority expressed the view that physician conscience rights must be integrally protected." He reminded delegates of the resolution passed at the 2013 Annual General Council "saying that no physician should be forced to participate in an assisted dying against their moral conscience," adding that "the Supreme Court noted that in their ruling." However, he cautioned that "there was disagreement about was this means."[23] Finally, he stated that there was "broad agreement" that physician freedom of conscience "must be protected in a way that balances patients' ability to access assisted dying."[24]

D2.2.6 Here he referred to four options for physicians who refuse to provide euthanasia or assisted suicide, somewhat different from those presented in the on-line consultation:[25]

1. Duty to refer directly to a non-objecting physician

2. Duty to refer to an independent third party.

3. Duty to provide complete information on all options and advise on how to access directly a separate central information, counselling and referral service.

4. Patient self-referral to a separate central information, counselling and referral service.

D2.2.7 In listing the "pros" and "cons" of each, he acknowledged that the third "may be the most widely morally acceptable option," but warned that it presupposed the existence of a separate counselling service - "a fairly large presupposition at this point in time."[26]

D2.2.8 The third option was a summary of what had been proposed to the CMA by the Christian Medical Dental Society, the Federation of Catholic Physicians Societies and Canadian Physicians for Life. The groups urged delegates to accept it for the following reasons:

> Options '1' and '2' require the objecting physician to refer. Many physicians will have moral convictions that assisted death is never in the best interests of the patient, while others may object to assisted death because of the particular circumstances of the patient. A referral is essentially a recommendation for the procedure, and facilitates its delivery. A requirement to refer means that physicians will be forced to act against their consciences.
>
> Option '4' allows the patient to directly access assisted death, but does not necessarily provide an opportunity for counselling by a physician who has a longer term relationship with the patient.
>
> Option '3' allows the discussion of all options to occur with the patient and the physician who knows them. If, after considering all of the options, the patient still wants assisted death, the patient may access that directly. This option ensures that all reasonable alternatives are considered. It respects the autonomy of the patient to access all legal services while at the same time protecting physicians' conscience rights.[27]

D2.2.9 After a lengthy discussion, the third option was approved in a straw poll, supported by about 75% of the delegates, who agreed that "physicians should provide information to patients on all end-of-life options available to them but should not be obliged to refer."

D2.2.10 This account of the outcome is consistent with the fact that only the first two options included a "duty to refer," while the third did not. A further point, which would not have been apparent to the delegates at the time, was that the outcome reflected the (undisclosed) fact that 69% of survey respondents had indicated that they were opposed to a requirement to refer to someone who would provide euthanasia or assisted suicide (D2.2.3).

D2.2.11 The day after the delegates approved the third option (a duty to provide information), Dr. Ken Burns and Dr. Shawn Whatley proposed another resolution specific to referral:

> The Canadian Medical Association policy on physician-assisted death will reflect

> that physicians with consciencious [sic] objections should not be obligated to refer for medical aid in dying. [Motion DM 5-60][28]

D2.2.12 The rationale offered in support of the motion repeated the kind of arguments made the day before:

> CMA has indicated (survey and draft document) that referral is an acceptable method to deal with a physician's conscience conflict. This not true for many physicians. A forced referral (even through another party) for a procedure they believe is wrong is not protecting conscience. CMA has opposed the College of Physicians and Surgeons of Ontario's new policy but appears to be backing down in its position. General Council needs to decide if it is going to protect even a minority of members' legal rights.
>
> A very large number of CMA membership see any form of forced referral against their conscience.They expect their organization to support their fundamental rights.[29]

D2.2.13 However, after significant opposition from a number of delegates, the motion was defeated, 79% of them voting against it.[30]

D2.2.14 The most likely explanation for this is a terminological problem that plagues discussion about "referral." It has a technical meaning: a letter written by a physician to another physician requesting treatment examination. It also has a popular meaning: some kind of informal direction to a patient about where to obtain or how to find a service or treatment. It is likely that many of the delegates who had, the day before, approved the third option, considered it to be a form of referral in the second sense. In that case, they likely rejected the resolution because it appeared to them to contradict what they had approved the previous day.

D2.2.15 Unfortunately, the rejection of the second motion created the impression in some quarters that the CMA was opposed to physician freedom of conscience. For example, Alex Schadenburg of the Euthanasia Prevention Coalition reported that the CMA "voted to reject a motion to protect the conscience rights of physicians who refuse to refer patients to die by euthanasia."[31] The *Western Catholic Reporter* published a story quoting Mr. Schadenburg under the headline, "Doctors to lose conscience rights under CMA decision."[32]

D2.2.16 At their October, 2015 meeting, the CMA Board of Directors approved *Principles-based Recommendations for a Canadian Approach to Assisted Dying* as amended in consequence of the discussion at the Annual General Council.[33] The section on conscientious objection stated:

> Physicians are not obligated to fulfill requests for assisted dying. There should be no discrimination against a physician who chooses not to participate in assisted dying. In order to reconcile physicians' conscientious objection with a patient's request for access to assisted dying, 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.[34]

D2.2.17 This was included the the CMA presentation on 20 October, 2015 to the panel appointed by the federal government to report on the implementation of the *Carter* ruling. The CMA offered the following comments:

> As the Federal External Panel is aware, the *Carter* decision emphasizes that any regulatory or legislative response must seek to reconcile the Charter rights of patients (wanting to access assisted dying) and physicians (who choose not to participate in assisted dying on grounds of conscientious objection). The notion of conscientious objection is not monolithic. While some conceptions of conscience encompass referral, others view referral as being connected to, or as akin to participating in, a morally objectionable act.
>
> It is the CMA's position that an effective reconciliation is one that respects, and takes account of, differences in conscience, while facilitating access on the principle of equity. To this end, the CMA's membership strongly endorses the recommendation on conscientious objection as set out in section 5.2 of the CMA's enclosed *Principles-based Recommendations for a Canadian Approach to Assisted Dying*.[35]

D2.2.18 The section in the document concerning conscientious objection was later modified by the Board of Directors. The revision did not change the original section (underlined in the text below), but added further details.

> Physicians are not obligated to fulfill requests for assisted dying. This means that physicians who choose not to provide or participate in assisted dying are not required to provide it or participate in it or to refer the patient to a physician or a medical administrator who will provide assisted dying to the patient. There should be no discrimination against a physician who chooses not to provide or participate in assisted dying.
>
> Physicians are obligated to respond to a patient's request for assistance in dying. There are two equally legitimate considerations: the protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience and the assurance of effective patient access to a medical service. <u>In order to reconcile physicians' conscientious objection with a patient's request for access to assisted dying, physicians are expected to provide the patient with complete information on all options available, including assisted dying, and advise the patient on how they can access any separate central information, counseling, and referral service.</u>
>
> Physicians are expected to make available relevant medical records (i.e., diagnosis, pathology, treatment and consults) to the attending physician when authorized by the patient to do so; or, if the patient requests a transfer of care to

> another physician, physicians are expected to transfer the patient's chart to the new physician when authorized by the patient to do so.
>
> Physicians are expected to act in good faith, not discriminate against a patient requesting assistance in dying, and not impede or block access to a request for assistance in dying.[36]

D3. CMA rejects "effective referral"

D3.1 The Canadian Medical Association has continually grappled with the issue of referral for morally contested procedures since at least 1970, when the CMA Board of Directors decided that it would be ethical for a physician to refer a patient to another physician for consideration of an abortion, but not to an "abortion counselling agency."[37] The difficult compromise eventually arrived at required objecting physicians to disclose personal moral convictions that might prevent them from recommending a procedure to patients, but did not require the physician to refer the patient or otherwise facilitate the morally contested procedure.[38]

D3.2 It appears that the compromise was primarily a pragmatic response to controversy. At any rate, the CMA did not offer a principled ethical or philosophical rationale to support it, beyond general references to the need to "strike a balance" between patient and physician autonomy or rights. In 2014/2015, when the College of Physicians and Surgeons of Ontario (CPSO) developed a policy requiring objecting physicians to make an "effective referral," the CMA was notably absent from the public controversy surrounding it.

> An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral.[39]

D3.3 However, a crisis of sorts seems to have been generated by the Carter ruling, as physicians awakened to its implications for freedom of conscience and religion and even for the legitimate diversity of clinical judgement. Within this context, the perennially controversial issue of referral became more urgent, with literally life or death consequences attached to it. Perhaps as a result, the CMA has now issued a statement that articulates the basis for its rejection of "effective referral," this time in response to CPSO plans to impose "effective referral" for euthanasia and assisted suicide.[40]

Notes

1. Canadian Medical Association Policy: *Euthanasia and Assisted Death* (Update 2014) (https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA_Policy_Euthanasia_Assisted%20Death_PD15-02-e.pdf) Accessed 2015-06-26

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

3. Canadian Medical Association, *A Canadian Approach to Assisted Dying: A CMA Member Dialogue Summary Report.* (August, 2015) (Hereinafter, "Summary Report"), p. 2 (https://www.cma.ca/Assets/assets-library/document/en/advocacy/Canadian-Approach-Assisted-Dying-e.pdf) Accessed 2015-10-23.

4. *Summary Report*, p. 2.

5. *Ed2-webcast* - 13:40-13:45

6. *Ed2-webcast* - 15:00-15:22

7. 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 (http://news.nationalpost.com/news/canada/how-far-should-a-doctor-go-mds-say-they-need-clarity-on-supreme-courts-assisted-suicide-ruling) 2015-07-04

8. In a 2014 poll of 5,000 CMA members, 27% of physicians surveyed said they were willing to participate in assisted suicide, while 20% were willing to participate in euthanasia. 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. Moore E. "Doctor is hoping feds will guide on assisted suicide legislation." *Edson Leader*, 12 February, 2015. (http://www.edsonleader.com/2015/02/12/doctor-is-hoping-feds-will-guide-on-assisted-suicide-legislation) Accessed 2015-07-16.

9. *Ed2-webcast* - 15:00-15:22

10. *Ed2-webast* - 15:23 - 15:39

11. *Ed2-webast* - 15:42 - 15:51

12. Assuming, (a) that those who would provide euthanasia or assisted suicide for terminal illness make up the 10% difference between 19% and 29% of the subset of willing physicians, and (b) that those willing to provide euthanasia and assisted suicide for psychological suffering would also be willing to provide the services for the non-terminally ill and the terminally ill, though the reverse would not necessarily hold.

13. *Ed2-webcast* - 16:50-17:13

14. http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/ePanel_psa_results_EN.pdf

15. *Ed2-webcast* - 17:20-17:25

16. *Ed2-webcast* - 17:14-17:38

17. *Ed2-webcast* - 17:38-17:55

18. Picard A. "Less than a third of doctors willing to aid in assisted dying: CMA poll." Globe and Mail, 25 August, 2015 (http://www.theglobeandmail.com/news/national/less-than-a-third-of-doctors-willing-toparticipate-in-assisted-dying-poll/article26100505/) Accessed 2015-10-22

19. Kirkey S. "Majority of doctors opposed to participating in assisted death of patients: CMA survey." *National Post*, 25 August, 2015. (http://news.nationalpost.com/news/canada/0826-na-assisted-death) Accessed 2015-10-22

20. Vogel L. "Many doctors won't provide assisted dying." CMAJ, 31 August, 2015 (http://www.cmaj.ca/content/early/2015/08/31/cmaj.109-5136.full.pdf) Accessed 2015-10-22

21. *Ed2-webcast* - 20:09.

22. *Ed2-webcast* - 15:53-16:22.

23. Ed2-webcast - 20:09-20:41

24. *Ed2-webcast* - 20:41-20:50

25. *Ed2-webcast* - 16:22-16:31

26. *Ed2-webcast* - 22:29-22:50

27. Christian Medical and Dental Society, *Doctors' Group urges Canadian Medical Association to defend conscience rights on assisted death*. News release, 24 August, 2015 (http://www.newswire.ca/news-releases/doctors-group-urges-canadian-medical-association-to-defend-conscience-rights-on-assisted-death-522719121.html) Accessed 2015-10-23

28. 148th General Council Delegates' Motions - End-of-life Care (https://www.cma.ca/Assets/assets-library/document/en/about-us/gc2015/delegate-motion-eol_en.pdf) Accessed 2015-10-23

29. 148th General Council Delegates' Motions - End-of-life Care (https://www.cma.ca/Assets/assets-library/document/en/about-us/gc2015/delegate-motion-eol_en.pdf) Accessed 2015-10-23

30. Rutka J. "Conscientious objections, referral for assisted dying prove controversial topics at CMA meeting ." Canadian Health Care Network, 26 August, 2015

31. Schadenburg A., "Canadian Medical Association delegates rejects conscience rights for physicians with regard to euthanasia." (http://alexschadenberg.blogspot.ca/2015/08/canadian-medical-association-rejected.html) Accessed 2015-10-23

32. Gyapong D. "Doctors to lose conscience rights under CMA decision." *Western Catholic Reporter*, 14 September, 2015 (http://www.wcr.ab.ca/ThisWeek/Stories/tabid/61/entryid/6861/Default.aspx) Accessed 2015-10-23

33. CMA Board of Directors October 2015 Meeting Highlights (https://www.cma.ca/Assets/assets-library/document/en/about-us/2015-oct-cma-board-of-directors-highlights-e.pdf) Accessed 2015-10-23

34. *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (https://www.cma.ca/Assets/assets-library/document/en/advocacy/submissions/cma-submission-to-federal-external-panel-e.pdf) Accessed 2015-10-23

35. CMA Submission to the Federal External Panel on Options for a Legislative Response to *Carter vs. Canada* (Federal External Panel) 19 October, 2015 (https://www.cma.ca/Assets/assets-library/document/en/advocacy/submissions/cma-submission-to-federal-external-panel-e.pdf) Accessed 2015-10-24

36. Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2016) (https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf) Accessed 2016-01-09.

37. Board of Directors Meeting: "Therapeutic Abortion Study Major Association Project: Finance Committee Reports Mild Optimism for Year." *CMAJ* Volume 103(11) 1218, November 21, 1970. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1930622/pdf/canmedaj01607-0085.pdf) Accessed 2015-06-17

38. Murphy S. "NO MORE CHRISTIAN DOCTORS, Appendix 'F' - The Difficult Compromise. Canadian Medical Association, Abortion and Freedom of Conscience." *Protection of Conscience Project* (http://www.consciencelaws.org/background/procedures/birth002-F.aspx)

39. College of Physicians and Surgeons of Ontario, *Professional Obligations and Human Rights* (March, 2015) (http://www.cpso.on.ca/Policies-Publications/Policy/Professional-Obligations-and-Human-Rights) Accessed 2015-12-28.

40. Canadian Medical Association, "Submission to the College of Physicians and Surgeons of Ontario: Consultation on CPSO Interim Guidance on Physician-Assisted Death"(13 January, 2016) (http://www.consciencelaws.org/background/policy/associations-013.aspx)

Appendix "E"
International comparisons

E1. Netherlands

E1.1 Consensual homicide and assisted suicide continue to be prohibited by the *Penal Code* in the Netherlands. The Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* does not actually authorize either physician-assisted suicide or euthanasia, but provides a defence to criminal charges for physicians who adhere to its requirements.[1] In this respect, it is analogous to the provisions of the Canadian *Criminal Code* on therapeutic abortion from 1969 to 1988, and to the exemptions offered in the *Carter* decision.

E1.2 One of the requirements of the Dutch law is that the physician must believe that the patient's request is "well-considered." Another is that the physician must believe that the patient's suffering is "lasting and unbearable." A physician who did not actually believe one or both of these things and who killed a patient or helped a patient commit suicide or aided or abetted either act would have no defence to a charge of murder or assisted suicide.

E1.3 Physicians who object to euthanasia and assisted suicide for reasons of conscience usually do not believe that a request for either can be "well-considered." Moreover, they may not believe that a patient's suffering is "lasting and unbearable," particularly if the suffering can be relieved. On both points, the available defence requires actual belief; doubt is insufficient to provide a defence to a criminal charge.

E1.4 Since the legal prohibition of homicide and assisted suicide is not displaced in such circumstances, there can be no obligation on the part of objecting physicians to provide or refer for euthanasia or physician-assisted suicide. They have no obligation to commit or cooperate in the commission of a criminal offence. The Royal Dutch Medical Association makes this clear:

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

E1.5 There is no duty to participate in or refer for euthanasia or assisted suicide in the Netherlands.

E2. Luxembourg

E2.1 A physician who refuses to perform euthanasia or assisted suicide must notify a patient of his refusal and the reasons for it.

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

E2.2 This is a patient-initiated transfer of medical records.

E3. Belgium

E3.1 A physician who refuses to perform euthanasia or assisted suicide must notify a patient of his refusal and the reasons for it, and, at the request of the patient, transfer the medical file to another physician.[4]

E3.2 The obligation to notify the patient and transfer records upon request are identical to those found in the law in Luxembourg. What is described here is a patient-initiated transfer of medical records.

E3.3 Moreover, consensual homicide continues to be prohibited in Belgium. Like the law in the Netherlands, the *Belgian Act on Euthanasia of May 28, 2002*, does not actually authorize euthanasia, but provides a defence to criminal charges for physicians who adhere to its requirements.[5] In this respect, it is analogous to the provisions of the Canadian *Criminal Code* on therapeutic abortion from 1969 to 1988 and to exemptions offered in the *Carter* decision.

E3.4 One of the requirements of the Belgian law is that the physician must ensure that the patient's request is "well-considered." Another is that the physician must ensure that the patient is in "a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated." A physician who did not actually ensure all of these things and who killed a patient or aided or abetted homicide would have no defence to a charge of murder.

E3.5 Physicians who object to euthanasia for reasons of conscience usually do not think that they can ensure that a request for it is "well-considered." Moreover, they are unlikely to think that a patient's condition can be described as "medically futile," and may well believe that suffering can be alleviated. On both points, the available defence requires a firm conclusion; doubt is insufficient to provide a defence to a criminal charge.

E3.6 Since the is a legal prohibition of homicide is not displaced in such circumstances, there can be no obligation on the part of objecting physicians to provide or refer for euthanasia. They have no obligation to commit or cooperate in the commission of a criminal offence.

E4. Oregon

E4.1 A physician who is unable or unwilling to provide assisted suicide must, at the request of the patient, transfer the medical file to another physician. This is a patient-initiated transfer of medical records like that required in Luxembourg and Belgium.

E4.2 The Oregon *Death with Dignity Act* allows health care facilities to prohibit "participation" in assisted suicide on their premises. In that particular situation - when a physician wants to refer a patient for assisted suicide - the law provides that "participation" does not include referral. Thus, the health care facility may prohibit the provision of a lethal drug on its premises, but may not prohibit a referral by a willing physician to an external source.[6]

E4.3 The special definition of "participation" to exclude referral in this particular situation confirms that the term would normally be understood to include referral; a special definition would otherwise be unnecessary.

E5. Washington (state)

E5.1 A physician who is unable or unwilling to provide assisted suicide must, at the request of the patient, transfer the medical file to another physician. This is a patient-initiated transfer of medical records like that required in Luxembourg, Belgium and Oregon.

E5.2 The Washington *Death with Dignity Act* allows health care facilities to prohibit "participation" in assisted suicide on their premises. In that particular situation - when a physician wants to refer a patient for assisted suicide - "participation" does not include referral. Thus, the health care facility may prohibit the provision of a lethal drug on its premises, but may not prohibit a referral by a willing physician to an external source.[7] The provision is identical to that in Oregon's *Death with Dignity Act*.

E5.3 The special definition of "participation" to exclude referral in this particular situation confirms that the term would normally be understood to include referral; the special definition would otherwise be unnecessary.

E6. Vermont

E6.1 Vermont's *Patient Choice and Control at the End of Life Act* is not silent on the subject of referral. It imposes a duty of referral only on physicians who wish to provide assisted suicide [§ 5283.a(7)].[8] The statute does not impose a duty of referral on physicians who refuse to participate in assisted suicide.

E6.2 Instead, the statute states that "a physician, pharmacist, *nurses or other person* shall *not* be under *any* duty, *by law*, or contract, to *participate* in the provision of a lethal dose of medication to a patient." [§ 5285(a). Emphasis added] Note particularly that the statute nullifies any duty that might be said to exist at common law or through the operation of another statute.

E6.3 Since, in Vermont, only physicians can prescribe a lethal does of medication and only physicians or pharmacists can dispense it, the extension of protection to nurses or other persons indicates that the term "participate" is used in the statute in its normal sense, to encompass other acts that may contribute to the provision of lethal medication, such as referral.

E7. California

E7.1 California's assisted suicide law provides that health care providers may refuse to "participate" in any way in the provision of assisted suicide. They may refuse "to inform a patient regarding his or her rights" to assisted suicide, and they may refuse to refer to a physician who provides assisted suicide.[9]

If a health care provider is unable or unwilling to carry out a qualified individual's

request under this part and the qualified individual transfers care to a new health care provider, the individual may request a copy of his or her medical records pursuant to law.[10]

E7.2 Facilities may prohibit employees, contractors or others working within the scope of their employment on their premises from participating in assisted suicide,[11] as long as it first provides notice of its policies.[12] Having given notice, they may take action for policy violations.[13] However, they may not prohibit employers, contractors, etc. from participating in assisted suicide elsewhere.[14]

E7.3 Facilities may not prohibit employees, contractors or others on their premises from performing a diagnosis or assessment (even if it could be used for the purpose of facilitating assisted suicide), informing a patient of the diagnosis, prognosis, etc. advising a patient about the availability of assisted suicide elsewhere, or, upon the patient's request, providing a referral to another health care provider for assisted suicide.[15]15 The provision is analogous to laws in Oregon (E4.2) and Washington (E5.2).

E7.4 In the particular situation described in E7.3, when a physician wants to refer a patient for assisted suicide, "participation" does not include referral. The special definition of "participation" to exclude referral in this particular situation confirms that the term would normally be understood to include referral; the special definition would otherwise be unnecessary.

Notes

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

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

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

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

5. *BAE*, Section 3.

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

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

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

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

10. *California HSC* 443.14 (e)3

11. *California HSC* 443.15 (a)

12. *California HSC* 443.15 (b)

13. *California HSC* 443.15 (c)

14. *California HSC* 443.15 (d)

15. *California HSC* 443.15 (f)3

Appendix "F"

An Act to Safeguard Against Homicide and Suicide

Section 241.1 Criminal Code

Compulsion to participate in homicide or suicide

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

Punishing refusals to participate in homicide or suicide

241.1(2) Every one commits an offence who

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

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

Intimidation to participate in homicide or suicide

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

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

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

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

Definitions

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

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

Punishment

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

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

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